The Systemic Failure to Protect Children with Mental Health Issues: An Analysis of the Failings of the Family Law and Criminal Justice Systems

by

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Abstract

A significant majority of children who are engaged with the family law (child welfare) and youth criminal justice systems suffer with mental health issues. Only a fraction of them get treatment. Without adequate supports and services these children may become enmeshed in a “vicious cycle”, with significant short and long-term consequences for children and families, as well as society as a whole. In this Thesis, I explore the role of the law, in theory and in practice, in the failure to provide these children with needed mental health services. Specifically, I investigate how the definition of mental health issues in the family law (child welfare) and criminal justice systems, and the failure in both systems to recognize the impact of the intersection of various factors (e.g. socioeconomic status, race, gender) on individual children (and families), leads to a systemic failure to adequately protect children with mental health issues.
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Introduction

The Problem: The Failure to Meet the Needs of Children with Mental Health Issues who are Engaged with the Family Law and Criminal Justice Systems

Introduction

Huge numbers of children in Canada, and around the world, suffer with mental health issues. Treatment and prevention of childhood mental health issues has been identified locally and internationally as an urgent priority. Nevertheless, only a fraction of affected children are getting needed services and supports. Left untreated, childhood mental health issues can have serious short and long-term consequences for individual children and families, and society as a whole. The prevalence of mental health issues and the severity of the consequences that may arise where these issues are not adequately addressed, appears particularly pronounced for children who are engaged with the family law (child welfare) and criminal justice systems.

Children who are engaged with the family law (child welfare) and criminal justice systems face multiplicative challenges and complex problems, including a higher rate of mental health issues than their counterparts in the general population. A significant proportion of these children are not getting the supports and services they need, and the difficulties they face may get compounded and exacerbated by the additional challenges they experience while engaged with these systems (e.g. multiple moves, custodial sentences). Many of these children often ultimately experience negative outcomes, including ongoing mental health issues and repeated engagement with the criminal justice system into adulthood. The result is that the legal system, which is mandated to protect children from harm, may in fact be creating and perpetuating the interlocking oppression and inequality experienced by many of these children.

In this Thesis, I explore the failure of the law to protect children with mental health issues. Specifically, I investigate how the definition of mental health issues in the family law
(child welfare) and criminal justice systems, as well as the failure in both systems to recognize the impact of the intersection of various factors (e.g. socioeconomic status, race, gender) on individual children (and families), leads to a systemic failure to adequately protect children with mental health issues. This work will contribute to an understanding of how and why the law fails to protect children with mental health issues, and will highlight areas for further research into how these systemic failures can be addressed.

In order to situate this work, in this introductory Chapter I begin by providing an overview of the broader problem, the prevalence of mental health issues amongst children generally, the gap between mental health service needs and service use, and the resulting consequences. Next, I consider the prevalence of mental health issues amongst children who are engaged with the family law (child welfare) and criminal justice systems, the failure to meet the service needs of these children adequately, and the often negative consequences experienced as a result. I then discuss the need for treatment and prevention services generally, and particularly for children who are engaged with the family law (child welfare) and criminal justice systems. Thereafter, I provide an overview of the focus of this Thesis, the specific population of interest, and my methodology. Lastly, I set out a road map, briefly describing the arguments and areas of focus in the subsequent Chapters.
The Situation: A Significant Gap between Mental Health Needs and Service Use

Prevalence and (Lack of) Treatment in the General Population

Nearly a million children in Canada suffer with mental health issues. Only a small percentage of these children get needed services and treatment. A child’s mental health may be affected by the intersection of various individual and environmental factors. These factors may include genetics and biology, social disadvantage and marginalization (e.g. poverty, racism, sexism), parenting (e.g. coercive, (un)responsive), family dysfunction, (in)stability (e.g. multiple moves), and caregiver functional issues (e.g. mental health or addictions issues). Many mental disorders (mental states meeting relevant clinical criteria in the Diagnostic and Statistical Manual of Mental Disorder (“DSM”), e.g. anxiety, depression) have their first onset during

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4 Boyle & Georgiades, supra note 1 at 218; CMHO, supra note 3 at 1-2; Stern et al, supra note 1 at 550; The Honourable Justice Brian Scully & Dr Judy Finlay, “Cross-over Youth: Care to Custody” (2015) Report completed on behalf of the Cross-over Youth Committee, Toronto, Ontario at 2, 5; Malla et al, supra note 1 at 218; Stewart et al, supra note 3 at 132; see also Flood & Thomas, supra note 2 at 48; Chandler, “Mental Health and Disability”, supra note 3 at 5-7.

5 The DSM is a widely used and accepted diagnostic classification system, published by the American Psychiatric Association, which sets out the clinical criteria that define psychiatric conditions (see Thomas A Ban, “Academic Psychiatry and the Pharmaceutical Industry” (2006) 30 Prog Neuropsychopharmacol Biol Psychiatry 429 at 434; Hy Bloom & The Honourable Richard D Schneider, Mental Disorder and the Law: A Primer for Legal and Mental Health Professionals, 2nd ed (Toronto: Irwin Law, 2017) at 5-8; Boyle & Georgiades, supra note 1 at 205-07).
Childhood. Children as young as three or four years of age have been identified as having mental disorders, including anxiety and depression. Suicide is a leading cause of death among children as young as ten years of age and through adolescence, and research suggests that for every completed suicide there are many more young people who have seriously thought about or attempted suicide.

Left untreated, childhood mental health issues carry significant short and long-term consequences for individual children and families, and society as a whole. Without adequate treatment, childhood mental health issues may negatively impact educational attainment, physical health, well-being, life satisfaction, family functioning, employment, and socioeconomic status, and may increase the risks of ongoing mental health issues, drug or alcohol addictions, suicidality, and engagement with the criminal justice system. At a societal level these consequences may result in significant costs, including direct and indirect economic costs (e.g. lost productivity, policing, health services). The prevention and treatment of childhood mental health issues has been identified by governments and researchers as an “urgent public health priority”. Nevertheless, the failure to provide timely, or any, services to the

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7 Waddell et al, supra note 1 at 174; Climie, supra note 1 at 122.
8 Malla et al, supra note 1 at 218; Joanna L Henderson, Gloria Chaim & E B Brownlie, “Collaborating with Community-Based Services to Promote Evidence-Based Practice: Process Description of a National Initiative to Improve Services for Youth with Mental Health and Substance Use Problems” (2017) 14 Psychol Serv 361 at 361; CMHO, supra note 3 at 1; Flood & Thomas, supra note 2 at 45.
9 Climie, supra note 1 at 122; Schwean & Rodger, supra note 1 at 137, 138-39; Malla et al, supra note 1 at 217, 218; Waddell et al, supra note 1 at 174; Stern et al, supra note 1 at 550; Henderson, Chaim & Brownlie, supra note 8 at 362; see also Dey et al, supra note 6 at 410-11, 413.
10 Schwean & Rodger, supra note 1 at 137, 138-39; Climie, supra note 1 at 122; Malla et al, supra note 1 at 217, 218; Stern et al, supra note 1 at 550; Waddell et al, supra note 1 at 174; Boyle & Georgiades, supra note 1 at 217-18; Emmeline Chuang & Rebecca Wells, “The Role of Inter-agency Collaboration in Facilitating Receipt of Behavioral Health Services for Youth Involved with Child Welfare and Juvenile Justice” (2010) 32 Child Youth Serv Rev 1814 at 1814; CMHO, supra note 3 at 1-2; Henderson, Chaim & Brownlie, supra note 8 at 362.
11 Schwean & Rodger, supra note 1 at 137; Climie, supra note 1 at 122; Waddell et al, supra note 1 at 174; Stern et al, supra note 1 at 550; Malla et al, supra note 1 at 217.
12 Stern et al, supra note 1 at 549; Waddell et al, supra note 1 at 177; Malla et al, supra note 1 at 217; see also Flood & Thomas, supra note 2 at 48.
children who need them persists. Explanations for the significant gap between children’s mental health service needs and service use include: issues with identification and diagnosis, and with accessibility, availability, and acceptability of services.

Before any intervention can take place, an adult (e.g. teacher, parent, child protection worker) must recognize that a child may have a mental health issue, and may have a need for treatment. Mental health issues are often less visible and tangible than physical health issues, and manifestations of distressing mental states may vary widely between individuals. Mental health issues may be particularly difficult to identify and diagnose in children. Pursuant to the medical model, diagnosis focuses on the identification of “symptoms” (attributed to the individual’s biology) which evidence the existence or absence of pathology (i.e. a mental “illness” or “disorder”). Children differ in their “developmental trajectories”, and may experience “symptoms” at various developmental stages, and with varying levels of severity. Depending on their ages and levels of functioning, children may be unable to articulate what they are experiencing, and doctors may need to rely heavily on the observations of the adults involved in the child’s life (e.g. teachers, parents).

And, as noted by Justice LeBlanc in *H. (P.) v. Eastern Regional Integrated Health Authority*, “psychiatry is not an exact or perfect science...”
and, by extension, even health care professionals acknowledge some uncertainty with regard to diagnosis, treatment options and prognosis”.21

Where a child has been identified as having a mental health issue or diagnosed with a mental disorder, the next step is to seek, locate, and access adequate services; a task which many children will depend on an adult to undertake.22 In trying to locate and access services, many families find themselves simultaneously engaged with multiple, separate service sectors and agencies.23 As Vicki Schwean and Susan Rodger have noted, “the service delivery system and pathways to treatment for child and youth mental health in Canada, and in Ontario specifically”, are said to be “costly, highly fragmented, and difficult to navigate for families and children”.24

Children and families in need of mental health services may encounter a variety of barriers to locating and accessing adequate services.25 Barriers to locating and accessing adequate services may arise at the individual, community, and systems-level, and may include, stigma, caregivers’ behaviours and attitudes surrounding help-seeking, caregivers’ perceptions of the problem (e.g. severity), previous experience with health services, geographic location (e.g. rural versus urban), social position (e.g. socioeconomic status, immigration status), funding/costs, (lengthy) wait times, efficacy and adequacy of available services, availability of service providers and of specialized services, and lack of coordination across service sectors and agencies (i.e. fragmentation of services).26 Barriers to service use also may impact upon

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21 H (P), supra note 16 at paras 79, 3, 61; consider also Mayes, Bagwell & Erkulwater, supra note 16 at 152, 159; Boyle & Georgiades, supra note 1 at 219, 220; Bloom & Schneider, supra note 5 at 5-8; Edward Shorter, A History of Psychiatry: From the Era of the Asylum to the Age of Prozac (New York: John Wiley & Sons Inc, 1997) at 298-305.
22 Reid et al, supra note 2 at 385; Schwean & Rodger, supra note 1 at 138, 142, 158; Kendall & Comer, supra note 15 at 56; Stern et al, supra note 1 at 550.
23 Henderson, Chaim & Brownlie, supra note 8 at 362; Reid et al, supra note 2 at 391; Stern et al, supra note 1 at 558-59.
24 Schwean & Rodger, supra note 1 at 138; see also Flood & Thomas, supra note 2 at 35, 42-43; Henderson, Chaim & Brownlie, supra note 8 at 362; Stern et al, supra note 1 at 558-59.
25 Schwean & Rodger, supra note 1 at 139, 142-43.
26 Ibid; Thomas & Flood, supra note 2 at 36, 46-47; Gill et al, supra note 1 at 479; Stern et al, supra note 1 at 550; Reid et al, supra note 2 at 391, 393.
engagement and retention once services have been located. Research suggests that even where services are located, many families do not proceed with treatment, and attrition rates are high amongst those who do commence a course of treatment. Barriers to engagement and retention may include, poverty, racism, lack of social supports, lack of adequate child care or transportation, scheduling difficulties, waiting lists, service providers’ or program hours, and caregivers’ perceptions about treatment (e.g. relevance, utility, demands, acceptability) and service providers (e.g. cultural competence).

Prevalence and (Lack of) Treatment in the Child Welfare and Youth Criminal Justice Population

A significant and disproportionate number of children who are engaged in the family law (child welfare) and criminal justice systems experience mental health issues. Research suggests that as many as two-thirds of children in the care of the Children’s Aid Society (“CAS”) may have diagnosed mental health issues (i.e. “disorders”), and that others may have undiagnosed needs. Research also suggests that mental health issues are far more prevalent amongst children engaged with the criminal justice system than in the general population, with some studies estimating that more than 90% of justice-involved children meet the criteria for diagnosis of a mental disorder. Notably, a disproportionate number of the children engaged

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27 Stern et al, supra note 1 at 550; Reid et al, supra note 2 at 385, 393.
28 Stern et al, supra note 1 at 550.
29 Ibid at 550-52; Reid et al, supra note 2 at 385, 393; consider also Schwane & Rodger, supra note 1 at 138.
31 Scully & Finlay, supra note 4 at 3; Bala et al, supra note 30 at 139; consider also Chuang & Wells, supra note 10 at 1814; Stewart et al, supra note 3 at 132; Van Wert et al, supra note 30 at 59; Freedman, Wong & Corrado, supra note 30 at 140; Philip Burge, “Prevalence of Mental Disorders and Associated Service Variables Among Ontario Children Who Are Permanent Wards” (2007) 52 Can J Psychiatry 305 at 312.
32 McCormick, Peterson-Badali & Skilling, supra note 30 at 213; Peterson-Badali et al, supra note 30 at 6-7; see also McLeod, supra note 30 at 267; Chuang & Wells, supra note 10 at 1814; Bala et al, supra note 30 at 139; Scully & Finlay, supra note 4 at 3; Freedman, Wong & Corrado, supra note 30 at 139-40; Denise C. Herz et al, Addressing the Needs of Multi-System Youth: Strengthening the
with the CAS also become engaged with the criminal justice system, and they are more likely to be charged, detained, and sentenced to custody than their counterparts in the general population.33

The prevalence of mental health issues amongst children in the care of the CAS (and those engaged in the criminal justice system) may relate to the intersection of the individual and environmental factors noted above (e.g. social disadvantage, caregiver functioning issues).34 It may relate also to the additional and multiplicative effects of the maltreatment and trauma to which these children may have been exposed (e.g. neglect, abuse, removal from the familial home, the repeated moves experienced by some children in care).35 Childhood maltreatment, as well as involvement with the CAS and other individual and environmental factors, have also been associated with an increased likelihood of (repeated) engagement with the criminal justice system.36

Despite the prevalence of mental health issues amongst children engaged with the CAS and criminal justice system, only a small number of these children receive adequate services.37 Children in care who experience mental health issues may face many of the same barriers experienced by their counterparts in the general population (e.g. fragmentation of services,
waiting list, issues with access and availability), and also may face additional barriers (e.g. multiple moves, lack of consistent caregivers, treatment models designed for parent and child dynamics). As The Honourable Justice Brian Scully and Dr. Judy Finlay note, “[w]ithout positive relationships and strong adult supports, youth in care are less likely than youth out of care to have their mental health needs adequately addressed”. Where adequate supports and services are not provided to children with mental health issues who are engaged in the family law (child welfare) and criminal justice systems, the children as well as society more generally may experience dire consequences, including placement disruptions and repeated engagement in the criminal justice system.

Need for Treatment

Treatment for mental health issues is generally determined pursuant to the tenants of the medical model, the dominant paradigm through which mental health issues are conceptualized. Under the medical model, problematic mental states or behaviours are characterized as “symptoms” of an “illness” or “disorder” that occurs within the individual (biological causes) and requires individual medical intervention (namely pharmacotherapy, possibly coupled with psychotherapy). As I illustrate and argue in this Thesis, the ways mental health issues are conceptualized and defined in the family law (child welfare) and criminal justice systems (and specifically in the governing legislation), reflect the medical model and embrace the individual

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38 Schwean & Rodger, supra note 1 at 138, 139, 142-43; Thomas & Flood, supra note 2 at 36, 46-47; Gill et al, supra note 1 at 479; Stern et al, supra note 1 at 550-52; Reid et al, supra note 2 at 385, 391, 393; Hambrick et al, supra note 55 at 66, 69, 75; Kerns et al, supra note 35 at 316, 319, 320, 322; Bala et al, supra note 30 at 131, 141-44; Scully & Finlay, supra note 4 at 8-9, 15.
39 Scully & Finlay, supra note 4 at 3; see also Bala et al, supra note 30 at 139.
40 Bala et al, supra note 30 at 135-37, 139, 142, 149, 151; Chuang & Wells, supra note 10 at 1814; Scully & Finlay, supra note 4 at 2-3, 6, 25; Freedman, Wong & Corrado, supra note 30 at 149-51; Herz et al, supra note 32 at 17; Kerns et al, supra note 35 at 316.
focus and medical orientation that underpin this paradigm. And, as I also illustrate and argue in this Thesis, this individual focus and medical orientation fails to acknowledge the various intersecting individual and environmental factors that may impact negatively upon children’s mental health, and masks the interlocking oppression and inequality that children, particularly those engaged with the family law (child welfare) and criminal justice systems, may face.

Children with mental health issues, particularly those engaged with the family law (child welfare) and criminal justice systems, often experience a variety of interlocking challenges and disadvantages (e.g. poverty, maltreatment, trauma, cognitive impairments). To truly protect these children and promote their well-being, their cumulative needs must be addressed holistically through the provision of adequate and appropriate supports and services, including but not limited to mental health services and supports that address individual and environmental factors. Early intervention, and adequate and appropriate treatment, may mitigate the negative impact and consequences childhood mental health issues can have on children and families as well as on society more generally.

Where timely and effective services are not provided, children with mental health issues may find themselves caught in a “downward spiral”, with their mental states deteriorating and their related suffering and experiences of disadvantage worsening. For children in care, early

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43 Schwean & Rodger, supra note 1 at 143-44; Carrie Smith et al, “Role Specialization and Service Integration in Child Welfare: Does Organizational Structure Influence the Decision to Refer to Supportive Services?” (2017) 82 Child Youth Serv Rev 139 [Smith et al, “Role Specialization and Service Integration”] at 139; Lil Tommyr et al, “Anxiety and/or Depression in 10-15-Year-Olds Investigated by Child Welfare in Canada” (2011) 48 J Adolesc Health 493 at 493; Scully & Finlay, supra note 4 at 25-26, 2-3; Bala et al, supra note 30 at 130, 134-35; Stewart et al, supra note 3 at 132.
44 Van Wert et al, supra note 30 at 59; Raymond R Corrado, Sarah Kuehn & Irina Margaritescu, “Policy Issues Regarding the Over-representation of Incarcerated Aboriginal Young Offenders in a Canadian Context” (2014) 14 Youth Justice 40 at 54; Bala et al, supra note 30 at 131, 142-43, 144; Scully & Finlay, supra note 4 at 25; Schwean & Rodger, supra note 1 at 143-44, 145; Stewart et al, supra note 3 at 133, 145, 147-48, 150-51; consider also McCormick, Peterson-Badali & Skillling, supra note 30 at 219; Hambrick et al, supra note 35 at 75, 76.
45 Dey et al, supra note 6 at 407; Malla et al, supra note 1 at 217-20; Scully & Finlay, supra note 4 at 2, 25; Flood & Thomas, supra note 2 at 45; Freedman, Wong & Corrado, supra note 30 at 141, 149, 150; Schwean & Rodger, supra note 1 at 145.
46 Malla et al, supra note 1 at 217, 219; Bala et al, supra note 30 at 142; Scully & Finlay, supra note 4 at 3, 25; Ontario, Office of the Provincial Advocate for Children and Youth for Ontario, Statement on Child and Youth Mental Health in Ontario (Toronto: Office of the Provincial Advocate for Children and Youth for Ontario, 2011) at 3; CMHO, supra note 3 at 1; see also Gill et al, supra note 1 at 479.
and adequate intervention may interrupt the “vicious cycle” which may otherwise ensnare these children and result in existing behavioural or mental health issues being exacerbated, and additional difficulties being created and compounded, including multiple moves between residential placements (generally group homes) and repeated engagement with the criminal justice system.47 And, a failure to provide early and effective services also may negatively impact the potential effectiveness of treatment, should adequate services eventually be received.48

Research suggests that early interventions also may be important where a child experiences distressing mental states which do not (yet) meet the threshold for diagnosis as a “disorder”.49 Providing early and effective services to these children may alleviate difficulties and lessen the social, health, and functional issues that might otherwise ensue.50 Interventions, in the form of prevention programs (generally based in schools), before any signs of a possible mental health issue have arisen, also have been identified as an important and lacking element in promoting mental health for all children and preventing and addressing mental health issues.51 However, the provision of holistic, wraparound services and supports requires the collaboration and coordination of various service sectors and agencies, entities which, at present, generally continue to operate in silos (i.e. in isolation).52

47 Scully & Finlay, supra note 4 at 2-3, 6; Bala et al, supra note 30 at 135-37, 139, 142, 149; Freedman, Wong & Corrado, supra note 30 at 150; Kerns et al, supra note 35 at 316.
48 Malla et al, supra note 1 at 217, 219.
49 Ibid at 218; see also Schwean & Rodger, supra note 1 at 151, 152-53.
50 Malla et al, supra note 1 at 218.
51 Waddell et al, supra note 1 at 174, 177; Boyle & Georgiades, supra note 1 at 220; Climie, supra note 1 at 123; Schwean & Rodger, supra note 1 at 139-40, 149-51; Flood & Thomas, supra note 2 at 51; having school-based mental health services within the educational system has also been identified as a means to increase and facilitate access to needed services by children with mental health issues (see Climie at 123; Schwean & Rodger at 139-40, 149-50, 156).
52 Bala et al, supra note 30 at 131, 141-44; Scully & Finlay, supra note 4 at 8-9, 15; Schwean & Rodger, supra note 1 at 138-39, 142-44, 151-53; Reid et al, supra note 2 at 385, 391, 393; Thomas & Flood, supra note 2 at 35, 42-43; Henderson, Chaim & Brownlie, supra note 8 at 362; Stern et al, supra note 1 at 556-59; Kerns et al, supra note 35 at 316, 320, 323-24; Stewart et al, supra note 3 at 147.
Thesis Focus, Population of Interest and Methodology

The State has a legal obligation to protect children from harm, including a failure to provide needed medical treatment, and can intervene with parental rights (e.g. the rights to nurture and make decisions for a child) where a child’s life or health may be in jeopardy.\textsuperscript{53} In this Thesis, I explore how and why the legal systems mandated to protect children are failing to meet this mandate. I focus on the way mental health issues are defined and characterized in the relevant child welfare and criminal justice legislation and the way these statutory provisions are implemented in practice (including the failure to consider intersectionality), to elucidate the role of the law in creating and perpetuating a systemic failure to protect children with mental health issues.

Understanding the relationship between how mental health issues are defined in the relevant legislation, the failure to consider intersectionality, and the (often negative) outcomes experienced by children with mental health issues in the family law (child welfare) and criminal justice systems, is necessary in order to further understandings of the role of the law in the failure to adequately meet the needs of children with mental health issues. A deeper understanding of why and how the family law (child welfare) and criminal justice systems are failing to protect children with mental health issues, and are creating and perpetuating the (often negative) outcomes experienced by these children, is an imperative first step towards understanding how to address the gaps in the legal system and better meet the needs of these children. This work will open avenues for further research into how these systemic failures can

be addressed, so that children with mental health issues receive needed supports and services and adequate protection.

In undertaking this work, my population of interest is children with mental health issues who are engaged with the family law (child welfare) and criminal justice systems. In referring to “child” or “children”, I adopt the definition set out in the *Child, Youth and Family Services Act, 2017* (“CYFSA”), the legislation governing child welfare in Ontario. The CYFSA defines “child” as “a person younger than 18”. Where at issue, I also adopt the definition of “young person” in the *Youth Criminal Justice Act* (“YCJA”), using this term to refer to a person who is “twelve years old or older, but less than eighteen years old”. The family law (child welfare) system refers to the legal system governing child welfare (namely in the Province of Ontario), and the criminal justice system refers to the legal system governing youth criminal justice in Canada (the purviews and mandates of these systems is described in detail in Chapter One).

Finally, “mental health issues” refers to mental states (e.g. thoughts, emotions) or behaviours that are more than transient and cause distress, impairment and/or suffering. The terms “mental disorder”, “emotional harm” and “mental, emotional or developmental condition” as defined in the CYFSA and YCJA (by incorporation of the *Criminal Code*) will be used where called for by the subject matter.

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54 CYFSA, supra note 53.
55 Ibid, s 2(1); it is beyond the scope of this Thesis to address situations where children (e.g. “mature minors”) may have capacity to consent to treatment on their own behalf. Thus, while some of the “children” within the designated age range (zero to younger than 18) may be capable, at law, to consent to their own treatment, for purposes of this Thesis it is assumed that the consent of a parent or other adult (e.g. child protection worker) is required.
56 Youth Criminal Justice Act, SC 2002, c 1 (“YCJA”).
57 Ibid, s 2(1); see also CYFSA, supra note 53, s 2(1); the definition of “child” under section 2(1) of the YCJA (namely, a person under 12 years old) is not being adopted for use in this Thesis.
58 Consider Aneshensel, Phelan & Bierman, supra note 18 at 8-9; Chandler, “Mental Health and Disability”, supra note 3 at 4; Boyle & Georgiades, supra note 1 at 205.
59 Criminal Code, RSC 1985, c C-46.
60 The various ways “mental disorder” has been defined within and across different disciplines, including psychiatry, family law (child welfare), and criminal justice, is described in detail in Chapter Two.
In undertaking this analysis, I rely on legislation (namely the CYFSA, YCJA, and Criminal Code), jurisprudence, government policy documents and reports, and academic literature from various disciplines. My research is theoretically informed by existing academic research that has looked at the prevalence of mental health issues amongst children engaged with the family law (child welfare) and criminal justice systems, the failure to provide adequate services to these children, and the common (often negative) outcomes they experience. For example, Nicholas Bala et al raise questions about why children in care are overrepresented in the criminal justice system and in custodial facilities, and explore the challenges faced by these children (e.g. maltreatment, mental health issues, multiple placements, harsher criminal sanctions), and the need for collaboration across service sectors and a more holistic approach in order to adequately address the needs of these children. Using insights from Bala et al’s suggested approach, I will explore these challenges, particularly for children with mental health issues, and how they are perpetuated by the legal system.

In doing so, my research is informed also by the works of theorists like Kimberlé Williams Crenshaw and the intersectionality paradigm. Intersectionality explores how individuals’ social positions are shaped and defined through the interaction of various characteristics (e.g. race, gender, age) which marginalize some and empower others, and how

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61 The CYFSA recently came into force, replacing the Child and Family Services Act, RSO 1990, c C.11 (“CFSA”). The provisions in the CYFSA regarding mental health issues mirror, or are worded similarly to, those in the CFSA. Where reference is made in the case law or literature to a section of the CFSA, the equivalent section in the CYFSA, and, where relevant, any difference in language, is noted either in the body of the text or in the footnotes. Reference to a child’s capacity to consent to treatment under the Health Care Consent Act, 1996, SO 1996, c 2 (“HCCA”) has been added to the “in need of protection” provisions in the CYFSA (ss 74(2)(g), (i), (j)), such that a child may be “in need of protection” where they have suffered or are likely to suffer “emotional harm” (or suffer from a “mental, emotional or developmental condition”), the child is “incapable of consenting to treatment under the” HCCA, and their parent “refuses or is unavailable or unable to consent” to treatment (the reference to the HCCA was not included in these provisions in the CFSA). As noted in footnote 55, it is beyond the scope of this Thesis to address situations where a child may have the capacity to consent to treatment.

62 Bala et al, supra note 30.

social structures and systems perpetuate these power dynamics.\textsuperscript{64} Using this lens, I explore the challenges and disadvantages (e.g. maltreatment, poverty) experienced by children with mental health issues who are engaged in the family law (child welfare) and criminal justice systems, and the ways these legal systems may be perpetuating and compounding these difficulties.\textsuperscript{65} This analysis allows for a deeper, more contextual understanding of the multifaceted needs of these children, and exposes the potential of various services and systems to more adequately address those needs.\textsuperscript{66}

**Road Map of this Thesis**

Children with mental health issues who are engaged in the family law (child welfare) and criminal justice systems are not getting the supports and services they need. In this Thesis, I demonstrate how and why the legal system is failing to protect these children. I begin in Chapter One by explaining how I will carry out my analysis, and why an analysis that considers how the law is written, and how it operates in practice, is necessary in order to understand the relationship between the law and the outcomes experienced by children with mental health issues. In doing so, I provide an overview of the *CYFSA, YCJA,* and *Criminal Code,* and illustrate why it is necessary to consider both the family law (child welfare) and criminal justice systems, as well as the role of the CAS, in order to understand how and why the legal system is failing to protect children with mental health issues. Having laid this foundation, in Chapter Two I describe how mental health issues are characterized and defined in the legislation and the


\textsuperscript{65} See Cho, Williams Crenshaw & McCall, *supra* note 63 at 797, 798; MacKinnon, *supra* note 63 at 1020, 1028; Brown, Jones & Greiner, *supra* note 63 at 157; Minaker, *supra* note 64 at 292, 297, 299, 301.

\textsuperscript{66} Consider Minaker, *supra* note 64 at 302-04; Corrado, Kueln & Margaritescu, *supra* note 44 at 54; MacKinnon, *supra* note 63 at 1020-21, 1028; Cho, Williams Crenshaw & McCall, *supra* note 63 at 787, 795-96, 797; see also Brown, Jones & Greiner, *supra* note 63 at 156, 179.
paradigm these definitions reflect (i.e. the medical model), and explain why these conceptualizations are problematic for children with mental health issues.

In Chapter Three I consider how the statutory definitions of mental health issues are being applied in practice in the family law (child welfare) and criminal justice systems, using jurisprudence to illustrate the types of circumstances in which these provisions are used, and how they shape experienced outcomes in actual cases involving children with mental health issues. Using a similar approach, in Chapter Four I consider how the statutory definitions have been interpreted and implemented by the CAS and the effects this has had on the lives and experiences of children with mental health issues who are engaged with the CAS. Next, in Chapter Five, I provide an overview of intersectionality, and explore how children in the family law (child welfare) and criminal justice systems are treated as generic, and how using an intersectional analysis could produce outcomes which more adequately meet the needs of children with mental health issues. Finally, I conclude by discussing and summarizing the findings made in Chapters One to Five, and reiterate how they support my overall argument; namely that, in practice, the law fails to protect children with mental health issues due to the way that mental health issues are defined in family law and in criminal law, and because both systems do not recognize the importance of intersectionality. I also note the gaps in the law and existing academic literature and suggest areas where further research is needed.
Chapter One

The Family Law System, Criminal Justice System, and Children’s Aid Societies: Crossover, Clashes, and the Failure to Protect Children with Mental Health Issues

Introduction

Children with mental health issues who are involved with the family law (child welfare) system are amongst the most vulnerable in society. As described in the Introduction, they face a myriad of risks and challenges, including involvement in the criminal justice system. When these children become engaged in the criminal justice system, as often happens, they are placed in an even more vulnerable position, and the significant risks and challenges they face are exacerbated and compounded. In this Chapter, I demonstrate that an analysis of the failure of the law to protect children with mental health issues must include an examination of both the family law (child welfare) and criminal justice systems, an exploration of the laws (as written and in practice) governing these systems, and consideration of the role of Children’s Aid Societies ("CAS") and child protection workers. To do so, I begin by providing an overview of the statutory frameworks governing the family law (child welfare) system and the youth criminal justice system and discuss the necessity of exploring not only what the laws say, but how they operate in practice. Next, I review the extensive ‘crossover’ of children between the family law (child welfare) and criminal justice systems, exploring why so many children with child protection needs end up in the criminal justice system, and why so few of these children receive needed services and supports from either system. Finally, I describe the central role CAS and child protection workers play in the lives of these children and the impact they have on everything from whether a child protection allegation is investigated, to whether a child charged with a criminal offence is granted bail. The foregoing provides the basis for the analysis I undertake in the balance of this Thesis.
Statutory Framework

Family Law System

The Child, Youth and Family Services Act, 20171 (“CYFSA”) governs child welfare and CAS (i.e. child protection agencies) in Ontario.2 The “paramount purpose” of the Act is to “promote the best interests, protection and well-being of children”.3 Additional purposes of the Act include that “[t]he least disruptive course of action…should be considered” and that “[s]ervices to children and young persons should be provided in a manner that”, amongst other things, “respects a child’s or young person’s need for continuity of care and for stable relationships within a family and cultural environment” and “takes into account physical, emotional, spiritual, mental and developmental needs and differences among children and young persons”, their “race, ancestry, place of origin, colour, ethnic origin, citizenship, family diversity, disability, creed, sex, sexual orientation, gender identity and gender expression”, and their “cultural and linguistic needs”.4

The CYFSA sets out the functions of CAS, including investigating child protection allegations, protecting children, providing services to families to protect children, and providing care for, and supervision to, children.5 It also governs the provision of services to families and children on a voluntary basis (i.e. with a person’s consent) and the placing, by voluntary agreement, of children in the CAS’ care on a temporary basis.6 Pursuant to the Act, a CAS may make an application to the Court for a finding that a child is “in need of protection”.7 The Act

1 Child, Youth and Family Services Act, 2017, SO 2017, c 14 (“CYFSA”); as noted in the Introduction, the CYFSA was recently enacted, replacing the Child and Family Services Act, RSO 1990, c C.11.
3 CYFSA, supra note 1, ss 1(1), 2(1); child is defined as a person younger than eighteen years of age (Ibid, s 2(1)).
4 Ibid, s 1(2).
5 Ibid, s 35(1).
6 Ibid, ss 22, 75-77.
7 Ibid, s 81(1).
provides that a child may be found to be “in need of protection” for a variety of reasons, including where a child has been, or there is a risk that they will be, physically harmed, sexually abused or exploited, or emotionally harmed as a result of a parent’s actions or inactions.\(^8\) Children also may be found to be “in need of protection” where a parent fails or refuses to provide treatment to address physical harm, “emotional harm”, or a “mental, emotional or developmental condition”.\(^9\) The provisions regarding “emotional harm” and “mental, emotional or developmental condition” will be discussed in detail in Chapters Two and Three.

The CYFSA governs the apprehension of children by the CAS and the conduct of child protection hearings, and sets out the orders that can be made where a child has been found to be “in need of protection” (e.g. supervision orders, interim or extended CAS care, access orders).\(^10\) It sets out the process for a review of the status of a child who is the subject of an order for CAS supervision or interim or extended care, and provides for appeals of Court orders under the child protection provisions (except regarding assessments).\(^11\) The Act also addresses the provision of legal representation for a child and sets out the requirements (duty) to report child protection concerns.\(^12\) The CYFSA provides for orders requiring a child, parent, or other person to undergo a medical, emotional, developmental, psychological, educational or social assessment and for the admission and commitment of a child with a “mental disorder” to a secure treatment facility.\(^13\)

The CYFSA also addresses the detention of children under youth criminal justice legislation and provides for the rights of children in the care of the CAS and the youth criminal justice system.\(^14\)

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\(^8\) Ibid, ss 74(2)(a)-(d), (f), (h).
\(^9\) Ibid, ss 74(2)(c), (g), (i), (j).
\(^11\) Ibid, ss 113-116, 121.
\(^12\) Ibid, ss 78, 125.
\(^13\) Ibid, s 98, Part VII.
\(^14\) The Honourable Justice Brian Scully & Dr Judy Finlay, “Cross-over Youth: Care to Custody” (2015) Report completed on behalf of the Cross-over Youth Committee, Toronto, Ontario at 7; CYFSA, supra note 1, Parts VI, II.
Criminal Justice System (Youth)

The *Youth Criminal Justice Act*\(^{15}\) (“*YCJA*”) provides the framework governing criminal justice practices and procedures for young persons.\(^{16}\) The Act aims to balance the protection of the public with rehabilitation and reintegration of young people.\(^{17}\) It provides for the use of extrajudicial measures and for sentencing (e.g. fines, restitution, community service, probation, support and supervision programs, non-residential programs, custody and supervision orders, rehabilitative custody and supervision orders).\(^{18}\) It also provides for a young person’s right to counsel and the provision of notices to parents (defined to include the CAS where a child is in care).\(^{19}\) The Act sets out the requirements for detention and custodial sentences, and specifically provides that custody shall not be used “as a substitute for appropriate child protection, mental health or other social measures”.\(^{20}\)

The *YCJA* allows for referrals “to a child welfare agency for assessment to determine whether the young person is in need of child welfare services”.\(^{21}\) It also provides that an assessment of the young person may be ordered at any stage in the proceedings, where, amongst other things, the “court has reasonable grounds to believe that the young person may be suffering from a physical or mental illness or disorder, a psychological disorder, an emotional disturbance, a learning disability or a mental disability”.\(^{22}\) The *YCJA* stipulates that the provisions of the *Criminal Code*\(^{23}\) are applicable “in respect of offences alleged to have been committed by young persons”, with necessary modifications, unless the provisions are inconsistent with or excluded

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\(^{15}\) *Youth Criminal Justice Act*, SC 2002, c 1 (“*YCJA*”).
\(^{16}\) *Ibid*, Preamble, s 2(1); Scully & Finlay, *supra* note 14 at 8; “young person” is defined in the *YCJA* as a person over twelve but under eighteen years of age (s 2(1)).
\(^{17}\) *YCJA*, *supra* note 15, s 3(1), Preamble; Scully & Finlay, *supra* note 14 at 8.
\(^{18}\) *YCJA*, *supra* note 15, Parts 1, 4.
\(^{19}\) *Ibid*, ss 25, 26, 2(1); Bala *et al*, *supra* note 2 at 131.
\(^{20}\) *YCJA*, *supra* note 15, Part 1, ss 28-31, 39, 42.
\(^{21}\) *Ibid*, s 35.
\(^{22}\) *Ibid*, s 34.
\(^{23}\) *Criminal Code*, RSC 1985, c C-46.
by the *YCJA*. It states that, with the same caveats regarding inconsistencies or exclusions, and necessary modifications, “section 16 (defence of mental disorder) and Part XX.1 (mental disorder) of the *Criminal Code* apply…in respect of proceedings under this Act in relation to offences alleged to have been committed by young persons”. I explore the way that mental health issues are conceptualized and defined in the *CYFSA* and *Criminal Code* in Chapter Two, where I consider the legislative definitions and provide a comparative analysis of them through the lens of the medical model and social models.

**Law on Paper and Law in Practice**

Taken on its own the legislation governing child welfare and youth criminal justice seems to provide a mechanism for protecting children and meeting their physical, mental, and emotional needs. However, as the following discussion (and subsequent Chapters) demonstrates, in practice, the laws are not having the desired effect and, in many instances, are exacerbating the problems (e.g. mental health issues, criminal involvement) of the children they are designed to protect. This is particularly the case for children who are engaged with both the family law (child welfare) system and the youth criminal justice system and who have mental health issues. As critical theorists like Margaret Davies have pointed out, “law is not in fact confined to its own sphere of operation but constructs and otherwise impinges upon subjects, social life, so-called ‘private’ relationships, and so forth”.

That the written law affects the lives of, and relationships between, children, families, and society, will become apparent through the topics I discuss in this Thesis. I elaborate on the

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24 *YCJA*, supra note 15, s 140; the *YCJA* also provides that “[u]nless otherwise provided, words and expressions used in this Act have the same meaning as in the *Criminal Code*” (s 2(2)).
25 *Ibid*, s 141(1).
26 The medical model conceptualizes mental health issues as a disease of the individual requiring medical intervention as treatment, whereas social models, such as the social model of disability, shift the focus from an illness requiring redress within the individual, to the effects of external social forces on the occurrence, conceptualization, definition and experience of mental health issues (see Chapter Two at 50, 62-68 and related references).
effect of outside forces (e.g. social, political, commercial) on legal spheres in Chapter Two, where I review the ways mental health issues are defined in the legislation and the dominant perspectives these definitions reflect (namely, the medical model). I illustrate the ways the law impinges upon children, families, and society through a review of the implementation of the legislative definitions in the CYFSA and Criminal Code by the Courts (discussed in Chapter Three) and CAS (discussed in Chapter Four), and the related (often negative) outcomes experienced by children with mental health issues who are engaged in the family law (child welfare) or criminal justice systems. I further illustrate the effects of the interactions between legal spheres, individuals, and society through the adoption, in Chapter Five, of an intersectional lens to analyze the way the law as written treats children as generic, and the implications of the failure to consider and address the effects of social and environmental factors on children’s mental health. I reveal the interactions and overlap between the family law (child welfare) and criminal justice systems, and the related impacts on children engaged in these legal spheres, as well as on society generally, throughout these discussions and in the balance of this Chapter.

As described in the Introduction, mental health issues are prevalent amongst children engaged in the family law (child welfare) system and in the criminal justice system. The needs of children with mental health issues who are engaged in the family law (child welfare) or criminal justice systems are complex and present significant difficulties. The complexities and the difficulties in meeting the needs of these children are significantly exacerbated and complicated when children with mental health issues are engaged in both the family law (child welfare) and criminal justice systems. To see why this is, it is important to understand why an

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28 See Introduction at 7 and related references.
30 Green, supra note 29 at 22, 25.
examination of both the family law (child welfare) system and the criminal justice system, as 
they operate and overlap in practice, is integral in order to understand how and why the law fails 
to protect children with mental health issues.

**Crossover: Family Law System and Criminal Justice System**

**Engagement with Child Welfare and Criminal Justice**

Children who are engaged in the family law (child welfare) system, and those who are in 
need of child protection services, often end up in the criminal justice system. Many of these 
children, particularly those with mental health or behavioural issues, are “dumped” into the 
youth criminal justice system as a result of minor offences. The prevalence of children with 
child protection and mental health or addiction issues who end up in the criminal justice system 
has led some to describe this system as “our society’s default system, taking in all those youth 
that fall between the cracks of other systems and resources”. Others have suggested that the 
failure to recognize the relationship between maltreatment and delinquency, and to work 
collaboratively across systems to more effectively respond to the difficult issues presented where 
children with protection needs become engaged in the criminal justice system, leaves many 
children to “fall into the crack that separates the two systems”.

In the result, despite the prohibition in the YCJA against using custody “as a substitute for 
appropriate child protection, mental health or other social measures”, children with protection 
needs, especially those with mental health issues, often end up in the criminal justice system, 
where they are more likely to be charged and detained than children who are not involved in the

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32 Bala *et al*, *supra* note 2 at 131; McLeod, *supra* note 31 at 268; Green, *supra* note 29 at 22.
33 Green, *supra* note 29 at 22.
34 Herz *et al*, *supra* note 31 at 1; Bala *et al*, *supra* note 2 at 131.
family law (child welfare) system.\textsuperscript{35} While some of the characteristics common to the children who become engaged in the family law (child welfare) system and the criminal justice system – mental health issues, behavioural issues – have been mentioned, an in-depth consideration of who these children are and how they are treated by both systems demonstrates how each system, separately and together, are failing these children.

Who are “Crossover” Youth?

Children who are engaged with both the family law (child welfare) and criminal justice systems are described in the literature by a variety of terms, including “crossover children”, “crossover youth”, “crossover kids”, “dually-involved youth” and “dually-adjudicated youth”.\textsuperscript{36} At the “broadest level”, “crossover children” or “crossover youth” generally refers to children who have been maltreated and who have engaged in delinquent behaviour.\textsuperscript{37} The terms “dually-involved youth” and “dually-adjudicated youth” are generally considered to be subsets or subgroups of “crossover children” or “crossover youth”.\textsuperscript{38} The term “dually-involved youth” is used to describe children who are involved with or receiving services from both the CAS and the criminal justice system.\textsuperscript{39} And, “dually-adjudicated youth” refers to a further subset group, being children who are involved with both the family law (child welfare) and criminal justice systems, and are subject to concurrent legal proceedings in both systems.\textsuperscript{40}

Numerous authors have recognized the difficulties in providing “precise definitions” to categorize and describe the unique circumstances of the individual children who become

\begin{itemize}
\item \textsuperscript{35} YCJA, supra note 15, ss 29(1), 39(5); Green, supra note 29 at 22; McLeod, supra note 31 at 262, 273; Scully & Finlay, supra note 14 at 5; Bala \textit{et al}, supra note 2 at 134, 139-40.
\item \textsuperscript{36} Bala \textit{et al}, supra note 2 at 133; Denise C Herz, Joseph P Ryan & Shay Bilchik, “Challenges Facing Crossover Youth: An Examination of Juvenile-Justice Decision Making and Recidivism” (2010) 48 Fam Ct Rev 305 at 305-06.
\item \textsuperscript{37} Bala \textit{et al}, supra note 2 at 133; see also Herz, Ryan & Bilchik, supra note 36 at 305-06; Herz \textit{et al}, supra note 31 at 1.
\item \textsuperscript{38} Herz, Ryan & Bilchik, supra note 36 at 305; Bala \textit{et al}, supra note 2 at 133.
\item \textsuperscript{39} Bala \textit{et al}, supra note 2 at 133; Herz \textit{et al}, supra note 31 at 13, 1-2; Herz, Ryan & Bilchik, supra note 36 at 306.
\item \textsuperscript{40} Bala \textit{et al}, supra note 2 at 133; Herz, Ryan & Bilchik, supra note 36 at 306; Herz \textit{et al}, supra note 31 at 2.
\end{itemize}
engaged with the family law (child welfare) and criminal justice systems. Authors like Nicholas Bala et al caution that, while the “terms have some descriptive utility”, using these labels may “obscure the fact that these are individuals with unique needs”, and also may fail to acknowledge that “it is not the youth who ‘crosses over,’ but rather the systems”. These labels also may be somewhat misleading insofar as they suggest that these children are engaged in only two systems – family law (child welfare) and criminal justice – where in reality many of these children also may need the services of, or be involved with, other systems, including the education (or special education) system and the mental health system. While being cognizant of the individual circumstances of the children involved in the family law (child welfare) and criminal justice systems, particularly those who are struggling with mental health issues, for ease of reference in this Thesis, where appropriate, I adopt the terms “crossover youth”, “dually-involved youth”, and “dually-adjudicated youth” as defined above.

Why the “Crossover” between Systems?

Overview

As Bala et al argue, “[e]ach youth has an individual history and unique life course that may provide an explanation or context for understanding how they came to be involved with both the child welfare and youth justice systems”. While it is important to remember that each child is an individual with a unique history, circumstances, and challenges, certain “patterns and commonalities” are often discernable amongst the children that become engaged with both the CAS and the criminal justice system. Specifically, research has identified several contributing

41 Bala et al, supra note 2 at 133; Herz et al, supra note 31 at 1.
42 Bala et al, supra note 2 at 133; see also Scully & Finlay, supra note 14 at 2.
43 Scully & Finlay, supra note 14 at 2; Bala et al, supra note 2 at 133.
44 Bala et al, supra note 2 at 134.
45 Ibid.
factors to becoming a crossover youth including: maltreatment, mental health and addiction issues, nature and number of child protection placements, educational difficulties, family problems (e.g. domestic violence, parental criminal involvement, parental mental health or addictions issues), and harsher treatment of children in care in the criminal justice system.

I describe a number of these factors in greater detail in the following sections. The primary focus of the discussion is on the transitions involved where a child who is engaged with the CAS becomes involved in the criminal justice system. Specifically, in the sections that follow I trace the factors often at play along the “judicial continuum of intervention”, in an effort to elucidate how interventions in the lives of children move, as The Honourable Justice Malcolm McLeod describes it, from “various child protection orders, where intervention is supposed [to] involve therapy and the reunification of the young person with her family; through to YCJA proceedings, where intervention is supposed to involve accountability, rehabilitation and reintegration of the young person into the community”.

**Maltreatment**

Not surprisingly, child maltreatment is associated with increased rates of involvement with the family law (child welfare) system. Child maltreatment has also been associated with an increased risk of delinquency and involvement in the criminal justice system. Numerous studies have linked maltreatment to significantly increased rates of delinquency and detention as compared to children not subjected to maltreatment. While studies differ as to which types of

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46 Various demographic factors (e.g. gender, race, socioeconomic status, age) may also contribute to “crossover” between systems. The role of these factors, particularly as they intersect with one another, is explored in Chapter Five.


48 McLeod, *supra* note 31 at 239.

49 Bala *et al*, *supra* note 2 at 135.

50 *Ibid*; Ryan *et al*, *supra* note 47 at 1035.

maltreatment – e.g. physical abuse, sexual abuse, neglect – have the strongest impact on future delinquency, most researchers seem to agree that there is a relationship between maltreatment and delinquency.52

Some researchers have found that the services (e.g. mental health treatment) provided to maltreated children through the family law (child welfare) system may mitigate or protect against the increased risk of delinquency.53 While these findings seem promising, the reality remains that the number of children in care who become involved in the criminal justice system is “much higher” than children who are not in care.54 It may be that the increased rate of children in care being involved in the criminal justice system relates to the maltreatment which brought these children to the attention of the CAS; in other words, as Bala et al explain, “it may not be involvement in the child welfare system per se that causes offending behaviour, but rather the family problems that resulted in a child coming into care are related to the offending behaviour”.55 However, the circumstances encountered while in care (e.g. multiple placements and group home placements) may be correlated to the high rates of involvement with the criminal justice system amongst children in care.56 And, regardless of the causal factors involved, the outcome is highly problematic and disconcerting: children who are engaged in the family law (child welfare) system, particularly those with mental health issues, are significantly overrepresented in the criminal justice system and in custody facilities.57

52 Jonson-Reid & Barth, supra note 51 at 507; Herz et al, supra note 31 at 15.
53 Jonson-Reid & Barth, supra note 51 at 515, 517-19.
54 Bala et al, supra note 2 at 133; McLeod, supra note 31 at 261.
55 Bala et al, supra note 2 at 135; see also Scully & Finlay, supra note 14 at 3.
56 Bala et al, supra note 2 at 135; Scully & Finlay, supra note 14 at 3.
57 See Introduction at 7-8 and related references.
Mental Health and Addiction Issues

Just as it has an impact on the risk of delinquency, the maltreatment (e.g. neglect, abuse) and related trauma suffered by children in care may contribute, at least in part, to the high prevalence of mental health and substance abuse issues amongst these children. As discussed in the Introduction, research suggests that a significant number of children in care have diagnosed mental health needs and that there are likely many more children who have undiagnosed mental health needs. And, using drugs and alcohol is more likely for children in care than children who are not in care. Children with mental health and addiction issues are also significantly overrepresented in the criminal justice system. As I describe in detail in Chapters Three and Four, despite the significant numbers, only a small percentage of children who are involved with the family law (child welfare) and/or criminal justice systems receive adequate services for mental health and addiction issues, leading in many cases to dire consequences for individual children and society more generally.

Amongst the consequences related to untreated mental health and addiction issues is (ongoing) engagement in the criminal justice system. The occurrence of mental health and addiction issues amongst children in care has been connected to involvement in the criminal justice system. Numerous studies have shown that the “majority” of crossover youth suffer from mental health and addiction issues. Researchers have suggested that the lack of “adequate access” to mental health and addiction treatment services for children in care may be a

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58 Bala et al, supra note 2 at 139; Scully & Finlay, supra note 14 at 3; Herz, Ryan & Bilchik, supra note 36 at 309.
59 See Introduction at 7 and related references.
60 Scully & Finlay, supra note 14 at 3; Bala et al, supra note 2 at 139.
61 See Introduction at 7 and related references; Bala et al, supra note 2 at 139; Herz, Ryan & Bilchik, supra note 36 at 309.
62 See Introduction at 8-11 and related references.
63 Emmeline Chuang & Rebecca Wells, “The Role of Inter-agency Collaboration in Facilitating Receipt of Behavioral Health Services for Youth Involved with Child Welfare and Juvenile Justice” (2010) 32 Child Youth Serv Rev 1814 at 1814; Bala et al, supra note 2 at 139; Herz, Ryan & Bilchik, supra note 36 at 309; Herz et al, supra note 31 at 17.
64 Bala et al, supra note 2 at 139.
65 Herz, Ryan & Bilchik, supra note 36 at 309; Chuang & Wells, supra note 63 at 1814.
“significant factor” leading to involvement in the criminal justice system. Part of the failure to adequately meet the needs of children in care who are suffering from mental health and addiction issues is said to relate to the reality that children in care “often do not reside in placements that encourage the formation of positive social bonds and close personal relationships with adults”.  

*Multiple Placements and Group Homes*

Children in out-of-home care often experience multiple placements, moving from and between various residences (e.g. relatives’ homes, foster homes, group homes). Multiple placements have been cited as a factor which may increase the risk of involvement with the criminal justice system. Many children who have been removed from their familial homes and faced the further disruptions of multiple placements struggle with attachment issues. Multiple placements may exacerbate children’s negative self-image, prevent them from building and maintaining trusting relationships, and prompt them to act out. When children act out or experience “behavioural” issues, they often face additional moves, to other foster homes or group homes, or into the criminal justice system. The circular relationship between group home placements, acting out, and involvement with the criminal justice system has been likened to a “vicious cycle” or “revolving door”.

In many cases children exhibiting “behavioural” issues and/or mental health issues will be moved from foster care into a group home, or from one group home to another. Living in a group home rather than a foster home or a relative’s home is considered to be a risk factor for

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66 Bala *et al*, *supra* note 2 at 139.
67 *Ibid*.
68 Scully & Finlay, *supra* note 14 at 2; Bala *et al*, *supra* note 2 at 139.
69 Bala *et al*, *supra* note 2 at 139; Herz *et al*, *supra* note 31 at 15; see also Scully & Finlay, *supra* note 14 at 2.
70 Scully & Finlay, *supra* note 14 at 2; Bala *et al*, *supra* note 2 at 139.
71 Scully & Finlay, *supra* note 14 at 2-3; Bala *et al*, *supra* note 2 at 139.
72 Scully & Finlay, *supra* note 14 at 2-3; Bala *et al*, *supra* note 2 at 139.
73 Scully & Finlay, *supra* note 14 at 6; Bala *et al*, *supra* note 2 at 149, 137.
74 Bala *et al*, *supra* note 2 at 135, 139; McLeod, *supra* note 31 at 257.
future engagement in the criminal justice system, and children living in these homes are more likely to be charged with criminal offences than children living in foster homes or relative’s homes.\footnote{Bala et al, supra note 2 at 135; Herz et al, supra note 31 at 15; Scully & Finlay, supra note 14 at 4.} The increased likelihood of delinquency amongst children residing in group homes may be related to the fact that children with “more serious behaviour issues are more likely to be placed in group homes”.\footnote{Bala et al, supra note 2 at 136.} The increase may also be related to exposure in the group homes to “delinquent peer associations”.\footnote{Ryan et al, supra note 47 at 1036.} However, it is important to note that the increased likelihood of involvement with the criminal justice system has also been linked to the tendency of group home employees to call the police for behaviours that generally are not reported to police in other settings (e.g. family homes, foster homes).\footnote{Bala et al, supra note 2 at 136.}

Group homes commonly have 5 to 12 residents, and typically are privately operated and run by independent corporations for profit.\footnote{Ibid at 135; Scully & Finlay, supra note 14 at 9.} They are generally staffed by young employees, who are “poorly paid with limited training and insufficient supervision”.\footnote{Scully & Finlay, supra note 14 at 26.} Most of these employees lack the professional training, experience, and judgement to effectively and appropriately handle the complex mental, emotional, and behavioural needs of the children living in group homes.\footnote{Scully & Finlay, supra note 14 at 26; Bala et al, supra note 2 at 138.} The situation is further exacerbated when, as is common, therapeutic resources are insufficient and the children and staff do not receive the care and support they need.\footnote{McLeod, supra note 31 at 257; Scully & Finlay, supra note 14 at 26.}

In many group homes, “order” is maintained by strictly enforcing rules and resorting to “intrusive strategies to exert control over the environment”.\footnote{McLeod, supra note 31 at 257; Scully & Finlay, supra note 14 at 26.}
homes, employees use the police and criminal charges as part of a “continuum of escalating responses”. Thus, employees use the police as “a behaviour management strategy”, calling them more often and for lesser offences then happens where children live with natural or foster parents. This results in children living in group homes being charged, often repeatedly, for actions that are “technically criminal” (e.g. pushing someone), but that are typically dealt with in family or foster home environments without engaging the police. And, as I describe further below and in Chapter Three, once children living in group homes become engaged with the criminal justice system, the risk of further engagement in that system increases.

Criminal Justice System Engagement for Crossover Youth

Overview

Children who are engaged in the family law (child welfare) system and the criminal justice system have been described as “a particularly vulnerable population who face unique challenges during their interactions with the youth justice system”. Involvement with the criminal justice system exacerbates and increases the risks and challenges faced by these already “at-risk” children (including increasing the risk of ongoing involvement in the criminal justice system), and presents them with additional difficulties (e.g. navigating between the family law (child welfare) and criminal justice systems). Crossover youth often are considered “higher risk” and often are stigmatized and labeled as “bad kids” and “beyond help”. Children who are involved in the family law (child welfare) system when they become engaged with the criminal justice system (i.e. dually-involved youth) face harsher treatment than children who are not

84 McLeod, supra note 31 at 257.
85 Scully & Finlay, supra note 14 at 4; Bala et al, supra note 2 at 136.
86 Scully & Finlay, supra note 14 at 4.
87 Bala et al, supra note 2 at 137; McLeod, supra note 31 at 261.
88 Bala et al, supra note 2 at 130.
90 Chuang & Wells, supra note 63 at 1820; Bala et al, supra note 2 at 151.
involved with the CAS, and are more likely to be charged, detained pending adjudication, and sentenced to custody.\(^{91}\)

*Charges*

Children who are in care are charged with criminal offenses at significantly higher rates than children who are not in care.\(^{92}\) This is particularly problematic for children living in group homes, where children are regularly reported to police by group home employees, generally in response to minor behavioural infractions.\(^{93}\) As The Honourable Justice Brian Scully and Dr. Judy Finlay point out, once children in care become involved with the criminal justice system, “they are put in the position of incurring further charges for a full array of bail and probation conditions”.\(^{94}\) Strict bail and probation conditions often are imposed upon dually-involved youth.\(^{95}\) When the children who live in group homes – under already restrictive conditions – have further restrictions imposed upon them, they may breach bail conditions and find themselves back in Court facing new charges.\(^{96}\)

These charges are often “administration of justice offences”, such as breaching bail conditions (e.g. curfew) and “rehabilitative” conditions (e.g. counseling or other treatment programs).\(^{97}\) Thus, while “status offences” (e.g. “sexual immorality”) are no longer prosecutable in Canada, dually-involved youth often find themselves subject to strict conditions which, when breached, land them back in Court on new charges.\(^{98}\) Once a dually-involved youth “has been convicted of more than one breach of a sentence order, she is legally eligible to be sentenced to

\(^{91}\) Bala *et al.*, *supra* note 2 at 130, 139-40; Herz, Ryan & Bilchik, *supra* note 36 at 306; Herz *et al.*, *supra* note 31 at 17.

\(^{92}\) McLeod, *supra* note 31 at 262.

\(^{93}\) See *supra* notes 84-86.

\(^{94}\) Scully & Finlay, *supra* note 14 at 6.

\(^{95}\) Ibid.

\(^{96}\) Ibid.

\(^{97}\) McLeod, *supra* note 31 at 262.

\(^{98}\) Ibid at 262, 263; Scully & Finlay, *supra* note 14 at 6.
I describe the effects of the police involvement with, and the nature and effect of the criminal charges against, children engaged with the CAS in greater detail in Chapter Three, as well as the reality that crossover youth are more likely to be detained and put in custody than children who are not in care, and they often “fall through the cracks” and do not get the services they need.100

**Child Protection Referrals and Conferences**

The *YCJA* provides methods that a judge may use to encourage engagement between the family law (child welfare) system and the criminal justice system and to try to get a child needed services. However, as I describe briefly in this section and explore more fully in Chapter Three, these provisions rarely result in sufficient communication and coordination between systems, or in crossover youth receiving the services they need. A judge or prosecutor, as well as police officers, youth workers, and justices of the peace, may convene a conference “for the purpose of making a decision required to be made under” the *YCJA*.101 The conference may be convened for a variety of reasons, including discussing “appropriate extrajudicial measures, conditions for judicial interim release, sentences, including the review of sentences, and reintegration plans”.102 A judge may use this provision to bring together a multidisciplinary team – the child protection worker and/or youth worker, the children’s advocate, representatives from group homes – as well as the child and possibly others (e.g. family members) to discuss the supervision and service options available for the child.103

A judge also may engage a child protection agency in a child’s criminal proceedings by making a referral, pursuant to the *YCJA*, to an agency “for an assessment to determine whether

99 McLeod, *supra* note 31 at 264; *YCJA*, *supra* note 15, s 39(1)(b).
100 Bala *et al*., *supra* note 2 at 139-40, 147, 151; Scully & Finlay, *supra* note 14 at 6.
101 *YCJA*, *supra* note 15, s 19(1).
103 Green, *supra* note 29 at 23.
the young person is in need of child welfare services”. A judge may use this provision when they believe the child is in need of child protection, mental health and/or other services. However, as The Honourable Justice Ross Green notes, the “power of a judge under s. 35…is limited to directing the referral, and does not include the power to order the provision of services by a child protection, mental health, or other social agency”. The efforts some judges make to coordinate between the family law (child welfare), criminal justice, and other systems (e.g. mental health, education) are laudable and may help some crossover youth get at least some of the services they need. However, “[c]rossover youth too rarely get the coordinated services and support that they require”, and many children with behavioural or mental health issues end up detained and sentenced to custody.

**Detention and Custody**

Children who are involved with the CAS may be “more likely to be detained pending a bail hearing and sentenced into custody” than children who are not in care. A correlation has been found also between a child having behavioural issues and the likelihood of being sentenced to custody. The significance of the connections between involvement in the family law (child welfare) system (and behavioural issues) and the likelihood of detention and custody are particularly salient in light of the founding principles of the *YCJA*, and the provisions in the Act regarding sentencing. The *YCJA* “emphasizes diversion and extra-judicial sanctions as a first response to youth crime and reserves custodial sentences for the most extreme cases”. The Act also provides that detention is not to be used “as a substitute for appropriate child protection,
mental health or other social measures”. Despite these provisions, as I describe further in Chapter Three, children who have child protection needs, including those with mental health issues, are regularly being “dumped” into the criminal justice system, where they are more likely to be detained and sentenced to custody than children who are not in care.

In some cases, the increased likelihood of detention for children who are involved with the CAS arises because of a lack of communication between systems. When a child is arrested and becomes engaged with the criminal justice system, arresting officers may not know that the child is involved with the CAS. When the child appears in Court, judges and prosecutors also may be unaware of the child’s involvement with the CAS. A child protection worker can act as a support and advocate for the child in the criminal justice system, and can provide the Court with important information about the child’s housing and the support or supervision that could be provided. Where officials (e.g. police, prosecutors, judges) are unable to determine the identity of the child’s legal guardian, the chances of the child being detained after arrest may increase. And, even in cases where officials are aware that the child’s “legal parent” is the State (i.e. CAS) and can contact the child protection worker, the worker may be unavailable if the arrest occurs “outside of normal working hours”. Where the child protection worker does not engage in the bail hearing or other proceedings, the child is not

112 YCJA, supra note 15, ss 29(1), 39(5); McLeod, supra note 31 at 262.
113 McLeod, supra note 31 at 262, 267; Bala et al, supra note 2 at 131, 139-40; Scully & Finlay, supra note 14 at 6; Chuang & Wells, supra note 63 at 1820.
114 Ryan et al, supra note 47 at 1038.
115 Bala et al, supra note 2 at 148, 140; Ryan et al, supra note 47 at 1038.
116 Bala et al, supra note 2 at 148, 140; Ryan et al, supra note 47 at 1038.
117 Bala et al, supra note 2 at 140-41.
118 Ibid at 140.
119 Where a child is in care, the CAS becomes the child’s “parent” for purposes of the YCJA (YCJA, supra note 15, s 2(1); Bala et al, supra note 2 at 131).
120 Bala et al, supra note 2 at 140.
only left to attend Court alone, but also may face delays and longer periods of detention than a child not in care.\textsuperscript{121}

In addition to increased rates of detention pending trial, children involved with the family law (child welfare) system are also more likely to be sentenced to custody than children who are not in care.\textsuperscript{122} Children who are placed in custody may face the additional challenges and consequences of the discontinuation of the involvement of the CAS upon their incarceration.\textsuperscript{123} In a study of children incarcerated in secure youth custody facilities in Canada, only one quarter (25\%) of the children surveyed “reported continuing involvement in the child welfare system while they were in custody”.\textsuperscript{124} Amongst other things, the fact that “services that the youth receives through the child welfare system often do not follow him or her to the youth justice system” is highly problematic because it may result in the CAS not being available to support or assist the child, including when they are released and reintegrated into the community.\textsuperscript{125}

The “siloing” between the professionals and agencies in the family law (child welfare) and criminal justice systems is particularly problematic for the significant number of crossover youth who suffer with mental health issues, as a lack of coordination and communication may contribute to the failure of both systems to provide these children with adequate mental health services.\textsuperscript{126} In thinking about crossover youth, it is important to remember that these children are involved with, or in need of, child protective services for a reason and that, as Joseph P. Ryan \textit{et al} argue, “[p]ushing crossover youth deeper into the justice system is unnecessary and unlikely to resolve the complex needs associated with maltreatment and juvenile offending”.\textsuperscript{127}

\begin{itemize}
\item \textsuperscript{121} \textit{Ibid} at 140-41; Scully & Finlay, supra note 14 at 24.
\item \textsuperscript{122} Bala \textit{et al}, supra note 2 at 139-40; Ryan \textit{et al}, supra note 47 at 1046.
\item \textsuperscript{123} Bala \textit{et al}, supra note 2 at 134.
\item \textsuperscript{124} \textit{Ibid}.
\item \textsuperscript{125} \textit{Ibid} at 142, 134; Ryan \textit{et al}, supra note 47 at 1047.
\item \textsuperscript{126} Bala \textit{et al}, supra note 2 at 142.
\item \textsuperscript{127} Ryan \textit{et al}, supra note 47 at 1047; see also Bala \textit{et al}, supra note 2 at 142.
\end{itemize}
Crisscross: Family Law System and Criminal Justice System

Different Agencies, Courts, and Professionals

The family law (child welfare) system and the criminal justice system are two separate “legal and administrative systems”, each with its own “rules, standards, and objectives”. In many jurisdictions, including those where child welfare and youth justice services (e.g. probation and secure custody) are regulated by the same Ministry (such as in Ontario), the systems operate completely separately (some provinces have more unified systems, such as Quebec, where there is one Court that deals with child welfare and youth criminal cases, and one agency that provides services to children in care and young offenders). In keeping with this separation, in many locations, child protection cases and youth criminal justice cases are dealt with in different Courts.

Even where child protection and youth criminal justice matters are dealt with in the same Court, judges and Courts may “specialize”, such that they deal with either family law matters (including child protection) or criminal matters (including youth criminal justice). In some localities, judges may deal with both child protection and youth criminal cases, and a judge may become aware that a child is “dually” involved in concurrent proceedings and may try to coordinate services; however, there is “no institutional effort to co-ordinate proceedings”. Dually-adjudicated youth generally even have separate counsel for each proceeding; for example, dually-adjudicated youth in Ontario can have a lawyer for their child protection case appointed by the Office of the Children’s Lawyer, and a defence lawyer for their criminal

128 Bala et al, supra note 2 at 146.
129 Ibid at 132.
130 Ibid.
131 Ibid.
132 Ibid.
proceedings, possibly funded by Legal Aid Ontario. The representation by separate counsel in each system can cause difficulties for the various agencies and Courts involved in the child protection or criminal justice proceedings, and is emblematic of the separation of the systems and the general lack of communication or coordination between these systems.

(Lack of) Communication and Coordination

Dually-involved youth are obliged to navigate between two separate systems (and potentially other systems, such as the mental health system and/or the education system). In the process they “will encounter numerous individuals with a myriad of roles” – judges, prosecutors, counsel for their child protection case, defence counsel, probation officers, police, teachers, child protection workers – many or all of whom rarely if ever are in communication with one another. The lack of communication between the agencies and professionals in each of the systems is an oft cited problem, and one that often contributes to the negative outcomes experienced by crossover youth.

Lack of communication between the two systems is a recurrent issue and “all too often, there is delay, missing information, and duplication or lack of co-ordination in service provision” as a result. The lack of communication and coordination may be traceable, at least in part, to the different mandates of the two systems. In child protection cases the child is generally considered to be a victim in need of State protection. In criminal justice proceedings the child is generally seen as the perpetrator, whom society may need to be protected against. The
different mandates, and the philosophies that underpin them, may lead to culture “clashes” and make communication and collaboration between systems difficult. Another “barrier” to collaboration “is that limited resources and often rigid funding gives the impression that collaboration will take valuable time and resources away from the ‘primary mission’ of an agency”. Issues of coordination and communication may be further complicated by the involvement of other government and legal agencies as well as community agencies (e.g. mental health agencies, educational institutions, reintegration support agencies, child advocacy groups). When a number of agencies are involved with a child, a lack of collaboration can result in confusion about the roles and responsibilities of each of the agencies. As Bala et al argue, the fragmentation amongst the services for children – including those provided in the family law (child welfare) and youth criminal justice systems – “creates gaps” and “allows different agencies to ‘avoid blame’” where a “reasonable level of quality of care” is not provided to the child. The lack of collaboration is unfortunate, and is often particularly problematic for children with mental health issues. Research suggests that “inter-agency collaboration, the sharing of resources and information between agencies, results in faster access to mental health services which in turn leads to better mental outcomes for youth”. This is particularly significant for crossover youth because, as noted, a significant number of these children have mental health needs and without proper treatment their mental states may further deteriorate.

142 Ibid; Scully & Finlay, supra note 14 at 8; Bala et al, supra note 2 at 141.
143 Bala et al, supra note 2 at 141.
144 Scully & Finlay, supra note 14 at 9.
145 Bala et al, supra note 2 at 141.
146 Ibid at 142.
147 Ibid at 141; see also Scully & Finlay, supra note 14 at 16; Chuang & Wells, supra note 63 at 1815; Herz, Ryan & Bilchik, supra note 36 at 317.
148 See Introduction at 7 and related references; see also supra notes 63-65; Bala et al, supra note 2 at 142; Scully & Finlay, supra note 14 at 25; Ontario, Office of the Provincial Advocate for Children and Youth for Ontario, Statement on Child and Youth Mental Health in Ontario (Toronto: Office of the Provincial Advocate for Children and Youth for Ontario, 2011) at 3; Children’s Mental Health Ontario,
Children’s Aid Societies: An Integral Player

Overview

As I detail further in Chapter Four, child protection agencies (or CAS) and child protection workers play an integral role in the family law (child welfare) system. And, they also play an important and needed role where a child in care becomes engaged with the criminal justice system – such as at the time of the arrest or at the bail hearing. Child protection workers’ involvement with children and families usually begins with suspected child maltreatment (e.g. abuse, neglect) being reported to the CAS. When protection concerns are reported to the CAS, they are “assessed” by child protection workers and, where there are “reasonable and probable grounds” that a child may be “in need of protection”, an investigation is started. Decisions as to whether an investigation is warranted are governed by statutory and policy frameworks. Despite this, significant differences in case decisions have not only been observed between jurisdictions, but also within jurisdictions that are governed by common statutory and policy frameworks.

Research suggests that child protection workers’ decisions regarding whether to investigate a child protection allegation are often based primarily on the immediate potential threats to a child’s safety. However, research also suggests that the decision may be

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150 Scully & Finlay, supra note 14 at 19-20, 24; Bala et al, supra note 2 at 140-41.
151 Wegner-Lohim, Kyte & Trocmé, supra note 2 at 3.
153 McLeod, supra note 31 at 254; Wegner-Lohim, Kyte & Trocmé, supra note 2 at 3-4.
154 Wells, Fluke & Brown, supra note 152 at 542, 543; McLeod, supra note 31 at 254.
influenced by a variety of other factors (described below), including factors outside of those prescribed in written policies. I explore the decisions of child protection workers at various stages along the “service continuum” (initial assessment, investigation, intervention, etc.) in more depth in Chapter Four, regarding cases involving children with mental health issues. However, I briefly canvass the nature and variance in these important decisions below, to illustrate the impact child protection workers have throughout the child protection process, beginning with the decision as to whether to investigate a claim.

Investigation Decisions

When first assessing an alleged child protection concern, the primary focus of child protection workers is generally about threats of imminent or ongoing danger to the child. Research suggests that child protection workers’ decisions regarding investigations often are influenced strongly by the “presence or severity of injury”. However, research also suggests that these and other decisions (e.g. whether to intervene, service referrals) may be influenced by various other factors including, who made the referral and completeness of the referral, type of alleged maltreatment (e.g. sexual abuse), perpetrator intent and level of cooperation with CAS, child’s age, ethnicity, and disability (existence, type), and organizational (agency) structure.

The families who come in contact with CAS as a result of reported child protection concerns, “are among the most vulnerable groups in society and typically present with exceptionally complex needs”. The parents or other caregivers may be struggling with a series

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156 Wells, Fluke & Brown, supra note 152 at 525, 539-40, 542; Smith et al, “Role Specialization and Service Integration”, supra note 155 at 140.
157 Smith et al, “Role Specialization and Service Integration”, supra note 155 at 140.
158 Ibid at 146; Butler et al, supra note 155 at 359.
160 Wells, Fluke & Brown, supra note 152 at 525, 539-40; Manders & Stoneman, supra note 159 at 230, 235; Smith et al, “Role Specialization and Service Integration”, supra note 155 at 140-41.
161 Smith et al, “Role Specialization and Service Integration”, supra note 155 at 139.
of challenges, including mental health, addictions, physical or cognitive issues, poverty, and domestic violence. The children may, in addition to imminent threats to their safety, be dealing with physical or mental health issues, developmental delays, or other difficulties. Decisions regarding whether an investigation is warranted may be “especially difficult” where a child has a disability. There are several possible reasons for this – lack of information about the disability, ambiguities and multiple plausible explanations (e.g. injuries may be explained by abuse, or by the manifestations of the disability), and biases, attitudes, and beliefs of child protection workers. Researchers have found that child protection workers’ decisions – regarding investigating, intervening, recommending services, apprehension, etc. – may be affected both by whether a child has a disability, and the type of disability (e.g. physical, developmental, mental).

Other research suggests that organizational structure – specialized departments dealing with different phases of the child protection process (e.g. some workers conduct investigations, others provide ongoing services) or “generalist structure” (e.g. the same workers conduct investigations and provide ongoing services) – and service integration between the child protection agency and other service providers (e.g. mental health professionals) may have an effect on child protection workers’ decision making. Studies have found that child protection workers in “generalist agencies” and “multiservice” (integrated) agencies are more likely to make service referrals while a case is being investigated, as compared to child protection workers in specialized agencies. And, referrals to support services are more often part of the

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162 Ibid.
163 Ibid.
164 Manders & Stoneman, supra note 159 at 230.
165 Ibid at 230, 235.
166 Ibid at 230, 235-36.
167 Smith et al., “Role Specialization and Service Integration”, supra note 155 at 140-41.
168 Ibid at 140, 145, 147.
investigation phase in “multiservice” agencies than in single service agencies (generalized or specialized).\textsuperscript{169} I describe the effects of organizational structure and various other factors (such as presence and type of disability, personal beliefs and biases) on the decisions made by child protection workers, as well as the importance of these threshold decisions, in greater detail in Chapter Four.

The importance of the threshold decision made by child protection workers as to whether an alleged child protection issue merits an investigation cannot be overstated.\textsuperscript{170} Nor can the decision at the conclusion of an investigation as to whether the concerns have been substantiated or not.\textsuperscript{171} Child protection workers make a decision as to whether a child is likely to be “in need of protection” well \textit{before} the Court is asked to make a finding that a child is “in need of protection” and, in this way, are essentially the gatekeepers who decide if Court proceedings will be commenced at all. The implications are particularly salient for children with mental health issues given the relationship between maltreatment and mental health issues, the significant number of children in care who are dealing with mental health issues, and the research findings regarding the effects of childhood mental health issues on child protection workers’ decisions regarding investigation, intervention, and service referral (all of which I discuss in detail in Chapter Four).\textsuperscript{172}

\textbf{Substantiated Cases}

Where child protection workers conclude that reported concerns have been substantiated (as opposed to not being substantiated or being inconclusive) and the child is “in need of protection”, a child protection worker may work with the child and family on a voluntary basis,

\textsuperscript{169} \textit{Ibid} at 146.
\textsuperscript{170} Consider Wells, Fluke & Brown, supra note 152 at 542, 543.
\textsuperscript{171} See Wegner-Lohim, Kyte & Trocmé, supra note 2 at 4; consider Lens, Cary Katz & Spencer Suarez, supra note 149 at 107-08.
\textsuperscript{172} Bala et al, supra note 2 at 139; Herz, Ryan & Bilehik, supra note 36 at 309; Scully & Finlay, supra note 14 at 3; Manders & Stoneman, supra note 159 at 230, 235-36; Smith et al, “Role Specialization and Service Integration”, supra note 155 at 140-41.
or services may be mandated by Court order.\(^\text{173}\) Child protection workers may make referrals to a variety of services in an effort to address some of the complex issues and needs that often confront the children and families that become engaged with the CAS.\(^\text{174}\) Services to which referrals are made include child-focused services, such as psychological evaluations or counselling, and parent-focused services, such as anger management or substance abuse treatment programs.\(^\text{175}\) The making of decisions by child protection workers regarding referrals to treatment and support services has been characterized as a “critical task”.\(^\text{176}\) However, as I discuss in depth in Chapter Four, referrals to mental health services for children involved with the CAS (and identification of the need for these services) are discretionary and inconsistent, and despite the significant number of children in care who have mental health issues, only a small percentage of these children receive the mental health services they need.\(^\text{177}\)

**Child Protection Proceedings**

Child protection proceedings may be commenced by the CAS for a finding that a child is “in need of protection” and orders allowing the CAS to intervene in the family.\(^\text{178}\) Child protection proceedings often are engaged where a child protection worker believes it is necessary to “apprehend” a child (i.e. take the child into care and put them in an out-of-home placement such as a foster home or a relative’s home).\(^\text{179}\) As I discuss further in Chapters Three and Four, child protection workers continue to play a central role when cases proceed to Court for “in need

\(^\text{173}\) Wegner-Lohim, Kyte & Trocmé, supra note 2 at 4, 5; CYFSA, supra note 1, ss 22, 101.

\(^\text{174}\) Smith et al, “Role Specialization and Service Integration”, supra note 155 at 139, 140; Manders & Stoneman, supra note 159 at 230.

\(^\text{175}\) Manders & Stoneman, supra note 159 at 230; Smith et al, “Role Specialization and Service Integration”, supra note 155 at 139.

\(^\text{176}\) Smith et al, “Role Specialization and Service Integration”, supra note 155 at 139.

\(^\text{177}\) Jill A Hoffman et al, “Child Welfare Caseworkers’ Perspectives on the Challenges of Addressing Mental Health Problems in Early Childhood” (2016) 65 Child Youth Serv Rev 148 at 152-54; Manders & Stoneman, supra note 159 at 235-36; Scully & Finlay, supra note 14 at 3; Chuang & Wells, supra note 63 at 1814.

\(^\text{178}\) McLeod, supra note 31 at 244; CYFSA, supra note 1, ss 81, 74.

\(^\text{179}\) Bala et al, supra note 2 at 131; Butler et al, supra note 155 at 356; McLeod, supra note 31 at 244; CYFSA, supra note 1, ss 81, 74(4), 101.
of protection” determinations and orders regarding care and custody of the child and mandated services.180

The information a child protection worker gathers about a child and family, and the assessments and recommendations they make, often inform the Court during child protection proceedings.181 Child protection workers are involved with the child and family before Court proceedings and, subject to the Court’s directions, generally continue to be involved with them on an ongoing basis.182 Once a child has been found by the Court to be “in need of protection” and an order regarding care and custody of the child (e.g. supervision order, order placing the child in the interim or extended care of the CAS) made, child protection workers continue to play a central role in the lives of these children.183 Child protection workers have the authority and responsibility for making key decisions affecting the lives of these children (e.g. where they live).184 And, the way a child protection worker treats a child in their charge (e.g. the amount of time they spend with them, the nature of their interactions) can have a significant impact on the child and how they form relationships with other people.185

Summary: Crisscrossing Systems and the Failure to Provide Protection

The statutes governing the family law (child welfare) system and the youth criminal justice system contain various provisions designed to protect and support the vulnerable children that become engaged with these two systems. A review of the law in practice reveals an overlap between these legal spheres and the extensive “crossover” of children between the family law (child welfare) and criminal justice systems, with children in care, particularly those with mental

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180 Lens, Cary Katz & Spencer Suarez, supra note 149 at 107-08; see also Butler et al., supra note 155 at 359.
181 Lens, Cary Katz & Spencer Suarez, supra note 149 at 107-08, 110-11; Butler et al., supra note 155 at 361, 358.
182 Lens, Cary Katz & Spencer Suarez, supra note 149 at 107-10.
183 Scully & Finlay, supra note 14 at 18-19; Lens, Cary Katz & Spencer Suarez, supra note 149 at 108-10.
184 Scully & Finlay, supra note 14 at 18; Lens, Cary Katz & Spencer Suarez, supra note 149 at 108.
185 Scully & Finlay, supra note 14 at 18-19; see also Bala et al., supra note 2 at 139.
health issues, being significantly overrepresented in the criminal justice system. It also reveals that, of these children, few are getting the services they need or receiving the support and protection the legislation was intended to provide. The reasons the family law (child welfare) and criminal justice systems are failing these children are multiple and complex and involve various facets and actors within both systems, including a significant role played by child protection workers.

I explore the implementation of the legislative provisions that affect children with mental health issues and the outcomes these children experience in depth in Chapters Three and Four. Before delving into the implementation of the legislation by the family law (child welfare) and criminal justice systems and by the CAS, in the next Chapter I focus on the written law and how mental health issues are conceptualized and defined in the CYFSA and the YCJA (by adoption of the definition in the Criminal Code). My analysis includes an assessment of the type of model the statutory definitions reflect (medical or social) and the implications this has for children with mental health issues generally, and specifically with respect to adequately meeting their protection needs.
Chapter Two

How Words Can Deprive a Child of Needed Care: Legislative Definitions of Mental Health Issues in the Family Law and Criminal Justice Systems

Introduction

A significant number of children who are engaged with the family law (child welfare) system and the criminal justice system have mental health issues.¹ Despite the high prevalence of mental health issues amongst children who are in care and/or involved in the youth criminal justice system, only a small percentage are getting the services and supports they need.² The prevalence of mental health issues and the relevance of certain mental states is acknowledged in legislation in both the family law (child welfare) and criminal justice systems. The Child, Youth and Family Services Act, 2017³ (“CYFSA”), and the Youth Criminal Justice Act⁴ (“YCJA”) and Criminal Code⁵, contain provisions regarding obtaining assessments to determine whether a child has emotional or psychological issues. And, they contain provisions that govern and guide the Court as to the outcomes available where certain mental states are found to exist (and related criteria are met).

In this Chapter, I argue that the way mental health issues are defined in the CYFSA and YCJA (by incorporation of the provisions of the Criminal Code) reflects a medical model, and that this contributes to the failure to adequately meet the protection needs of children with mental health issues who are engaged in the family law (child welfare) and criminal justice systems. I begin by briefly reviewing the terminology used in the academic literature to describe mental health issues and the significance of the labels applied to different mental states. Next, I set out

¹ See Introduction at 7 and related references.
² See ibid at 8 and related references.
³ Child, Youth and Family Services Act, 2017, SO 2017, c 14 (“CYFSA”); as noted, the CYFSA was recently enacted, replacing the Child and Family Services Act RSO 1990, c C.11 (“CFSA”).
⁴ Youth Criminal Justice Act, SC 2002, c 1 (“YCJA”).
⁵ Criminal Code, RSC 1985, c C-46.
the definitions relating to mental health issues in the CYFSA in the context of child protection ("emotional harm" and "mental, emotional or developmental condition") and committal to secure treatment programs ("mental disorder"), and in the Criminal Code ("mental disorder"). I then describe the medical model and the models (referred to collectively herein as "social models") that challenge this dominant paradigm. Finally, I demonstrate how the definitions in the legislation reflect the medical model and outline the related implications for children with mental health issues who are engaged in the family law (child welfare) and criminal justice systems.

**Different Terms, Different Implications**

The concepts of mental health and mental disorder are complex, and purport to capture a wide range of cognitions, emotions, and behaviours. The ways that different mental states are conceptualized and understood reflect the complex interaction of a variety of factors, including social (e.g. dominant ideas of what is “normal”), political, legal, and professional trends (e.g. changes in the dominant paradigms adopted within the psychiatric profession). These conceptualizations can change over time, evolving with new scientific developments or shifts in public opinions. Indeed, over time and across cultures, the ways different mental states have been conceptualized have varied widely, including, as Jennifer A. Chandler notes, being

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8 Hy Bloom & The Honourable Richard D Schneider, *Mental Disorder and the Law: A Primer for Legal and Mental Health Professionals, 2nd ed* (Toronto: Irwin Law, 2017) at 5; Noah, supra note 7 at 249.

9 The shifting views within psychiatry regarding what constitutes a “disorder” is clearly demonstrable when the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM") is considered. The DSM is a (very widely used and accepted) diagnostic classification system which is published by the American Psychiatric Association and sets out the clinical criteria that define psychiatric conditions (Thomas A Ban, “Academic Psychiatry and the Pharmaceutical Industry” (2006) 30 Prog Neuropsychopharmacol Biol Psychiatry 429 at 434; Bloom & Schneider, supra note 8 at 5). The DSM has been revised and re-released seven times since it was first published in 1952, with some revisions being minor and others more substantial (Bloom & Schneider at 5-6; Shorter, supra note 7 at 298, 300-05). Some previously classified “disorders” (e.g. homosexuality) have been “delisted” (“depathologized”), many more phenomena have been “pathologized”, and the number of distinct disorders in the DSM has increased significantly over subsequent editions (e.g. DSM II, published in 1968, listed 180 disorders, DSM-IV, published in 1994, listed 297) (Shorter at 302-03, 305, 299).
attributed to supernatural phenomena versus being understood in biological terms. The way different mental states are conceptualized is often reflected in the terminology that is chosen to describe these phenomena.

The terminology used to describe different mental states reflects the ways the mental states are understood and also suggests how they should be dealt with. For example, in biological psychiatry different mental states are understood “primarily in terms of the biological functioning of the nervous system”. Understanding different mental states in biological terms medicalizes the mental states. Where a mental state is medicalized, it is defined as a medical problem (an illness or disorder) that requires treatment by medical intervention (often medication). Characterizing certain mental states as illness or disorder not only connotes a medical orientation, it also encourages a view of the mental states or behaviours (the symptoms of the mental illness or disorder) as atypical or problematic (an assessment that necessitates judgments as to what is normal or acceptable), and as requiring remediation (through medical intervention).

Though dominant, the medical model and the related language (illness, disorder), is not universally accepted. Some scholars refer to “mental health problems”.

12 Ibid at 3.
15 Smith, supra note 13 at 76, 77; Chandler, “Mental Health and Disability”, supra note 11 at 6-7; Timothy T Culbert, “Mental Health Reform for a New Government in New Brunswick” (2011) 62 UNBLJ 173 at 177; Aneshensel, Phelan & Bierman, supra note 6 at 9, 4; Bloom & Schneider, supra note 8 at 42; Lemmens & Sheldon, supra note 14 at 240.
16 Chandler, “Mental Health and Disability”, supra note 11 at 4; Noah, supra note 7 at 244-45; Aneshensel, Phelan & Bierman, supra note 6 at 3, 4; Culbert, supra note 15 at 177; Kaiser, “Redirecting the Ship”, supra note 13 at 153.
17 See Kaiser, “Redirecting the Ship”, supra note 13 at 153; Aneshensel, Phelan & Bierman, supra note 6 at 4; Chandler, “Impact of Biological Psychiatry”, supra note 10 at 832.
terminology which acknowledges the existence of distressing mental states or behaviours, without suggesting a need for medical intervention. Others speak of “mental disability”, a term tied to the “social model of disability” which shifts the focus from an ailment within an individual, to the effects of social factors such as economic barriers and lack of accommodation.

Some of this terminology (though not necessarily the related definitions) is adopted within the legal system. Mental health issues are engaged and differently defined in a wide variety of legal contexts, with significant implications. In the criminal context, mental health issues may come to the fore where there are questions about the fitness of the accused to stand trial, or about the availability of the defence of mental disorder (as I discuss in Chapter Three, mental health issues also may be relevant to a variety of other legal determinations, including regarding admissibility of statements, assessments, and sentencing). In the civil context, mental health issues commonly come to the fore in relation to the rules and procedures governing hospitalization and treatment (e.g. involuntary committal). However, mental health issues also intersect with legal issues in a variety of other contexts. As I discussed in Chapter One, these other contexts include proceedings under the CYFSA in regards to the committal of

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18 Chandler, “Mental Health and Disability”, supra note 11 at 4; Culbert, supra note 15 at 177.
20 Consider Noah, supra note 7 at 271-72; Bloom & Schneider, supra note 8 at 8; John E Gray, Margaret A Shone & Peter F Liddle, Canadian Mental Health Law & Policy, 2nd ed (Markham, ON: LexisNexis Canada Inc, 2008) at 14-15; Cooper v R (1979), [1980] 1 SCR 1149, [1979] SCC No 139 (SCC) [Cooper] at para 42; Children’s Aid Society of Simcoe (County) v A (M), 2011 ONSC 5115, 207 ACWS (3d) 94 [A (M)] at para 28.
24 See ibid.
children to secure treatment programs and in regards to protection findings in child protection proceedings.\textsuperscript{25}

\textbf{Legislative Definitions}

\textbf{Family Law System}

The \textit{CYFSA} provides that a child may be found to be “in need of protection” where\textsuperscript{26} a child has suffered, or there is a risk that they are likely to suffer, “emotional harm”, resulting from the “actions, failure to act, or pattern of neglect” of the parent or person having charge of the child.\textsuperscript{27} A child may also be found to be “in need of protection” where the child has suffered, or there is a risk that they are likely to suffer, “emotional harm”, and the parent or person having charge of the child fails to provide services or treatment or (where the child is incapable of consenting) to consent to treatment to remedy, alleviate or, in the case of risk, prevent, the harm.\textsuperscript{28} In addition, a finding that a child is “in need of protection” also may be made where the child suffers from a “mental, emotional or developmental condition” which, “if not remedied, could seriously impair the child’s development” and the child’s parent or person having charge of the child fails to provide or (where the child is incapable of consenting) to consent to “treatment to remedy or alleviate the condition”.\textsuperscript{29}

The \textit{CYFSA} also contains provisions addressing the committal or emergency admission of children to secure treatment programs.\textsuperscript{30} Pursuant to the provisions in the Extreme Measures section of the \textit{CYFSA} (Part VII), where specified criteria are met, a child with a “mental

\textsuperscript{25} \textit{CYFSA, supra} note 3, Part VII, ss 74(2)(f)-(j).

\textsuperscript{26} The basis upon which a child may be “in need of protection” are also reflected in s 125(1) in relation to the duty to report suspected child maltreatment (e.g. physical harm, emotional harm, sexual molestation, etc.) (\textit{CYFSA, supra} note 3).

\textsuperscript{27} \textit{Ibid}, ss 74(2)(f), (h).

\textsuperscript{28} \textit{Ibid}, ss 74(2)(g), (i); the \textit{CYFSA} provides that the child be “incapable of consenting to the treatment under the Health Care Consent Act, 1996” for the finding of “in need of protection” to be based on the parent’s failure to consent to treatment (ss 74(2)(g), (i), (j)). The capacity of a child to consent was not mentioned in the related provisions in the \textit{CFSA, supra} note 3. It is beyond the scope of this Thesis to address situations where a child has capacity to consent to treatment on their own behalf.

\textsuperscript{29} \textit{CYFSA, supra} note 3, s 74(2)(j).

\textsuperscript{30} \textit{Ibid}, ss 157, 158; secure treatment programs are locked treatment facilities where “continuous restrictions are imposed on the liberty of the children” (\textit{Ibid}).
disorder” may be committed or admitted on an emergency basis to a secure treatment program.31 The term “mental disorder” is defined in the Act, as is the term “emotional harm”.32 The way these terms, and the reference to “mental, emotional or developmental condition” are defined and understood is described below. For purposes of this discussion the terms are considered in isolation. However, in reviewing these definitions it is important to remember that they are part of a larger legislative scheme and are to be interpreted in accordance with the objective of that scheme.33 The definitions in the CYFSA are part of a broader child welfare framework, with the paramount purpose of promoting the best interests, protection and well-being of children, and additional purposes (where consistent with the paramount purpose) of supporting the family unit and minimizing state intervention.34

Child Protection – Emotional Harm and Mental, Emotional or Developmental Condition

The term “emotional harm” is defined in section 74(2)(f) of the CYFSA as being “demonstrated by serious, (i) anxiety, (ii) depression, (iii) withdrawal, (iv) self-destructive or aggressive behaviour, or (v) delayed development”.35 The jurisprudence establishes that the “types” of emotional harm listed in section 74(2)(f) are “exhaustive in determining whether a child is in need of protection”.36 To come within the definition of “emotional harm”, the “specified criteria in the legislation must be met”.37 Where conclusions drawn from the evidence are of “something less, or different” than the listed criteria, the claim that a child has suffered, or is at risk of suffering from, “emotional harm” will not be made out.38

31 Ibid, ss 164, 171.
32 Ibid, ss 157, 74(2)(f).
33 C (NV) v Catholic Children’s Aid Society of Toronto, 2017 ONSC 796, 276 ACWS (3d) 625 [C (NV)] at para 35.
34 CYFSA, supra note 3, s 1; C (NV), supra note 33 at para 35.
35 This definition is mirrored in s 125(1)(f) in the context of duty to report (CYFSA, supra note 3).
36 Catholic Children’s Aid Society of Toronto v R (M) (2003), 126 ACWS (3d) 966, [2003] OJ No 4385 (ONCJ) [R (M)] at para 13; C (NV), supra note 33 at paras 88, 89; while these cases refer to the CFSA, supra note 3, section 37(2)(f) of the CFSA, mirrors section 74(2)(f) of the CYFSA, supra note 3.
37 C (NV), supra note 33 at para 82.
38 Ibid at paras 82, 89.
For the purposes of the child protection provisions in the CYFSA, “emotional harm” does not capture “every kind of emotional harm” that a child may experience.\textsuperscript{39} Courts have recognized that children may experience “many emotions” that may be “harmful”, but “not harmful enough to require state intervention”.\textsuperscript{40} As Justice Spence pointed out in Catholic Children’s Aid Society of Toronto v. R. (M.) (“R. (M.)”), the wording in section 37(2)(f) of the CFSA (now section 74(2)(f) of the CYFSA) suggests “that the legislature intended to limit the types of emotional harm that could lead to a finding that a child is in need of protection”.\textsuperscript{41} The legislature could have, but did not, include language that would allow for a broader interpretation of “emotional harm”.\textsuperscript{42} This broader interpretation would be available if, for example, the legislature had chosen language whereby “emotional harm” is demonstrated by conditions (e.g. oppositional defiant disorder, conduct disorder) diagnosed by a mental health professional (e.g. psychologist or psychiatrist), including (rather than limited to), anxiety, depression, etc.\textsuperscript{43} Instead, the definition of “emotional harm” in the legislation sets out specific enumerated grounds.\textsuperscript{44} These enumerated grounds connote problems that are generally serious in nature and that are certainly more serious than more transitory or temporary feelings of, for example, fear or anger.\textsuperscript{45} Indeed, the legislation explicitly stipulates that the enumerated grounds are to be “serious”; “emotional harm” is “demonstrated by serious” anxiety, depression, withdrawal, self-destructive or aggressive behaviour, or delayed development (emphasis added).\textsuperscript{46}

In R. (M.), Justice Spence noted that the inclusion of the words “demonstrated by serious…” in the legislative definition, in addition to the enumerated grounds selected, “also

\textsuperscript{39} R (M), supra note 36 at para 11.
\textsuperscript{40} Ibid; see also A (M), supra note 20 at para 28.
\textsuperscript{41} R (M), supra note 36 at para 10.
\textsuperscript{42} Ibid.
\textsuperscript{43} Ibid.
\textsuperscript{44} Ibid; C (NV), supra note 33 at para 82; CYFSA, supra note 3, s 74(2)(f).
\textsuperscript{45} R (M), supra note 36 at para 11; A (M), supra note 20 at para 28.
\textsuperscript{46} CYFSA, supra note 3, s 74(2)(f); see also R (M), supra note 36 at para 12.
suggest that the kind of emotional harm intended to be captured by this section is limited to emotional harm that would have the most serious and greatest impact on the individual”. That the term “serious” is “an adjective with some meaning” was also recognized by Justice Kukurin in *Kunuwanimano Child and Family Services v. S. L.* Querying where the “line” was to be drawn between serious and not serious, Justice Kukurin stated: “I would require the opinion of a qualified emotional and mental health practitioner, preferably one who has examined the child beforehand, to satisfy me that this child is at risk of harm on this ground, and that the symptoms of the emotional harms [sic] was serious”.

As I describe in greater detail in Chapter Three, establishing that a child suffers from “emotional harm”, as demonstrated by one or more of the enumerated criteria that are included in the legislative definition (e.g. anxiety, depression), will generally require medical evidence, most often the evidence of an expert qualified to make clinical or psychiatric diagnoses. However, as I also discuss, while expert medical evidence may be persuasive, the weight to be given to the evidence and the ultimate decision as to whether a legislative definition is met, remains with the trier of fact (i.e. the Court or Board). And, as I also illustrate and discuss in Chapter Three, despite the specificity of the definition and use of expert evidence, the relationship and distinction between “behavioural issues” (e.g. defying authority by engaging in acts like truancy, drinking, sexual activity) and “emotional harm” (as defined in the legislation) becomes blurred in some cases.

47 *R (M)*, *supra* note 36 at para 12.
49 *R (M)*, *supra* note 36 at para 11; *A (M)*, *supra* note 20 at paras 28, 29.
Assessments of mental states and behaviours are also relevant under section 74(2)(j) of the CYFSA. Section 74(2)(j) addresses circumstances in which a child “suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child’s development” and where the parent or person having charge of the child “does not provide treatment or access to treatment” or (where the child is incapable of consenting) “refuses or is unavailable or unable to consent to the treatment to remedy or alleviate the condition”. Unlike the case of “emotional harm”, the reference in section 74(2)(j) to “mental, emotional or developmental condition” is not defined. The predecessor provision in the CFSA has been referred to by the Courts as “the section targeting special needs children and failure or inability to provide appropriate treatment”. The term “special need” is defined in Part III of the CYFSA, Funding and Accountability, as meaning, in relation to select provisions, “a need that is related to or caused by a developmental disability or a behavioural, emotional, physical, mental or other disability”. The term “special need” is not defined in the interpretation section in Part V, Child Protection, nor is it referenced in the provisions relating to findings of “in need of protection”.

A request to “import” a definition where the existence or absence of a “mental disability” was in issue was considered by Justice Katarynych in Catholic Children’s Aid Society of Metropolitan Toronto v. T. (N.). In that case, Her Honour was asked to use the definition of “mental disorder” in the Extraordinary Measures part of the CFSA, in determining whether a mother whose child was in care was “under a mental disability” and therefore required representation by Ontario’s Public Guardian and Trustee pursuant to the Rules governing the

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52 CYFSA, supra note 3, s 74(2)(j).
53 C (NV), supra note 33 at para 138; while this case refers to section 37(2)(h) of the CFSA, supra note 3, section 74(2)(j) of the CYFSA, supra note 3 is substantially similar (with the addition of reference to the child being incapable of consenting on their own behalf).
54 CYFSA, supra note 3, s 62.
55 See ibid, s 74.
child protection proceedings. Refusing to import the definition of “mental disorder”, Justice Katarynych noted that the definition in Part VI (now Part VII of the CYFSA) was “reserved” for the situations in that part of the Act and stated: “where words are not defined by statute or Rule, and no binding case authority is submitted in support of an argument that the words must be interpreted in a certain manner, as a matter of common sense, a court has recourse to the use of the words in ordinary legal or lay parlance”.

Extraordinary Measures

The term “mental disorder”, as it is used in relation to the emergency admission or commitment of children to secure treatment programs under Part VII (Extraordinary Measures), is defined in section 157 of the CYFSA. Section 157 of the CYFSA provides that “mental disorder” means “a substantial disorder of emotional processes, thought or cognition which grossly impairs a person’s capacity to make reasoned judgments”. The definition of “mental disorder” in section 112 of the CFSA (now section 157 of the CYFSA) has been characterized as being “somewhat narrow and stringent”. The Child and Family Services Review Board (“CFSRB”) has stated that the “test under the Act is not dependent on having a DSM disorder”, but that “the existence or traits of a DSM disorder can be evidence of a mental disorder under the Act” (as I discuss in Chapter Three, a review of the jurisprudence suggests that DSM diagnosis are highly influential, if not largely determinative, in many cases).

56 Catholic Children’s Aid Society of Metropolitan Toronto v T (N) (1999), [2000] WDFL 619, 1999 CarswellOnt 4811 (WLNext Can) (ONCJ (Prov Div)) at paras 20, 3, 17, 1, aff’d [2000] WDFL 620 (ONSC), leave to appeal refused, 2000 CarswellOnt 2230 (ONSC (Div Ct)).
57 Ibid at paras 20, 21; consider also Children’s Aid Society of Niagara Region v P (H) (2003), 125 ACWS (3d) 647, [2004] WDFL 49 (ONSC) [P (H)] at para 34.
58 Youthdale Treatment Centres Ltd v M (R) (1993), 43 ACWS (3d) 1168, [1994] WDFL 043 (ONCJ (Gen Div) [Div Ct]) [M (R)] at para 35; the cases herein refer to the definition of “mental disorder” in section 112 of the CFSA, supra note 3, which mirrors the definition in section 157 of the CYFSA, supra note 3.
59 M v Youthdale Treatment Centres, 2013 CFSRB 24 [M] at para 9; Y v. Youthdale Treatment Centres, 2013 CFSRB 20 [Y] at para 9; N v Youthdale Treatment Centres, 2013 CFSRB 18 [N] at para 6; the CFSRB is the board that conducts reviews of the emergency admission of children to secure treatment programs pursuant to section 171 of the CYFSA, supra note 3.
The CFSRB has also similarly noted that the definition of “mental disorder” under the CFSA (now CYFSA) is different from and “narrower” than the definition under the Mental Health Act (“MHA”), where “mental disorder” is defined as “any disease or disability of the mind”.\(^6^0\) In S. I. v. Youthdale Treatment Centres, the CFSRB held that the definition under the MHA, “clearly encompasses more disorders than does the CFSA definition”.\(^6^2\) In that case, the fact that the child had been held for a psychiatric assessment under the MHA (Form 1) was considered, but was held to be “in no way determinative of whether a mental disorder existed under the CFSA”.\(^6^3\) Similarly, the admitting psychiatrist’s indication that the child met the criteria for being held under the MHA at the time of the emergency admission to the secure treatment program was “of more, but still limited significance”, because “mental disorder” is defined differently under the MHA and CFSA (now CYFSA) (the latter being a narrower definition).\(^6^4\)

In regard to the second prong of the definition of “mental disorder” in the CFSA (now CYFSA) – “which grossly impairs a person’s capacity to make reasoned judgments” – the Court has held that “impulsiveness and bad judgment do not equate to gross impairment of a person’s capacity to make reasoned judgments”.\(^6^5\) In Children’s Aid Society of Niagara Region v. P. (H.), Justice Quinn held that “[c]onduct that is worrisome or a nuisance to others, bizarre, antisocial, belligerent, eccentric or even assaultive or self-assaultive is not, by that fact alone, necessarily enough to qualify” to meet the statutory requirements for ordering committal to a secure treatment program.\(^6^6\) Although Justice Quinn made these remarks in the context of interpreting

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\(^6^0\) Mental Health Act, RSO 1990, c M.7 (“MHA”).
\(^6^1\) S I v Youthdale Treatment Centres, 2010 CFSRB 30 [S I] at para 44; see also MHA, supra note 60, s 1(1).
\(^6^2\) S I, supra note 61 at para 44.
\(^6^3\) Ibid; see also MHA, supra note 60, s 15(1.1).
\(^6^4\) S I, supra note 61 at para 44.
\(^6^5\) Children’s Aid Society of Sudbury & Manitoulin (Districts) v C (C) (1999), 101 ACWS (3d) 304, 1999 CarswellOnt 4865 (WLNext Can) [C (C)] at para 23.
\(^6^6\) P (H), supra note 57 at para 36.
the reference to “serious bodily harm” in section 117(1)(b) of the *CFSA* (now section 164(1)(b) of the *CYFSA*), the CFSRB has held that the “decision is relevant to assessing the issue of whether the Child’s judgment was grossly impaired by a substantial disorder of thought, emotion or cognition as it addresses the types of decisions the child has been making (her judgment)”. I illustrate and discuss the types of mental states and behaviours that have been found by the Court and the CFSRB to meet (or fail to meet) the statutory definition in Chapter Three.

As I illustrate through the discussion in Chapter Three, the provisions under Part VII (Extraordinary Measures) can have a significant impact on the lives of the children who are the subject of applications for placement in secure treatment – both those who are placed in secure treatment programs and those who are not. The Extraordinary Measures section of the *CFSA* (now *CYFSA*) has been characterized as an “intrusive” section of the Act. The definition of “mental disorder” is central to this part of the Act; a child cannot be committed or admitted on an emergency basis to a secure treatment program unless the child is found to have a “mental disorder” as defined in section 157 of the *CYFSA*. Where a child is found to meet the definition of “mental disorder”, and the other criteria for committal (section 164) or emergency admission (section 171) to a secure treatment program are met, the child “is kept in a secure setting – that is, the child loses his/her freedom” for a specified period of time, subject to renewal. The CFSRB has recognized that these types of restrictive placements are to be used

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67 Pursuant to section 164(1)(b) of the *CYFSA* (previously section 117(1)(b) of the *CFSA*), one of the criteria for committal to a secure treatment program is that the Court be “satisfied that,...the child has, as a result of the mental disorder, within the 45 days immediately preceding [one of three occurrences]...caused or attempted to cause serious bodily harm to themself or another person” (section 171(2)(b) contains a similar requirement regarding “serious bodily harm”) (*CYFSA, supra* note 3; *CFSA, supra* note 3).
69 *C (C), supra* note 65 at para 20.
70 *CYFSA, supra* note 3, ss 164, 171; *C (C), supra* note 65 at para 20.
71 *M (B), supra* note 58 at para 35; see also *CYFSA, supra* note 3, ss 157, 158, 164, 171, 165, 167.
only in “the most dire of circumstances”, and only when all of the legislative criteria have been met.\textsuperscript{72}

\textbf{Criminal Justice System}

Considerations of freedom and liberty are also at issue in criminal justice proceedings, which similarly require that a specific legislative definition of “mental disorder” be met before the provisions invoking this term (e.g. defence of mental disorder) can succeed.\textsuperscript{73} In the criminal context, as Justice Trotter explains, speaking for the Ontario Court of Appeal in \emph{Nelson v. Livermore} (“\emph{Nelson}”), the focus is generally on “mental disorders that are incapacitating, in the sense of compromising criminal responsibility, or rendering a person unfit to stand trial”.\textsuperscript{74} Pursuant to the \emph{Criminal Code}, “[n]o person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong”.\textsuperscript{75} The statute codifies a presumption that the accused does “not suffer from a mental disorder so as to be exempt from criminal responsibility”.\textsuperscript{76} The presumption is rebutted where it is proved, on a balance of probabilities, that the accused was suffering from “a mental disorder so as to be exempt from criminal responsibility”.\textsuperscript{77} The burden of proof to establish that an accused is not criminally responsible by reason of mental disorder (“NCRMD”) rests with the party that raises the issue.\textsuperscript{78} As I discuss in Chapter Three, the existence of mental health issues, particularly those coming within the definition of “mental disorder”, are also relevant to a number of other matters in criminal proceedings, including findings as to an accused’s fitness to stand trial.

\textsuperscript{72} \textit{KD}, supra note 68 at para 22.
\textsuperscript{73} Consider \textit{Criminal Code}, supra note 5, ss 16, 2.
\textsuperscript{74} \textit{Nelson}, supra note 21 at para 58; see also \textit{Criminal Code}, supra note 5, ss 16, 2.
\textsuperscript{75} \textit{Criminal Code}, supra note 5, s 16(1); see also s 672.34.
\textsuperscript{76} \textit{Ibid}, s 16(2).
\textsuperscript{77} \textit{Ibid}.
\textsuperscript{78} \textit{Ibid}, s 16(3).
Section 2 of the Criminal Code defines “unfit to stand trial” as meaning “unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to (a) understand the nature or object of the proceedings, (b) understand the possible consequences of the proceedings, or (c) communicate with counsel”. As I noted in Chapter One, subject to being inconsistent with or excluded by the YCJA, “section 16 (defence of mental disorder) and Part XX.1 (mental disorder) of the Criminal Code apply, with any modifications that the circumstances require, in respect of proceedings under this Act in relation to offences alleged to have been committed by young persons”.79 As I also noted, the YCJA also generally provides that, subject to any inconsistencies or exclusions, the provisions of the Criminal Code “apply, with any modifications that the circumstances require, in respect of offences alleged to have been committed by young persons”.80

Mental Disorder

The term “mental disorder” is defined in section 2 of the Criminal Code as meaning, in the Act, “a disease of the mind”. The jurisprudence indicates that “mental disorder” should be given a broad and liberal interpretation, rather than applying a narrow or limited interpretation.81 The “classic formulation”82 of the meaning of “disease of the mind” was established by the Supreme Court of Canada (“SCC”) in Cooper v. R. (“Cooper”), where Justice Dickson (as he then was), speaking for the majority, stated that “‘disease of the mind’ embraces any illness, disorder or abnormal condition which impairs the human mind and its functioning, excluding, however, self-induced states caused by alcohol or drugs, as well as transitory mental states such

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79 YCJA, supra note 4, s 141(1).
80 Ibid, s 140; see also s 2(2), which provides that “[u]nless otherwise provided, words and expressions used in this Act have the same meaning as in the Criminal Code”.
81 Ordano, supra note 50 at paras 27, 100; Nelson, supra note 21 at para 57; Cooper, supra note 20 at para 49.
82 Nelson, supra note 21 at para 57.
as hysteria or concussion”. The “broad definition” articulated by Justice Dickson in *Cooper* has, as Justice Trotter noted in *Nelson*, “stood the test of time”. It has been cited and relied upon by numerous decisions, and remains the interpretation applied to the term “mental disorder” and the concept of a “disease of the mind” in relation to the *Criminal Code*.

Various conditions (e.g. personality disorder, Fetal Alcohol Spectrum Disorder, psychopathy) have been found by the Courts to constitute a “mental disorder” in specific cases (I discuss the illnesses, disorders, and conditions that have led to findings of NCRMD or unfit to stand trial in greater detail in Chapter Three). In addition, although “self-induced” states caused by alcohol or drugs are excluded from being considered a “disease of the mind” under the *Criminal Code*, the jurisprudence reflects that “sometimes a substance-induced psychosis may be found to be a disease of the mind”. While confirming that “temporary and self-induced ‘toxic psychosis’ are not diseases of the mind”, Courts have recognized that “factors may occur alongside a drug-influenced state which keeps s. 16 of the *Criminal Code* relevant in the case”.

In order for an alcohol or drug induced state to come within the definition of “mental disorder” for purposes of an NCRMD finding, at the time of the criminal act the accused must have been suffering from an underlying mental disorder which was exacerbated by the intoxication “to the point of psychosis”. In *R. v. J. (J.J.)*, Justice Jenkins comments on two “analytical tools” that can assist in this assessment, the “internal cause factor” and the “continuing danger factor”. The “internal cause factor” is concerned with the individual

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83 *Cooper*, supra note 20 at para 51.
84 *Nelson*, supra note 21 at para 57.
86 See *Cooper*, supra note 20 at para 77; *Bloom & Schneider*, supra note 8 at 8; Byrick & Walker-Renshaw, *supra* note 85 at 6-11; Verbrugge, *supra* note 50 at 6; *Nelson*, supra note 21 at para 57.
88 *J (JJ)*, *supra* note 85 at para 21.
89 Byrick & Walker-Renshaw, *supra* note 85 at 6-11.
90 *J (JJ)*, *supra* note 85 at para 22.
accused, and “whether the drug use would cause a ‘normal person’ to react in a similar way” (if it would not, an NCRMD finding may still be available). The “continuing danger factor” is concerned with public safety and “assessing the likelihood of recurring danger to others despite any willful action by the accused, including drug use” (where danger is likely to arise because of the “inherent condition”, it is more likely the condition will be considered a “disease of the mind”).

Models of Mental Disorder

Medical Model

Medicalization

Medicalization generally involves defining a natural or non-medically defined condition or occurrence “as a medical problem, understanding it through a medical framework, and treating it using a medical solution”. It involves a shift whereby naturally occurring happenings (e.g. menstruation, hyperactivity, sadness) are conceptualized in medical terms, namely as “medical conditions” (sickness) that require medical treatment. Conceiving of different mental experiences as medical conditions (illnesses, disorders) is just one of many ways that different mental states and behaviours have been conceptualized over time and across cultures (e.g. in moral or ethical terms, in biological terms, as character flaws, as supernatural phenomena, etc.). It is beyond the scope of this Thesis to review how conceptualizations of different mental states have evolved to the current characterizations of illness and disorder.

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91 Ibid.
92 Ibid.
93 It is beyond the scope of this Thesis to engage in the debate about what model, if any, should be the model of mental disorder. Rather, in this Chapter, I describe models of mental disorder that are discussed in the academic literature, and then assess which model is reflected in the legislative definitions in the CYFSA and Criminal Code.
94 Smith, supra note 13 at 76; Aneshensel, Phelan & Bierman, supra note 6 at 9.
95 Smith, supra note 13 at 76; Lemmens & Sheldon, supra note 14 at 224; Aneshensel, Phelan & Bierman, supra note 6 at 3, 9; Shorter, supra note 7 at 289-92.
96 Smith, supra note 13 at 76; Chandler, “Impact of Biological Psychiatry”, supra note 10 at 832; Shorter, supra note 7 at 26-32.
97 Aneshensel, Phelan & Bierman, supra note 6 at 4; Smith, supra note 13 at 76; Chandler, “Impact of Biological Psychiatry”, supra note 10 at 832; Chandler, “Mental Health and Disability”, supra note 11 at 4.
However, it is nonetheless important to take note of the shift to a medical orientation, and of the role played by psychopharmacology in the ascendency of the medical model as the dominant paradigm through which mental health issues are conceptualized.98

The ascendency of the medical model in psychiatry, whereby naturally occurring conditions (e.g. hyperactivity, anxiety, unhappiness) came to be conceptualized as illnesses or disorders, began in earnest in the latter part of the 20th century.99 With the introduction and growing popularity of new antidepressant and antipsychotic medications and the release of a new diagnostic classification system in the “science-driven” DSM-III in the 1980s, the dominant paradigm in psychiatry became firmly rooted in the medical model.100 The paradigm underpinning biological psychiatry reflects a medical orientation which, as Edward Shorter states, “stresses the neurosciences, with their interest in brain chemistry, brain anatomy, and medication, seeing the origin of psychic distress in the biology of the cerebral cortex”.101

Symptoms – Diagnosis – Cure

Under the medical model normally occurring phenomena (e.g. sadness) are medicalized, such that they come to be seen as illnesses or disorders.102 Under this paradigm, mental illness or disorder is thought of in the same way as physical illness or disorder, namely, as a specified condition that requires medical treatment.103 Pursuant to the medical model, a constellation of “symptoms” are “diagnosed” as “illness(es)” or “disorder(s)” that require “treatment” by a

98 Consider Smith, supra note 13 at 76; Shorter, supra note 7 at 289-92, 297-98, 319-25; Lemmens & Sheldon, supra note 14 at 224; Ban, supra note 9 at 437; Kaiser, “Redirecting the Ship”, supra note 13 at 153.
99 Smith, supra note 13 at 76; Shorter, supra note 7 at 289-92; Aneshensel, Phelan & Bierman, supra note 6 at 3.
100 Shorter, supra note 7 at 291, 300-02, 319-25; Smith, supra note 13 at 76, 77; see also Ban, supra note 9 at 432-35; Kaiser, “Redirecting the Ship”, supra note 13 at 153.
101 Shorter, supra note 7 at 26; see also Chandler, “Impact of Biological Psychiatry”, supra note 10 at 832; Culbert, supra note 15 at 177; Aneshensel, Phelan & Bierman, supra note 6 at 4; Andersen-Watts, supra note 13 at 142, n 3; Smith, supra note 13 at 78.
102 Aneshensel, Phelan & Bierman, supra note 6 at 3; Smith, supra note 13 at 76; Kaiser, “Redirecting the Ship”, supra note 13 at 153-54.
103 Culbert, supra note 15 at 177; Aneshensel, Phelan & Bierman, supra note 6 at 4, 5.
doctor (psychiatrist).\textsuperscript{104} Not surprisingly, the medical professional (the psychiatrist) is a central figure under the medical model both in regards to treatment and assessment.\textsuperscript{105}

At the most basic level, the assessment as to what mental states and behaviours are classified (diagnosed) as a mental illness or disorder depends on conceptions about what constitutes normal or healthy mental states and behaviours.\textsuperscript{106} Against this backdrop, under the medical model problematic mental states or behaviours are seen as “signs and symptoms” of pathology.\textsuperscript{107} The individual is seen as having something “wrong” with them, of being “impaired” by something that is properly characterized (diagnosed) as a mental illness or disorder.\textsuperscript{108} The illness or disorder is regarded as something that is inherent to the individual.\textsuperscript{109} It is explained by factors internal to the individual, such as “genetic defects, biochemical imbalances, hormonal dysregulation, and neuronal deficits”\textsuperscript{110}.

The illness or disorder is believed to be treatable and curable through medical interventions, namely medications (pharmacotherapy), possibly coupled with psychotherapy (i.e. “talk therapy”).\textsuperscript{111} As the illness or disorder is seen as a malfunction or defect within the individual, treatments are focused on medical interventions directed at rectifying these internal problems.\textsuperscript{112} They are aimed at eradicating or alleviating the symptoms (i.e. problematic mental


\textsuperscript{105} See Kaiser, “Redirecting the Ship”, \textit{supra} note 13 at 153-54; Kaiser, “Constrained Progress”, \textit{supra} note 104 at 7; Aneshensel, Phelan & Bierman, \textit{supra} note 6 at 4, 8.

\textsuperscript{106} Aneshensel, Phelan & Bierman, \textit{supra} note 6 at 3; Noah, \textit{supra} note 7 at 244-45.

\textsuperscript{107} Aneshensel, Phelan & Bierman, \textit{supra} note 6 at 4; Noah, \textit{supra} note 7 at 244.

\textsuperscript{108} Aneshensel, Phelan & Bierman, \textit{supra} note 6 at 4, 8; Kaiser, “Redirecting the Ship”, \textit{supra} note 13 at 153-54; Kay Wheat, “Mental Health and Stigma – How Best to Protect Workers from Discrimination” (2013) 34 Windsor Rev Legal Soc Issues 1 (WLNext Can) at 25.


\textsuperscript{110} Aneshensel, Phelan & Bierman, \textit{supra} note 6 at 4; Chandler, “Impact of Biological Psychiatry”, \textit{supra} note 10 at 832; Smith, \textit{supra} note 13 at 76-77; Andersen-Watts, \textit{supra} note 13 at 142, n 3.

\textsuperscript{111} Aneshensel, Phelan & Bierman, \textit{supra} note 6 at 4; Culbert, \textit{supra} note 15 at 177; Smith, \textit{supra} note 13 at 76-78; Kaiser, “Redirecting the Ship”, \textit{supra} note 13 at 153; Mosoff \textit{et al}, \textit{supra} note 109 at 461, n 88; Andersen-Watts, \textit{supra} note 13 at 147; Kaiser, “Constrained Progress”, \textit{supra} note 104 at 7.

\textsuperscript{112} Andersen-Watts, \textit{supra} note 13 at 146; Wheat, \textit{supra} note 108 at 26, 34; Mosoff \textit{et al}, \textit{supra} note 109 at 461, n 88; see also Kaiser, “Redirecting the Ship”, \textit{supra} note 13 at 154.
states or behaviour) of the illness or disorder. The focus under the medical model on treating mental illnesses or disorders through medical interventions is to be contrasted with the focus under social models on the effects of external rather than internal factors.

**Social Models**

There are a number of different paradigms that challenge the premises underpinning the medical model and offer alternative ways of conceptualizing and addressing mental health issues. These models include, for example, disability, sociopolitical, biopsychosocial, psychosocial, and human rights models. There is, of course, variance amongst the perspectives underpinning different paradigms, including regarding such fundamental premises as whether certain mental states or behaviours are legitimately illnesses or disorders, or whether they reflect anything being “wrong” at all. For the most part, however, these models reject the individualistic focus in the medical model and emphasize the importance of considering the broader social circumstances at play. To facilitate the within discussion, I use the term “social models” to refer generally to models that acknowledge the effects of social factors on mental health and on the construction and experience of “disability” more generally (i.e. mental and physical “disabilities”).

Social models present alternatives to the medical model and challenge the premises upon which it is based, particularly the notion that certain mental states or behaviours are properly understood as signs and symptoms of a mental illness or disorder occurring within the individual

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113 Andersen-Watts, supra note 13 at 147, 151; Wheat, supra note 108 at 25, 34; Kaiser, “Redirecting the Ship”, supra note 13 at 153; Culbert, supra note 15 at 180.
114 See Kaiser, “Redirecting the Ship”, supra note 13 at 155, 157, 155-56, n 73; Andersen-Watts, supra note 13 at 152; Mosoff et al, supra note 109 at 461, n 88.
115 See Kaiser, “Redirecting the Ship”, supra note 13 at 155, 155-56, n 73; Shorter, supra note 7 at 26, 29; Aneshensel, Phelan & Bierman, supra note 6 at 9-10.
116 Aneshensel, Phelan & Bierman, supra note 6 at 8, 9; see also Wheat, supra note 108 at 26, 34.
117 Andersen-Watts, supra note 13 at 152; Mosoff et al, supra note 109 at 461, n 88; Wheat, supra note 108 at 26.
118 Consider Kaiser, “Redirecting the Ship”, supra note 13 at 155-56, n 73; Aneshensel, Phelan & Bierman, supra note 6 at 9-10.
and treatable by medical intervention. As Carol S. Aneshensel, Jo C. Phelan, and Alex Bierman recognize, adherents to social models do not necessarily reject the notion that there are “sets of emotions, cognitions, and behaviors that tend to occur together, to be subjectively distressing, to create impairment, and to put the person at risk of adverse consequences” (i.e. that these “phenomena have an objective reality apart from their subjective interpretation”). However, many question whether these mental states and behaviours are properly characterized as illnesses or disorders (i.e. whether they are properly defined in medical terms). They observe that while similar distressing or impairing mental states and behaviours may occur across diverse settings (i.e. in different countries, cultures, etc.), the labels applied to these states, and the way they are defined, differs across cultures (e.g. being defined in medical terms versus being understood as having to do with the spirit or soul).

As the foregoing suggests, many social model adherents may accept that there are certain mental states or behaviours that are distressing or impairing and that these states are not merely a social construct. They also may accept the notion that these states may have biological basis and that medical care (including the use of medication) may be an important and beneficial part of alleviating these states. However, proponents of social models reject the characterization of mental states or behaviours as dysfunctions within the individual, focusing instead on the relationship between social systems and how mental health issues occur and are conceptualized, defined, and experienced.

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119 Andersen-Watts, supra note 13 at 152; Mosoff et al, supra note 109 at 461, n 88; Aneshensel, Phelan & Bierman, supra note 6 at 4; Kaiser, “Redirecting the Ship”, supra note 13 at 153.
120 Aneshensel, Phelan & Bierman, supra note 6 at 8-9.
121 Ibid at 9.
122 Ibid.
123 Ibid; see Andersen-Watts, supra note 13 at 152-53.
124 Kaiser, “Redirecting the Ship”, supra note 13 at 157-58; Aneshensel, Phelan & Birman, supra note 6 at 5; Andersen-Watts, supra note 13 at 156, 160.
125 Andersen-Watts, supra note 13 at 152-53; see also Kaiser, “Redirecting the Ship”, supra note 13 at 157-58; Wheat, supra note 108 at 26; Aneshensel, Phelan & Bierman, supra note 6 at 15.
Social models acknowledge the effects of life events (e.g. past stressful situations) and circumstances (e.g. social environment) on mental health. They consider the ways that conceptions of disabilities are constructed in (by) society and the effects of social factors on the occurrence and experience of these disabilities. Social models confront complex social issues including inequality, discrimination, access to employment, poverty, prejudice, exclusion, social barriers (e.g. stigma and institutional barriers), and consider how the disadvantages experienced by people with mental or physical disabilities are produced in social systems and structures.

Social models, as Judith Mosoff et al explain, “understand the disadvantage experienced by people with disabilities as flowing not from the impairment itself, but rather from society’s response to those impairments, in particular the construction of barriers to full participation in society based on the application of normative standards”.

Under a social model, the disadvantage experienced by people with disabilities (mental or physical) is seen as a failure within society to accommodate, rather than a failing on the part of the individual. In other words, rather than being attributed to a defect within the individual, the disadvantages experienced by people with “disabilities” (mental or physical traits that are characterized as atypical by dominant social norms) are attributed to social systems and structures that are designed for a “specifically-abled subset of the population” and that do not meet the needs of “other” individuals. Rather than focusing on how to get the individual to assimilate and comply with dominant social mores, the onus is placed on society to adapt

126 See Shorter, supra note 7 at 26, 29.
127 Kaiser, “Redirecting the Ship”, supra note 13 at 155, 157; see also Kaiser, “Constrained Progress”, supra note 104 at 6; Andersen-Watts, supra note 13 at 152-53, 156-57.
128 Kaiser, “Constrained Progress”, supra note 104 at 7; Andersen-Watts, supra note 13 at 152-53, n 69, 156-57, 159; consider also Aneshensel, Phelan & Bierman, supra note 6 at 13, 14.
129 Mosoff et al, supra note 109 at 461, n 88; see also Wheat, supra note 108 at 24; Andersen-Watts, supra note 13 at 156-57.
130 Andersen-Watts, supra note 13 at 152-53.
131 Ibid at 152, 152-53, n 69; Wheat, supra note 108 at 34, 26.
attitudes, social structures, and physical environments to accommodate the individual. Using a social lens highlights the importance of addressing social barriers and inequalities (e.g. stigma, poverty, housing issues, exclusion) and of providing appropriate, available, and accessible social supports and services (e.g. crisis prevention, mental health services).

**Legislative Definitions: Rooted in a Medical Model**

The ways “mental disorder” and other mental health concepts (e.g. “emotional harm”) are conceptualized and defined differs within and between various areas of the law and various legislative enactments. And, the ways mental health issues (e.g. “mental disorder”, “emotional harm”) are conceptualized and defined for legal purposes, does not necessarily mirror (though also may largely reflect) the way these concepts are viewed in the discipline of psychiatry. As Justice Dickson observed in *Cooper*: “Although the term expresses a legal concept, and a finding is made according to a legal test, psychiatric knowledge is directly linked to the legal conclusion, for medical testimony forms part of the evidence on which the trier of fact must reach its decision. But medical and legal perspectives differ”.

Whether a legislative definition is met is a legal question which is to be answered (i.e. the ultimate decision made) by the trier of fact. The definitions (or the provisions that apply them) in the *CYFSA* and *Criminal Code* relating to “mental disorder”, “emotional harm”, and

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134 Consider *CYFSA, supra* note 3, ss 74(2)(f), 157; *Criminal Code, supra* note 5, s 2; see also *Cooper, supra* note 20 at para 43; as I noted in the Introduction and illustrate in Chapter Three, conceptual differences also arise within the psychiatric field.
135 Consider Noah, *supra* note 7 at 271-72; Bloom & Schneider, *supra* note 8 at 8; *A (M), supra* note 20 at para 28.
136 In *Cooper*, the SCC was considering the meaning of the phrase “disease of the mind” (*supra* note 20 at para 41). The case, and the meaning the Court ascribed to this phrase, is detailed above, in the section regarding the definition of “mental disorder” in the criminal context.
137 *Cooper, supra* note 20 at para 42; see also *Ordano, supra* note 50 at para 100; Noah, *supra* note 7 at 271-72; Bloom & Schneider, *supra* note 8 at 8; the role of medical evidence in family law (child welfare) and criminal justice proceedings is discussed in detail in Chapter Three.
138 *Ordano, supra* note 50 at paras 34, 90, 91; Bloom & Schneider, *supra* note 8 at 64-65; Verbrugge, *supra* note 50 at 6; see also the discussion in Chapter Three.
“mental, emotional or developmental condition” may be characterized as containing legal criteria or reflecting a legal test or model.\textsuperscript{139} However, as I argue, the definitions still turn on a conceptualization that categorizes different mental states or behaviours in medical terms and thus reflect a medical model.

\textit{Legal Criteria}

In the context of placement in a secure treatment program under the Extraordinary Measures section (Part VII) of the CYFSA, the definition of “mental disorder”\textsuperscript{140} requires that there be a nexus between the disorder and the gross impairment of the child’s capacity to make reasoned judgements.\textsuperscript{141} Dual requirements are found also in the provisions of the \textit{Criminal Code} dealing with the defence of mental disorder. As outlined above, pursuant to section 16(1) of the \textit{Criminal Code}, for a finding of NCRMD it must be established that the act or omission at issue occurred “while” the accused was “suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong” (emphasis added).\textsuperscript{142} The first requirement is to establish that the accused was suffering from a “mental disorder” (“disease of the mind”) at the relevant time.\textsuperscript{143} The second requirement concerns the effects of the disorder, namely whether the “mental disorder” rendered the accused “incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong”.\textsuperscript{144}

\textsuperscript{139} Consider CYFSA, supra note 3, ss 74(2)(f)-(j), 112; Criminal Code, supra note 5, ss 2, 16.
\textsuperscript{140} The term “mental disorder” is defined as “a substantial disorder of emotional processes, thought or cognition which grossly impairs a person’s capacity to make reasoned judgements” (CYFSA, supra note 3, s 157).
\textsuperscript{141} Ibid; consider C (C), supra note 65 at paras 22, 39; N, supra note 59 at para 12; E P v Youthsdale Treatment Centres, 2015 CFSRB 10 [E P] at para 24.
\textsuperscript{142} See also J (JJ), supra note 85 at para 14.
\textsuperscript{143} See Criminal Code, supra note 5, s 16(1); see also Cooper, supra note 20 at para 53; J (JJ), supra note 85 at para 14.
\textsuperscript{144} J (JJ), supra note 85 at para 14; Verbrugge, supra note 50 at 10; Cooper, supra note 20 at paras 51-53; Criminal Code, supra note 5, s 16(1).
In the context of the child protection provisions in the CYFSA dealing with “emotional harm” and “mental, emotional or developmental condition”, the requirements that must be met for a finding that a child is “in need of protection” are “twofold”. The first requirement in the context of the “emotional harm” provisions is that the child has suffered, or there is a risk that the child is likely to suffer, “emotional harm”. The second requirement is that: either the “emotional harm” suffered, or the risk of likely suffering, results from the “actions, failure to act or pattern of neglect” on the part of the child’s parent or person having charge of the child; or, the parent or person having charge of the child “does not provide services or treatment or access to services or treatment” or (where the child is incapable of consenting on their own behalf) “refuses or is unavailable or unable to consent to the treatment to remedy or alleviate” or to “prevent” the harm. The requirements in section 74(2)(j) of the CYFSA similarly require that “the child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child’s development and the child’s parent or the person having charge of the child does not provide treatment or access to treatment” or (where the child is incapable of consenting) “refuses or is unavailable or unable to consent to the treatment to remedy or alleviate the condition” (emphasis added).

Medical Model: Adoption in Legislative Definitions

The trier of fact ultimately determines whether the criteria in a legislative definition and/or in related provisions are met. This determination turns on the presence or absence of certain mental states, specifically those that are of the kind set out in the legislative definition.

145 See S L, supra note 48 at para 91; see also CYFSA, supra note 3, ss 74(2)(f)-(i); McLeod, supra note 51 at 243-44.
146 CYFSA, supra note 3, ss 74(2)(f)-(i); see also S L, supra note 48 at para 91; pursuant to the CYFSA, s 74(2)(f), “emotional harm” is “demonstrated by serious” anxiety, depression, withdrawal, self-destructive or aggressive behaviour, or delayed development.
147 CYFSA, supra note 3, ss 74(2)(f)-(i); consider also SL, supra note 48 at para 91.
148 Ordano, supra note 50 at paras 34, 90; Bloom & Schneider, supra note 8 at 64-65; Verbrugge, supra note 50 at 6; A (M), supra note 20 at paras 28, 29.
149 Consider CYFSA, supra note 3, ss 74(2)(f), 157; Criminal Code, supra note 5, ss 2, 16, Part XX.1; see also R v Deguire, 2013 ONCJ 204, 106 WCB (2d) 319 [Deguire] at para 22.
That the child suffers (a word used in both the CYFSA and Criminal Code\textsuperscript{150}) from a mental state of the kind prescribed in the legislation (i.e. “emotional harm”, “mental disorder”) must be established in order for the provisions dealing with mental health issues to apply (e.g. findings of “in need of protection” due to “emotional harm”, the defence of mental disorder).\textsuperscript{151} As I argue, the legislative definitions adopt a conceptualization of mental health issues that is reflective of the medical model, embracing the paradigm’s individual focus and medical orientation.

Pursuant to the CYFSA, “emotional harm” is “demonstrated by serious” anxiety, depression, withdrawal, self-destructive or aggressive behaviour or delayed development.\textsuperscript{152} And, a “mental disorder” is a “substantial disorder of emotional processes, thought or cognition which grossly impairs a person’s capacity to make reasoned judgements”.\textsuperscript{153} For purposes of criminal proceedings, “mental disorder” is defined as a “disease of the mind”.\textsuperscript{154} “Disease of the mind” has been interpreted to mean “any illness, disorder or abnormal condition which impairs the human mind and its functioning, excluding, however, self-induced states caused by alcohol or drugs, as well as transitory mental states…”.\textsuperscript{155} These definitions are premised on the characterization (diagnosis) of certain mental states as problematic (disorders), occurring within the individual and warranting (individual) intervention.

The legislative definitions turn on whether the child’s mental state can be said to be a mental condition (i.e. “mental disorder”, “emotional harm”) as defined in the legislation.\textsuperscript{156} The focus is on the individual child, and the existence or absence of the kind of mental states referred

\begin{itemize}
\item \textsuperscript{150} See CYFSA, supra note 3, ss 74(2)(f)-(j); Criminal Code, supra note 5, s 16.
\item \textsuperscript{151} CYFSA, supra note 3, ss 74(2)(f), 157; Criminal Code, supra note 5, ss 2, 16, Part XX.1; consider also Deguire, supra note 149 at para 22.
\item \textsuperscript{152} CYFSA, supra note 3, s 74(2)(f).
\item \textsuperscript{153} Ibid, s 157.
\item \textsuperscript{154} Criminal Code, supra note 5, s 2.
\item \textsuperscript{155} Cooper, supra note 20 at para 51; see also Ordano, supra note 50 at para 27.
\item \textsuperscript{156} Consider Deguire, supra note 149; R (M), supra note 36; C (NV), supra note 33; A (M), supra note 20; M (R), supra note 58; M, supra note 59; Y, supra note 59; N, supra note 59; S I, supra note 61; C (C), supra note 65; K D, supra note 68; Nelson, supra note 21; Cooper, supra note 20; Ordano, supra note 50; Morrill, supra note 85; J (JJ), supra note 85.
\end{itemize}
to in the legislation (a determination generally made in reference to a child’s words and
dependencies, and pursuant to the assessment of a medical professional).157 While the ultimate
decision as to whether the legal criteria for findings under a particular legislative definition are
met remains with the trier of fact, this legal conclusion is linked to medical (psychiatric)
knowledge.158 Determinations as to whether a mental state is of the kind prescribed in the
legislative definition generally require medical evidence, most often from an expert qualified to
make clinical or psychiatric diagnosis.159 As Justice Wilson noted in a child protection case
involving allegations of risk of emotional harm, “[a]lthough there is no absolute requirement for
expert evidence under section 37(2)(g) [of the CFSA, now section 74(2)(h) of the CYFSA], the
case law indicates that such evidence will, as a practical matter, usually be required to support a
finding under that section”.160

That the legislative definitions adopt a medical orientation is bolstered further by the
focus in the provisions related to the definitions (and in the jurisprudence, as I discuss in Chapter
Three) on individual (medical) treatment. The focus on individual (medical) treatment is
apparent in a number of provisions governing family law (child welfare) and criminal justice
proceedings. For example, in the criminal context the Court has the authority to order that,
where an accused has been found unfit to stand trial, “treatment of the accused be carried out for
a specified period not exceeding sixty days, subject to such conditions as the court considers
appropriate”.161 Examples of the focus on individual (medical) treatment in the family law (child
welfare) context are found in the sections of the CYFSA that provide that a child who is found to

157 See Chapter Three at 80-92, 100-01, 105-10, 112-13, 126-28 and related references.
158 See ibid at 109-12, 127-28 and related references.
159 Ibid.
160 C (NV), supra note 33 at para 91; see also Cooper, supra note 20, where, in a criminal context, Justice Dickson (as he then was) noted
that although “disease of the mind” expressed “a legal concept, and a finding is made according to a legal test, psychiatric knowledge is
directly linked to the legal conclusion, for medical testimony forms part of the evidence on which the trier of fact must reach its
decision” (para 42).
161 Criminal Code, supra note 5, s 672.58; see also Chandler, “Mental Health Law”, supra note 21 at 393-94.
have suffered or is likely to suffer “emotional harm” or to suffer from a “mental, emotional or developmental delay”, may be found to be “in need of protection” where the child’s parent fails to provide services or treatment to address (remedy, alleviate, prevent) the harm or condition.\textsuperscript{162} Another example under the \textit{CYFSA} is that, where specified criteria are met, a child who is found to suffer from a “mental disorder” may be placed against their wishes in a locked secure treatment facility for purposes of receiving treatment (including possibly psychotropic medication) for their “mental disorder”.\textsuperscript{163}

\textbf{Implications of Legislative Definitions Premised on a Medical Model}

The way mental health issues are defined shapes the way these issues (and the people ‘suffering’ from them) are seen and dealt with in legal and social contexts.\textsuperscript{164} The parameters of the definition determine what kinds of mental states will be characterized as aberrant (i.e. a mental illness or disorder) and what outcomes and options will be available.\textsuperscript{165} Under a medical model, certain mental states or behaviours are seen as aberrant, “signs and symptoms” of an “illness” or “disorder” that is \textit{attributable} to biological causes (i.e. internal causes within the individual) and that is to be \textit{accommodated} (treated) through (individual) medical interventions.\textsuperscript{166} The focus in the medical model on individual illnesses and individual cures (medication), fails to acknowledge or address the effects of environmental factors (e.g. social disadvantages, poverty, discrimination, inequality, stigma) on mental health.\textsuperscript{167} Where the Court

\textsuperscript{162} \textit{CYFSA}, supra note 3, ss 74(2)(g), (i), (j).
\textsuperscript{163} Ibid, ss 158, 164, 171, 176.
\textsuperscript{164} Consider Chandler, “Mental Health and Disability”, \textit{supra} note 11 at 6; Chandler, “Impact of Biological Psychiatry”, \textit{supra} note 10 at 833-34; consider also Noah, \textit{supra} note 7 at 306; Andersen-Watts, \textit{supra} note 13 at 162.
\textsuperscript{165} Consider Chandler, “Impact of Biological Psychiatry”, \textit{supra} note 10 at 840-41; Kent Roach & Andrea Bailey, “The Relevance of Fetal Alcohol Spectrum Disorder in Canadian Criminal Law from Investigation to Sentencing” (2009) 42 UBC L Rev 1 at 52; Andersen- Watts, \textit{supra} note 13 at 142.
\textsuperscript{166} Chandler, “Mental Health and Disability”, \textit{supra} note 11 at 6; Chandler, “Impact of Biological Psychiatry”, \textit{supra} note 10 at 839; Aneshensel, Phelan & Bierman, \textit{supra} note 6 at 4; Mosoff \textit{et al}, \textit{supra} note 109 at 461, n 88; Culbert, \textit{supra} note 15 at 177; Smith, \textit{supra} note 13 at 76-77; Kaiser, “Redirecting the Ship”, \textit{supra} note 13 at 153.
\textsuperscript{167} See Andersen-Watts, \textit{supra} note 13 at 142, n 3; Mosoff \textit{et al}, \textit{supra} note 109 at 461, 461, n 88; Wheat, \textit{supra} note 108 at 25; Kaiser, “Redirecting the Ship”, \textit{supra} note 13 at 154-55; Culbert, \textit{supra} note 15 at 180; Chandler, “Mental Health and Disability”, \textit{supra} note 11 at 6-7.
assesses mental health issues through the individualistic focus of the medical model (by way of legislative definitions premised on this model), the myriad of environmental (social) factors (e.g. discrimination, poverty, addiction) that may impact upon a child’s mental health may be missed (I discuss the importance of considering the various environmental or social factors that can impact upon a child’s mental health in detail in Chapter Five).\textsuperscript{168}

Environmental factors also may not be addressed in terms of treatment, as the focus under the medical model is on interventions directed at rectifying an illness within an individual, rather than on addressing social disadvantages or barriers.\textsuperscript{169} As Chandler points out, “[t]here is evidence that clinicians are more likely to favour pharmacotherapy when patients’ conditions are framed in biological, as opposed to psychosocial, terms”.\textsuperscript{170} In keeping with these findings and with the dominance of the medical model, as Rachael Andersen-Watts indicates, in the case of mental health issues “treatment often means psychotropic drugs”, possibly in combination with psychotherapy.\textsuperscript{171} Psychotropic medications include “antidepressants, antimanics, antianxiety medication, and antipsychotics”.\textsuperscript{172} While many proponents of social models acknowledge that medication may play an important role in the treatment of some mental health issues, critics argue that medications provide “temporary symptom control” and “do not cure the putative disease causing the symptoms”.\textsuperscript{173} They also note that these drugs can have serious side effects.\textsuperscript{174}

\begin{footnotesize}
\textsuperscript{168} Consider Andersen-Watts, supra note 13 at 159, 161; Kaiser, “Constrained Progress”, supra note 104 at 7; Mosoff et al, supra note 109 at 460-61.

\textsuperscript{169} Aneshensel, Phelan & Bierman, supra note 6 at 4; Kaiser, “Redirecting the Ship”, supra note 13 at 157, 153; Mosoff et al, supra note 109 at 461, n 88; Andersen-Watts, supra note 13 at 152.

\textsuperscript{170} Chandler, “Impact of Biological Psychiatry”, supra note 10 at 833; see also Bloom & Schneider, supra note 8 at 42; Andersen-Watts, supra note 13 at 147; see also Aneshensel, Phelan & Bierman, supra note 6 at 4.

\textsuperscript{171} Andersen-Watts, supra note 13 at 147; see also Aneshensel, Phelan & Bierman, supra note 6 at 4; Bloom & Schneider, supra note 8 at 42.

\textsuperscript{172} Andersen-Watts, supra note 13 at 144, n 18.

\textsuperscript{173} Aneshensel, Phelan & Bierman, supra note 6 at 5; Andersen-Watts, supra note 13 at 160, 156; Kaiser, “Redirecting the Ship”, supra note 13 at 157-58.

\textsuperscript{174} Andersen-Watts, supra note 13 at 154.
\end{footnotesize}
Critics also caution about the overprescribing of psychotropic drugs, especially to individuals “without a clear diagnosis and who do not have access to other mental health supports and services”.\(^{175}\) Another concern, one which is particularly relevant for children, is the “scale of off-label” prescriptions, whereby a medication is prescribed for uses other than those for which it was tested and approved (e.g. prescribing Selective Serotonin Reuptake Inhibitors, such as Paxil, to children).\(^{176}\) I discuss and illustrate the extensive prescribing of psychotropic medications (off-label) to children in care and crossover youth, and the legislative provisions that bear on this, in Chapters Three and Four.\(^{177}\)

The inclusion of provisions relating to mental health issues in the CYFSA and YJCA (and by incorporation, the Criminal Code) represents an acknowledgment of the potential role or relevance of these issues, at least in specified circumstances (e.g. that a child may be “in need of protection” in relation to “emotional harm” or an accused may be unfit to stand trial by reason of a “mental disorder”).\(^{178}\) The provisions, and the jurisprudence that has interpreted and applied them (discussed in Chapter Three), provides the Court and relevant Boards (e.g. the CFSRB) with directions and guidance for dealing with mental health issues when they arise in particular adjudicative proceedings.\(^{179}\) However, the adjudication of these cases remains complicated.\(^{180}\) And, the applicability of the provisions relating to mental health issues in the child welfare and criminal justice context turn on the existence or absence of a “mental disorder” (or “emotional

\(^{175}\) Lemmens & Sheldon, supra note 14 at 240.
\(^{176}\) Ibid at 240-41.
\(^{177}\) The “impact of commercial interests on the development, marketing and prescription of psychopharmaceutical products” is an important consideration in the discussion of the (widespread) use of psychotrophic medications (Lemmens & Sheldon, supra note 14 at 223). However, engaging in this subject matter is beyond the scope of this Thesis.
\(^{178}\) Consider Deguire, supra note 149 at para 13; see CYFSA, supra note 3, ss 74(2)(f)-(i); Criminal Code, supra note 5, s 2.
\(^{179}\) Consider Deguire, supra note 149 at para 13; CYFSA, supra note 3, ss 74(2)(f)-(j), Part VII; Criminal Code, supra note 5, s 16, Part XX.1.
\(^{180}\) Consider Deguire, supra note 149 at para 14; see also Chapter Three.
harm” or “mental, emotional or developmental condition”), as this term is defined by the particular legislative provision relevant to the given case.\footnote{Criminal Code, supra note 5, s 2; CYFSA, supra note 3, ss 74(2)(f), (j), 157.}

The ways mental health issues are defined in different pieces of legislation reflect different legislative objectives and purposes.\footnote{Consider Culbert, supra note 15 at 176; C (NV), supra note 33 at para 35; S I, supra note 61 at para 44; Cooper, supra note 20 at para 52; Nelson, supra note 21 at para 58; consider also Noah, supra note 7 at 306.} The definitions determine what kinds of mental states may meet the legislative requirements, such that the relevant provisions (e.g. whether an accused has a “mental disorder” for purposes of NCRMD, or whether a child has suffered “emotional harm” for purposes of findings of “in need of protection”) may be invoked.\footnote{Deguire, supra note 149 at para 22; Criminal Code, supra note 5, s 16, Part XX.1; CYFSA, supra note 3, ss 74(2)(f)-(j).} They revolve around the premise that certain mental states represent aberrant conditions that occur within an individual and are treatable (curable) with individual (medical) interventions.\footnote{Consider Andersen-Watts, supra note 13 at 142, 152; Mosoff \textit{et al}, supra note 109 at 461, n 88; Aneshensel, Phelan \& Bierman, supra note 6 at 4; Kaiser, “Redirecting the Ship”, supra note 13 at 153.} The implications of this individualistic focus are set out in Chapters Three and Four, where I discuss and illustrate the implementation of the definitions and related provisions by the Courts and Children’s Aid Societies, and the resulting outcomes experienced by children with mental health issues. The implications will be further expounded upon in Chapter Five, where I demonstrate the relationship between the failure to consider the effects of the interactions of various environmental or social factors (e.g. trauma, poverty, discrimination) and the failure of the family law (child welfare) and criminal justice systems to protect children with mental health issues.

\textbf{Summary: Legislative Definitions and Medicalization}

Mental health issues have been defined and described through the use of a myriad of terms, each of which conveys different conceptualizations and characterizations of certain
mental states. This diversity of terminology exists within the discipline of law, where the characterization and definition of different mental states varies between and within various areas of law and pieces of legislation. The definitions in the CYFSA and Criminal Code prescribe what kinds of mental states will be considered “mental disorders” (or “emotional harm”) for purposes of particular provisions within the respective legislative enactments (e.g. committal to secure treatment, findings of NCRMD). These definitions reflect the individualistic focus and medical orientation in the medical model. They are premised on the notion that certain aberrant mental states are properly characterized as disorders or conditions which are inherent in the individual and require individual focused (medical) intervention. The definitions turn on whether the individual *suffers* from particular mental states (disorders), a determination that generally requires medical evidence.

Where the focus of the inquiry is on the existence or absence of a disorder within an individual, the effects of environmental or social factors (e.g. discrimination, poverty, stigma) is obscured. As I discuss in detail in Chapter Five, considering and addressing environmental or social factors may be essential in order to adequately meet the complex needs of children with mental health issues who are engaged with the family law (child welfare) and criminal justice systems. While medical interventions may play an important role in certain circumstances in addressing some of the needs of children with mental health issues who are engaged in the family law (child welfare) or criminal justice systems, focusing solely on individual causes (e.g. biology) and treatment (e.g. pharmacotherapy) fails to acknowledge or address the multiplicative, complex challenges and disadvantages (e.g. maltreatment, trauma, racism, instability) many of these children face. The failure to adequately address the cumulative needs (e.g. mental health, educational, welfare) of these children can carry serious consequences for
individual children and society more generally (e.g. ongoing mental health issues, repeated engagement in the criminal justice system). I discuss and illustrate these consequences throughout the balance of this Thesis, beginning in the next Chapter, where I examine the ways in which the legislative definitions are implemented by the Courts and CFSRB, and the (often negative) outcomes experienced by children with mental health issues who are involved in the family law (child welfare) and criminal justice systems.
Chapter Three

The Implications of Implementation: How the Application of Legislative Provisions related to Mental Health Issues in the Family Law and Criminal Justice Systems Fails to Protect Children

Introduction

In the preceding Chapters I raised serious questions about the heavy reliance in legislation, and in the legal systems which implement it, on definitions of mental “illnesses” or “disorders” that prioritize an individualistic focus and medical model orientation rather than adopting a more “holistic” approach as suggested by Nicholas Bala et al and by various social models of disability. I argued that the theoretical implications of this individualistic focus include the failure to acknowledge or address the effects of environmental or social factors (e.g. discrimination, stigma, poverty), and the tendency to see treatment as individual (medical) interventions (namely pharmacotherapy), rather than addressing social disadvantages and barriers. In this Chapter, I explore the implications of the individual focus and medical model underpinnings of the legislative provisions relating to mental health issues, through the lived experiences of children with mental health issues who are engaged in the family law (child welfare) and criminal justice systems. Specifically, I examine the ways the legislative provisions have been implemented (or not utilized) in family law (child welfare) and criminal justice proceedings, and the resulting (often negative) outcomes experienced by children with mental health issues.

I begin my analysis with an overview of the provisions for dealing with mental health issues within the Child, Youth and Family Services Act, 2017 (“CYFSA”), focusing on the ways

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1 See Chapter Two at 62-76 and related references; Chapter One at 25-39 and related references; Introduction at 9-11 and related references.
2 See Chapter Two at 73-76 and related references; Introduction at 9-11 and related references.
3 Child, Youth and Family Services Act, 2017, SO 2017, c 14, Sched 1 (“CYFSA”); the CYFSA recently came into force, replacing the Child and Family Services Act, RSO 1990, c C.11 (“CFSA”). The provisions dealing with mental health issues in the CYFSA generally mirror, or are substantially the same as, those in the CFSA. References in the jurisprudence to the CFSA have been noted, and the
and circumstances under which these provisions are implemented and the outcomes that may result. I then provide a similar overview of mental health provisions in the *Youth Criminal Justice Act*\(^4\) ("YCJA") and the *Criminal Code*,\(^5\) exploring the factual circumstances that engage these provisions and the types of dispositions made in these cases. Next, I evaluate the role of mental health practitioners, and specifically the reliance in legal cases involving mental health issues on expert (medical) evidence. I also examine the links between the way mental health issues are conceptualized and defined in the legislation and the outcomes experienced by children with mental health issues. The key issues shaping this discussion are diagnosis and treatment, and the limited use of the mental health provisions, revealing the failure to identify children with mental health needs, the tendency to incarcerate these children, the lack of available services and supports, and the (over) use of psychotropic medications. Finally, I discuss the role a lack of coordination between systems plays in the outcomes experienced by children with mental health issues who are engaged in the family law (child welfare) and criminal justice systems, and assess whether some of the alternative programs (e.g. mental health courts, integrated courts) may better address the needs of these children.

**Legislative Provisions in Practice in the Family Law System**

**Child Protection Provisions**

Pursuant to the *CYFSA*, a child may be found to be “in need of protection” for a variety of reasons.\(^6\) These reasons include situations where a child has suffered, or there is a risk that they are likely to suffer, “emotional harm” and the harm either arises as a result of the actions or inactions of the child’s parent, or the parent fails to provide services or treatment or (where the

\(^4\) *Youth Criminal Justice Act*, SC 2002, c 1 ("YCJA").  
\(^5\) *Criminal Code*, RSC 1985, c C-46.  
\(^6\) *CYFSA*, supra note 3, s 74(2).
child is incapable of consenting) to consent to treatment to address the harm. They also include circumstances where a child suffers from a “mental, emotional or developmental condition” which, “if not remedied, could seriously impair the child’s development” and the child’s parent fails to provide or (where the child is incapable of consenting) to consent to “treatment to remedy or alleviate the condition”. Where the Children’s Aid Society (“CAS”) has reason to believe these circumstances exist, they may commence child protection proceedings by applying to the Court for a finding that a child is “in need of protection”.

When adjudicating child protection proceedings the Court must first determine whether, on a balance of probabilities, the child is “in need of protection” pursuant to one of the enumerated grounds in section 74(2) of the CYFSA. In the case of the provisions relating to mental health issues, an assessment of whether the requirements of the statutory provisions are met will require a threshold determination as to whether the child’s mental state comes within the parameters of “emotional harm” (or is such that they are likely at risk of “emotional harm”), or whether they suffer from a “mental, emotional or developmental condition”. For example, the exhibited emotions of distrust, fear, guilt and anger were not seen to meet the definition of

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7 Ibid, ss 74(2)(f)-(i); see also Chapter Two at 51-54, 70 and related references.
8 CYFSA, supra note 3, s 74(2)(j); see also Chapter Two at 51, 55-56, 70 and related references.
9 CYFSA, supra note 3, s 81(1); see also Kunuwanimano Child and Family Services v S L, 2017 ONCJ 518, 283 ACWS (3d) 771 [S L] at para 87; I discuss CAS investigations and decision making, including child apprehension and commencing child protection proceedings, in detail in Chapter Four.
10 See C (NV) v Catholic Children’s Aid Society of Toronto, 2017 ONSC 796, 276 ACWS (3d) 625 [C (NV)] at paras 129, 71, 46, 89; S L, supra note 9 at paras 87, 88, 17; Catholic Children’s Aid Society of Toronto v R (M) (2003), 126 ACWS (3d) 966, [2003] OJ No 4385 (ONCJ) [R (M)] at para 6; Jewish Family and Child Service v K (S), 2015 ONCJ 246, 254 ACWS (3d) 599 [K (S)] at para 165, 167; the “issue of whether a child is a child in need of protection under the Act is to be decided without a consideration of the child’s best interests” (Children’s Aid Society of Ottawa v D (C) (2009), 175 ACWS (3d) 1074, 68 RFL (6th) 425 (ONSC) [D (C)] at para 31). The “issue of a child’s best interests can only come into play after the Society has been allowed, by virtue of its statutorily granted powers, to intervene in that parental responsibility [for the care of their children] because of protection issues” (Ibid at para 32). Where a child is found to be “in need of protection”, the Court must determine the appropriate disposition that is in the child’s best interests (e.g. supervision order, interim or extended CAS care) (CYFSA, supra note 3, ss 101(1), 101(8), 102(1), 74(3); see also K (S) at paras 217, 223).
11 CYFSA, supra note 3, ss 74(2)(f)-(j); C (NV), supra note 10 at para 82; R (M), supra note 10 at paras 10-13; as I detailed in Chapter Two, “emotional harm” is defined in the legislation as being “demonstrated by serious, (i) anxiety, (ii) depression, (iii) withdrawal, (iv) self-destructive or aggressive behaviour, or (v) delayed development” (CYFSA, s 74(2)(f); see also R (M) at paras 10-13; C (NV) at para 82). As I also detailed, “mental, emotional or developmental condition” is not defined in the child protection provisions but (in reference to the term in the CFSA, supra note 3, s 37(2)(h)) has been referred to by the Courts as the “section targeting special needs children” (C (NV) at para 138).
“emotional harm” or to “translate…into risk of emotional harm as defined” in the CFSA (now the CYFSA) on the facts in Catholic Children’s Aid Society of Toronto v. R. (M.) (“R. (M.)”), a case involving an eight-year-old girl who had been apprehended after being sexually abused by one or both of her brothers.\(^\text{12}\)

The statutory requirements (under the CFSA) for “emotional harm”, however, were found to have been met in Children’s Aid Society of Simcoe (County) v. A. (M.) (“A. (M.)”), wherein Justice Eberhard indicated that a “series of referrals and the diagnosis [mutism, oppositional defiant disorder (“ODD”) and anxiety, made by a psychiatrist who assessed the child]”, provided “compelling evidence that the child was experiencing emotional harm arising from the domestic conflict”.\(^\text{13}\) In A. (M.), the child (age seven at the time of apprehension) was, as outlined in the psychiatric opinion, exhibiting shyness, “verbally very silent”, “somewhat oppositional”, and suffering ongoing stress from the parental discord.\(^\text{14}\) As the foregoing cases illustrate, the definitional lens through which “emotional harm” is viewed colours the assessment of a child’s mental state and the determination as to whether or not it constitutes one of the enumerated conditions in the CYFSA. The definitional lens adopted thus effects the conclusion drawn on the issue of “emotional harm”, a decision that may be determinative of the ultimate outcome of the case. For example, subject to the existence of other grounds, a finding that a child does not suffer from “emotional harm” would result in the case being dismissed.

This effect is also illustrated in the case of Catholic Children’s Aid Society of Metropolitan Toronto v. B. (S.) (“B. (S.)”), where findings on both the existence of a “mental, emotional or developmental condition” and a risk of “emotional harm” (amongst other grounds)

\(^\text{12}\) R (M), supra note 10 at paras 14, 13, 35, 1, 18; despite making this finding, Justice Spence noted that, even if such a risk had been established, it could be “adequately addressed by placing [the child] in her mother’s care pursuant to a supervision order” and, the mother having consented to the making of a supervision order, disposed of the case accordingly (Ibid at paras 40, 42).

\(^\text{13}\) Children’s Aid Society of Simcoe (County) v A (M), 2011 ONSC 5115, 207 ACWS (3d) 94 [A (M)] at paras 29, 25, 22, 40.

\(^\text{14}\) Ibid at paras 1, 22, 23.
were made. In B. (S.), Justice Jones held that “the gross neglect of all three children by the parents placed the children at substantial risk of physical and emotion harm under clauses 37(2)(b) and (g) of the [CFSA (now sections 74(2)(b) and (h) of the CYFSA)]” and that “the parents’ gross neglect of the medical and educational needs of [their son], who suffers from a mental and developmental condition known as foetal alcohol effect, satisfies me that [that child] is a child in need of protection under clause 37(2)(h) [now section 74(2)(j)] as well”.

Unlike in the case of R. (M.), the finding that the children were “in need of protection” under sections 37(2)(b), (g) and (h) of the CFSA (sections 74(2)(b), (h) and (j) of the CYFSA) was also found to be supported by the findings of fact that led the Court to conclude that all three children “were sexually molested or exploited” by their parents.

The effect of viewing mental health issues through a particular definitional lens premised on the medical model is also highlighted in the following cases, where the effect is observable in the way protective services are evaluated. In Children’s Aid Society of Sudbury & Manitoulin (Districts) v. D. (D.), a finding that two children were “in need of protection” pursuant to sections 37(2)(g) and (h) of the CFSA (sections 74(2)(h) and (j) of the CYFSA) was made, with Justice Guay recognizing that the children had “made huge strides in resolving the cognitive and developmental problems afflicting them at the time of apprehension”, and noting that the psychological and psychiatric evidence showed that the “children would be adversely emotionally affected by their removal from their current [foster] home and would suffer in their continuing development as a result”.

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16 Ibid.
17 Ibid at para 49.
18 Children’s Aid Society of Sudbury & Manitoulin (Districts) v D (D) (1997), 75 ACWS (3d) 862, 1997 CarswellOnt 5089 (WLNext Can) (ONCJ (Prov Div)) [D (D)] at para 35.
In another case, *Kenora-Patricia Child & Family Services v. M. (A.)* ("M. (A.)"), all parties agreed that remaining in a specialized treatment foster home was in the best interests of a thirteen-year-old autistic girl who was “severely developmentally delayed” and “non-verbal” and who had “significant behavioural problems” and could not be left alone. However, the parents argued that the child was “not a child in need of protection but rather a child in need of services”, and that she should remain in a specialized treatment home funded by the province, but under their direction (rather than that of the CAS). In finding that the child was “in need of protection”, in *M. (A.)* Justice Wolder noted that the child had a “developmental condition” and rejected the parents’ argument that no treatment could alleviate the condition (such that section 37(2)(h) of the *CFSA* was inapplicable), holding that while “autism may be a relatively static condition”, the child’s “enjoyment of life” could be “heightened by modifying her behaviour through the use of proper communication tools, by providing consistency in her daily environment and through treatment and counselling at a special residential setting”. While the parents’ actions and behaviours clearly contributed to the ultimate disposition in this case (see note 21), the focus on the child’s “condition” and the potential for treatment reflects the individualistic focus and medicalization of mental health issues adopted in the law.

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20 *Ibid* at para 5.
21 *Ibid* at paras 120-121; in *M (A)*, the evidence demonstrated, amongst other things, the parents’ “rough handling” of the child, their “resistance to medication” for her, their “inability and unwillingness” to acknowledge the risk factors posed by their behaviour, and their lack of familiarity with her needs and lack of training and skill regarding her care (*Ibid* at para 116). The protection finding under section 37(2)(h) was further to Justice Wolder’s finding that the child was still “in need of protection” pursuant to section 37(2)(i) of the *CFSA* as the parents were unable to care for the child, and the child had been brought before the Court with the parents’ consent (*Ibid* at para 109). The child was also found to be “in need of protection” under section 37(2)(i), the parents’ having effectively abandoned her as a result of their refusal to exercise access for over two years and their inability or unwillingness to resume the care of their daughter, who was in a residential placement (*Ibid* at para 122). Sections 37(2)(h), (i), and (j) of the *CFSA*, *supra* note 3, have been replaced by sections 74(2)(j), (n) and (k) of the *CYFSA*, *supra* note 3.
Extraordinary Measures Provisions

A child’s mental state – as evidenced by their words and behaviours – is also a central issue in determinations under the Extraordinary Measures section of the CYFSA.\(^\text{22}\) Under Part VII, a child may be committed to a secure treatment program where the Court is satisfied that certain enumerated legislative criteria are met.\(^\text{23}\) The first criteria for committal (and for emergency admission, discussed below) is that “the child has a mental disorder”.\(^\text{24}\) The term “mental disorder” is defined, for purposes of the Extraordinary Measures provisions, as “a substantial disorder of emotional processes, thought or cognition which grossly impairs a person’s capacity to make reasoned judgments”.\(^\text{25}\) While the existence of a “mental disorder” as defined in the CYFSA is not dependent on a child having a psychiatrically diagnosed disorder (pursuant to the Diagnostic and Statistical Manual of Mental Disorders (“DSM”)),\(^\text{26}\) a review of the jurisprudence suggests these diagnoses are highly influential, if not determinative, in many cases. For example, in Children’s Aid Society of Algoma v. M. (K.A.L.) (“M. (K.A.L.)”), the Court found a fourteen-year-old girl had “more than one mental disorder”, having been diagnosed with post-traumatic stress disorder (“PTSD”), ODD, and mood disorder.\(^\text{27}\) The child in M. (K.A.L.) had been in care for several years, had been admitted to psychiatric facilities on a number of occasions, had engaged in self-harming behaviours,\(^\text{28}\) and was currently facing charges for assaulting staff at her group home.\(^\text{29}\)

\(^{22}\) See CYFSA, supra note 3, ss 157, 164, 171.
\(^{23}\) Ibid, s 164(1).
\(^{24}\) Ibid, ss 164(1)(a), 171(2)(a).
\(^{25}\) Ibid, s 157; see also Chapter Two at 56-59, 69 and related references; note that the definition of “mental disorder” in the Extraordinary Measures section of the CYFSA mirrors that in the CFSA.
\(^{26}\) M v Youthdale Treatment Centres, 2013 CFSRB 24 [M] at para 9; Y v Youthdale Treatment Centres, 2013 CFSRB 20 [Y] at para 9; N v Youthdale Treatment Centres, 2013 CFSRB 18 [N] at para 6; the DSM is a widely used and accepted diagnostic classification system published by the American Psychiatric Association (see Chapter Two at 48, n 9).
\(^{27}\) Children’s Aid Society of Algoma v M (KAL), 2010 ONCJ 324, 191 ACWS (3d) 1101 [M (KAL)] at paras 2, 6; the Court ultimately found that all of the criteria for committal were met in this case (Ibid at para 6).
\(^{28}\) The child’s self-harming behaviours, as noted by the Court, included “cutting her wrists with broken light bulbs and jumping into a cold lake and refusing to come out” (Ibid at para 7).
\(^{29}\) Ibid at paras 2-7.
A pattern involving multiple placements, serious self-harm and harm of others,\(^\text{30}\) (repeated) criminal engagement, and multiple diagnoses was also observed in *Children’s Aid Society of Waterloo (Regional Municipality)* v. *R. (K.*) (“R. (K.*)”), a case involving a fifteen-year-old girl living in a group home.\(^\text{31}\) In *R. (K.*)*, the child had been admitted to hospital numerous times for mental health issues, and had been diagnosed by a number of professionals at various times with a variety of disorders, including adjustment disorder, PTSD, conduct disorder, borderline traits, judgment disorder, bipolar disorder, ODD, reactive childhood attachment disorder, fetal alcohol disorder, a learning disability, and an intellectual disability.\(^\text{32}\) Referring to the “plethora of documentation and reports from hospitals, the CPRI [Children’s Psychiatric Research Institute], doctors, psychologists and psychiatrists that all concur that [the child] has mental health disorders”, Justice McSorley held that “the court must find that [the child] does suffer from several mental disorders, thus satisfying the test under clause 117(1)(a) [of the *CFSA*, now section 164(1)(a) of the *CYFSA*]”.\(^\text{33}\) Justice McSorley also found that the other statutory criteria were met, and ordered the child be committed to a secure treatment program for 180 days.\(^\text{34}\)

\(^{30}\) The child’s self-harming behaviours, as noted by the Court, included running into the road and lying down in traffic, refusing medication, cutting herself, writing on the walls with her own blood, sticking a piece of glass in her vagina (requiring reparative surgery), climbing on the roof (she was brought down after police tasered her), going to a strange man’s home, tearing into walls exposing electrical wires, eating glass, stones and screws, inserting pencil lead into her ear, and threatening or attempting suicide a dozen times (*Children’s Aid Society of Waterloo (Regional Municipality)* v *R. (K.*)*, 2009 ONCJ 684, 186 ACWS (3d) 418 [R (K*)] at paras 7, 8).

\(^{31}\) *Ibid* at paras 5, 7-13, 23, 4, 18, 21, 23; the child had been exposed to alcohol and drugs in utero and had been apprehended at five years old as a result of “serious neglect, physical abuse and sexual abuse”, and had been in care for ten years, during which time she had 12 to 14 primary placements in foster homes, group homes, and treatment homes (*Ibid* at paras 18, 4, 5). During her time in a group home (approximately three years) she had been engaged with the police on over sixty occasions, and had numerous criminal charges and convictions (*Ibid* at paras 23, 9-12).

\(^{32}\) *Ibid* at paras 4, 18, 21, 23.

\(^{33}\) *Ibid* at para 24; s 164(1)(a) of the *CYFSA*, supra note 3 (previously s 117(1)(a) of the *CFSA*, *supra* note 3) requires that a child have a “mental disorder” as defined in the Act.

\(^{34}\) *R (K*), *supra* note 30 at para 44.
All of the statutory criteria were also met, and an order for committal made, in Centre for Addiction and Mental Health v. C. S., a case involving a sixteen-year-old girl who had “experienced two very traumatic events” (the death of her biological mother by overdose and being robbed at knife point) and had “ongoing mental health difficulties including her suicidal ideation and attempts”. In finding that the child had a “mental disorder”, Justice Starr pointed to the numerous mental disorders with which the child had been diagnosed, as well as the symptoms of these disorders, and illustrated how her “persistent suicidal ideation and her compulsion to take her own life, is the direct result of her mental disorders and a symptom of almost every one of them”. Having accepted a psychiatrist’s “evidence that [the child] would likely commit suicide at the first opportunity if released into the community”, and having found that the case for committal was made out (albeit, “just barely”), Justice Starr made an order for committal to a secure treatment program.  

An order for secure treatment was not granted in Weechi-it-te-win Child & Family Services v. F. (D.K.) (“F. (D.K.)”), however, the child was found to have a “mental disorder”, the existence of which was “so obvious” that an expert report was “not necessary”. In reaching this conclusion, Justice Little noted that it was supported by “[a]ll of the affidavits evidence”,

35 Centre for Addiction and Mental Health v C.S, 2018 ONCJ 127, 2018 CarswellOnt 3084 (WLNext Can) [C.S] paras 111, 5, 6; after a “serious suicide attempt with intent to die” (taking multiple medications at her group home), the child was admitted to a psychiatric facility as an involuntary patient under the Mental Health Act, RSO 1990, c M.7, but after treating her for several months, the facility sought to have the girl committed to a secure treatment program at another facility (Ibid at paras 7-10, 34, 1).  

36 Ibid at paras 21-31; Justice Starr noted that the child had “been diagnosed with Post-Traumatic Stress Disorder, Social Anxiety Disorder, Borderline Personality Disorder, Attention Deficit Hyperactivity Disorder, Bulimia Nervosa, Obsessive Compulsive Disorder, as well as, Cannabis Use Disorder, Cannabis induced Psychotic Disorder, Alcohol Use Disorder, and Stimulant Use Disorder” and that the symptoms of the child’s “various disorders include: hyper vigilance, increased difficulties with managing anger and irritability, a persistent sense that the world cannot be safe, and the sense of a foreshortened future” (Ibid at paras 22, 23).  

37 Ibid at paras 88, 108, 111.  

38 Weechi-it-te-win Child & Family Services v F (DK) (2001), 108 ACWS (3d) 659, [2001] OJ No 3995 [F (DK)] at paras 14, 5, 6; the evidence in F (DK) failed to establish that the child had caused or attempted to cause bodily harm to herself or another person within the time frame specified in the legislation, such that the requirements in s 117(1)(b) of the CFSA (now s 164(1)(b) in the CYFSA, supra note 3) were not met (paras 7, 10).
which demonstrated that the child was “unable to look after her own safety”, lied, ran away, and apparently, on occasion, “consumed alcohol to the point where her very life is in jeopardy”.  

The opposite conclusion, namely that the (medical) evidence failed to establish the existence of a “mental disorder” as defined in the CFSA was reached in *Children’s Aid Society of Sudbury & Manitoulin (Districts) v. C. (C.)* (“C. (C.)”).  

*C. (C.)* involved a fourteen-year-old girl in care, a “troubled youth” who had a tendency to run away and had engaged in impulsive and potentially harmful behaviour. While acknowledging that serious bodily harm might befall the child as a result of her conduct, Justice Humphrey concluded that she had not caused, attempted to cause, or threatened serious bodily harm to herself or others, and that “[t]he fact that she may gravitate towards undesirable associates and a lifestyle that may well put her at risk for harm is more a case of poor judgment than it is a lack of capacity to make reasoned judgment”. In reaching the conclusion that the child’s capacity to make reasoned judgments was not grossly impaired (as required for a finding of “mental disorder”), Justice Humphrey relied on the evidence of a psychiatrist who had assessed the child (and diagnosed her with adjustment disorder with disturbance of conduct and emotion), namely his indication that the child was cognizant of her actions and understood their implications.

A child’s capacity to make reasoned judgments, amongst other factors, is also a consideration in emergency admissions to secure treatment programs.  

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39 *Ibid* at para 5; Justice Little also noted that the child had “already been found to be in need of protection by reason of a finding on consent that she suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair her development” (*Ibid* at para 4).  

40 *Children’s Aid Society of Sudbury & Manitoulin (Districts) v C (C)* (1999), 101 ACWS (3d) 304, 1999 CarswellOnt 4865 (WLNext Can) (ONCJ) [*C (C)*] at para 22.  

41 *Ibid* at paras 4, 5, 37; these behaviours included standing in front of a moving train and only getting off the tracks at the last second, getting into a physical altercation with another resident at her group home (she was convicted of uttering a threat, an assault charge was withdrawn, and her only other criminal convictions were for breach of probation), using drugs and alcohol and blacking out, and associating with “undesirable individuals” (including at the headquarters of an alleged escort service where she indicated she had been raped) (*Ibid* at paras 25, 28, 29, 35, 36).  

42 *Ibid* at paras 38, 39.  

43 *Ibid* at paras 6, 22.  

44 *CYFSA, supra* note 3, ss 157, 171(2).
require that the administrator (the person in charge of the secure treatment program) “believes on reasonable grounds” that enumerated legislative criteria, which are substantially similar to those considered by the Court and include the same requirement that the child have a “mental disorder”, are met.\textsuperscript{45} This determination may be challenged by applying to have it reviewed by the Child and Family Services Review Board (“CFSRB”), who, following a hearing, must release the child from the secure treatment program unless they are “satisfied that the child meets the criteria for emergency admission”.\textsuperscript{46}

For example, the CFSRB was not satisfied that the threshold criteria requiring that a child have a “mental disorder” was met in \textit{K.D. v. Youthdale Treatment Centres} (“\textit{K.D.”}), a case involving the emergency admission of a fifteen-year-old girl who ran away a few times, skipped school and, according to her mother, used drugs, cut herself, lost 20 pounds in six months, and engaged in some sexual activity with boys.\textsuperscript{47} Having received evidence about the child’s behaviour from her mother, the CFSRB concluded that the evidence did not demonstrate that the child had a “mental disorder” as defined in the \textsl{CFSA} (now \textsl{CYFSA}) and granted the application for release.\textsuperscript{48} The CFSRB also granted an application for release in \textit{E.P. v. Youthdale Treatment Centres}, a case involving a fifteen-year-old girl who had been the victim of trauma (sexual assault, kidnapping, and being put in a prostitution ring), and who had been superficially cutting herself, using drugs, running away from home, not attending school, slamming doors and throwing objects in the home, engaging in “inappropriate friendships” including involvement with an older man, and had, according to her father, lost a lot of weight.\textsuperscript{49} Citing the secure

\textsuperscript{45} \textit{Ibid}; see also \textit{Y, supra} note 26 at para 17; \textit{M, supra} note 26 at para 21.
\textsuperscript{46} \textit{CYFSA, supra} note 3, ss 171(9)-(13); as the CFSRB noted in \textit{S I v Youthdale Treatment Centres}, 2010 CFSRB 30 [\textit{S I}] (in relation to the predecessor provisions in the \textsl{CFSA}), “[t]he criteria are clinical in nature and include an assessment of whether the child has a mental disorder and whether no less restrictive method of providing appropriate treatment is appropriate” (para 25).
\textsuperscript{47} \textit{K D v Youthdale Treatment Centres}, 2015 CFSRB 21 [\textit{K D}] at paras 3, 1, 4, 5, 10.
\textsuperscript{48} \textit{Ibid} at paras 9, 10, 20, 25, 26; the CFSRB also heard from the supervising psychiatrist at the program, “but because he was not familiar with the child or her admission, his evidence was not helpful and carried no weight” (\textit{Ibid} at para 17).
\textsuperscript{49} \textit{E P v Youthdale Treatment Centres}, 2015 CFSRB 10 [\textit{E P}] at paras 3-7, 11-16, 19-21, 24.
treatment facility’s failure to provide “a provisional medical diagnosis that indicated that the Child has a mental disorder”, and that “the behavioural evidence . . . did not establish the existence of a mental disorder”, the CFSRB concluded that the legislative requirement that the child suffer from a “mental disorder” had not been met. 50

The CFSRB did find that the legislative criteria (in the CFSA), including the requirement that the child suffer from a “mental disorder”, were satisfied in B. (G.) v. Youthdale Treatment Centres, wherein “considerable weight” was given to “the evidence in the psychiatric Admission Summary as well as all the other evidence about [the child’s] pre-admission behaviour and situation”. 51 The CFSRB was “persuaded to find a mental disorder” based on evidence that the child’s “poor judgement was escalating” as demonstrated by his “propensity to inflict cuts on his forearms”, “trafficking in narcotics on school property”, theft of Oxycontin pills, and breaking of light bulbs and a bookcase at his group home. 52 The “pattern of behaviour exhibited by [the child]” was also seen to demonstrate that a child had a “mental disorder” as defined in the CFSA (now the CYFSA) in C.M. v. Youthdale Treatment Centres (“C.M.”), a case involving a fourteen-year-old who had been living in a group home and had a history of hospitalization for self-harm and suicide attempts, and who was provisionally diagnosed with a series of mental disorders. 53 The behaviour cited as demonstrative of the child having a “mental disorder” in C.M. included, 

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50 Ibid at paras 22, 23, 2.
51 B (G) v Youthdale Treatment Centres, 2008 CFSRB 63 [B (G)] at paras 22, 9; in the Admission Summary, two psychiatrists had provisionally diagnosed the fifteen-year-old with adjustment disorder (acute with mixed disturbance of emotions and conduct), ODD, attention deficit hyperactivity disorder (“ADHD”), and a learning disorder (math and reading comprehension) (Ibid at paras 7, 1, 8).
52 Ibid at paras 12-16; the CFSRB found that theft of the Oxycontin pills, “seen in the context of his daily tobacco smoking, and his escalating marijuana smoking and dealing” showed “itself as the next step in an escalating drug problem brought on by, and illustrative of, his impaired capacity to make reasoned judgments” (Ibid at para 15).
53 C M v Youthdale Treatment Centres, 2010 CFSRB 33 [C M] at paras 23, 10; the provisional diagnosis included possible mood disorder (depression versus bipolar), dysthymia, ODD, ADHD, and sleep disorder (Ibid at para 10).
taking stolen codeine pills to cope with feelings of being overwhelmed, running away, making
suicidal statements, and cutting herself.\textsuperscript{54}

Behavioural evidence including cutting, seeking out danger mainly in the form of
climbing on trees and roofs, and running away, were also found to support the finding of the
CFSRB in \textit{J.M. v. Youthdale Treatment Centres} ("J.M."), that a boy in his early teens had a
“mental disorder”.\textsuperscript{55} An extensive list of behaviours indicative of a “mental disorder”, as defined
in the \textit{CFSA} (now \textit{CYFSA}), was cited by the CFSRB in \textit{S.I. v. Youthdale Treatment Centres}
(“S.I.”), a case involving a fifteen-year-old girl who, in the proceeding months, had experienced
a number of foster care and group home placements, had problems sleeping, and had lost 25 to
30 pounds.\textsuperscript{56} The behaviours listed by the CFSRB in support of the finding of a “mental
disorder” in S.I. included that the child, who had been increasingly sad and depressed, was
engaging in increasingly impulsive activities as indicated by her repeatedly running away, lying
about being hit by a car, suicidal statements, using drugs, and staying with (and bringing her
younger sister to) older men who were possibly gang members and who had abused her, possibly
confined her, and involved her in intravenous drug use, “drug-muling”, and unprotected sex.\textsuperscript{57}

As the foregoing cases demonstrate, in determining whether a child has a “mental
disorder” for purposes of committal or emergency admission to secure treatment programs, there

\textsuperscript{54} \textit{Ibid} at paras 21-23, 12-13, 15-16; notably, this finding lined up with that of the admitting psychiatrist, who cited “ongoing suicidal
ideation, self-injury behaviour such as cutting, substance abuse and engaging in risky sexual behaviour” as evidence of the child’s
“substantial disorder of emotional process and thought” (\textit{Ibid} at para 9).

\textsuperscript{55} \textit{J M v Youthdale Treatment Centres}, 2012 CFSRB 56 [J M] at paras 22, 23, 16; the child in \textit{J M} also had “sleeping difficulties” and an
inability “to deal with any discussion of feelings or tolerate close proximity to other persons”; and had told his parents that danger
soothed him and that he heard voices (\textit{Ibid} at paras 22, 16, 17). The CFSRB “did not hear direct evidence regarding a specific and
definitive current diagnosis”, but the paediatrician had diagnosed the child with ADHD, a learning disability, a “sensitive and anxious
temperament”, depression, and an anxiety disorder (\textit{Ibid} at paras 23, 21). The paediatrician also provided behavioural evidence, which
was supplemented by evidence from a child and youth worker at a mental health centre day program the child had attended, and from the
child’s parents (\textit{Ibid} at para 23).

\textsuperscript{56} \textit{S I}, supra note 46 at paras 45, 6-7.

\textsuperscript{57} \textit{Ibid} at paras 8, 41, 10, 11, 45-47; the admitting psychiatrist gave evidence that the child had conduct disorder, “parent-child conflict”
and polysubstance abuse, and possibly also PTSD, sleep and mood disorders, and Fetal Alcohol Spectrum Disorder (she also had severe
learning disabilities), and indicated that the child’s “less-adaptive behaviours are a result of her cognitive limitations and trauma-related
difficulties i.e. her mental disorder” (\textit{Ibid} at paras 42, 7, 47).
is a notable focus on the individual child’s words and behaviours, and often a heavy reliance on psychiatric evidence (namely diagnoses) in determining whether the child’s mental state meets the statutory criteria. These cases also suggest a crossover of children in care (particularly those living in group homes) into secure treatment programs.\(^{58}\) And, they offer real life examples of how children with mental health issues who are in care (generally having experienced multiple placements and housed in group homes) “crossover” and become engaged (repeatedly) with the criminal justice system.\(^{59}\)

**Legislative Definitions in Practice in the Criminal Justice System**

A child’s mental state may be relevant at various stages of criminal proceedings.\(^{60}\) As Angela Campbell and Beth Mountford argue, “[t]he question of a young offender’s mental health is most explicitly broached at three instances in criminal proceedings” namely, determinations regarding fitness to stand trial, criminal responsibility (i.e. whether the accused is not criminally responsible by reason of mental disorder (“NCRMD”)), and sentencing.\(^{61}\) However, a child’s mental state may also be relevant to various other aspects of the criminal process, including the use of extrajudicial measures (diversion), bail and remand determinations, and the voluntariness and admissibility of statements made by the child.\(^{62}\) Information about a child’s mental health may be received by the Court through several methods, including pre-sentence reports and Court

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\(^{58}\) Eg M (KAL), supra note 27; R (K), supra note 30; B (G), supra note 51; C M, supra note 53; S I, supra note 46.

\(^{59}\) Eg M (KAL), supra note 27; R (K), supra note 30.


\(^{61}\) Campbell & Mountford, supra note 60 at 410; consider also Peterson-Badali et al, supra note 60 at 8; Chandler, “Mental Health Law”, supra note 60 at 393.

\(^{62}\) Gray, Shone & Liddle, supra note 60 at 30; Bloom & Schneider, supra note 60 at 54; Peterson-Badali et al, supra note 60 at 8.
ordered psychological assessments. The inclusion, and use, of legislative provisions acknowledging the possible legal relevance of mental health issues is in keeping with the principles and objectives set out in the *YCJA*.

The first enumerated ground in the *YCJA*’s declaration of principle section is to “protect the public” by holding a child accountable for offences through proportionate measures, while also “promoting the rehabilitation and reintegration” of these children, and “supporting the prevention of crime by referring young persons to programs or agencies in the community to address the circumstances underlying their offending behaviour”. Thus, as Nicholas Bala and Julian V. Roberts have noted (in relation to an earlier, but similar, version of the Act’s principles), the first enunciated principle in the Act, “encourages judges and other professionals to focus on responding to youth crime in a fashion that facilitates the rehabilitation of young offenders, rather than on imposing custodial sentences that would merely incapacitate them”. The emphasis on rehabilitation and the provisions in the legislation regarding mental health issues is explored further in the next sections. However, it is important to recognize that, as Michele Peterson-Badali *et al* argue, while “[m]ental health issues are highly prevalent in the youth justice system”, and while they “are considered in a number of contexts in the *YCJA*” (e.g. sentencing dispositions, assessments), the “use of these sections of the Act actually arise quite infrequently in the day-to-day functioning of the youth justice system”. I discuss these

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63 Canada, Youth Justice Research, Research and Statistics Division, *Fetal Alcohol Spectrum Disorder and The Youth Criminal Justice System: A Discussion Paper*, by Paul Verbrugge (Ottawa: Department of Justice Canada, October 2003) at 20; Peterson-Badali *et al*, *supra* note 60 at 9; Campbell & Mountford, *supra* note 60 at 411; *YCJA, supra* note 4, ss 40(2)(f), 34.

64 *YCJA, supra* note 4, s 3(1)(a); see also Peterson-Badali *et al*, *supra* note 60 at 8.


provisions (assessments, fitness to stand trial and NCRMD, sentencing), after I explore the methods for diverting a child with mental health issues away from the criminal justice system.

**Diversion – Extrajudicial Measures**

Diverting criminal cases for resolution outside of legal proceedings is one way the rehabilitation objectives of the *YCJA* may be met.67 The *YCJA* provides that extrajudicial measures are “often the most appropriate and effective way to address youth crime” and “allow for effective and timely interventions focused on correcting offending behaviour”.68 Extrajudicial measures include police taking no further action, police warnings, cautions, or referrals to community programs or agencies, Crown cautions, and extrajudicial sanctions.69 Extrajudicial sanctions are “non-court, community-based programs”, and may be used where other extrajudicial measures are inadequate (for example, due to the seriousness of the offence or history of offences) and several enumerated criteria,70 including the existence of an authorized program, are met.71 Where programs exist,72 a child with mental health issues who is alleged to have committed an offence may be diverted to social services, such as counselling or other

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67 Rose Ricciardelli *et al.*, “From Knowledge to Action? The *Youth Criminal Justice Act* and Use of Extrajudicial Measures in Youth Policing” (2017) 18 Police Pract Res 599 at 600; Bala & Roberts, *supra* note 65 at 46; Bala, Carrington & Roberts, *supra* note 65 at 137; Verbrugge, *supra* note 63 at 30; *YCJA*, *supra* note 4, ss 3(1), 4-10.

68 *YCJA*, *supra* note 4, ss 4(a)-(b); Verbrugge, *supra* note 63 at 30; extrajudicial measures are “presumed to be adequate to hold a young person accountable for his or her offending behaviour” where the crime is non-violent and a first conviction (*YCJA*, s 4(c)). However, even where a child has previously been found guilty of an offence, or previously been dealt with by extrajudicial measures, where they are adequate to hold a child accountable, and their use is consistent with the principles of the extrajudicial measures section, nothing in the Act precludes the use of extrajudicial measures (*Ibid*, s 4(d); Bala & Roberts, *supra* note 65 at 47; Bala, Carrington & Roberts, *supra* note 65 at 137-38).

69 *YCJA*, *supra* note 4, ss 6-8, 10; Bala, Carrington & Roberts, *supra* note 65 at 137; Bala & Roberts, *supra* note 65 at 46; Ricciardelli *et al.*, *supra* note 67 at 607-08, 600-01; Verbrugge, *supra* note 63 at 30.

70 The enumerated criteria include the child being advised of the right to counsel, accepting responsibility for the criminal act, and “fully and freely” consenting to the sanction (*YCJA*, *supra* note 4, ss 10(2), (3); see also Bala, Carrington & Roberts, *supra* note 65 at 138; Verbrugge, *supra* note 63 at 30). And, they require that there be “sufficient evidence” to prosecute the offence, and that the sanction be part of a “program of sanctions” authorized by the province (*YCJA*, ss 10(2)(f), (a); see also Bala & Roberts, *supra* note 65 at 47; Bala, Carrington & Roberts at 138).

71 Bala, Carrington & Roberts, *supra* note 65 at 137, 138; *YCJA*, *supra* note 4, ss 10(1)-(3); see also Bala & Roberts, *supra* note 65 at 46, 47; Verbrugge, *supra* note 63 at 30; extrajudicial sanctions may only be used if, amongst other things, “it is part of a program of sanctions authorized by the Attorney General” or another designated person (*YCJA*, s 10(2)(a)).

72 The lack of availability of adequate community supports and programs is a recurring theme in the applicability of legislative provisions dealing with mental health issues, and is specifically discussed throughout this Chapter.
treatment programs, rather than being formally charged. Where children are formally charged, their mental health issues may be legally significant to a variety of matters, including the admissibility of statements.

**Statements**

Children engaged with the criminal justice system are entitled to the same protections under the *Canadian Charter of Rights and Freedoms* (“Charter”) as adults who are accused of criminal acts (e.g. right to be secure against unreasonable search or seizure, right not to be arbitrarily detained or imprisoned). They are also entitled to specific rights protections pursuant to the *YCJA*, including with regards to statements made while being questioned by police about a suspected crime (e.g. right to silence, right to consult counsel and a parent). Despite the constitutional and legislated protections, as Bala and Roberts argue, “[m]ost youths…are quite unsophisticated and despite being cautioned by the police waive their rights to consultation with a lawyer or parent”. Children may have difficulty understanding and exercising their rights (e.g. to consult counsel, to remain silent), a problem that may be exacerbated where they are suffering from a mental health issue, particularly one that affects their cognitive abilities (e.g. Fetal Alcohol Spectrum Disorder (“FASD”)). The existence of

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73 Despite the requirement that the young person consent, concerns have been raised by some that where a person is diverted from a criminal proceeding on the condition that they attend a treatment program, their consent to the treatment may be coerced (see Chandler, “Mental Health Law”, *supra* note 60 at 392). It is beyond the scope of this Thesis to engage in the debate about the potentially coercive nature of diversion practices conditioned on treatment attendance.

74 YCJA, *supra* note 4, s 6(1); Verbrugge, *supra* note 63 at 30; Bala, Carrington & Roberts, *supra* note 65 at 137; Ricciardelli *et al*, *supra* note 67 at 600-01; Gray, Shone & Liddle, *supra* note 60 at 30.


76 Bala & Roberts, *supra* note 65 at 44; *Charter*, *supra* note 75, ss 8, 9.

77 YCJA, *supra* note 4, s 146; Bala & Roberts, *supra* note 65 at 44; see also *Charter*, *supra* note 75, s 10; specifically, the YCJA provides that the police must “clearly” explain to a child, “in language appropriate to his or her age and understanding”, that they have the right to silence, that what they say may be used as evidence, that they have the right to consult counsel and a parent (or adult relative or other appropriate adult), and that the person consulted, if any, is to be present when the statement is made (unless the young person “desires otherwise”) (YCJA, s 146(2); Bala & Roberts at 44; Kent Roach & Andrea Bailey, “The Relevance of Fetal Alcohol Spectrum Disorder in Canadian Criminal Law from Investigation to Sentencing” (2009) 42 UBC L Rev 1 at 23).

78 Bala & Roberts, *supra* note 65 at 44; see also Roach & Bailey, *supra* note 77 at 13.

79 Roach & Bailey, *supra* note 77 at 13, 14.
mental health issues may also affect the voluntariness, and thus the admissibility, of a statement.\(^\text{80}\) If the child is not advised of and given the opportunity to exercise their rights (e.g. consulting counsel), or if their statement is not made voluntarily, the statement may not be admissible against the young person in Court.\(^\text{81}\) Statements may also be inadmissible if they are made during a Court ordered assessment, unless the child consents or it is used for specific purposes, such as determinations regarding fitness to stand trial and NCRMD.\(^\text{82}\)

**Assessments**

The Court may order that a child undergo a psychological assessment if, amongst other things, there are concerns about a child’s mental health.\(^\text{83}\) Assessment orders under the *YCJA* may be made at any stage of the proceedings and may be used for a number of purposes, including for “making or reviewing a youth sentence”.\(^\text{84}\) An assessment can provide the Court with relevant information about the existence and nature of mental health issues faced by a child.\(^\text{85}\) However, as Peterson-Badali *et al* have observed, “there is a paucity of information available on why and how youth are referred for these assessments, which are conducted on a very small proportion of youth”.\(^\text{86}\) For example, in *R. v. A. (J.)* (“A. (J.)”) an assessment was

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\(^\text{80}\) Verbrugge, *supra* note 63 at 9; see also Roach & Bailey, *supra* note 77 at 15-17; while beyond the scope of this Thesis, it should be noted that researchers have also voiced concerns about the possibility of false confessions being made by people who have mental health issues, like FASD, that affect their cognitive abilities (see Roach & Bailey at 17, 21, 24).

\(^\text{81}\) *YCJA, supra* note 4, s 146(2); in the case of a “technical irregularity” in complying with the requirements to advise a young person of their rights and allow them to exercise those rights, the statement may be admitted if the Court is satisfied that doing so “would not bring into disrepute the principle that young persons are entitled to enhanced procedural protection to ensure that they are treated fairly and their rights are protected” (*Ibid*, s 146(6)).

\(^\text{82}\) *Ibid*, s 147; the *Criminal Code* contains similar provisions regarding assessments ordered under Part XX.1, pursuant to which statements made during an assessment are inadmissible without the consent of the accused, except for specific purposes, including determining fitness to stand trial or NCRMD, if the accused raises their mental capacity or the prosecutor raises the matter after a verdict (*supra* note 5, s 672.21).

\(^\text{83}\) *YCJA, supra* note 4, s 34(1); see also Campbell & Mountford, *supra* note 60 at 411; Peterson-Badali *et al*, *supra* note 60 at 9; Verbrugge, *supra* note 63 at 20.

\(^\text{84}\) *YCJA, supra* note 4, ss 34(1), (2); Peterson-Badali *et al*, *supra* note 60 at 9; Roach & Bailey, *supra* note 77 at 49; Verbrugge, *supra* note 63 at 20.

\(^\text{85}\) Verbrugge, *supra* note 63 at 20; Peterson-Badali *et al*, *supra* note 60 at 9; Roach & Bailey, *supra* note 77 at 29; *YCJA, supra* note 4, s 34; consider also *R v A (J)* (2010), 90 WCB (2d) 431, [2010] NJ No 317 (NL Prov Ct) [A (J)] at paras 4, 16; *R v W (M)*, 2017 ONCA 22, [2017] WDFL 1077 [W (M)] at n 2, leave to appeal refused, [2017] SCCA No 109 (SCC); *R v S (R)*, 2014 ONSC 4279, 121 WCB (2d) 623 [S (R)] at n 2.

\(^\text{86}\) Peterson-Badali *et al*, *supra* note 60 at 9; consider also *A (J)*, wherein Justice Gorman questioned why an assessment had not been ordered sooner, the proceedings having been ongoing for almost a year, and noted that this was “another example of a young person who required intervention at a much earlier stage of the proceedings” (*supra* note 85 at para 4).
requested for the sentencing hearing of a thirteen-year-old who had plead guilty to eleven offences and who was facing three additional charges (the offences were “of a relatively minor nature”).\(^{87}\) Having found that the boy was “a young person in need of professional intervention”, and that he appeared to have “significant behavioural problems” and had at times been “unable to control his behaviour”, but that he could not “be kept in custody to determine if there are underlying psychological issues related to his behaviour”, in \(A. (J.)\) Justice Gorman made a referral pursuant to section 35 of the \(YCJA\) to have the CAS determine if the child was in need of child welfare services.\(^{88}\)

The \textit{Criminal Code} also provides for the conducting of assessments\(^{89}\) in certain circumstances, including for purposes of determinations regarding fitness to stand trial, the availability of the defence of mental disorder, and dispositions on findings of unfitness or NCRMD.\(^{90}\) While the sections on fitness to stand trial and NCRMD are relevant for children with mental health issues in some cases, as Peterson-Badali \textit{et al} have also observed, “findings of not criminally responsible…and unfit to stand trial are quite rare in the youth justice system”.\(^{91}\)

\(^{87}\) \textit{A (J)}, \textit{supra} note 85 at paras 1-5, 16; according to counsel the completion of the assessment would take approximately thirty days (Ibid at para 5).

\(^{88}\) Ibid at paras 4, 16; in the result, having considered the circumstances of the case, Justice Gorman ordered that the child be released with conditions (Ibid at paras 16, 22, 23).

\(^{89}\) Note that an assessment order cannot direct that an accused receive or submit to psychiatric or other treatment (\textit{Criminal Code}, \textit{supra} note 5, s 672.19; Chandler, “Mental Health Law”, \textit{supra} note 60 at 393).

\(^{90}\) \textit{Criminal Code, supra} note 5, ss 672.11, 672.12; see also Chandler, “Mental Health Law”, \textit{supra} note 60 at 393, 395; Katharine Byrick & Barbara Walker-Renshaw, \textit{A Practical Guide to Mental Health and the Law in Ontario: Revised Edition} (Toronto: Ontario Hospital Association, 2016) at 6-3; Gray, Shone & Liddle, \textit{supra} note 60 at 30.

\(^{91}\) Peterson-Badali \textit{et al}, \textit{supra} note 60 at 8; consider also Verduin-Jones & Butler, \textit{supra} note 66 at 497; Kaiser, “Constrained Progress”, \textit{supra} note 66 at 2.
Fitness to Stand Trial

Pursuant to the Criminal Code\textsuperscript{92}, an accused is “presumed fit to stand trial” unless the contrary is proven on a balance of probabilities.\textsuperscript{93} As I described in Chapter Two, to counter the presumption it must be established that the accused is unable to understand the proceedings or instruct counsel “on account of a mental disorder”.\textsuperscript{94} The term “mental disorder” is defined as “disease of the mind”.\textsuperscript{95} In Cooper v. R., Justice Dickson (as he then was), speaking for the majority of the Supreme Court of Canada (“SCC”), explained that “‘disease of the mind’ embraces any illness, disorder or abnormal condition which impairs the human mind and its functioning, excluding, however, self-induced states caused by alcohol or drugs, as well as transitory mental states such as hysteria or concussion”.\textsuperscript{96} That a “mental disorder” is an illness, disorder, or condition that may be treatable (by medical means) or curable, is reflected in the provisions of the Criminal Code and YCJA related to treating an accused to render them fit for trial and to revisiting the matter annually.\textsuperscript{97}

Where an accused is found unfit to stand trial, the Criminal Code provides that the Court may direct the involuntary treatment of the accused for a period of up to sixty days to render

\textsuperscript{92} As previously noted, the YCJA provides that the provisions in Part XX.1 of the Criminal Code are generally applicable (subject to inconsistencies or exclusions) to proceedings under the Act, but also sets out certain modifications to these provisions, including regarding timelines, designated hospitals, and disposition hearings (supra note 4, ss 141(1), (10), (11), (6); see also Criminal Code, supra note 5, s 672.33(1); Campbell & Mountford, supra note 60 at 411). Pursuant to s 672.45 of the Criminal Code, disposition hearings may be held by the Court or, if not so heard, by the Review Board, in cases of both unfit to stand trial and NCRMD (see also Winko v Forensic Psychiatric Institute, [1999] 2 SCR 625, [1999] SCJ No 31 (SCC) [Winko] at paras 23, 25).

\textsuperscript{93} Criminal Code, supra note 5, s 672.22; see also Roach & Bailey, supra note 77 at 34; where the Court has “reasonable grounds” to “believe that the accused is unfit to stand trial”, the Court may direct “that the issue of fitness of the accused be tried” (Criminal Code, s 672.23; see also Roach & Bailey at 29). Pursuant to s 672.25 of the Criminal Code, the trial of the issue of an accused’s fitness may be postponed by the Court until the close of the prosecution’s case (see also Roach & Bailey at 30).

\textsuperscript{94} See Chapter Two at 60 and related references; see also Chandler, “Mental Health Law”, supra note 60 at 393; the test has been characterized as “restrictive”, with fitness requiring only that the accused be able to understand the proceedings (e.g. charges, Court process, possible consequences), and be able to instruct counsel (i.e. have “limited cognitive capacity”) (Byrick & Walker-Renshaw, supra note 80 at 6-7; Roach & Bailey, supra note 77 at 38, 28; Gray, Shone & Liddle, supra note 60 at 30). Criminal Code, supra note 5, s 2.


\textsuperscript{96} Roach & Bailey, supra note 77 at 28-29; Criminal Code, supra note 5, ss 672.58, 672.32, 672.33; YCJA, supra note 4, s 141(10).
them fit for trial. Where an accused cannot be made fit to stand trial, they may be discharged on such conditions as the Court or Review Board considers appropriate, or detained in custody in a hospital. A *prima facie* case (i.e. that there is sufficient evidence to put the accused on trial) must be made out annually, until the accused is acquitted or tried. Where the Court is satisfied that the accused “remains unfit to stand trial and is not likely to ever become fit to stand trial” and “does not pose a significant threat to the safety of the public”, a stay of proceedings may be ordered where it is “in the interests of the proper administration of justice”. Where the Court holds an inquiry to determine whether a stay should be granted, the Court “shall order an assessment of the accused”. As described above, assessments may also be ordered in relation to determinations of NCRMD.

**Not Criminally Responsible by Reason of Mental Disorder**

The defence of mental disorder provides that a person is not criminally responsible for a criminal act committed while “suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong”.

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98 Criminal Code, supra note 5, ss 672.58, 672.59(1); Chandler, “Mental Health Law”, supra note 60 at 393-94; Byrick & Walker-Renshaw, supra note 90 at 6-34; Gray, Shone & Liddle, supra note 60 at 30; the order may only be made where the Court is “satisfied, on the basis of the testimony of a medical practitioner”, that the accused is unfit, the treatment “will likely make the accused fit to stand trial” within sixty days, without treatment “the accused is likely to remain unfit to stand trial”, the “risk of harm” from the treatment is “not disproportionate” to the anticipated benefit, and the treatment is “the least restrictive and least intrusive treatment” that could make the accused fit to stand trial (Criminal Code, s 672.59; consider also ss 672.61 (exclusion of psychosurgery, electro-convulsive therapy, or other prohibited treatment), 672.62 (consent of hospital required, consent of accused not required)).

99 Review Boards are established or designated for each province and may hold hearings and make or review dispositions relating to an accused who has been found unfit to stand trial or NCRMD (see Criminal Code, supra note 5, ss 672.38, 672.47, 672.5, 672.54).

100 Ibid, ss 672.45, 672.47, 672.54; Chandler, “Mental Health Law”, supra note 60 at 394; Roach & Bailey, supra note 77 at 41. YCJA, supra note 4, s 141(10); Criminal Code, supra note 5, s 672.33(1); Chandler, “Mental Health Law”, supra note 60 at 394-95; Campbell & Mountford, supra note 60 at 411; Roach & Bailey, supra note 77 at 28-30.

101 Criminal Code, supra note 5, ss 672.851(5); see also s 672.11(e); Chandler, “Mental Health Law”, supra note 60 at 393.

102 Criminal Code, supra note 5, s 672.851(5); see also s 672.11(c); Chandler, “Mental Health Law”, supra note 60 at 393.

103 Criminal Code, supra note 5, s 672.11(b); see also Chandler, “Mental Health Law”, supra note 60 at 395; note that a fitness assessment and an assessment for purposes of NCRMD are different processes, and the focus of the former is much narrower than that of the latter (see J (JJ), supra note 96 at para 121; R v Ordano, 2017 BCPC 32, 137 WCB (2d) 54 [Ordano] at paras 98, 76).

104 As noted previously, s 16 and Part XX.1 of the Criminal Code apply to youth criminal justice proceedings, subject to any inconsistencies, exclusions, or modifications set out in the YCJA (YCJA, supra note 4, s 141; see also Verbrugge, supra note 63 at 10).

105 See Criminal Code, supra note 5, s 16(1); Chapter Two at 59, 69 and related references.
notion that some mental illnesses can undermine an individual’s ability to form the blameworthy intent that is an essential component of an offence”. The accused is presumed not to have a mental disorder that renders them not criminally responsible, unless the “contrary is proved on the balance of probabilities”. As I described in Chapter Two, to succeed on a claim of NCRMD, a two stage test must be met: the accused must have “suffered from a mental disorder” at the time of the offence and it must have been so severe as to render the accused “incapable of either appreciating the nature and quality of his actions or from knowing they were wrong” (emphasis in the original).

Commenting on the meaning of “knowing that [the act] was wrong” in *R. v. Oommen*, Justice McLachlin (as she then was) speaking for the SCC, noted that section 16(1) of the *Criminal Code* “embraces not only the intellectual ability to know right from wrong, but the capacity to apply that knowledge to the situation at hand”. This point is illustrated in *R. v. J. (J.J.*) (“J. (J.J.*)”), a case involving a teenage boy (age seventeen at the time of the offence) who admitted to stabbing his sister to death and stabbing his cousin with the intention of killing her. Relying on the evidence of two psychiatrists who had assessed the child, Justice Jenkins concluded that there was “no doubt, based upon all of the reports before the Court, that the accused suffers from a mental illness, specifically, schizophrenia” and that there was a “clear

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108 *Criminal Code, supra* note 5, s 16(2); see also *Morrill, supra* note 96 at para 10; *Ordano, supra* note 104 at para 26; Verbrugge, *supra* note 63 at 10; Byrick & Walker-Renshaw, *supra* note 90 at 6-11; the burden of proof is on the party that raises the issue, and the matter is determined after the accused is found to have committed the criminal act for which they were charged (*Criminal Code*, ss 672.34, 672.1, 16(1); Verbrugge at 10; Byrick & Walker-Renshaw at 6-11).
109 See Chapter Two at 69 and related references; *Morrill, supra* note 96 at paras 10, 161; Roach & Bailey, *supra* note 77 at 38; Campbell & Mountford, *supra* note 60 at 414; Byrick & Walker-Renshaw, *supra* note 90 at 6-11.
110 *Ordano, supra* note 104 at paras 101, 102; see also *Criminal Code, supra* note 5, s 16(1); *J (JJ), supra* note 96 at para 14; *Morrill, supra* note 96 at para 161; *R v Oommen, [1994] 2 SCR 507, [1994] SCJ No 60 (SCC) [Oommen] at para 19; Roach & Bailey, *supra* note 77 at 38; Campbell & Mountford, *supra* note 60 at 414; Byrick & Walker-Renshaw, *supra* note 90 at 6-11; the way “mental disorder” is defined is set out above in the section on fitness to stand trial and is discussed in depth in Chapter Two at 59-62.
111 *Oommen, supra* note 110 at para 35; an in-depth review of the meaning of “appreciating the nature and quality of the act or omission or of knowing that it was wrong” is beyond the scope of this Thesis. For a discussion of the meaning of these terms consider *Cooper, supra* note 96; *Oommen, supra* note 110; *Ordano, supra* note 104.
112 *J (JJ), supra* note 96 at paras 2, 8.
link” between the offences and the delusions that resulted from his condition. Justice Jenkins concluded that “[t]he accused’s schizophrenia rendered him incapable of knowing that his actions were morally wrong” and, having noted that while “he understood his actions were illegal, his delusions made him believe his actions were morally justified”, found the accused NCRMD.

Where an accused is found NCRMD, they may be discharged absolutely, discharged with conditions, or detained in custody in a hospital. In determining which disposition is “necessary and appropriate in the circumstances”, the Court (or Review Board) must take into account public safety, the accused’s mental condition, reintegration of the accused into society, and the accused’s other needs. Where an absolute discharge is not granted, an order for conditional discharge or hospital detention can be used to encourage the accused to get treatment for their “mental disorder” (for example, including a condition requiring attendance at a treatment program in the disposition order). However, as Justice McLachlin (as she then was) noted for the majority of the SCC in Winko v. Forensic Psychiatric Institute (“Winko”), “[a]lthough the court or Review Board has a wide latitude in determining the appropriate

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113 Ibid at paras 3, 15, 19; in J (JJ), shortly after the offence, the accused (who was in care, and living in a group home) told his outreach worker that he had stabbed his sister because she “stole my rap music” and had refused to give it back despite being offered $100,000 to do so (Ibid at paras 10, 11). Citing the reports of the assessing psychiatrists, Justice Jenkins found that at the time of the offence the boy had delusions about the anticipated success of his rap music and his sister having stolen his rap sheets, and that the acts he committed in the ensuing confrontation were the “result of his condition” (Ibid at para 19).

114 Ibid at para 30; having made this finding, in line with the submissions of counsel, Justice Jenkins deferred the disposition hearing to the Review Board, “which direction was also recommended by [the psychiatrist] and will allow for appropriate treatment planning for the accused in a hospital setting” (Ibid at para 31).

115 Criminal Code, supra note 5, s 672.54; see also Winko, supra note 92 at paras 3, 21, 27; Chandler, “Mental Health Law”, supra note 60 at 395; James E Moran, “Mental Disorder and Criminality in Canada” (2014) 37 Intl J L & Psychiatry 109 at 115.

116 Criminal Code, supra note 5, s 672.54; see also Winko, supra note 92 at para 55; Chandler, “Mental Health Law”, supra note 60 at 395-96.

117 Like in the case of diversion from the criminal justice system into the mental health system, despite the requirements that the accused consent, concerns about coercion may arise in the mental health system, see Byrick & Walker-Renshaw, supra note 90 at 6-34; Peterson-Badali et al, supra note 60 at 9; Gray, Shone & Liddle, supra note 60 at 30, 430, 432; an absolute discharge is to be granted where the Court (or Review Board) is of the opinion that the accused is “not a significant threat to the safety of the public” (Criminal Code, supra note 5, s 672.54(a); see also Winko, supra note 92 at paras 3, 49, 57, 69; Chandler, “Mental Health Law”, supra note 60 at 395-96). Dispositions (other than an absolute discharge) are to be reviewed annually, but may be reviewed at other times as well (eg if restrictions on the accused’s liberty are significantly increased or a review hearing is requested by the person in charge of the place where the accused is detained or by the accused or any other party) (Criminal Code, ss 672.81, 672.82; see also Winko at para 28).
conditions to be imposed, it can only order that psychiatric or other treatment be carried out if
the NCR accused consents to that condition, and the court or Review Board considers it to be
reasonable and necessary”.¹¹⁹

**Sentencing**

As noted above, only a small portion of accused in both the youth and adult criminal
justice systems are found to be unfit to stand trial or NCRMD.¹²⁰ As such, in many cases a
child’s mental health issues may become most (legally) relevant at the sentencing stage (i.e.
following a finding of guilt).¹²¹ The YCJA provides the Court with a variety of sentencing
options.¹²² It also provides that the Court may convene a conference, to consider
recommendations on an appropriate sentence, and may order a psychological assessment for
purposes of making or reviewing a sentence.¹²³ Information about a child’s mental health may
also come to the Court’s attention through a pre-sentence report, which provides information on
a variety of matters that are considered relevant to the restrictions on custody and the purposes
and principles of sentencing in the YCJA.¹²⁴

¹¹⁹ Winko, supra, note 92 at para 27; see also Criminal Code, supra note 5, s 672.55(1); YCJA, supra note 4, s 42(8); Gray, Shone &
Liddle, supra note 60 at 30; Byrick & Walker-Renshaw, supra note 90 at 6-34; in some cases provincial Mental Health Acts may provide
a means for involuntary treatment, however, it is beyond the scope of this Thesis to address involuntary committal (and capacity
determinations) under these Acts (consider Ross Green, “Where the Systems Collide: Youth Court, Child Protection, Interdisciplinary
¹²⁰ Peterson-Badali et al, supra note 60 at 8; Kaiser, “Constrained Progress”, supra note 66 at 2; Verbrugge, supra note 63 at 24.
¹²¹ YCJA, supra note 4, ss 41, 19, 34; Bala, Carrington & Roberts, supra note 65 at 49; Deborah K
Lovett & Angela R Westmacott, “Criminal Code Court-Ordered Psychiatric and Psychological Assessments and the Role of the Forensic
Psychiatric Services Commission” (2011) 69 Advocate 663 at 669.
¹²² Verbrugge, supra note 63 at 20; YCJA, supra note 4, ss 40(1)-(2), 39(6)-(7), 42(1); see also Bala & Roberts, supra note 65 at 49; the
pre-sentence report may include the results of interviews with the child, their family, and/or the victim, any history of offences, and the
availability of community programs and the child’s willingness to avail of them, amongst other things (YCJA, s 40(2)).
Purposes and Principles of Sentencing

The YCJA provides that the purpose of sentencing “is to hold a young person accountable for an offence through the imposition of just sanctions that have meaningful consequences for the young person and that promote his or her rehabilitation and reintegration into society, thereby contributing to the long-term protection of the public”. Various sentencing provisions have the potential to address the mental health needs of children, and sentencing decisions may be affected by the perceived likelihood that the child will complete and benefit from treatment. However, the imposition of these sentences is subject to the principle of proportionality – a “sentence must be proportionate to the seriousness of the offence and the degree of responsibility of the young person for that offence”. Thus, as Bala and Roberts argue, “rehabilitative concerns can modify a sentence to reduce its severity, but a youth court should not impose a disproportionately intrusive sentence to attempt to achieve rehabilitative objectives”.

Custody

As I described in Chapter One, a significant number of children with mental health issues (especially those who are also engaged in the family law (child welfare) system) become involved with the criminal justice system, and a disproportionate number find themselves in custody. The YCJA stipulates that the Court “shall not commit a young person to custody”

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125 YCJA, supra note 4, s 38(1).
126 Eg ibid, ss 42(2)(j), (m), (r).
127 Campbell & Mountford, supra note 60 at 410, 412; Roach & Bailey, supra note 77 at 52; Verdun-Jones & Butler, supra note 66 at 504, 502; as noted below, treatment can only be ordered with the child’s consent (YCJA, supra note 4, s 42(8); see also Peterson-Badali et al, supra note 60 at 8-9; Verbrugge, supra note 63 at 26; consider also Criminal Code, supra note 5, ss 672.19, 672.55).
128 YCJA, supra note 4, s 38(2)(c); see also Bala & Roberts, supra note 65 at 51; Bala, Carrington & Roberts, supra note 65 at 145; Verbrugge, supra note 63 at 23.
129 Bala & Roberts, supra note 65 at 51; see also Verbrugge, supra note 63 at 24, 19.
unless one of four circumstances exist: (a) the child committed a violent offence; (b) the child
failed to comply with non-custodial sentences; (c) the child committed a serious (indictable)
offence and has an extensive criminal history; or (d) exceptional cases where the child
committed a serious (indictable) offence and the aggravating circumstances make a non-
custodial sentence inconsistent with the purposes and principles of sentencing set out in the
Act.131 Even where one of these four criteria are met, the Court must take a number of other
considerations into account before imposing a custodial sentence.132

Before imposing a custodial sentence, the Court must consider “all alternatives to custody
raised at the sentencing hearing that are reasonable in the circumstances” and must be satisfied
that there is “not a reasonable alternative, or combination of alternatives” to the custodial
sentence.133 And, unless the parties consent and it is considered unnecessary, the Court also
must consider a pre-sentence report and “any sentencing proposal made by the young person or
his or her counsel”.134 The YCJA specifically provides that custody is not to be used “as a
substitute for appropriate child protection, mental health or other social measures”.135 While
some custody facilities may offer more and better programing and rehabilitative services than
others, the correctional system was not designed to meet the mental health needs of children and,
as Justice Forestell noted in R. v. S. (R.) (“S. (R.)”), “[t]here are limits…to the rehabilitation that
is possible in a custodial setting”.136 However, as will be seen, issues with the availability of
programing and rehabilitative services also arise with non-custodial sentences.137

131 YCJA, supra note 4, s 39(1); Verbrugge, supra note 63 at 25; Bala, Carrington & Roberts, supra note 65 at 146; Bala & Roberts,
supra note 65 at 54.
132 YCJA, supra note 4, ss 39(2)-(6); Bala, Carrington & Roberts, supra note 65 at 147.
133 YCJA, supra note 4, s 39(2); Bala, Carrington & Roberts, supra note 65 at 147.
134 YCJA, supra note 4, ss 39(6), (7); Bala & Roberts, supra note 65 at 55; Bala, Carrington & Roberts, supra note 65 at 148.
135 YCJA, supra note 4, s 39(5) [regarding custodial sentences]; see also ss 29(1) [regarding pre-sentencing detention], 38(2) [regarding
considering sanctions other than custody and imposing the least restrictive sentence]; Peterson-Badali et al, supra note 60 at 8; Bala,
Carrington & Roberts, supra note 65 at 145, 148; Bala & Roberts, supra note 65 at 55.
136 Bala & Roberts, supra note 65 at 56-57; Justice Malcolm McLeod, “The Ashley Smith Story – A Judge’s Perspective” (2012) 59
Crim L Q 237 at 237-38; Gray, Shone & Liddle, supra note 60 at 433; S (R), supra note 85 at paras 40, 37, 11.
137 Consider Bala, Carrington & Roberts, supra note 65 at 148-49; Verdun-Jones & Butler, supra note 66 at 502.
Community-Based Sanctions

The *YCJA* provides for a number of community-based sanctions, including: reprimands, absolute discharge, conditional discharge, fines, restitution, community service, and probation. The *YCJA* also provides that the Court may order a child to attend a non-residential program or order them into an intensive support and supervision program (“ISSP”) if the Provincial Government has decided to make services available. While the latter provisions may be more specifically aimed at getting the child into a treatment program, as Peterson-Badali *et al* argue, in addition to the “specialized mental health sentencing options, judges may also attach conditions involving mental health treatment to community dispositions such as probation” (e.g. including a condition requiring attendance at a treatment program).

For example, in *S. (R.)*, a nineteen-year-old who was convicted of offences committed when he was seventeen (manslaughter, aggravated assault, careless use of a firearm and possession of a firearm without a license) was sentenced to custody and supervision for a period of two and a half years, “with one day of secure custody” and the balance of the sentence being “served under conditional supervision in the community”. In deciding on this disposition, Justice Forestell considered the boy’s circumstances (familial relationships, school and employment, criminal history, conduct in custody, remorse) and the results of a section 34 psychiatric assessment, and found that the “combination of [the boy’s] developmental delays and his reluctance to seek appropriate help combined to lead to these offences” and that while “[h]is

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138 *YCJA*, supra note 4, ss 42(2)(a)-(k); Bala & Roberts, *supra* note 65 at 55-56; Bala, Carrington & Roberts, *supra* note 65 at 148-49.
139 *YCJA*, supra note 4, ss 42(2)(m), (l), 42(3); Bala, Carrington & Roberts, *supra* note 65 at 148-49; Bala & Roberts, *supra* note 65 at 56; Verbrugge, *supra* note 63 at 25.
140 Peterson-Badali *et al*, *supra* note 60 at 9; Gray, Shone & Liddle, *supra* note 60 at 30, 430, 432; while conditions may be included, the child cannot be compelled to participate in treatment; the *YCJA* provides that nothing in the sentencing section “abrogates or derogates from the rights of a young person regarding consent to physical or mental health treatment or care” (*YCJA*, *supra* note 4, s 42(8); Peterson-Badali *et al* at 9; Verbrugge, *supra* note 63 at 26; see also Gray, Shone & Liddle at 30, 430-32; Byrick & Walker-Renshaw, *supra* note 90 at 6-34). However, as noted above, while beyond the scope of this Thesis to discuss, in some cases treatment may be compelled where a person lacks capacity to consent (see note 119; consider also Verbrugge at 26).
141 *S (R)*, *supra* note 85 at paras 2, 55, 54.
developmental limitations were not within his control”, his “choices about where and when to seek help were and are within his control”.142 Having found that the just over two years spent in custody had “served to hold [the boy] to account for what he did” and that “the benefits of custodial rehabilitation for this young person have already been achieved”, Justice Forestell held that the “next step” was to “ensure that the progress made by [the boy] continues as he is reintegrated into society”.143 To this end, in addition to the mandatory conditions imposed under the community supervision order, the order contained further conditions including that the boy “attend counselling, including for anger management or substance abuse as recommended by the Provincial Director” and “attend vocational counselling as recommended by the Provincial Director”.144

**Intensive Rehabilitative Custody and Supervision**

Where a child has been found guilty of a serious offence (e.g. first or second degree murder),145 and is “suffering from a mental illness or disorder, a psychological disorder or an emotional disturbance”, the Court may make an intensive rehabilitative custody and supervision (“IRCS”) order.146 For an IRCS order to be made, “a plan of treatment and intensive supervision” has to have been “developed for the young person”, there must be “reasonable grounds” to believe “the plan might reduce the risk of the young person repeating the offence or committing a serious violent offence”, and the Provincial Director has to have determined a

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142 *Ibid* at paras 17-41, 49.
143 *Ibid* at paras 53, 52.
144 *Ibid* at para 58.
145 Specifically, an IRCS order may be made if, amongst other things, either: “(i) the young person has been found guilty of a serious violent offence, or (ii) the young person has been found guilty of an offence, in the commission of which the young person caused or attempted to cause serious bodily harm and for which an adult is liable to imprisonment for a term of more than two years, and the young person had previously been found guilty at least twice of such an offence” (*YCJA, supra* note 4, s 42(7)(a)). A “serious violent offence” means an offence under the provisions of the *Criminal Code* regarding first or second degree murder, attempt to commit murder, manslaughter, or aggravated sexual assault (*Ibid*, s 2(1); see also *R v C (RB)*, 2009 SKPC 117, 85 WCB (2d) 262 [C (RB)].
146 *YCJA, supra* note 4, ss 42(2)(r), 42(7); Bala & Roberts, *supra* note 65 at 57; Campbell & Mountford, *supra* note 60 at 411-12; Peterson-Badali *et al*, *supra* note 60 at 9; Verbrugge, *supra* note 63 at 26; Bala, Carrington & Roberts, *supra* note 65 at 151; as Campbell and Mountford point out, “[b]ecause IRCS orders follow a conclusion that a young person is guilty of a serious offence, they are an alternative to an adult sentence” (at 412; see also *YCJA*, s 64; Verbrugge at 26; *W (M)*, *supra* note 85).
program is available and appropriate. For example, in setting aside adult sentences and imposing IRCS orders on two adolescents convicted for a first degree murder committed when they were sixteen, in *R. v. W. (M.)* (“W. (M.”) the Ontario Court of Appeal specifically noted the appellants’ “rehabilitative potential” and the availability of an IRCS program.

An IRCS order could not be made in *S. (R.)* because, despite all of the other criteria having been met, the Provincial Director would not consent to the boy’s participation, citing his belief that the boy had not shown enthusiasm for treatment and had indicated he did not need treatment outside of academic support and would not accept medication as part of his treatment. Justice Forestell found the Provincial Director’s “reasons troubling” noting, amongst other things, that given his “cognitive limitations” (including an inability to reason abstractly), it was “unreasonable” to expect the boy to fully appreciate his recently received diagnoses and related treatment needs, or to be able to answer a hypothetical question about taking medications that had not been prescribed for him. However, because the Provincial Director refused his consent, Justice Forestell did not consider an IRCS program in determining an appropriate sentence. The “resources required to develop effective individualized IRCS

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147 *YCJA,* supra note 4, ss 42(7)(c), (d); *Campbell & Mountford,* supra note 60 at 411-12; *Peterson-Badali et al,* supra note 60 at 9; *Verbrugge,* supra note 63 at 26; *Bala & Roberts,* supra note 65 at 57; IRCS orders must be for a specified duration and include a “continuous period of intensive rehabilitative custody” followed by “conditional supervision in the community” (*YCJA,* s 42(r); *Campbell & Mountford* at 411; *Bala & Roberts* at 57).

148 *W (M),* supra note 85 at paras 2, 3, 10.

149 *S (R),* supra note 85 at paras 2, 8, 9; as noted above, in *S (R),* a nineteen-year-old was convicted of manslaughter, aggravated assault, careless use of a firearm and possession of a firearm without a license for offences committed when he was seventeen (*Ibid* at paras 2, 23).

150 *Ibid* at paras 10, 12, 13; specifically, Justice Forestell raised concerns about the plan proposed for the boy in *S (R),* namely that it was “focused entirely on secure and open custody” and, without addressing the placement recommendation of the assessing psychiatrist, indicated the boy should remain in the facility where he had “just spent over two years” (*Ibid* at para 11). Justice Forestell further noted that it was “not surprising that [the boy] showed little enthusiasm for more than two years in the same place doing the same programs” (especially as the custodial period exceeded that sought by the Crown) and that “[i]n light of [the boy’s] cognitive limitations, to expect him to have a full appreciation of his diagnosis [received two weeks earlier] and resulting treatment needs is unreasonable” (*Ibid* at paras 11, 12). Finally, Justice Forestell found it “very concerning that the Provincial Director relies on [the boy’s] refusal to agree to take prescribed medication as a basis to deny consent for him to participate in the IRCS programme”, noting that the “highly qualified medical practitioner” who had just completed a thorough psychiatric and psychological assessment of the boy had not prescribed any medications or indicated “any diagnosis that would be likely to require prescription medication” and that it was “unreasonable to pose such a hypothetical question” to a boy who, the assessment indicated, had “developmental delays [that] make him unable to reason abstractly” (*Ibid* at para 13).

151 *Ibid* at paras 9, 8.
plans for young offenders” is cited by Campbell and Mountford as a possible explanation for the “limited use of this sentencing option”, with the authors noting that “[d]evising such plans calls upon provincial actors to identify and deliver appropriate mental health resources to young people, which is a significant challenge given the overarching challenges of delivering appropriate mental health treatment programs for young offenders in Canada”.\(^\text{152}\)

The use made of available programing by an accused may also be a consideration in making an IRCS order. For example, the “growth” achieved by the adolescents through the programing available in the provincial system was an influential factor in the Court of Appeal’s decision in \(W. (M.)\), with the Court noting that IRCS orders would mean that the adolescents each have “the benefit of a decade of intensive treatment and counselling”, which would provide them with “the kind of support” that each had demonstrated they responded well to.\(^\text{153}\) Another consideration noted by the Court in \(W. (M.)\) was that each of the adolescents had indicated they were willing to participate in the IRCS program.\(^\text{154}\) In keeping with the child’s rights regarding consent to treatment, an IRCS order will only be imposed if there is evidence that the child will voluntarily participate in the treatment plan.\(^\text{155}\) Where an IRCS order is made and a child fails to comply, they may face legal consequences, including increased time in custody.\(^\text{156}\)

The inclusion of the IRCS and other provisions acknowledging mental health issues in the \(YCJA\) theoretically provides opportunities to better address the needs of children with mental health issues who are engaged with the criminal justice system. However, as the foregoing

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\(^{152}\) Campbell & Mountford, supra note 60 at 413.

\(^{153}\) \(W. (M.)\), supra note 85 at paras 135-38, 157; both adolescents in \(W. (M.)\) were found to have “emotional disturbances”, with the Court of Appeal finding, on the basis of the evidence of a psychiatrist who had conducted section 34 assessments, that one of the adolescents had “emotional disturbances involving anger and anxiety, and was diagnosed with conduct disorder and an unspecified anxiety disorder with post-traumatic symptoms” and the other had “clear problems with aggression flowing from anger, distrust, poor coping strategies and negative peer influence” (ibid at paras 32, 129, 38, 148).

\(^{154}\) Ibid at paras 136, 153, 157, 160.

\(^{155}\) \(YCJA\), supra note 4, s 42(8); Campbell & Mountford, supra note 60 at 412; Bala & Roberts, supra note 65 at 57; Bala, Carrington & Roberts, supra note 65 at 151; Verbrugge, supra note 63 at 26.

\(^{156}\) \(W. (M.)\), supra note 85 at paras 63-67; as Justice Epstein also noted, one of the incentives to encourage compliance is the potential for decreased time in custody (ibid at paras 69-71).
demonstrates, in practice, many of these provisions (e.g. unfit to stand trial, NCRMD, assessments) are used infrequently\textsuperscript{157} and, even where a judge wishes to make use of a provision, their efforts may be frustrated by the unavailability of services or a lack of communication between systems.\textsuperscript{158} I discuss the lack of adequate supports and services and siloing between systems later in this Chapter, along with the issues surrounding identifying (and a failure to identity) children with mental health issues.

The Role of Mental Health Practitioners in Family Law and Criminal Justice Proceedings

Expert Evidence\textsuperscript{159}

Where the legislative provisions relating to mental health issues (e.g. child protection claims on the basis of “emotional harm”, criminal cases where fitness or NCRMD have been raised) are in issue, the Court will often require expert evidence in relation to the mental state of the child.\textsuperscript{160} Expert (medical) evidence may provide the Court with information and opinions regarding the nature and effect of different mental health issues and their potential existence (diagnosis) and treatability in a given case.\textsuperscript{161} While it is for the trier of fact to decide what

\textsuperscript{157} Peterson-Badali et al, supra note 60 at 20, 8, 9; see also Verdun-Jones & Butler, supra note 66 at 497; Kaiser, “Constrained Progress”, supra note 66 at 2; \textsuperscript{A (J)}, supra note 85 at para 4.

\textsuperscript{158} Eg S (R), supra note 85 at paras 8, 10; see also R v M (S) (2004), 61 WCB (2d) 63, 2004 CarswellOnt 5138 (WLNext Can) (ONCJ) [M (S)]; R v D (WAL), 2004 SKPC 40, 245 Sask R 98 [D (WAL)].

\textsuperscript{159} It is beyond the scope of this Thesis to engage in a discussion about qualifying experts, court-appointed versus party-retained experts, or issues of admissibility, objectivity, bias, reliability, impartiality, etc. While these are important considerations, the focus in this Chapter is on the role of expert evidence relating to mental health issues in child welfare and youth criminal justice proceedings (which expert evidence is often provided by court-appointed assessors) (see CYPSA, supra note 3, s 98; YCJA, supra note 4, s 34; see also Nicholas Bala & Katherine Duvall Antonacopoulos, “The Controversy over Psychological Evidence in Family Law Cases” in Belinda Brooks-Gordon and Michael Freemann, eds, \textit{Law and Psychology} (Oxford: Oxford University Press, 2006) 218 at 234). For a discussion about qualifying experts, court-appointed versus party-retained experts, and issues of admissibility, impartiality, etc. in the context of cases involving children, see Nicholas Bala, Rachel Birnbaum & Carly Watt, “Addressing Controversies about Experts in Disputes over Children” (2017) 30 Can J Fam L 71. For a discussion of psychiatric evidence (qualification of experts, bias, ultimate issue, etc.) in legal proceedings, see also Bloom & Schneider, supra note 60. For a discussion of the role of parenting capacity assessments in child welfare proceedings (including their limitations and critique evidence), see Children’s Aid Society, Region of Halton v W (A), 2016 ONCJ 358, 268 ACWS (3d) 585.

\textsuperscript{160} C (NV), supra note 10 at paras 91-96, 100, 105; C (A) v A (V), 2012 ONCJ 7, 216 ACWS (3d) 109 [C (A)] at paras 65, 69; S L, supra note 9 at para 93; R (M), supra note 10 at para 11; \textit{Morrill}, supra note 96 at paras 80, 84, 160; \textit{Ordano}, supra note 104 at para 34; Bala, Birnbaum & Watt, supra note 159 at 74, 125; Bala & Duvall Antonacopoulos, supra note 159 at 235, 233; Bloom & Schneider, supra note 60 at 75, 53-54; Stephen Butler et al, “Child Maltreatment: The Collaboration of Child Welfare, Mental Health, and Judicial Systems” (1995) 19 Child Abuse & Negl 355 at 356.

\textsuperscript{161} Bloom & Schneider, supra note 60 at 49, 75, 64-65; Bala & Duvall Antonacopoulos, supra note 159 at 233; Bala, Birnbaum & Watt, supra note 159 at 125; see also eg Ordano, supra note 104; \textit{Morrill}, supra note 96; J (LJ), supra note 96; C (V), supra note 10; S L, supra note 9; Children’s Aid Society of Niagara Region v P (H) (2003), 125 ACWS (3d) 647, [2004] WDFL 49 (ONSC) [P (H)]; A (M), supra note 13; C (C), supra note 40; W (M), supra note 85.
weight to give to this evidence and to determine the ultimate issues in the case (e.g. whether a child has a “mental disorder” and is unfit to stand trial), as the jurisprudence demonstrates, psychiatric evidence may be highly influential or determinative in many cases on decisions regarding whether the criteria in the statutory provisions relating to mental health issues have been met.¹⁶²

*Child Welfare Proceedings*¹⁶³

The significant influence a mental health professional’s expert opinion may have on the outcome in a given case is evident in numerous cases where the legislative provisions of the *CFSA* (now *CYFSA*) dealing with mental health issues are engaged.¹⁶⁴ For example, in *Kunuwanimano Child and Family Services v. S.L.*, Justice Kukurin noted that “I would require the opinion of a qualified emotional and mental health practitioner, preferably one who has examined the child beforehand, to satisfy me that this child is at risk of harm on this ground [“emotional harm”], and that the symptoms of the emotional harms [sic] was serious”.¹⁶⁵ This evidence having not been presented, His Honour declined to find the child “in need of protection on risk of emotional harm grounds”.¹⁶⁶ Recognizing that “the finding that a diagnosis meets the statutory definition” does not depend “on the clinician making a finding in the words of the

¹⁶² *Ordano*, supra note 104 at paras 34, 90, 91; Bala & Duvall Antonacopoulos, supra note 159 at 236, 224, 225; Bala, Birnbaum & Watt, supra note 159 at 76-77, 74; Bloom & Schneider, supra note 60 at 64-65, 75, 66; Butler, supra note 160 at 360, 361; see also eg *Morrill*, supra note 96; *A (M)*, supra note 13; *P (H)*, supra note 161; *R (K)*, supra note 30; *B (G)*, supra note 51; *D (D)*, supra note 18; *K (S)*, supra note 10; *C S*, supra note 35; *W (M)*, supra note 85; *J (J)*, supra note 96; *C (C)*, supra note 40; while expert evidence regarding a child’s mental state is often provided by psychiatrists, it also may be provided by other professionals, such as psychologists or social workers (*Bloom & Schneider* at 67-68; see also Bala & Duvall Antonacopoulos at 225-26, 218, n 1; Bala, Birnbaum & Watt at 83; *R (M)*, supra note 10 at para 11; eg *Ordano*; *P (H)*; *R (K)*; *J M*, supra note 55). The Courts may also receive opinions from witnesses who are not qualified as experts (including child protection workers) and, as Justice Zisman noted in *K (S)*, “[t]his is usual for social workers in child protection cases to give opinions, based on their education and clinical experience, about a variety of issues including the quality of parent and child interactions, the emotional state of people, appropriate placement and adoption issues” (para 147; Bala, Birnbaum & Watt at 116-17, 76, n 8; see also Butler at 359).

¹⁶³ Notably, the witnesses providing expert evidence in child welfare proceedings may have long standing working relationships with the CAS which may, in some cases, raise concerns about a “lack of independence” (Bala, Birnbaum & Watt, supra note 159 at 116-18, 120). The role of child protection workers in cases involving children with mental health issues is discussed in detail in Chapter Four.

¹⁶⁴ See eg *R (K)*, supra note 30; *B (G)*, supra note 51; *D (D)*, supra note 18; *K (S)*, supra note 10; *C S*, supra note 35; *A (M)*, supra note 13; *C (C)*, supra note 40; consider also Butler, supra note 160 at 356; Bala & Duvall Antonacopoulos, supra note 159 at 225.

¹⁶⁵ *S L*, supra note 9 at para 93.

¹⁶⁶ Ibid; see also *C (NY)*, supra note 10 at para 100; *C (A)*, supra note 160 at paras 65, 69, 112, 113.
statute”, in *A. (M.)*, Justice Eberhard found that a child was “in a state of prolonged and serious emotional harm as demonstrated by selective mutism, ODD and anxiety” (disorders diagnosed by a psychiatrist).\(^\text{167}\) That the child had been diagnosed with several mental disorders (namely, PTSD, ODD, and mood disorder) was also noted by the Court in *M. (K.A.L.)* in relation to the finding that the child had “more than one mental disorder”.\(^\text{168}\)

**Criminal Context**

As I have illustrated, psychiatric evidence may be relied upon in a variety of situations in the criminal context where issues of a child’s mental state and the existence or absence of a “mental disorder” may be relevant, such as regarding the voluntariness of statements, fitness to stand trial, NCRMD, disposition hearings, and sentencing.\(^\text{169}\) For example, in reaching the conclusion that the accused in *J. (J.J.)* was suffering from schizophrenia and that it “rendered him incapable of knowing that his acts were morally wrong”, Justice Jenkins relied on and adopted the opinions of the psychiatrists who assessed the accused to find that he was “suffering from this condition at the time of the offences”, and that there was “a clear link between these acts and his pre-existing mental illness”.\(^\text{170}\)

The opinions of two experts (psychiatrists) were also accepted by the Court in *R. v. Morrill* in finding that the adult defendant had a “mental disorder” and that it was probable that he was suffering from that “mental disorder” at the time of the offence (shooting at RCMP

\(^{167}\) *A (M), supra note 13 at paras 28, 40; Justice Eberhard referred to the behaviours and diagnosis mentioned by the psychiatrist and noted that “‘[a]nxiety’ is named”, and “[p]rotracted refusal to speak must surely be seen as a serious response to the stressors in the child’s life in the nature of withdrawal, or so counterproductive as to be self destructive, or so backsliding as to be delay in development” (anxiety, withdrawal, self-destructive behaviour, and delayed development are enumerated criteria in the definition of “emotional harm”) ([*Ibid* at paras 29, 22, 23; see also *CYFSA, supra note 3, s 74(2)(f) (previously *CFSA, supra note 3, s 37(2)(f)*)].)

\(^{168}\) *M (KAL), supra note 27 at para 6.

\(^{169}\) *Bloom & Schneider, supra note 60 at 49, 53-57, 64-65; Byrick & Walker-Renshaw, supra note 90 at 6-12; Morrill, supra note 96 at paras 80, 84, 160; eg *J (JJ)*, supra note 96; *W (M)*, supra note 85; *S (R)*, supra note 85; Cooper, supra note 96; Ordano, supra note 104; Oommen, supra note 110.

\(^{170}\) *J (JJ)*, supra note 96 at paras 15, 18, 19, 30.
Similarly, in *R. v. Ordano* (“Ordano”), Justice Flewelling accepted the opinion of the forensic psychiatrist that assessed the adult defendant, to the effect that “at the time of the offence, [he] was suffering from Bipolar Affective Disorder or, alternatively, a Schizo-Affective Disorder, accompanied by an acute manic episode with psychosis”, and concluded that “at the time of the offence, [the accused] was suffering from a mental disorder, namely a psychotic episode, and had lost touch with reality” and that the “mental disorder” had “rendered him incapable of appreciating the nature and quality of his actions or of knowing that they were wrong”.

**Links between Legislative Definitions and Experienced Outcomes**

**Reliance on Medical Evidence and a Medical Model**

As I have illustrated, a child’s mental state may be put in issue in a variety of circumstances, including to ground a claim for a finding that a child is “in need of protection”, that they should be admitted or committed to a secure treatment program, that they are unfit to stand trial, or that they are NCRMD. Where a child’s mental state is put in issue, the analysis turns on whether the child’s words and behaviours are atypical or problematic (i.e. symptomatic) such that the child can be said to have (i.e. can be diagnosed with) an illness or disorder of the kind (“mental disorder”, “emotional harm”, “mental, emotional or developmental condition”) addressed in the legislative provisions relating to mental health issues (e.g. whether a child’s

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171 *Morrill*, supra note 96 at paras 85, 149, 155, 160-62, 1; in reaching the conclusion that Mr. Morrill was NCRMD, Justice Erb held there “should be no dispute that expert evidence is necessary and relevant in this case”, noting, “[t]he evidence is directed at the complex issue of mental disorder in a case in which the court is required to determine whether an accused had a mental disorder at the time of the offences and if so, whether it prevented him from appreciating the nature of the conduct and knowing it was wrong” (*Ibid* at paras 162, 84).

172 *Ordano*, supra note 104 at paras 100, 101, 110, 115.

173 *CYFSA*, supra note 3, ss 74(2)(f)-(j), 117, 124; *Criminal Code*, supra note 5, ss 2, 16(1); see also eg *C (NV)*, supra note 10; *B (S)*, supra note 15; *R (M)*, supra note 10; *A (M)*, supra note 13; *D (C)*, supra note 10; *K (S)*, supra note 10; *F (DK)*, supra note 38; *C (S)*, supra note 35; *M (KAL)*, supra note 27; *C (C)*, supra note 40; *R (K)*, supra note 30; *Syl Apps Youth Centre v M (M)*, 2015 ONCJ 666, 261 ACWS (3d) 198 [M (M)]; *B (G)*, supra note 51; *C v Syl Apps Youth Centre*, 2013 CFSRB 22 [C]; *C M*, supra note 53; *E P*, supra note 49; *J G v Youthdale Treatment Centres*, 2011 CFSRB 24 [J G]; *J M*, supra note 55; *K D*, supra note 47; *M*, supra note 26; *N*, supra note 26; *RSP v Youthdale Treatment Centres*, 2017 CFSRB 2 [RSP]; *S I*, supra note 46; *Y*, supra note 26; *D (WAL)*, supra note 158; *J (JJ)*, supra note 96; *M (S)*, supra note 158; *S (R)*, supra note 85; *W (M)*, supra note 85.
mental state may be said to be anxiety of a serious enough nature to constitute “emotional harm”).

The focus on an individual assessment as to whether the child suffers from a legally relevant condition (illness) also is reflected in the emphasis in the legislation and jurisprudence on treatment. For example, as Justice McLachlin noted in Winko, the approach in Part XX.1 of the Criminal Code emphasizes “individual assessment and the provision of opportunities for appropriate treatment”. In other words, as Justice Flewelling noted in Ordano, where a person is found not criminally responsible, “the focus will be on treatment of the individual so as to ensure that the public is protected”. As I noted in Chapter Two, a focus on individual illnesses and individual treatment fails to acknowledge or address the effects of environmental factors (e.g. social disadvantages, discrimination, trauma) on mental health and may contribute to the failure to provide adequate treatment to children with mental health issues. As I have also noted, and as I explore further below, despite the focus in the legislation on illness and treatment, in practice many children with mental health issues are not getting treatment or are not getting adequate treatment services through either of the family law (child welfare) or criminal justice systems.

Failure of the Law in Practice to Meet the Objectives of the Law as Written

While both the CYFSA and the YCJA (and incorporated sections of the Criminal Code) contain various provisions intended to recognize and protect the needs of children with mental health issues, in practice many children with mental health issues are not getting adequate treatment services through either of the family law (child welfare) or criminal justice systems.

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174 CYFSA, supra note 3, ss 74(2)(f), (i), 157; Criminal Code, supra note 5, ss 2, 16(1).
175 Consider CYFSA, supra note 3, ss 74(2)(g), (i), (j), Part VII (Extraordinary Measures); Criminal Code, supra note 5, s 672.58; Winko, supra note 92 at paras 41, 43, 88; Ordano, supra note 104 at para 25; Roach & Bailey, supra note 77 at 40-41; as Roach and Bailey point out, some conditions, like FASD, may be permanent and thus not fit within the assumptions in the criminal justice system that atypical mental states are temporary and treatable (at 4, 3; consider also D (WAL), supra note 158 at para 31).
176 Winko, supra note 92 at para 43.
177 Ordano, supra note 104 at para 25.
179 See Introduction at 8-9 and related references; Chapter One at 44 and related references; consider also Davis et al, supra note 178 at 162, 174, 180-81; Peterson-Badali et al, supra note 60 at 11-13.
health issues, and although mental health issues are prevalent amongst children involved with the family law (child welfare) and criminal justice systems, in most instances these children are not getting needed supports and services through either system. One of the consequences of untreated mental health issues for many children in care is (ongoing) engagement in the criminal justice system. And, though there are provisions (e.g. assessments, IRCS and ISSP orders) in the criminal legislation directed at addressing situations where mental health is an issue, these provisions are used relatively infrequently, findings of NCRMD and unfit to stand trial are rare, and assessments are only conducted on a “very small proportion of youth”.

**Failure to Identify Children with Mental Health Issues**

In child protection and secure treatment program cases, the issue of the child’s mental health generally will have been identified prior to an application being heard (e.g. in child protection cases the grounds involving “emotional harm” or “mental, emotional or developmental condition” will be plead in the application, and in secure treatment applications a central issue is the assertion that a child has a “mental disorder”). That a child’s mental state may be relevant, however, may not come so readily (or at all) to the attention of the Court in criminal proceedings. For example, in *R. v. D. (W.A.L.)* (“D. (W.A.L.)”), Justice Whelan noted

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180 Eg *CYFSA*, supra note 3, ss 74(f)-(j) [“emotional harm” and “mental, emotional or developmental condition”], 98 [assessments]; *YCJA*, supra note 4, ss 19 [conferences], 28(1) [detention as a social measure prohibited], 34 [medical and psychological reports], 35 [referral to child welfare agency], 39(5) [custody as social measure prohibited], 42(2)(i) [ISSP], (m) [attendance non-residential program], (r) [RICS], 42(7) [requirements for IRCS orders], 42(8) [rights regarding consent to treatment], 141 [applicability of sections of *Criminal Code*]; *Criminal Code*, supra note 5, s 16 [defence of mental disorder], Part XX.1 [provisions regarding mental disorders (unfit, NCRMD)]; McLeod, *supra* note 136 at 267-68; Denise C Herz, Joseph P Ryan & Shay Bilchik, “Challenges Facing Crossover Youth: An Examination of Juvenile-Justice Decision Making and Recidivism” (2010) 48 Fam Ct Rev 305 at 309; Peterson-Badali *et al*, *supra* note 60 at 6-7; Grisso, *supra* note 130 at 8; see also Kaiser, “Constrained Progress”, supra note 66 at 2; Verdun-Jones & Butler, *supra* note 66 at 497.


182 Peterson-Badali *et al*, *supra* note 60 at 20, 8, 9; see also Kaiser, “Constrained Progress”, *supra* note 66 at 2; Verdun-Jones & Butler, *supra* note 66 at 497.

183 Whether and how (or if) children’s mental health issues are identified by child protection workers is discussed in Chapter Four.

184 *CYFSA*, supra note 3, ss 74(2)(b)-(j), 164, 171.
that in the approximately four years that twin adolescent brothers suffering from FASD had “interacted with the Justice System, [the boys] have repeatedly been treated without regard for their Primary Disabilities and this likely had a deleterious effect”. Justice Whelan also noted that the “lack of consistent supervision and support and the development over the years of Secondary Disabilities in [the boys] should have been known to various departments and agencies”, including Health and Education who had “been working with them from an early age”, the Department of Social Services who had “been involved with the family” since before the boys were born, and the Justice and Corrections departments who had “been involved since [the boys’] entry into the Youth Justice System at age 12 for [one brother] and at age 13 [for the other]”.

As the foregoing illustrates and as Thomas Grisso argues, in order to apply the provisions relating to mental health issues, the youth criminal justice system “must be able to identify youths with mental health needs” and “what those needs really are”. While screening or assessments may provide information about a child’s mental health issue, someone (e.g. judge, legal counsel, parents, the child themselves) must first recognize that the child may have a mental health issue that suggests a need for further investigation. Indeed, as Peterson-Badali et al note, the “lack of use” of the provisions in the YCJA related to mental health issues (e.g. IRCS and ISSP orders, assessments) in part “appears to be related to a lack of systematic screening for mental health concerns by trained personnel”.

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185 D (WAL), supra note 158 at para 43.
186 Ibid at para 44.
187 Grisso, supra note 130 at 4; see also Peterson-Badali et al, supra note 60 at 10.
188 It is beyond the scope of this discussion to engage in the debate about the benefits and drawbacks of widespread screening in the youth criminal justice system (for such a discussion, consider Peterson-Badali et al, supra note 60).
189 Consider Peterson-Badali et al, supra note 60 at 10; Grisso, supra note 130 at 4, 14; note that, as Gina Vincent and Thomas Grisso point out, identifying mental health issues in adolescence presents a number of complications (eg natural developmental changes) not at issue with adults (Gina Vincent & Thomas Grisso, “A Developmental Perspective on Adolescent Personality, Psychopathology, and Delinquency” in Thomas Grisso, Gina Vincent & Daniel Seagrave, eds, Mental Health Screening and Assessment in Juvenile Justice (New York: The Guilford Press, 2005) 22 at 37).
190 Peterson-Badali et al, supra note 60 at 20.
provisions related to mental health issues arguably represents a departure in practice from the situation envisioned in the written law, so too does the extent of the use of custody, particularly for children in care with mental health issues.

**Locking Up Children with Mental Health Issues**

Despite the inclusion of a number of provisions in the *YCJA* that militate against incarcerating children generally, and specifically provide that incarceration is not to be used as a substitute for appropriate mental health services, many children in care with mental health issues are disproportionately charged with criminal offences and detained in custody both pre- and post-trial.\(^\text{191}\) As I have indicated, the *YCJA* puts an emphasis on the objective of rehabilitation and the use of extrajudicial measures.\(^\text{192}\) And, the *YCJA* explicitly provides that custody (pre- and post-trial) is not to be used “as a substitute for appropriate child protection, mental health or other social measures”.\(^\text{193}\) Thus, as Justice Gorman stated in *A. (J.)*, “the Court is prohibited from denying bail to a young person on the basis that, for instance, the young person has no place to reside, their home situation is unacceptable or because there are mental health concerns”.\(^\text{194}\) However, despite these provisions, as The Honourable Justice Malcolm McLeod notes, “it is hard to escape the conclusion that principles of deterrence, denunciation and punishment continue to be the dominant considerations in sentencing ‘chronic’ offenders like Ashley Smith [troubled adolescent girls with mental health or behavioural issues, often also engaged in the child welfare system\(^\text{195}\)]; and that principles of rehabilitation and reintegration

\(^\text{191}\) *YCJA*, supra note 4, ss 3, 29, 38, 39; *supra* note 130.

\(^\text{192}\) Consider *YCJA*, supra note 4, Preamble, ss 3(1), 4-10, 38; *supra* at 93-95, 103 and related references; Chapter One at 34 and related references.

\(^\text{193}\) *YCJA*, supra note 4, ss 29(1), 39(5); *supra* note 135.

\(^\text{194}\) *A (J)*, supra note 85 at para 15.

\(^\text{195}\) Ashley Smith was “an emotionally damaged 19-year-old girl” who “strangled herself to death in a federal penitentiary” (McLeod, supra note 136 at 237). At the time of her death she “had been in custody for the last five years of her life” (*ibid*). Ashley Smith began exhibiting “behavioural issues” at thirteen-years-old and was subsequently engaged repeatedly with police and youth criminal justice, attracting numerous charges and convictions for minor offences (*ibid* at 266-73).
into the community are of no consequence whatsoever”. One of the constraints judges face when contemplating making orders that reflect the principles of rehabilitation and reintegration (e.g. attendance at non-residential programs and ISSP) is the lack of adequate supports and programs in the community.

**Lack of Services**

The use of the legislative provisions relating to children’s mental health issues requires the availability of adequate supports and programs in the community. For example, the availability and nature of the programs and services that police officers may use for diversionary referrals is dependent upon the implementation and administration of these programs and services by the Provincial Government. Where these programs and services are not available, the police will not be able to use the diversionary tactics prioritized in the *YCJA* and will be obliged to do nothing or turn the case over to the Crown for prosecution. A lack of available services may also be an issue where the matter is brought before the Court, for example where the judge makes an order that an assessment be carried out in a psychiatric hospital, but no beds or no facilities are available.

For example, after an order for assessment was made in *R v. M. (S.*)* (“M. (S.*)”), a thirteen-year-old girl had been detained for approximately two weeks “without any plan being made for the assessment” and “without any realistic expectation that a forensic assessment could

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196 *Ibid* at 271, see also 238-39.
197 Consider *YCJA*, supra note 4, s 42(3); Verdun-Jones & Butler, *supra* note 66 at 502; Bala, Carrington & Roberts, *supra* note 65 at 148-49; Bala & Roberts, *supra* note 65 at 56; Verbrugge, *supra* note 63 at 25.
199 Ricciardelli *et al.*, *supra* note 67 at 608, 609; although the *YCJA* is a federal statute, its administration is a provincial/territorial responsibility (*Ibid* at 601).
200 See *Ibid* at 608, 609.
201 A judge may order that a child who is the subject of criminal proceedings undergo a psychological assessment (*YCJA*, supra note 4, s 34). For purposes of the assessment, the Court may remand the youth to custody in a psychiatric hospital for thirty days, if custody is necessary to conduct the assessment, or the child is being detained in custody on other grounds (*Ibid*, ss 34(3), (4); Verbrugge, *supra* note 65 at 20).
be made” as there were no such facilities in existence. Commenting on the administration of anti-psychotic medication to the child to control her behaviour (discussed further below), Justice Dorval indicated that “the use of anti-psychotic medications were the direct results of the lack of facilities to conduct forensic assessments of youths below age 16” and found that as a result of this differential treatment based on age, “[t]he very young whom we as a society strive to protect, who are to be dealt with in conformity with s. 3 of the YCJA, are not dealt with equal human dignity.” In the result, Justice Dorval concluded that, in this case, the application of section 34 of the YCJA had contravened the child’s section 15 Charter rights and, having noted the nature of the charges (namely for offences related to a confrontation about the use of scissors in school whereupon the child threatened the teacher with the scissors), stayed the proceedings. Issues with access and availability of qualified mental health professionals and appropriate facilities to carry out assessments has also been found to be an issue in child welfare cases. And, a lack of adequate and available services is also a problem vis-à-vis ongoing treatment for children engaged in both the family law (child welfare) and criminal justice systems.

The conferencing provisions in the YCJA are one of the means that a judge and other professionals involved in youth criminal justice proceedings may use to try to find available services, coordinate amongst various actors, and establish a plan for the child. In addition, where there are concerns about a child’s mental health, the Court may refer the child to a child

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202 M (S), supra note 158 at paras 1, 20, 24, 16; the girl was a ward of the CAS and had ten different placements (in hospitals, treatment centres, and group homes) in the previous eighteen months (Ibid at para 1).
204 Ibid at paras 27-28.
205 See Bala, Birnbaum & Watt, supra note 159 at 128; P (H), supra note 161 at para 12.
206 Consider McLeod, supra note 136 at 255-56; Bala, Carrington & Roberts, supra note 65 at 148-49; Verdun-Jones & Butler, supra note 66 at 502.
207 See Chapter One at 33 and related references.
welfare agency pursuant to section 35 of the *YCJA*. However, the power of the Court is limited, and does not include the power to order that mental health (or other) services be provided. For example, in *D. (W.A.L.)*, Justice Whelan convened three conferences over a period of months, and used a section 35 child welfare referral to “bring representatives of the Provincial Government and other community organizations together” in an effort to develop “an effective plan to support” seventeen-year-old twin brothers who suffered from FASD and secondary disabilities (educational disruption, ongoing criminal engagement, and confinement) and had been found unfit to stand trial on charges related to stolen motor vehicles. Following two conferences that were “not productive”, subpoenas along with section 35 referrals were issued to requested attendees, and ultimately, while “[t]he commitment was not” what Justice Whelan “had hoped”, the services offered, particularly a vocational assessment “and alternate caregiver arrangement with the Aunt”, was found to represent “progress in the living circumstances of these Young Persons, that, with further cooperation, and attention from the Review Board, might be built upon”.

A series of section 35 referrals were not as successful in *R. v. M. (B.)* (“*M. (B.)*”), wherein the Court undertook a further review of the probation order of a teenage boy who suffered from FASD and for whom, Justice Turpel-Lafond indicated, there was “no placement…in terms of a suitable residence or other supports appropriate to his circumstances” (i.e. no family placement, no foster placements in the area). In *M. (B.)*, the boy was a

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208 See *ibid* at 33-34 and related references.
209 See *ibid* at 34 and related references.
210 *D (WAL)*, supra note 158 at paras 12, 13, 30, 1-4, 42.
211 *Ibid* at para 13; note that *D (WAL)* was decided prior to the enactment of section 672.851 of the *Criminal Code*, which permits a stay of proceedings where an accused is unlikely to ever become fit for trial and is not a significant threat to public safety (*Criminal Code*, supra note 5).
212 *R v M (B)*, 2003 SKPC 133, [2003] SJ No 602 [*M (B)*] at paras 7, 1, 11; the sentencing (probation) order under review was subsequently set aside in *R v M (B)*, 2003 SKCA 135, 60 WCB (2d) 337 [*M (B)*2], and a 15 month secure custody and 7.5 month community supervision order imposed in its place (para 78).
“troubled youth” who had previous involvement with the CAS and had been repeatedly engaged with the criminal justice system. The Court had repeatedly sought the involvement of the child welfare agency to provide financial assistance to the boy’s aunt and uncle such that they could care for him; however, “[n]o reply or follow-up was ever received by the Court” and “[t]he Court was advised in these proceedings that no action was taken on that matter”. In the result, Justice Turpel-Lafond stated that the Court could “only conclude that the situation is bleak” and that “it would appear that the Court has come up against the greatest obstacle faced in implementing the principles and procedures of the new Youth Criminal Justice Act – a lack of resources for youth like [the boy] who suffer from FASD and come from traumatic backgrounds”. The sentencing (probation) order under review in M. (B.) was subsequently set aside by the Saskatchewan Court of Appeal, with Justice Jackson noting that the Court regretted “the lack of more extensive programming which will assist FASD-designated youth in overcoming their difficulties, but, where custody is otherwise lawful, to sentence a youth to probation when there is no effective support does not protect the public and is not a fit sentence”.

The difficulties presented by a lack of available services were also confronted by the Court in Syl Apps Youth Centre v. M. (M.), where, in granting an application to extend a committal order, Justice Starr noted:

I have considered that the difficulty planning for [the child] is further compounded by the limited resources available (including residential treatment placements) including the limited

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213 M (B)2, supra note 212 at paras 4, 57; M (B), supra note 212 at paras 1-3, 6; while the Court of Appeal agreed that the child was a “troubled youth” with a FASD diagnosis, they were “not certain that the evidence” demonstrated the traumatic background, or repeated fostering with the CAS, that Justice Turpel-Lafond had found him to have had (M (B)2, supra note 212 at para 57).
214 M (B), supra note 212 at paras 10, 7; under Saskatchewan’s child welfare legislation, “an agreement can be entered into to provide financial assistance and compensation” to a caregiver where a “16 or 17 year old is in need of care and supervision and the parental situation is not appropriate or a parent is unwilling to care for a youth” (Ibid at para 7). In M (B), the boy apparently was “not considered to be a ‘child in need of protection’ and his mother’s residence was considered suitable” (Ibid at paras 7, 8). Justice Turpel-Lafond was of the “view that the lack of supports for the family in trying to care for [the boy] were a major factor in the breakdown of the situation [his living with the aunt and uncle]” (Ibid at para 11).
216 M (B)2, supra note 212 at para 76.
sources of funding for young persons in the adult sector. Further, there are wait lists for services and a myriad of hoops to jump through in order to access those resources. In [the child’s] case the situation is much worse as there simply are no placements or constellation of services in the community that could, in their present form, meet the needs of [the child] given her clinical profile.217

Other examples of the lack of available services include lengthy waiting lists for psychiatric services,218 as well as a lack of available psychiatrists in hospital emergency rooms. For example, in M. v. Youthdale Treatment Centres, the CFSRB noted that, after an incident where a child’s “anger increased to a point where he lost control and he kicked in French doors” and “kicked another door breaking the glass” and emergency services were called, the child was “taken to hospital and since there was no psychiatrist available, he was released after two hours when he said he could control his temper”.219 Following another incident, where the child ran away and, upon finding him, his parents brought him to hospital, he was admitted by the emergency doctor “involuntarily for the night because of his intense anger” and then “saw the hospital psychologist the following day”, who apparently “diagnosed the Child with ADHD and ODD” and “referred the Child to a psychiatrist for medication for these disorders”.220

217 M (M), supra note 173 at paras 9, 96; M (M) involved a seventeen-year-old who had already been in a secure treatment program for over 19 months and as a result of the extension would remain committed after her 18th birthday (Ibid at paras 2, 4). She had been committed as a result of self-harming (“drinking bottles of mouthwash, swallowing bottles of medication, swallowing batteries”) and violent and aggressive behaviour towards others (Ibid at paras 15, 17). Following admission to secure treatment she continued with chronic and severe self-harming behaviours, including “inserting objects into her body cavities, swallowing objects, head banging, superficial cutting, jumping/falling down flights of stairs, inserting her fingers into electrical sockets, self-induced vomiting, and self-strangulation/choking with her hands, clothing, cords, and fruit”, and swallowing a razor, defecating, and re-ingesting the razor (Ibid at paras 18, 19). Her aggressive behaviour towards others included, “punching, kicking, biting, throwing objects and threats to physically or sexually assault staff or peers” (Ibid at para 20). She had been diagnosed with autism spectrum disorder, mild intellectual delay, Tourette’s syndrome, ADHD and obsessive compulsive disorder (Ibid at para 16). The child had made improvements while in the secure treatment program, but continued to be “a patient with complex mental health diagnoses and needs and who remains at significant risk of serious harm given the chronicity and severity of her behaviours” and she required “a highly tailored, individualized, and resource intensive placement upon her discharge both to meet her ongoing treatment needs and to keep her safe” (Ibid at paras 23-24, 26, 95).

218 Eg K D, supra note 47 at para 13.

219 M, supra note 26 at para 11.

220 Ibid at para 12.
Mental health issues are often treated with psychotropic drugs. In some cases, like that of M. (S.) (discussed above), children may be given psychotropic medications not for diagnosed disorders, but to control their behaviour. In M. (S.), upon being admitted to the Children’s Hospital of Eastern Ontario a thirteen-year-old girl had been given anti-psychotic medication, before a full assessment, to “contain her behaviour” as the hospital did not have the facilities or staff to deal with her behaviour in another way (it was not a forensic psychiatric facility).

Addressing this issue, Justice Dorval stated that “[t]he administration of medication for the sole reason of controlling the behaviour of a child is outrageous but does not constitute cruel and unusual punishment” (such that it violated section 12 of the Charter) and noted that the use of anti-psychotic medications arose because a lack of forensic facilities leads to forensic assessments being conducted “in hospital settings which are not conceived for this process” and that the “inevitable difficulties lead psychiatrists to medicate to control behaviour”.

Of the cases I discussed above, many involved children on medications. For example, in J. (J.J.), in finding that the accused was suffering from schizophrenia (as indicated in the medical reports before the Court), the Court noted that the accused was being treated with Risperidone injections at the time the offence was committed. In M. (K.A.L.), the Court noted that a child, who “did not do well in foster home placement”, exhibited “problematic” behaviour, and was “depressed, irritable, and had difficulty following direction and was prone to

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222 See M (S), supra note 158; consider also J G, supra note 173.

223 M (S), supra note 158 at para 11.

224 Ibid at paras 22, 25.

225 In addition to the cases discussed in this paragraph, consider also P (H), supra note 161 at paras 7, 8, 23; C S, supra note 35 at paras 76, 102; N, supra note 26 at paras 21, 23; Syl Apps Youth Centre v S (R), 2012 ONCJ 6, [2012] WDFL 1612 [Syl Apps v S(R)] at para 15; K (S), supra note 10 at paras 2, 174, 176, 231.

226 J (J), supra note 96 at para 15.
angry outbursts”, had been prescribed medication by a child psychiatrist.\textsuperscript{227} The CFSRB referred to the medication a boy in his early teens was taking in \textit{J.M.}, noting that “a number of medications have been tried and discontinued” and that at the secure treatment facility “[a] thorough assessment will be done, with emphasis on the medication that the Child is currently taking, and which increases suicidal ideation as a side effect”.\textsuperscript{228} The CFSRB also noted that the fifteen-year-old girl in \textit{K.D.} had been given “Celexa (an anti-depressant) and Abilify (for treatment of bi-polar disorder)” by a hospital which had held her for three days as an involuntary patient, but “did not do any follow-up work, because the Child did not live in the Hospital’s catchment area”.\textsuperscript{229}

**Need for Integration**

As I discussed in Chapter One and have illustrated above, the failure of both the family law (child welfare) and criminal justice systems to provide children, particularly crossover youth, with adequate mental health services is due at least in part to the lack of coordination and communication between systems.\textsuperscript{230} One of the ways proposed to try to address the lack of collaboration across systems are “specialized courts” which, as Bala \textit{et al} explain, “are designed to remove certain cases from the regular court process into a forum that allows unique needs to be identified and more effectively addressed by allowing for co-ordinated involvement by various agencies”.\textsuperscript{231} A number of these specialized programs are already in use in Ontario.\textsuperscript{232} Mental health courts, for example, as Krista M. Davis \textit{et al} explain, “seek to divert accused persons with mental illness out of the criminal justice system and into community treatment

\textsuperscript{227} \textit{M (KAL)}, \textit{supra} note 27 at para 3.
\textsuperscript{228} \textit{J.M}, \textit{supra} note 55 at paras 1, 31, 35.
\textsuperscript{229} \textit{K.D}, \textit{supra} note 47 at para 11.
\textsuperscript{230} See Chapter One at 37-39 and related references.
\textsuperscript{231} Nicholas Bala \textit{et al}, “Child Welfare Adolescents & the Youth Justice System: Failing to Respond Effectively to Crossover Youth” (2015) 19 Can Crim L. Rev 129 at 146; see also Peterson-Badali \textit{et al}, \textit{supra} note 60 at 17.
\textsuperscript{232} Bala \textit{et al}, \textit{supra} note 231 at 147; Peterson-Badali \textit{et al}, \textit{supra} note 60 at 17.
through a more collaborative and less adversarial process than the traditional court system”. While beyond the scope of this Thesis to engage in a discussion about the strengths and challenges in mental health court programs, it bears noting that researchers have found that a significant portion of the children diverted into these programs still may not be receiving appropriate treatment. For example, in a study of a youth mental health court in Toronto, Ontario, Davis et al found that “approximately half of youth did not receive treatment matched to their mental health needs and another half of youth did not have areas of criminogenic need addressed through treatment”. To address the failure to adequately meet the needs of children engaged in the family law (child welfare) and criminal justice systems, Bala et al raise the possibility of “an integrated court that has jurisdiction over both child welfare and youth justice proceedings”. However, as Bala et al explain, there are “significant institutional challenges in taking this approach in Ontario” as well as “administrative and legal concerns” (e.g. the risk that a child may be detained “based on the needs of the youth rather than as a response to criminal behaviour”). Another possible method for coordinating between systems proposed by Bala et al, is to have “a case manager from one agency to co-ordinate service provision for individual youth”. As Bala et al explain, the “case manager could act as an advocate who could locate necessary services and

234 Davis et al, supra note 178 at 180; consider also Peterson-Badali et al, supra note 60, and Davis, Peterson-Badali & Skilling, supra note 233, for a discussion about the Risk-Needs-Responsivity framework, children’s mental health and criminogenic needs, and recidivism.
235 Bala et al, supra note 231 at 145; consider also The Honourable Justice Brian Scully & Dr Judy Finlay, “Cross-over Youth: Care to Custody” (2015) Report completed on behalf of the Cross-over Youth Committee, Toronto, Ontario at 21; see also discussion about the Crossover Youth Practice Model in Denise C Herz et al, Addressing the Needs of Multi-System Youth: Strengthening the Connection Between Child Welfare and Juvenile Justice (Washington DC: Center for Juvenile Justice Reform, 2012) at 39.
236 Bala et al, supra note 231 at 145, 150, 149; see also Scully & Finlay, supra note 235 at 21; while the YCJA prohibits the use of custody as a “substitute for appropriate child protection, mental health or other social measures”, where the Court perceives a child as having certain welfare needs (eg for shelter, food), there is potentially a risk that the child may be subjected to a more severe sentence (eg custody) then they might otherwise face (YCJA, supra note 4, ss 39(5), 29(1); see Bala et al at 150; McLeod, supra note 136 at 273; Green, supra note 119 at 22-23).
237 Bala et al, supra note 231 at 145.
co-ordinate them” and “could be aware of the youth’s background, organize services, develop a plan, and present this to the court”. 238

Even without an integrated court or case manager, Bala et al also raise the possibility that “the increased use of youth court conferencing would improve interagency communication and co-ordination”. 239 As noted, conferencing was used by Justice Whelan in D. (W.A.L.), “largely with a view to marshalling resources to provide [two adolescent boys suffering from FASD and secondary disabilities] with support and supervision in the community”. 240 In D. (W.A.L.), Justice Whelan noted that “[i]t was disappointing that the process was delayed and a decision [on disposition] not made until January 30th [2004, the twin adolescent boys having been initially found unfit to stand trial in April 2002] however, the Court’s experience over that time, reinforced the importance of bringing the representatives of Government and other organizations together with a view to arriving at a comprehensive plan to which there was commitment”. 241

In concluding remarks in D. (W.A.L.), Justice Whelan stated, in part:

It should not have been necessary for the Court to conduct this Conference to provoke cooperation and the marshalling of resources for [the boys]. Such planning is better performed within Government, by persons whose job it is to coordinate resources…

A coordinated umbrella approach which is designed to address the needs of persons like [the boys] who suffer from FASD, is essential to their remaining in the community. Their offending behaviour does not warrant committal to custody. On the other hand they present a risk to themselves and the safety of others in the community if they continue to drift without adequate supervision and support. The program and funding limits of the various programs that might be engaged to address their needs and the failure to adopt a coordinated approach are major barriers to solving the problems of FASD affected persons... 242

While beyond the scope of this Thesis to assess the availability and feasibility of methods that may increase coordination and better meet the needs of children with mental health issues who

238 Ibid at 145-46; the case managers should, as Bala et al further explain, “understand mental health, youth justice, and child welfare issues, as well as have familiarity with the school system” (Ibid at 146).
239 Ibid at 145.
240 D (WAL), supra note 158 at para 3.
241 Ibid at paras 24, 21.
242 Ibid at paras 84, 87.
are engaged in the family law (child welfare) and criminal justice systems (e.g. integrated courts, case managers), as Bala et al conclude, “[w]hat is critical is the recognition that the current approaches and systems are not working effectively, with negative consequences for many youth and long-term social costs”.243

Summary: The Practical Implications of Medicalized Legislative Definitions

The foregoing review of the implementation of (and failure to implement) legislative provisions relating to mental health issues demonstrates the nexus between the law, as written and in practice, and the (often negative) outcomes experienced by children with mental health issues who are engaged in the family law (child welfare) and criminal justice systems. As this review reveals, the individual focus and medical orientation reflected in the way mental health issues are defined in the legislation, is also reflected in the ways children’s mental states are conceptualized in practice. The assessment undertaken in practice generally focuses on an individual child’s words and behaviours (as symptoms) and whether the child’s mental state constitutes an aberrant condition (illness).244 This analysis often requires expert medical evidence, which is commonly heavily relied upon and highly influential in making determinations about whether a child’s mental state comes within a legislative definition.245

Determinations about whether a child’s mental state comes within a legislative definition (e.g. “emotional harm”, “mental disorder”) can have a direct impact on the ultimate outcome in both child welfare and criminal justice cases, for example whether a finding of “in need of protection” or NCRMD is available.

243 Bala et al, supra note 231 at 151.
244 Eg R (M), supra note 10; A (M), supra note 13; B (G), supra note 51; K D, supra note 47; E P, supra note 49; F (DK), supra note 38; C (C), supra note 40; C M, supra note 53; J M, supra note 55; S I, supra note 46.
245 Eg A (M), supra note 13; M (KAL), supra note 27; R (K), supra note 30; C S, supra note 35; C (C), supra note 40; B (G), supra note 51; J (JJ), supra note 96; consider also C (NV), supra note 10; C (A), supra note 160; S L, supra note 9; R (M), supra note 10; P (H), supra note 101; D (D), supra note 18; K (S), supra note 10; W (M), supra note 85; Ordano, supra note 104; Morrill, supra note 96.
For example, in R. (M.), the emotions of distrust, fear, guilt and anger expressed by an eight-year-old girl who had been sexually abused by one or both of her brothers were found not to amount to “emotional harm”, such that the girl was returned to her mother’s care.\textsuperscript{246} The shyness, verbal silence, “somewhat oppositional behaviour”, and stress observed by a psychiatrist, and diagnosed as mutism, ODD and anxiety, was found to amount to “emotional harm” in A. (M.), where a girl (age seven at the time of apprehension) was ultimately left in the custody of the father despite the mother’s objections.\textsuperscript{247} And, in B. (S.), gross neglect was found to have placed three children at risk of “emotional harm”, with the findings that the children were “in need of protection” and the decisions to leave the children in the care of the CAS, without access by the parents, being bolstered by findings that the parents had also sexually molested or exploited the children.\textsuperscript{248}

The impact of assessments of words and behaviours, and of expert evidence, on determinations as to whether a child has a “mental disorder” is also evident in the cases dealing with committal and emergency admission to secure treatment facilities. For example, in F. (D.K.), a girl who, according to affidavit evidence, demonstrated an inability to look after her own safety, to lie, run away, and occasionally consume “alcohol to the point where her very life is in jeopardy” was found (without an expert report) to have a “mental disorder” for purposes of committal.\textsuperscript{249} In C. (C.), a fourteen-year-old girl who was “troubled”, had a tendency to run away, and had engaged in impulsive and potentially harmful behaviour (including using drugs and alcohol and blacking out, hanging out at an alleged escort service where she said she had been raped) was found not to have a “mental disorder” for purposes of committal, the

\begin{footnotes}
\item[246]R (M), supra note 10 at paras 14, 13, 35, 1, 18, 40, 42.
\item[247]A (M), supra note 13 at paras 29, 25, 22, 23, 1, 45.
\item[248]B (S), supra note 15 at paras 37, 49, 60.
\item[249]F (DK), supra note 38 at paras 5, 6.
\end{footnotes}
psychiatrist who diagnosed the girl as having adjustment disorder having opined that she was cognizant of her actions and understood their implications.250

The above review also illustrates the crossover of children who have been found to be “in need of protection” and placed in care (often in group homes), and engagement in the criminal justice system. The cases discussed provide real life examples of children with mental health issues who are in care finding themselves engaged, repeatedly, with the criminal justice system.251 The jurisprudence also illustrates that while there are alternatives available, on paper, to better address the needs of these children (e.g. diversion, assessments, conditional discharge, IRCS), in practice these alternatives are often hamstrung by a lack of available services, a lack of coordination across systems, and a failure to identify or recognize a child’s mental health issues.252 For example, in M. (S.), a thirteen-year-old girl (in the care of the CAS, placed in a group home) had been detained for approximately two weeks and given psychotropic medications to control her behaviour because no facilities were available or existed to provide the assessment ordered in a criminal case stemming from an incident at school involving a threat with the use of scissors.253 In M. (B.), the Court lamented the lack of resources for an adolescent who had repeatedly been in “conflict with the law”, had not received supports for his FASD, and for whom the CAS had “no placement…in terms of a suitable residence or other supports appropriate to his circumstances”, and concluded that the boy’s situation was “bleak”.254

In the result, children with mental health issues who are engaged in the family law (child welfare) and criminal justice systems are not getting the services they need. Rather, many are

250 C (C), supra note 40 at paras 4, 5, 25, 35, 36, 22, 23, 39, 6.
251 Eg M (KAL), supra note 27; R (K), supra note 30; C (C), supra note 40; J (JJ), supra note 96; M (S), supra note 158; D (WAL), supra note 158.
252 Eg S (R), supra note 85; M (S), supra note 158; D (WAL), supra note 158; M (M), supra note 173; M, supra note 26.
253 M (S), supra note 158 at paras 1, 3, 16, 20, 22, 24-28.
254 M (B), supra note 212 at paras 31, 5, 11, 20, 22, 25, 1; see also M (B)2, supra note 212 at paras 76-78.
detained in custodial facilities that are ill-equipped to meet their needs. Many also are put on psychotropic medication. I explore the use of psychotropic medications amongst this population and the other challenges encountered by children in care in the next Chapter, where I explore the effects of the definitional lens adopted by examining the experiences of children with mental health issues in the care of the CAS.

\footnote{Eg M (S), supra note 158; J (JJ), supra note 96; M (KAL), supra note 27; J M, supra note 55; K D, supra note 47; P (H), supra note 161; C S, supra note 35; N, supra note 26; Syl Apps v S (R), supra note 225; K (S), supra note 10.}
Chapter Four

Unmet Mandate: The Failure of Children’s Aid Societies to Meet the Needs of Children with Mental Health Issues

Introduction

In the last Chapter I reviewed the implications of the individual focus and medical orientation of legislative provisions relating to mental health issues in the Child, Youth and Family Services Act, 20171 (“CYFSA”) and in the Youth Criminal Justice Act2 (“YCJA”) and Criminal Code,3 by examining the implementation of these legislative provisions in family law (child welfare) and criminal justice proceedings, and the resulting (often negative) outcomes experienced by children with mental health issues. In this Chapter, I scrutinize the relationship between the legislative provisions in the CYFSA, the decisions made by child protection workers, and the (often similarly detrimental) outcomes experienced by children with mental health issues who are engaged with Children’s Aid Societies (“CAS”) and who, in many cases, also become engaged with the criminal justice system. Specifically, through examples drawn from the jurisprudence and the academic literature, the connection between the way mental health issues are defined and characterized in the CYFSA and the subsequent failure, when put into practice, to provide adequate protection for children with mental health issues who are engaged in the family law (child welfare) system will be illustrated.

I begin by describing the statutory mandate, functions and powers of the CAS, paying particular attention to child protection workers’ decision making, the factors that may affect these decisions, and the implications of these decisions, at three critical stages of the CAS’

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1 Child, Youth and Family Services Act, 2017, SO 2017, c 14, Schedule 1 (“CYFSA”); as I have noted, the CYFSA recently came into force, replacing the Child and Family Services Act, RSO 1990, c C.11 (“CFSA”). The family law (child welfare) cases referred to in this Chapter were decided while the CFSA was in force. If relevant, references in the jurisprudence to the CFSA are noted, and the corresponding section in the CYFSA, along with any significant differences between the provisions, are set out in the text or related footnotes.
2 Youth Criminal Justice Act, SC 2002, c 1 (“YCJA”).
3 Criminal Code, RSC 1985, c C-46.
involvement with families. My analysis begins at the first stage of CAS involvement, when a report of alleged maltreatment or risk of harm is made to the CAS and a decision is made as to whether to investigate. I then consider the investigative stage, along with the decision as to whether to substantiate the claims of maltreatment or risk of harm. Thereafter, I look at the post-substantiation stage, with a focus on decision making regarding whether and how to address the maltreatment or risk of harm, and specifically what services to provide (e.g. parenting classes, counselling) and whether to remove the child from the home and place them in out-of-home care (e.g. kinship or foster care).

Next, I review the prevalence (noted in previous Chapters) of mental health issues amongst children engaged with the CAS and explore issues relating to (lack of) identification of mental health issues, the importance of early intervention, and the service referrals that are made (or not made), and services provided (or not provided) to children in care with mental health issues. I then discuss the commencement and conduct of Court proceedings by the CAS, the types of orders that are sought, and the powers given to the CAS and child protection workers when a child is put in interim or extended CAS care. Finally, I explore the importance and implications of child protection workers’ placement decisions and other interventions (or lack thereof) for children with mental health issues, particularly vis-à-vis the failure to provide these children with adequate protection.
Children’s Aid Societies – Representative of the State

The CAS’ Statutory Mandate: Protecting Children, Strengthening Families

The powers and obligations of the CAS are set out in the CYFSA, the legislation governing child welfare in Ontario.4 The paramount purpose of the CYFSA is “to promote the best interests, protection and well-being of children” and, where consistent with the paramount purpose, the other purposes involve helping and supporting families.5 In keeping with these purposes, the statutory functions of the CAS include: investigating allegations or evidence that a child may be “in need of protection”; protecting children when necessary; providing “guidance, counselling and other services to families for protecting children or for the prevention of circumstances requiring the protection of children”; providing care or supervision for children assigned to their care or supervision; and, performing any other duties pursuant to statute or regulation.6 In carrying out the duty to protect children and, when not in conflict with this paramount duty, support families, the CAS and child protection workers act as an agent of the State.7

The State has the power, pursuant to statute and common law, as the majority of the Supreme Court of Canada (“SCC”) recognized in B. (R.) v. Children’s Aid Society of Metropolitan Toronto, “to intervene to protect children whose lives are in jeopardy and to promote their well-being”.8 As such, while parents have an interest in raising their children as

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5 CYFSA, supra note 1, s 1; see also O (E), supra note 4 at paras 189, 164; D (B) v Children’s Aid Society of Halton (Region), 2007 SCC 38, [2007] 3 SCR 83 [D (B)] at para 64; See Chapter One at 18 and related references.
6 CYFSA, supra note 1, s 35(1); see also O (E), supra note 4 at para 190; child protection workers are protected from liability in the good faith execution of their statutory duties (CYFSA, ss 37, 126(2); see also D (B), supra note 5 at paras 60-61).
they see fit, the CAS is authorized to intervene in parental decision making rights where considered necessary to protect a child. The CAS has the power to make decisions that may permanently alter the lives of children and families for better or for worse, including the power to remove a child from the care of their parent(s). The power of apprehension may be exercised where there are reasonable and probable grounds to believe that a child (under 16 years of age) is “in need of protection” and that there is “no less restrictive course of action”, by obtaining a warrant from a justice of the peace authorizing the worker to remove the child from their home and place them in out-of-home care (e.g. a foster home, a relative’s home). The power also may be exercised without a warrant, where the child protection worker believes on reasonable and probable grounds that a child (under 16 years of age) is “in need of protection” and that “there would be a substantial risk to the child’s health or safety” in the time it would take to come before the Court.

The CAS continuously comes in contact with significant numbers of families and children with a variety of complex needs and difficulties (e.g. poverty, mental health and addictions issues, lack of social supports). The decisions made by child protection workers to

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Referrals for Support in Ontario” (2017) 7:101 Brain Sci 1 [Filippelli et al, “Infants Investigated”] at 3; CYFSA, supra note 1, s 35, Part IV.

9 B (R), supra note 8 at paras 82-83, 85-88; Children’s Aid Society of Ottawa v D (C) (2009), 175 ACWS (3d) 1074, 68 RFL (6th) 425 (ONSC) at paras 31, 32.


11 The criteria for finding that a child is “in need of protection”, particularly in relation to mental health issues, are discussed in detail in Chapters Two and Three.

12 CYFSA, supra note 1, ss 81(2), 74(1), (4); S L, supra note 10 at para 14; on the application of a person, a Court order authorizing apprehension may also be issued, where specified criteria are met (CYFSA, s 81(4)).

13 CYFSA, supra note 1, s 81(7); S L, supra note 10 at paras 15, 17.

apprehend a child or to otherwise intervene in a family, are often made in challenging circumstances (e.g. uncertainty about alleged maltreatment or risks, possible need for urgent intervention) and can, and often do, have significant consequences. The consequences a decision may carry are often uncertain, and mistakes may have irreversible life altering effects for children and their families (e.g. unnecessarily permanently removing a child from their parents, prematurely discontinuing involvement with a family resulting in serious harm or death to a child). As Justice Abella noted, speaking for the SCC in *D. (B.) v. Children’s Aid Society of Halton (Region)*, “[c]hild protection work is difficult, painful and complex”, and “[c]atering to a child’s best interests in this context means catering to a vulnerable group at its most vulnerable”.

In an effort to better protect children and avoid potentially catastrophic errors, many jurisdictions, including Ontario, have adopted standardized risk assessment models. These models (comprised of “systematic checklists”) are intended to promote consistency across the

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D (B), *supra* note 5 at para 64.

risk assessments made by child protection workers and avoid the errors that may arise where
decisions are made using individual judgement.19

Screening, Investigating, and Substantiating Claims

Allegations of maltreatment (e.g. physical abuse) or risk of harm (e.g. risk a child will
experience serious anxiety as a result of the actions or inactions of a parent) may be reported to
the CAS by a variety of people (e.g. physicians, psychologists, teachers, family members,
friends).20 As I described in detail in previous Chapters, a child may be “in need of protection”
for a variety of reasons, including suffering or being at risk of suffering physical harm, sexual
abuse, or “emotional harm”, as a result of their parents’ actions or inactions (e.g. failure to
protect the child, failure to provide or to consent to treatment).21 Where a person has
“reasonable grounds to suspect” that a child is “in need of protection” (i.e. that one or more of
the enumerated forms of maltreatment or risk of harm are occurring), the person is to
“immediately report the suspicion and the information on which it is based” to the CAS.22 A
person who fails to report a suspicion to the CAS is guilty of an offence and liable to a fine of up
to $5,000 where the person “performs professional or official duties with respect to children”
(e.g. health care professionals, teachers, school principals, family counsellors, lawyers, police
officers) and obtained the information in the course of carrying out these duties.23

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19 LeBlanc et al, supra note 18 at 405; Parada, Barnoff & Coleman, supra note 15 at 36-37, 41-43; Stoddart et al, supra note 15 at 2;
supra note 18; while the use of standardized models is relevant to the decision making of child protection workers, and thus, to this
Thesis, it is beyond the scope of this Thesis to review these models in detail, or to engage in the debates about their utility, advantages
and disadvantages.

20 CYFSA, supra note 1, ss 125(1), (6); Tonmyr et al, supra note 14 at 493; Barbara Fallon et al, “Opportunities for Prevention and
Intervention with Young Children: Lessons from the Canadian Incidence Study of Reported Child Abuse and Neglect” (2013) 7:4 Child
Adolesc Psychiatry Ment Health 1 [Fallon et al, “Opportunities for Prevention”] at 1, 12.

21 See Chapter One at 18-19 and related references; Chapter Two at 51 and related references; Chapter Three at 80-81 and related
references.

22 CYFSA, supra note 1, ss 125(1)-(3); where the child is 16 or 17 years of age, the person may make a report (s 125(4)).

23 Ibid, ss 125(5), (6), (9); consider also P (D), supra note 15 at para 21.
Where a report is received, it is screened (assessed) by a child protection worker and a determination is made as to whether the report comes within the CAS’ mandate and whether an investigation is required. The CYFSA stipulates what actions and inactions constitute maltreatment and risk of harm for purposes of State intervention. The parameters for decision making at the intake (and later) stages are established by the statutory provisions and are delineated also by the standardized tools child protection workers are obliged to use in undertaking risk assessments. However, as I will demonstrate, the legislative provisions may be only one of many factors influencing initial screening decisions, as well as the decisions made where claims proceed to an investigation.

Where the decision is made to proceed with an investigation, a child protection worker will investigate the allegations to determine whether the child has suffered maltreatment or is likely at risk of harm as defined in the “in need of protection” provisions in the Act. The child protection worker then will determine whether ongoing child welfare services are required and what services to provide. In certain cases, these decisions will include a determination to apprehend the child and place them in out-of-home care. In the majority of cases, children will

24 As described below, different CAS have different organizational structures, and may have workers that take on specialized roles (e.g. intake worker) or workers who take on more generalist roles (e.g. doing the initial assessment and investigation, as well as providing ongoing services) and, decision making in different organizations may be more collaborative (determined amongst a group) or individual (made by a given worker, in consultation with the supervisor) (consider Parada, Barnoff & Coleman, supra note 15 at 41-43; Bala, supra note 7 at 9; Smith et al, “Child Welfare Organizations: Placement Decisions”, supra note 10 at 574). Despite these variances, for ease of reference, herein reference is made to “child protection worker” to refer to the assessments and investigations undertaken by the CAS.

25 Fallon et al, “Opportunities for Prevention”, supra note 20 at 1; Parada, Barnoff & Coleman, supra note 15 at 41-42; see also CYFSA, supra note 1, s 126.

26 Supra note 21; S L, supra note 10 at paras 14-17; see also Parada, Barnoff & Coleman, supra note 15 at 41.

27 CYFSA, supra note 1, s 74(2); S L, supra note 10 at paras 14, 17; Parada, Barnoff & Coleman, supra note 15 at 41; LeBlanc, supra note 18 at 405; see also “Ontario Child Protection Standards”, supra note 18; “Ontario Child Protection Tools Manual”, supra note 18; “Eligibility Spectrum”, supra note 18.

28 Fallon et al, “Opportunities for Prevention”, supra note 20 at 1-3, 6-7; Tommyr et al, supra note 14 at 493; Fallon, Trocmé & MacLaurin, supra note 14 at 236-37; Baiden & Fallon, supra note 14 at 117; Stoddart et al, supra note 15 at 1.

29 Fallon et al, “Responding to Safety Concerns”, supra note 14 at 1-2; Parada, Barnoff & Coleman, supra note 15 at 42-43; in the CYFSA, supra note 1, “service” is defined as including, amongst other things, mental health or counselling services for the child or their family, a service for a child who is or may be in need of protection or for their family, a service related to residential care for a child, a service for a child or family that “is in the nature of support or prevention and that is provided in the community”, and a “service or program for or on behalf of a young person for purposes” of the YCJA (s 2(1)).

30 Fallon et al, “Responding to Safety Concerns”, supra note 14 at 2; Parada, Barnoff & Coleman, supra note 15 at 42, 43; Filippelli et al, “Infants and Ongoing Services”, supra note 15 at 2; CYFSA, supra note 1, ss 81, 82; where a child is apprehended (and remains in out-of-home care without the agreement of the parents), the matter is to be brought before the Court within five days (CYFSA, s 88).
remain in the home following the investigation, with the CAS providing ongoing supervision and services on a voluntary or non-voluntary basis.31

**Service Provision: A Duty to Children and Families**

Immediate safety concerns necessarily take precedence in some cases, such as where there is believed to be a substantial risk that if a child is not apprehended they will be seriously injured.32 In addition to addressing urgent protection needs, the CAS’ mandate also necessitates an understanding of the child and family’s ongoing problems and needs, and how to best address these needs to mitigate future protection risks, promote the well-being of the child and, where not in conflict with these paramount principles, support the family.33 The children and families engaged with the CAS often have multiple complex needs and challenges.34 Providing children and families with appropriate ongoing child welfare services and community based services is a central part of realizing the CAS’ mandate.35 This vital role is recognized in the principles set out in the Preamble to the *CYFSA*, which provide that “[c]hildren and families have better outcomes when services build on their strengths” and that “[p]revention services, early intervention services and community support services build on a family’s strengths and are invaluable in reducing the need for more disruptive services and interventions”.36

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32 Fallon *et al*,”Responding to Safety Concerns”, *supra* note 14 at 2, 6-7; Parada, Barnoff & Coleman, *supra* note 15 at 42-43; Smith *et al*, “Role Specialization and Service Integration”, *supra* note 14 at 146; *CYFSA*, *supra* note 1, s 81(7).
33 Fallon *et al*,”Responding to Safety Concerns”, *supra* note 14 at 2, 6-7; Tonmyr *et al*, *supra* note 14 at 493; Filippelli *et al*,”Infants Investigated”, *supra* note 8 at 1-2; *D (B)*, *supra* note 5 at para 64; *CYFSA*, *supra* note 1, s 1(1).
34 Fallon *et al*,”Responding to Safety Concerns”, *supra* note 14 at 3, 6-7; Smith *et al*,”Child Welfare Organizations: Placement Decisions”, *supra* note 10 at 574; Smith *et al*,”Role Specialization and Service Integration”, *supra* note 14 at 145; Chamberland *et al*, *supra* note 14 at 209-10; Filippelli *et al*,”Infants Investigated”, *supra* note 8 at 13; Fallon, Trocmé & MacLaurin, *supra* note 14 at 237; Tonmyr *et al*, *supra* note 14 at 493.
35 Fallon *et al*,”Responding to Safety Concerns”, *supra* note 14 at 6-7; Campbell, Springate & Trocmé, *supra* note 31 at 369; Filippelli *et al*,”Infants Investigated”, *supra* note 8 at 1-2; *CYFSA*, *supra* note 1, s 1.
36 *CYFSA*, *supra* note 1, Preamble, s 1(2).
It is recognized also in the stipulation in the CYFSA that one of the CAS’ functions is to provide services to families to protect children or prevent situations requiring protection. As Joanne Filippelli et al note, child protection workers “have been described as service brokers and gateway providers to services for children and youth”. The decisions a child protection worker makes in assessing the needs and problems of children and families and in making related referrals for services, can mean the difference between protecting a child and promoting their well-being or irreversibly imperiling the child and the family unit. These are significant and complex decisions, and while they are to be governed by statutory provisions and related guidelines, many other factors have been found to exert an (interactive) influence on the decisions made by child protection workers from intake, to investigation, to service provision and commencing Court proceedings.

Decisions: Governed by Statute?

Statutory Framework and Government Policies

The CYFSA establishes the criteria that must be met for a child to be found to be “in need of protection”. For example, the Act provides that a child is “in need of protection” where they suffer, or are likely to suffer, “emotional harm” (demonstrated by serious anxiety, depression, withdrawal, self-destructive or aggressive behaviour, or delayed development) resulting from the actions or inactions on the part of their parent. In setting out the criteria for findings of “in need of protection”, the statutory provisions and related guidelines prescribe the parameters of,

37 CYFSA, supra note 1, s 35(1)(c); see also O (E), supra note 4 at para 193; Fallon et al, “Opportunities for Prevention”, supra note 20 at 2.
40 Parada, Barnoff & Coleman, supra note 15 at 41; Jud, Fallon & Trocmé, supra note 14 at 984; Filippelli et al, “Infants Investigated”, supra note 8 at 15; Filippelli et al, “Infants and Ongoing Services”, supra note 15 at 10; Allan et al, supra note 14 at 2-3; Campbell, Springate & Trocmé, supra note 31 at 378, 380.
41 CYFSA, supra note 1, s 74.
42 Ibid, ss 74(2)(f), (h).
and grounds for, intervention by the CAS. As these parameters and grounds have been changed (broadened) by policy changes and legislative amendments over the past decades (e.g. lowering the threshold for intervention in the risk of harm provisions), changes in the number and nature of child protection investigations have also been observed. While this suggests the ways “in need of protection” are defined in the legislation impacts child protection interventions, research suggests that the effect of legislation on child protection practices may be limited, and that child protection workers’ decisions are influenced by the interaction of a variety of factors.

One of the factors that may influence and constrain child protection workers’ decisions is the allocation of public resources. Budgetary constraints may affect the priorities within the CAS, and may limit the investigations that a child protection worker can undertake and the services they can provide to children and families. In *Children’s Aid Society of Hamilton v. O. (E.)* (“O. (E.)”), Justice Gordon recognized the need for adequate funding, stating, “[a]dequate funding is required by the Society to investigate and prosecute its case” and “[t]he refusal of the provincial and federal governments to provide adequate funding for the Society and the court

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43 Parada, Barnoff & Coleman, *supra* note 15 at 41; *SL, supra* note 10 at paras 14, 17; see also Campbell, Springate & Trocmé, *supra* note 31 at 355-56.
45 Filippelli *et al.*, “Infants Investigated”, *supra* note 8 at 15; Filippelli *et al.*, “Infants and Ongoing Services”, *supra* note 15 at 10; Stodddart *et al.*, *supra* note 15 at 7.
46 Campbell, Springate & Trocmé, *supra* note 31 at 357; consider also Filippelli *et al.*, “Infants and Ongoing Services”, *supra* note 15 at 3-4.
renders meaningless the statutory direction in terms of the paramount and other purposes of the Act”.

Organizational Structure

The CAS’ organizational structure has been found to be another factor that may influence child protection workers’ decision making. Research suggests that organizational characteristics may impact on child protection workers’ decisions regarding ongoing services and referrals to specialized services. For example, as I noted in Chapter One, studies suggest that the way a CAS organization is structured – specialized structures (e.g. different workers have different areas of expertise, such as in infant health or domestic violence, or different workers deal with different phases of the child protection intervention) or “generalist” structures (e.g. the same worker carries out a number of tasks, such as investigating and providing ongoing services), and integration, if any, with other service providers – may impact child protection workers’ service referral decisions. Specifically, child protection workers in “generalist agencies” and “multiservice” (integrated) agencies have been found to be more likely than workers in specialized agencies to make referrals during the investigation stage, and service referrals have been found to more often be a part of the investigation phase in “multiservice” agencies than single service (generalist or specialized) agencies.

Possible explanations for these findings include specialists and generalists having different perceptions about professional roles and tasks (e.g. determining solely whether

49 O (E), supra note 4 at paras 180, 178.
50 Jud, Fallon & Trocmé, supra note 14 at 984, 987; Filippelli et al, “Infants Investigated”, supra note 8 at 15; Filippelli et al, “Infants and Ongoing Services”, supra note 15 at 10; Campbell, Springate & Trocmé, supra note 31 at 378.
53 See Chapter One at 42-43 and related references.
intervention is warranted versus assessing safety concerns and working to best meet the needs of the child and family) and/or having different knowledge and training (e.g. specifically and solely on investigative practices versus on investigative practices as well as providing ongoing service and support).\textsuperscript{54} In addition, workers in generalist and multiservice agencies may have more exposure to, and have built more working relationships with, other service providers, than workers in specialized agencies.\textsuperscript{55} In a similar vein, access to services and collaboration amongst service providers may be facilitated where the various services (e.g. mental health, addictions counseling) are available within the organization, such as in “multiservice” agencies.\textsuperscript{56} The geographic location of the CAS organization may affect service referrals for similar reasons, with child protection workers’ decisions regarding referrals and types of services referred potentially being influenced by the availability and accessibility (or lack thereof) of services in different regions (e.g. rural versus urban).\textsuperscript{57}

Studies exploring other decisions in the child protection process (e.g. the decision to provide ongoing services, placement decisions), have revealed mixed findings regarding the existence or strength of the relationship between organizational structure (e.g. integrated/collaborative, specialized, generalist) and decision making.\textsuperscript{58} While some of these studies have found an effect and others not, numerous studies, including those focused on organizational structure, have observed that case level factors (e.g. child’s age, caregiver risk factors) have a considerable influence on child protection workers’ decision making.\textsuperscript{59}

\textsuperscript{54} Smith \textit{et al}, “Role Specialization and Service Integration”, supra note 14 at 145-46.
\textsuperscript{55} Ibid at 146.
\textsuperscript{57} Filippelli \textit{et al}, “Infants Investigated”, supra note 8 at 15; Jud, Fallon & Trocmé, supra note 14 at 984, 987; MacLaurin & Bala, supra note 48 at 115; consider also Fallon & Trocmé, supra note 51 at 68-69.
\textsuperscript{59} Ibid at 574, 575, 579; Smith \textit{et al}, “Role Specialization and Service Integration”, supra note 14 at 145; Fallon & Trocmé, supra note 51 at 70.
Case Characteristics and Clinical Considerations

A number of case characteristics have been found to influence child protection workers in regards to various decisions, including substantiating claims, service referrals, and out-of-home placement. The case characteristics and clinical considerations that may influence child protection workers’ decision making include: child’s age (e.g. infants, adolescents), child functioning concerns (e.g. depression, anxiety, self-harming behaviours), referral source (e.g. hospital, police), perceptions of risk (e.g. severity), substantiation and nature of alleged protection concerns (maltreatment or risk of harm), nature of maltreatment or risk of harm (e.g. neglect, “emotional harm”, sexual abuse, exposure to intimate partner violence), caregiver risk factors and functioning concerns (e.g. mental or physical health issues, alcohol or drug addiction, limited social supports), child’s race or ethnicity, parents (perceived) intent and level of cooperation, intimate partner violence, and household moves and financial concerns (e.g. low socioeconomic status). Child protection workers’ intervention decisions also may be affected by the assessment of the problems in the case and their causes (e.g. issues related to a parent, or to the broader social context).

The nature and extent or existence of the problem may be more difficult to detect and substantiate in some cases as compared to others. For example, as Nico Trocmé et al note, “[u]nlike physical abuse or sexual abuse where investigations focus on discreet incidents of

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62 Campbell, Springate & Trocmé, supra note 31 at 357; Parada, Barnoff & Coleman, supra note 15 at 48; Jud, Fallon & Trocmé, supra note 14 at 988.
maltreatment, [emotional maltreatment] is not as easily defined and delimited”.

Incidents of emotional (psychological) maltreatment or the existence of “emotional harm” (e.g. anxiety, depression, aggression) or a “mental, emotional or developmental condition” are generally less visible and more ambiguous than, for example, incidents of physical abuse or neglect or the existence of physical harm (e.g. bruising, broken bones, poor hygiene).

Lack of identification of mental health issues amongst children involved with the CAS is a notable problem for children receiving needed services (discussed in detail below). Where the (potential) existence of mental health issues affecting the child is recognized, it may affect the child protection workers’ view of the problem(s) and consequent decisions regarding substantiation and service provision. Studies have found that child protection workers’ decisions regarding substantiation and service provision may be affected by the existence and nature of a child’s disability (e.g. physical disability, mental disorder). For example, in a study about the effects of cerebral palsy, intellectual disabilities, and emotional/behavioural disabilities, Jeanette E. Manders and Zolinda Stoneman found that, while child protection workers “believed that parents were primarily responsible for the abuse of all children, children with disabilities were more likely than other children to be seen as having characteristics that contributed to their abuse”, most child protection workers “felt at least some empathy with abusive parents”, and “[s]ervices recommended for families of children with disabilities were more child-focused than those recommended for typically developing children”.

63 Trocmé et al, supra note 44 at 832.
64 Chamberland et al, supra note 14 at 203; Trocmé et al, supra note 44 at 832; consider also C (W) v E (C), 2010 ONSC 3575, [2010] OJ No 2738 [C (W)] at paras 174, 178.
66 See Chapter One at 41-42 and related references.
68 Manders & Stoneman, supra note 60 at 230, 235; the study was conducted using vignettes (Ibid at 231).
The tendency to attribute partial responsibility to the child for the abuse they suffered was found to be “heightened when children with emotional/behavioral disabilities had less severe injuries”, empathy towards the abusive parent was “highest when the child victim had an emotional/behavioral disability”, and “families of children with emotional/behavioral disabilities were especially likely to be recommended for child-focused services”.69 The effect a child having a disability (and the type of disability) may have on problem attribution, substantiation, and service provision may be explained, in part, by a lack of information or knowledge about the child’s disability and possible ambiguities and the feasibility of multiple explanations for the harm suffered (e.g. injuries resulting from the disability, rather than actions or inactions on the part of parents).70 The effect also may be attributable, at least in part, to agency in decision making and the influence of a child protection worker’s personal biases, attitudes, and beliefs.71

Child Protection Workers’ Experience and Knowledge as Decision Making Factors

Child protection workers have been found to exercise considerable agency in decision making.72 In this way, while child protection workers may respect and rely upon the parameters and protocols established in the legislation and related guidelines (including standardized tools), their decisions are also influenced and guided by other factors, such as individual knowledge, experience and clinical judgement, and/or personal biases, attitudes, beliefs, and intuitions.73 The reliance and precedence child protection workers may give to their own clinical judgements is likely to increase as they gain knowledge and experience working with children and families and within the statutory framework and standardized protocols.74

69 Ibid at 235-36.
70 Ibid at 230, 235; consider also Dion et al, supra note 67 at 185.
71 Manders & Stoneman, supra note 60 at 230; Stoddart et al, supra note 15 at 2, 7; consider also Parada, Barnoff & Coleman, supra note 15 at 52-53.
72 Parada, Barnoff & Coleman, supra note 15 at 52-53, 41, 44; Campbell, Springate & Trocmé, supra note 31 at 378.
73 Manders & Stoneman, supra note 60 at 230; Parada, Barnoff & Coleman, supra note 15 at 43-46, 49; Campbell, Springate & Trocmé, supra note 31 at 378; Stoddart et al, supra note 15 at 2, 7; consider also LeBlanc et al, supra note 18 at 411.
74 See Parada, Barnoff & Coleman, supra note 15 at 49.
Working with Children and Families: Service Referrals

Working with children and families and providing them with “guidance, counselling and other services” is one of the statutorily mandated functions of the CAS.\(^{75}\) The CYFSA contemplates both the provision of services (including out-of-home placement) on a voluntary and non-voluntary basis.\(^{76}\) In cases where child protection proceedings have been commenced and a child has been found to be “in need of protection”, the CAS may seek an order placing a child in the care and custody of a parent under CAS supervision or placing the child in the interim or extended care and custody of the CAS.\(^{77}\) Before making one of these orders, the Court must ascertain “what efforts the society or another person or entity has made to assist the child before intervention” under the statutory child protection provisions.\(^{78}\)

Meeting the dual purposes of protecting children and supporting families may place child protection workers in a challenging position, gathering evidence to support a finding of maltreatment or risk of harm, while at the same time working to support parents and the family unit.\(^{79}\) In order to meet their statutory obligations and try to address the problems that brought a family to the CAS’ attention, child protection workers may provide services directly or may provide services by way of referrals to other service providers.\(^{80}\) Depending on the child protection workers’ view of the problem, the services provided may be focused primarily on the child or on the parent, or both.\(^{81}\) The services provided, directly or by referral, to children and/or parents by the CAS (or which the Courts have noted should have been provided) may include

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\(^{75}\) CYFSA, supra note 1, s 35(1); Children's Aid Society, Region of Halton v W (A), 2016 ONCJ 358, 268 ACWS (3d) 585 [W (A)] at para 285; consider also C (W), supra note 64 at para 176.

\(^{76}\) CYFSA, supra note 1, ss 75-77, 101, 109-111; see also Campbell, Springate & Trocmé, supra note 31 at 364-65.

\(^{77}\) CYFSA, supra note 1, s 101.

\(^{78}\) Ibid, s 101(2), consider also s 100(a); W (A), supra note 75 at para 286; Catholic Children's Aid Society of Toronto v M (C), 2011 ONCJ 648, 211 ACWS (3d) 100 [M (C)] at para 13; S L, supra note 10 at para 165.

\(^{79}\) O (E), supra note 4 at para 164; S L, supra note 10 at para 123; Bala, supra note 7 at 10; consider also Campbell, Springate & Trocmé, supra note 31 at 358.

\(^{80}\) See W (A), supra note 75 at para 287; M (C), supra note 78 at paras 28, 93; CYFSA, supra note 1, s 2(1).

\(^{81}\) Supra notes 66, 67; Chapter One at 44 and related references.
family service or support workers, parenting training or coaching, counselling, services to
address developmental or physical disabilities, etc.82 In some cases, consent is required before a
service can be administered. For example, the CYFSA provides that the consent provisions of the
Health Care Consent Act, 199683 apply where the service provided is a “treatment” to which that
Act applies (e.g. psychiatric care),84 and that a child who is 12 or older may consent to
counselling on their own behalf.85

**Children in Care with Mental Health Issues: The System’s Response**

**The Prevalence of Mental Health Issues and the Importance of Identification**

As I have discussed in previous Chapters, a significant number of children in care have
diagnosed mental health needs, and many more likely have undiagnosed mental health issues.86
And, as also discussed, the prevalence of mental health issues (e.g. anxiety, depression) amongst
children in care may be explained, at least in part, by the link between a history of maltreatment
and mental health issues.87 Children who have suffered abuse or neglect may be at a
significantly elevated risk for mental health issues as compared to children in the general
population.88 However, despite the links between maltreatment and mental health issues, and the
prevalence of mental health issues amongst children in care, many children in care are not
receiving needed assessment and treatment services for their mental health issues.89

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82 See W (A), supra note 75 at para 287; M (C), supra note 78 at paras 28, 93; O (E), supra note 4 at paras 194, 197; CYFSA, supra note 1, s 2(1).
84 “Treatment” is defined in section 2(1) of the HCCA, ibid, as meaning “anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment, plan of treatment or community treatment plan, but does not include” enumerated services (eg capacity assessments, taking a person’s health history, communication of a diagnosis, etc.). Pursuant to the Act, a person (regardless of age) is presumed to be capable, and the presumption is rebutted only where the evidence establishes that the person does not meet the statutory test for capacity (set out in section 4). Section 4 of the HCCA provides that a person is capable if they have the ability to understand information relevant to the treatment decision and to appreciate the reasonably foreseeable consequences of a decision or lack of one.
85 CYFSA, supra note 1, ss 22, 23; see also Campbell, Springate & Trocmé, supra note 31 at 364.
86 See Introduction at 7 and related references.
87 See Chapter One at 28 and related references.
88 Baiden & Fallon, supra note 14 at 115-16; consider also Tonmyr et al, supra note 14 at 497; Burge, supra note 65 at 312.
89 See Introduction at 8 and related references; Chapter One at 44 and related references; Burge, supra note 65 at 306; Filippelli et al, “Infants Investigated”, supra note 8 at 15, 2; Baiden & Fallon, supra note 14 at 122.
Child protection workers can play a vital role in matching children and families to needed supports and services. Whether a child’s mental health needs are adequately met may depend on a child protection worker identifying the existence of a possible mental health issue and deciding to refer the child (and family) for appropriate assessment and treatment services. Research suggests that child protection workers’ decisions regarding referrals for assessment or treatment services for mental health issues may be influenced by a variety of factors, including the individual worker’s training in, and knowledge and awareness of, mental health issues and services. As mentioned, studies have found that mental health service referral decisions may also be influenced by the type of maltreatment experienced by the child (e.g. sexual abuse, physical abuse, neglect).

The Unmet Need for Mental Health Services

Children who come to the attention of the CAS often have experienced maltreatment and trauma, and present with a variety of complex needs, including mental health issues. The obligations of the CAS to provide mental health and other services for a child in care were considered by the Ontario Court of Justice in *Catholic Children’s Aid Society of Toronto v. F. (V.)*, in the context of a costs motion brought by the Office of the Children’s Lawyer (“OCL”) against the CAS for unreasonably increasing the OCL’s costs by repeatedly failing to arrange for therapy and an educational assessment for a child in the CAS’ care. In this case, the CAS had

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90 Supra at 138 and related references.
91 Filippelli et al., “Infants Investigated”, supra note 8 at 15, 2; Baiden & Fallon, supra note 14 at 116; Burge, supra note 65 at 306; Hoffman et al, supra note 38 at 152-54, 148, 149.
92 Hoffman et al, supra note 38 at 148, 149, 153-54; Tommyr et al, supra note 14 at 497-98; Baiden & Fallon, supra note 14 at 123.
95 *Catholic Children’s Aid Society of Toronto v F (V)* (2003), 127 ACWS (3d) 909, [2003] OJ No 5211 (ONCI) [F (V)] at paras 2, 19.
known of the child’s service needs since the outset of the case, having apprehended her on the basis of an “urgent, unaddressed need for mental health treatment and educational support”.96 Ultimately finding that the CAS’ “behaviour was unreasonable” and awarding costs to the OCL on a full indemnity basis, Justice Cohen noted that “the society made an undertaking, the court made an order and yet, the society allowed an unacceptable time to elapse before an appropriate plan was finally put in place”, and that “[i]t should not be necessary for this court to order the society to provide services that it is under a statutory duty to provide”.97

Despite the statutory provisions, and the prevalence of mental health issues amongst children involved with the CAS and the importance of early intervention, many children in care do not receive adequate and timely needed services.98 A failure to intervene early and adequately address a child’s mental health (and other) needs, may carry significant short and long-term consequences for the child and for society more generally (e.g. self-harm and suicide, substance abuse, engagement with the criminal justice system).99 Children exhibiting behavioural (e.g. running away, aggression towards others) or mental health issues (e.g. depression, attachment disorder) may face multiple placements, and the challenges they face may be repeatedly exacerbated and compounded.100

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96 Ibid at paras 3, 13.
97 Ibid at paras 18, 19.
98 Supra note 89.
99 Scully & Finlay, supra note 94 at 2, 25; Emmeline Chuang & Rebecca Wells, “The Role of Inter-agency Collaboration in Facilitating Receipt of Behavioral Health Services for Youth Involved with Child Welfare and Juvenile Justice” (2010) 32 Child Youth Serv Rev 1814 at 1814; Tommyr et al, supra note 14 at 493-94; Bala et al, supra note 4 at 139, 142; Herz et al, supra note 94 at 20; Baiden & Fallon, supra note 14 at 123; Burge, supra note 65 at 313.
100 See Introduction at 9, 10-11 and related references; Chapter One at 29-30 and related references; see also eg RSP v Youthdale Treatment Centres, 2017 CFSRB 2 [RSP] at para 7; Children’s Aid Society of Waterloo (Regional Municipality) v R (K), 2009 ONCJ 684, 186 ACWS (3d) 418 [R (K)] at para 5.
Judicial Intervention

Child Protection Proceedings: Commencement and Conduct

Where a CAS becomes involved with a child and family they may, and in some cases must (e.g. where a child has been placed in out-of-home care without the agreement of the parents), bring the matter before the Court for a child protection hearing. The CAS may commence child protection proceedings by applying to the Court for a finding that a child is “in need of protection” and may seek an order regarding the care and custody of the child. Orders regarding the care and custody of the child can have a significant impact on the child and family, and in some cases may result in the child being permanently removed and cut off from their family. The CYFSA provides that where the Court finds that a child is “in need of protection” and “is satisfied that intervention through a court order is necessary to protect the child in the future, the court shall” order that the child be placed in the care and custody of a parent under the supervision of the CAS or placed in the interim or extended care and custody of the CAS.

In pursuing child protection proceedings, the obligations and role of the CAS is not akin to that of an ordinary litigant. As Justice Gordon noted in O. (E.), the CAS is an agent of the State, “and the adversarial concept of winning and losing does not apply” in child protection proceedings. In child protection proceedings, the CAS must act fairly and reasonably, and “exercise good faith, due diligence and reason”. The focus of the CAS should not be on “winning” the case, but rather on obtaining a disposition that is in the “best interests” of the

101 CYFSA, supra note 1, ss 81, 88-90, 101, 113, 115; see also Campbell, Springate & Trocmé, supra note 31 at 367.
102 CYFSA, supra note 1, ss 81, 90, 101.
103 Ibid, ss 101, 105.
104 Ibid, ss 101(1), 102; where a child is found to be “in need of protection”, but the Court “is not satisfied that a court order is necessary to protect the child in the future, the court shall order that the child remain with or be returned to the person who had charge of the child immediately before intervention under this [child protection] Part” (Ibid, s 101(8)). And, where the Court finds a custody order instead of an order for supervision or CAS care (under s 101(1)) to be “in a child’s bests interests, the court may make an order granting custody of the child to one or more persons, other than a foster parent of the child, with the consent of the person or persons” (Ibid, s 102(1)).
105 P (D), supra note 15 at para 13; O (E), supra note 4 at para 191.
106 O (E), supra note 4 at para 191.
107 Ibid at para 192.
child. The adoption by the CAS of “an aggressive litigation strategy” may offend the intent and statutory provisions in the CYFSA and may be “contrary to the best interests of the child”.

For example, in O. (E.), the CAS was found to have engaged in “deliberate non-disclosure”, with the affidavits of the child protection workers being drafted without inclusion of positive factors and events “so as to present the parents in a negative manner” and support the CAS’ position for the permanent removal of the child. In O. (E.), Justice Gordon found that by “failing to provide a full and complete presentation of the evidence”, the CAS had “misrepresented the case and misled the parents and the court”.

The importance of good faith efforts to resolve child protection cases in the best interests of the child is recognized also in the inclusion in the CYFSA of alternative dispute resolution (“ADR”) provisions. Pursuant to the CYFSA, where a child is or may be “in need of protection”, the CAS “shall consider whether a prescribed method of alternative dispute resolution could assist in resolving any issue related to the child or a plan for the child’s care”. The use of ADR can divert child protection cases out of the adversarial Court process and allow parties to discuss issues and negotiate resolutions, potentially leading to more ownership over, and satisfaction with, the ultimate outcome of the case. However, ADR may yield less promising

108 Ibid at para 22.
109 Ibid at paras 17, 204; CYFSA, supra note 1, s 35 (previously ss 15(3) & (4) in the CFSA, supra note 1).
110 O (E), supra note 4 at paras 18-19, 199; O (E) involved the apprehension of an infant at birth, on the basis of concerns regarding the parents’ ability to care for the child (paras 44-45). The investigation undertaken prior to the apprehension was limited (the file being received by the child protection worker the day before the birth, despite an initial report having been made to the CAS four months earlier) (Ibid at para 48). The CAS subsequently decided to seek permanent removal of the child from his parents, but did not disclose the change (from seeking a temporary order) to the parents (Ibid at paras 56, 199). The CAS had failed to provide recommended and needed services to the parents, had failed to prepare a plan of care with respect to the permanent removal, and had “[t]unnel vision” in seeking to support their position (Ibid at paras 197-201). In the result, the CAS in O (E), was found to have come “up well short of meeting its obligations” (para 205).
111 Ibid at para 27.
112 CYFSA, supra note 1, s 17(1).
113 Campbell, Springate & Trocmé, supra note 31 at 361.
results in certain cases and may be particularly problematic where a party is vulnerable or lacks equal bargaining power.\(^{114}\)

The inclusion of ADR provisions in the CYFSA is in keeping with the Act’s statement of other purposes, which stipulates that services to children “should be provided in a manner that”, amongst other things, “includes the participation of a child or young person, the child’s or young person’s parents and relatives and the members of the child’s or young person’s extended family and community, where appropriate”.\(^{115}\) The importance of this type of participation is explicitly recognized in provisions relating to certain major decisions for children who have been placed in the interim or extended care of the CAS.\(^{116}\)

**Powers: Decisions for Children in the Interim or Extended Care of the CAS**

Where children are in the interim or extended care of the CAS, the CYFSA provides that the CAS has “the rights and responsibilities of a parent for the purpose of the child’s care, custody and control”.\(^{117}\) As representatives of the CAS, child protection workers may act in the place of a parent and exercise decision making authority in relation to a variety of issues affecting a child in care, including regarding healthcare and where a child lives.\(^{118}\) The role and authority of child protection workers is generally not lost on children in care and, as The Honourable Justice Brian Scully and Dr. Judy Finlay note, “[y]outh in child welfare care ascribe tremendous authority, responsibility and centrality to the role of their child welfare worker”.\(^{119}\) Child protection workers are “very influential” in the lives of children in care, with their

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\(^{114}\) Ibid.

\(^{115}\) CYFSA, supra note 1, s 1(2)3vi; Campbell, Springate & Trocmé, supra note 31 at 364.

\(^{116}\) CYFSA, supra note 1, ss 3, 8, 13(2), 109(2)(e), (5).

\(^{117}\) Ibid, ss 110(1), 111(1).

\(^{118}\) Ibid, ss 110, 111, 109; Scully & Finlay, supra note 94 at 18-19; Bala et al, supra note 4 at 140, 144; MacLaurin & Bala, supra note 48 at 129; as noted above, the CAS’ authority to consent to treatment on behalf of a child is subject to the child being incapable of making health care decision(s) pursuant to the HCCA, supra note 83 (CYFSA, ss 110(2), 111(2); HCCA, s 4).

\(^{119}\) Scully & Finlay, supra note 94 at 18; Bala et al, supra note 4 at 144, 140-41.
behaviour and decisions potentially influencing everything from a child’s ability to form trusting relationships, to where and with whom the child will live.\textsuperscript{120}

The \textit{CYFSA} provides that where a child has been placed in the interim or extended care of the CAS, the CAS “shall choose a residential placement for the child”.\textsuperscript{121} The residential placement for the child is to be, amongst other things, “the least restrictive alternative for the child”, and take “into account the child’s views and wishes, given due weight in accordance with the child’s age and maturity, and the views and wishes of any parent who is entitled to access to the child”.\textsuperscript{122} The CAS also may change the residential placement (e.g. foster home, group home) of a child in care, and some of these children, especially those exhibiting behavioural or mental health issues, may experience numerous moves while in the care of the CAS.\textsuperscript{123}

\textbf{The Importance and Implications of Placement Decisions and Other Interventions}

\textbf{The Effects of Multiple and Group Home Placements}

The majority of children who come into contact with the CAS remain in their familial homes.\textsuperscript{124} Case characteristics associated with out-of-home placement include, amongst other things, being an infant or adolescent, and having behavioural or mental health issues.\textsuperscript{125} As I discussed in Chapter One and illustrated in Chapter Three, children in care, particularly those who exhibit behavioural or mental health issues, may be repeatedly moved to different placements and often end up in (numerous) group homes.\textsuperscript{126}

\begin{footnotesize}
\begin{enumerate}
\item[120] Scully & Finlay, supra note 94 at 18-20; consider also Bala \textit{et al}, supra note 4 at 139, 144; \textit{CYFSA}, supra note 1, s 109(2).
\item[121] \textit{CYFSA}, supra note 1, ss 109(2), 2(1); see also Scully & Finlay, supra note 94 at 18-19.
\item[122] \textit{CYFSA}, supra note 1, s 109(2).
\item[123] \textit{Ibid}, ss 109(6), (7); Scully & Finlay, supra note 94 at 2-3; Bala \textit{et al}, supra note 4 at 135-39; MacLaurin & Bala, supra note 48 at 131-32; \textit{M (C)}; \textit{supra} note 78 at 103; consider eg \textit{RSP}, supra note 100 at para 7; \textit{R (K)}, supra note 100 at para 5; \textit{S v Youthdale Treatment Centres}, 2010 CFSRB 30 [\textit{S v Y}] at para 7; \textit{R v M (S)} (2004), 61 WCB (2d) 63, 2004 CarswellOnt 5138 (WL Can) (ONCJ) [\textit{M (S)}] at para 2.
\item[125] Jud, Fallon & Trocmé, supra note 14 at 983; Filippelli \textit{et al}, “Infants Investigated”, \textit{supra} note 8 at 14.
\item[126] \textit{Supra} note 100; Chapter Three at 85-86, 88, 90-92, 117-18 and related references.
\end{enumerate}
\end{footnotesize}
having been removed from their familial home may prompt or exacerbate attachment issues, bolster negative self-image, hinder the building and maintaining of trusting relationships, and trigger further problematic behaviours. Acting out may lead to additional moves, from one foster home to another, from a foster home to a group home, or from one group home to another. And, these multiple moves and group home placements may, in turn, lead to (repeated) involvement with the criminal justice system. All of which – behavioural issues or mental health issues, multiple moves, placement in group homes, involvement in the criminal justice system – may trap a child in a “vicious cycle” or “revolving door”, whereby existing behavioural or mental health challenges are exacerbated and additional challenges prompted and intensified (e.g. multiple moves, repeated involvement with the criminal justice system).

Service Gaps: Children Fall Through the Cracks

Fragmentation of Services: Cracks and Criminality

Children who are engaged with the CAS face complex challenges, including histories of maltreatment and trauma, behavioural issues, physical health issues, mental health issues, drug and substance addictions, learning disabilities, and engagement with the criminal justice system. They may require services and supports from numerous sectors, including the family law (child welfare) system, youth criminal justice system, education system, and mental health system. In navigating these various systems, children may come into contact with a variety of

127 Scully & Finlay, supra note 94 at 2-3; Bala et al, supra note 4 at 139; consider eg RSP, supra note 100 at paras 27-28.
128 See Chapter One at 29 and related references; consider eg RSP supra note 100 at para 7; R (K), supra note 100 at para 8; J G v Youdhdale Treatment Centres, 2011 CFSRB 24 [J G] at paras 13, 15, 50, 51; Y v Youdhale Treatment Centres, 2013 CFSRB 20 [Y] at para 4.
129 See Chapter One at 29-33 and related references; Introduction at 10-11 and related references.
130 Ibid.
132 Scully & Finlay, supra note 94 at 8; Bala et al, supra note 4 at 133, 146; Filippelli et al, “Infants and Ongoing Services”, supra note 15 at 12; Krista M Davis et al, “A Process Evaluation of Toronto’s First Youth Mental Health Court” (2015) 57 Can J Corr 159 at 178;
organizations and individuals in addition to the CAS and child protection workers, including Crown counsel, judges, lawyers from the OCL and/or Legal Aid, police, child advocates, probation officers, teachers, clinicians, and group home staff.\textsuperscript{133} As I described in Chapter One, the siloing between professionals and agencies providing services to children is an oft cited problem, and one that contributes to the failure to provide children with the services they need.\textsuperscript{134}

Child services (e.g. child welfare, youth criminal justice, mental health) have been described as being complex and fragmented.\textsuperscript{135} Children, particularly those with limited adult support, may face considerable challenges and difficulties in navigating through and between these complex and fragmented systems.\textsuperscript{136} And, even where children are able to access service providers, the fragmentation and lack of communication and collaboration across systems may still result in a lack of adequate service provision.\textsuperscript{137} As I noted in Chapter One, a lack of collaboration across systems can result in confusion about the roles and responsibilities of different professionals and agencies, and can “create gaps” which allow different actors to avoid blame for failing to provide adequate supports and services.\textsuperscript{138} For children with mental health issues who are involved with the CAS, this can mean that needed mental health (and other) services are not provided.\textsuperscript{139}

\textsuperscript{133} See Chapter One at 38 and related references.
\textsuperscript{134} See \textit{ibid} at 37-39 and related references.
\textsuperscript{136} Scully & Finlay, \textit{supra} note 94 at 24, 3, 15; Davis \textit{et al.}, \textit{supra} note 132 at 178; Bala \textit{et al.}, \textit{supra} note 4 at 146, 142, 151.
\textsuperscript{137} Bala \textit{et al.}, \textit{supra} note 4 at 142, 141; consider also Scully & Finlay, \textit{supra} note 94 at 16.
\textsuperscript{138} See Chapter One at 39 and related references.
\textsuperscript{139} Bala \textit{et al.}, \textit{supra} note 4 at 142, 147; consider also Scully & Finlay, \textit{supra} note 94 at 16.
Failure to Provide Services and Reliance on Psychotropic Medications

Just as mental health issues are prevalent amongst children engaged with the CAS,\textsuperscript{140} so too is the use of psychotropic medications prevalent amongst children in care.\textsuperscript{141} Psychotropic medications may be beneficial in alleviating the symptoms of a child’s mental health issue, often in a relatively quick and cost effective manner.\textsuperscript{142} However, the use of these medications can carry serious side effects for children, including drowsiness, lethargy, “cognitive dulling” (dulled senses, lack of concentration, slow responsiveness) and drug dependence.\textsuperscript{143} In some cases, rather than being prescribed to address the symptoms of a diagnosed mental disorder, psychotropic medications have been administered (involuntarily) to children because of the drugs’ sedative effects.\textsuperscript{144} Used in this way, psychotropic medications act as “chemical restraints” which serve to control the behaviour of “difficult” children.\textsuperscript{145} For example, as I described in Chapter Three, in \textit{R. v. M. (S.)} (“M. (S.)”), anti-psychotic medication was administered to control the behaviour of a thirteen-year-old crossover youth while she was in hospital awaiting a Court ordered assessment in connection with a criminal case.\textsuperscript{146} Like so many other crossover youth, the child in \textit{M. (S.)} had experienced multiple placements and had been living in a group home prior to being detained on criminal charges.\textsuperscript{147}

\textsuperscript{140} See Chapter One at 7 and related references.
\textsuperscript{142} Lambe, supra note 141 at 26.
\textsuperscript{144} Klein \textit{et al}, supra note 141 at 182; Lambe, \textit{supra} note 141 at 23; \textit{M (S)}, \textit{supra} note 123 at paras 11, 22, 26; consider also Lemmens & Sheldon, \textit{supra} note 143 at 241-42.
\textsuperscript{145} Lambe, \textit{supra} note 141 at 23; consider Lemmens & Sheldon, \textit{supra} note 143 at 241; \textit{M (S)}, \textit{supra} note 123 at paras 22, 25.
\textsuperscript{146} See Chapter Three at 117-18, 122 and related references.
\textsuperscript{147} See \textit{ibid} at 117-18, 85-86, 88 and related references; see also Bala \textit{et al}, \textit{supra} note 4 at 135-39; Scully & Finlay, \textit{supra} note 94 at 2-3.
The use of psychotropic medications has been found to be more prevalent in some residential placements (e.g. group homes) than others (e.g. foster homes). As I have discussed, children in group homes may face particularly complex and cyclical challenges, including behavioural and mental health issues. And, as I have also discussed, staff in group homes generally lack the skills and training (as well as access to the resources) necessary to deal with the complex challenges faced by the children placed in these residences. Similarly, while psychotropic medications may alleviate certain symptoms and control certain problematic behaviours, the use of pharmacotherapy on its own fails to acknowledge or address the various challenges faced by children engaged with the CAS.

The use of psychotropic medications to address the mental health and behavioural issues experienced by children in care is in keeping with, and reflective of, the medical orientation adopted in the CYFSA. The reliance on psychotropic medications is consistent with the focus in the medical model on individual illnesses and individual medical cures. The child’s problematic mental states or behaviours are conceptualized as an illness or disorder occurring within the child and requiring treatment through individual medical intervention namely, psychotropic medication. Viewing their mental health issues through a medical model fails to acknowledge or address the various other complex challenges faced by children in care. Relying on psychotropic medications exclusively, without engaging other therapeutic interventions (e.g. talk therapy) or the supports and services needed to address the additional

148 Klein et al, supra note 141 at 182; consider also Lambe, supra note 141 at 23.
149 Supra at 152-53 and related references.
150 See Chapter One at 30 and related references; Lambe, supra note 141 at 22.
151 Lambe, supra note 141 at 24, 20, 26; Klein et al, supra note 141 at 181-83.
152 I discuss the medical model and the ways the legislative definitions of mental health issues in the CYFSA and YCJA and Criminal Code reflect a medical orientation in detail in Chapter Two.
153 See Chapter Two at 62-65 and related references.
154 Consider Lambe, supra note 141 at 25, 30; Klein et al, supra note 141 at 178, 181; See Chapter Two at 73-74 and related references; Chapter Three at 113.
difficulties experienced by children in care (e.g. histories of maltreatment and trauma, educational issues) fails to adequately address the mental health and other needs of these children.155

Meeting the complex needs of children in care requires the engagement of various professionals and agencies.156 In addition to child welfare and mental health services, the children engaged with the CAS may need supports and services related to educational needs, physical health issues, drug and alcohol addictions, and engagement with the criminal justice system, amongst others.157 Effectively serving these children and bridging the gaps that allow so many of them to “fall through the cracks” requires an integrated approach, with various professionals and agencies working collaboratively to develop and implement coordinated plans that provide these children with the various supports and services (e.g. housing, counselling, educational supports) they need.158 This would allow children’s needs to be more adequately met, and likely result in fewer children in care crossing over into the criminal justice system.159

Summary: The Statutory Mandate, Decision Making, and Individualistic Interventions

The mandate of the CAS is to protect children and promote their well-being and, where not in conflict with these obligations, to support families. In carrying out this mandate child protection workers make a series of decisions, from whether to investigate a claim of maltreatment or risk of harm to what, if any, ongoing services to provide. While operating within the overarching governance of the statute and related guidelines, child protection workers

155 Lambe, supra note 141 at 20, 26, 30; Klein et al, supra note 141 at 178, 181; consider also Scully & Finlay, supra note 94 at 16; Bala et al, supra note 4 at 141, 144.
156 Bala et al, supra note 4 at 144, 133, 146; Scully & Finlay, supra note 94 at 8-9; Filippelli et al, “Infants and Ongoing Services”, supra note 15 at 12; Davis et al, supra note 132 at 178; Filippelli et al, “Infants Investigated”, supra note 8 at 1-2; Herz, Ryan & Bilchik, supra note 132 at 305.
157 Sully & Finlay, supra note 94 at 25, 2-3, 15; Bala et al, supra note 4 at 130, 134-40; Doucet, Marion & Trocmé, supra note 131 at 4, 5; Herz et al, supra note 94 at 2, 21; Tonmyr et al, supra note 14 at 493; Klein et al, supra note 141 at 178, 183.
158 Bala et al, supra note 4 at 147, 144, 151; Scully & Finlay, supra note 94 at 15-16, 9; Chuang & Wells, supra note 99 at 1815; Klein et al, supra note 141 at 178, 183.
159 Consider Bala et al, supra note 4 at 144, 142; Scully & Finlay, supra note 94 at 15-16.
retain considerable agency in the decisions they make. Child protection workers’ decisions can have lifelong positive or negative consequences on children and families. Their choices can mean the difference between whether a child gets the supports and services they need to thrive or whether they are cast into a vicious cycle where the complex challenges they experience (e.g. mental health issues, learning difficulties) are exacerbated and compounded.

Where underpinned by a medical model, decisions about the causes of, and appropriate responses to, children’s behavioural or mental health issues are guided by the characterization of problematic behaviours and mental states as illnesses within the individual child, requiring medical intervention namely, psychotropic medications. The exclusive use of medical interventions (in the form of medications) to deal with the mental health issues experienced by children engaged with the CAS, fails to appreciate or adequately address the numerous complex challenges, including the mental health issues, faced by these children. I discuss the need to acknowledge and address these various challenges further in the next Chapter, where I explore how a failure to consider intersectionality in the family law (child welfare) and criminal justice systems results in the failure to adequately protect the children with mental health issues who are engaged with these systems.
**Chapter Five**

**Intersectionality: A Means to Stop Compounding Disadvantages and Instead Address the Needs of Children with Mental Health Issues who are Engaged with the Family Law and Criminal Justice Systems**

**Introduction**

In the preceding Chapters I have discussed and illustrated the failure of the family law (child welfare) and criminal justice systems to protect children with mental health issues adequately. I have described the ways different mental states are characterized and defined in the *Child, Youth and Family Services Act, 2017*[^1] (“CYFSA”) and in the *Youth Criminal Justice Act*[^2] (“YCJA”) and *Criminal Code*,[^3] and how these definitions reflect and adopt the individual focus and medical orientation of the medical model. And, I have reviewed the implementation of these legislative provisions in child welfare and criminal justice proceedings and by Children’s Aid Societies (“CAS”), and examined the resulting (often negative) outcomes experienced by children with mental health issues. In this Chapter, I further elucidate and demonstrate how the statutory definitions of mental health issues that are incorporated into the written law and are implemented by the family law (child welfare) and criminal justice systems, jeopardize the possibility of a positive outcome for children with mental health issues who are engaged with these systems. Specifically, I demonstrate how a failure to consider intersectionality in the family law (child welfare) and criminal justice systems results in a failure to adequately protect children with mental health issues.

I begin by providing an overview of what intersectionality means and illustrate what an intersectional analysis involves, using the consideration of determinants of mental health as an example. Next, I explore how children engaged with the family law (child welfare) and criminal

justice systems are treated as generic and why statutory remedies aimed at addressing discriminatory outcomes actually perpetuate oppression. Then, I review the demographics and characteristics of children involved with the CAS and in the criminal justice system, describe why an intersectional analysis is required when dealing with this population, and demonstrate the consequences of the failure to undertake this analysis. Finally, I consider what the adoption of a truly intersectional analysis would mean for the protection of children with mental health issues who are engaged with the family law (child welfare) and criminal justice systems.

**Intersectionality**

**Intersectionality: A Theoretical Paradigm**

Intersectionality is a theoretical paradigm that draws attention to the “dynamics of difference and sameness”, exploring how various different characteristics interact (intersect) to produce various power dynamics and interlocking oppressions.4 The paradigm is premised on the notion that individuals’ social positions or locations are shaped and defined by various characteristics: race, ethnicity, class, gender, sexual orientation, age, culture, (dis)ability, religion, etc.5 Rejecting the notion that social position is defined by any single characteristic (e.g. wealth), intersectionality looks to how various characteristics (e.g. race, gender) intersect to marginalize some and empower others.6 As Catharine A. MacKinnon explains, “intersectionality both notices and contends with the realities of multiple inequalities as it thinks

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about ‘the interaction of’ those inequalities in a way that captures the distinctive dynamics at their multidimensional interface”.7

Intersectionality exposes how viewing inequality along a single axis of power or axis of discrimination (e.g. race) overlooks the cumulative interaction between various axes of power or axes of discrimination (e.g. race and gender) and the inequalities and experiences this produces.8 In this way, the paradigm recognizes that various oppressions or inequalities may overlap and intersect, combining to shape and compound the differential “life chances” of individuals.9 In considering interlocking oppressions and inequalities, intersectionality examines not only the “additive effects” (sum) of two or more characteristics (e.g. race, class, gender), but also the “joint” (multiplicative) effects the interaction of different characteristics may have in constructing and constraining individuals’ choices and the circumstances in which their lives are embedded.10

Intersectionality calls attention to the role of societal structures and systems in the subordination and marginalization of individuals, and the (re)production of power dynamics and the conditions in which interlocking oppressions and inequalities occur.11 With respect to the legal system for example, intersectionality considers how statutory provisions purporting to be neutral may, in fact, create and uphold inequalities and shape individuals’ “life chances”.12

7 MacKinnon, supra note 6 at 1019; see also Cairney, Veldhuizen & Wade, supra note 5 at 56.
8 MacKinnon, supra note 6 at 1020; Cho, Williams Crenshaw & McCaIl, supra note 4 at 787, 795; Cairney, Veldhuizen & Wade, supra note 5 at 56; Williams, supra note 6 at 80-81.
9 Cho, Williams Crenshaw & McCaIl, supra note 4 at 788, 800, 803; MacKinnon, supra note 6 at 1020-21; Cairney, Veldhuizen & Wade, supra note 5 at 57, 64; Brown, Jones & Greiner, supra note 4 at 157.
10 Brown, Jones & Greiner, supra note 4 at 156; Cairney, Veldhuizen & Wade, supra note 5 at 57; MacKinnon, supra note 6 at 1028; Minaker, supra note 5 at 304.
11 Cho, Williams Crenshaw & McCaIl, supra note 4 at 797; MacKinnon, supra note 6 at 1020; Cairney, Veldhuizen & Wade, supra note 5 at 64; consider also Brown, Jones & Greiner, supra note 4 at 157; see also Minaker, supra note 5 at 301.
12 Cho, Williams Crenshaw & McCaIl, supra note 4 at 798, 800; Naomi Nichols & Jessica Brainmoh, “Community Safety, Housing Precariousness and Processes of Exclusion: An Institutional Ethnography from the Standpoints of Youth in an ‘Unsafe’ Urban Neighbourhood” (2018) 44 Crit Sociol 157 at 159; I explore this phenomenon in detail below, in relation to the statutory provisions in the CYFSA and YCJA.
Intersectionality also considers how laws and social policies purportedly designed to address inequality, in practice, continue to perpetuate discrimination and marginalization.  

**Determinants of Mental Health**

Intersectional analysis seeks to understand how the interaction of various characteristics produce multiplicative effects that shape and re-shape power dynamics and experiences of overlapping oppressions and inequalities. Thus, in considering the occurrence and nature of mental health issues from an intersectional perspective, rather than focus solely on, for example, individual biological causes, an intersectional analysis inquires into how various characteristics (or related social positions) influence incidents of mental health issues and what these associations say about causation. Studies that have considered the relationship between mental health and various characteristics and social positions (e.g. gender, marital status, race, ethnicity, socioeconomic status) suggest that mental health issues (i.e. disorders) are more prevalent amongst individuals occupying disadvantaged social positions. Research focused specifically on children has similarly suggested the existence of links between socioeconomic disadvantages (e.g. poverty, inadequate housing, single-parent family structure) and the extent of children’s mental health issues.

The links between social positions and mental health have often been explained by theories of “social selection” or “social causation”, or a combination of both. Social selection

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13 Williams, *supra* note 6 at 81-82, 95; I also explore this phenomenon below.
14 See Brown, Jones & Greiner, *supra* note 4 at 179; Cho, Williams Crenshaw & McCall, *supra* note 4 at 795; MacKinnon, *supra* note 6 at 1020; Cairney, Veldhuizen & Wade, *supra* note 5 at 57.
16 Cairney, Veldhuizen & Wade, *supra* note 5 at 50; Aneshensel, Phelan & Bierman, *supra* note 15 at 10, 12.
posits that mental health issues (disorders) may produce different social positions (e.g. an
dividuals’ mental health issues impair their ability to earn an income, causing them to live in
poverty). Social causation on the other hand, posits that challenges or disadvantages related to
social positions may cause mental health issues (e.g. exposure to stress and/or adversity increases
the risk of mental health issues developing). With the emergence of research indicating that
many mental health issues (i.e. diagnosed disorders, such as schizophrenia) are significantly
affected by genetics and other biological factors, many researchers now focus on understanding
the interaction between biology and social environment and the relevance of each in regards to
specific disorders (e.g. schizophrenia versus post-traumatic stress disorder). In many cases, the
risk or occurrence of mental health issues is influenced by the existence or absence and
interaction of various factors (e.g. genetics, class, trauma, stress, age, exposure to toxins) and
mental “disorders” may both produce and be the product of different characteristics and social
positions.

In addition to having an effect on, or being affected by, the occurrence of mental health
issues, different characteristics and related social positions also can affect the experience and
impact of mental health issues and the interactions an individual has with professionals and
institutions (e.g. psychiatrists, hospitals). Different characteristics or social positions may
affect whether individuals will see themselves and/or will be diagnosed (labelled) as “mentally
ill” (i.e. whether their behaviours or mental states will be characterized as symptomatic of a

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19 Cairney, Veldhuizen & Wade, supra note 5 at 50; Aneshensel, Phelan & Bierman, supra note 15 at 10.
20 Cairney, Veldhuizen & Wade, supra note 5 at 50; Aneshensel, Phelan & Bierman, supra note 15 at 13.
21 Cairney, Veldhuizen & Wade, supra note 5 at 50, 51.
22 Ibid at 51-53; consider also Melissa Van Wert et al, “Which Maltreated Children are at Greatest Risk of Aggressive and Criminal
Behavior? An Examination of Maltreatment Dimensions and Cumulative Risk” (2017) Child Abuse & Negl 49 at 50; Children’s Aid
Society of Sudbury & Manitoulin (Districts) v D (D) (1997), 75 ACWS (3d) 862, 1997 CarswellOnt 5089 (WLNextCan) (ONCJ (Prov
Div)) [D (D)] at para 15.
23 Aneshensel, Phelan & Bierman, supra note 15 at 10, 2; Cairney, Veldhuizen & Wade, supra note 5 at 51, 57.
mental “disorder”). They may affect help-seeking (i.e. whether assistance is sought) and the nature and type of any treatment that is pursued (e.g. psychotherapy, pharmacotherapy). And, an individual’s characteristics and related social positions may affect the availability and accessibility of, or barriers to (e.g. costs, lack of transportation), treatment.

The False Construct of the Generic Child

Statutory Remedies Perpetuating Interlocking Oppression and Inequality

On paper, many of the statutory provisions relating to children (e.g. “in need of protection” provisions) appear to be “neutral”, while others purport to address documented oppression and inequality (e.g. sentencing provisions aimed at counteracting the overrepresentation of Aboriginal youth in custody). However, in practice these provisions – both those that are “neutral” and those aimed at rectifying oppression and inequality – may maintain or compound the discrimination and disadvantages experienced by marginalized individuals. This may occur where laws purporting to be “neutral” are applied “equally”, without regard for the interlocking inequality and oppression produced through the interaction of various characteristics or for the role of legal (and other social) systems and structures in creating and perpetuating the subordination of certain individuals. For example, Judith Mosoff et al argue that “the experience of Indigenous mothers reveals a history of colonialist and racist processes of regulation of Indigenous families, yet child protection law tends to erase this history

25 Aneshensel, Phelan & Bierman, supra note 15 at 2; Cairney, Veldhuizen & Wade, supra note 5 at 57.
26 King et al, supra note 24 at 91; Aneshensel, Phelan & Bierman, supra note 15 at 13.
27 Consider Cho, Williams Crenshaw & McCall, supra note 4 at 798, 800; Nichols & Braimoh, supra note 12 at 159; Judith Mosoff et al, “Intersecting Challenges: Mothers and Child Protection Law in BC” (2017) 50 UBC L Rev 435 at 438-39; Raymond R Corrado, Sarah Kuehn & Irina Margaritescu, “Policy Issues Regarding the Over-representation of Incarcerated Aboriginal Young Offenders in a Canadian Context” (2014) 14 Youth Justice 40 at 42; Williams, supra note 6 at 80; CYFSA, supra note 2, ss 38(2)(d), 50(1), 3(1)(c)(iv); Criminal Code, RSC 1985, c C-46, supra note 3, s 718.2(e).
28 Consider Cho, Williams Crenshaw & McCall, supra note 4 at 798, 800; Nichols & Braimoh, supra note 12 at 159; see Mosoff et al, supra note 27 at 438-39; Corrado, Kuehn & Margaritescu, supra note 27 at 42; Williams, supra note 6 at 80.
29 Consider Cho, Williams Crenshaw & McCall, supra note 4 at 797, 798; Brown, Jones & Greiner, supra note 4 at 157, 179; Mosoff et al, supra note 27 at 438-40; Nichols & Braimoh, supra note 12 at 159.
through the supposedly neutral application of the best interests of the child standard, the key legal principle in child protection law”. 30

Laws purportedly aimed at rectifying inequality and oppression may similarly be applied in a manner that overlooks or masks the unequal power dynamics embedded in legal (and other social) systems and structures and that, rather than remedying them, compounds the disadvantages experienced by marginalized and subordinated individuals. 31 For example, in an effort to curb the over-representation of Aboriginal youth in custody facilities, sentencing provisions discouraging the use of custody and requiring judges to pay “particular attention to the circumstances of aboriginal young persons” were included in the YCJA. 32 However, as Raymond R. Corrado, Sarah Kuehn and Irina Margaritescu observe, the sentencing provisions as well as many other policies aimed at “addressing the over-representation of Aboriginal offenders have been unsuccessful” and, in some instances, these policies “have even pronounced [Aboriginal youths’] adverse situation in the criminal justice system”. 33

The failure of statutory provisions to achieve their remedial aims and the production of worse outcomes for the target population may be due at least in part 34 to the manner in which these statutory provisions are applied, and particularly how information about the circumstances of the individual is interpreted. 35 In the criminal justice system (and in the family law system) risk assessment may factor prominently in decision making, both at the sentencing stage and at

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31 Consider Williams, supra note 6 at 80, 87; Mosoff et al, supra note 27 at 438; Corrado, Kuehn & Margaritescu, supra note 27 at 42, 53; Nichols & Braimoh, supra note 12 at 159; Cho, Williams Crenshaw & McCall, supra note 4 at 797.
32 Corrado, Kuehn & Margaritescu, supra note 27 at 42; YCJA, supra note 2, ss 38(2)(d), 50(1); see also Williams, supra note 6 at 80.
33 Corrado, Kuehn & Margaritescu, supra note 27 at 42, 41; see also Williams, supra note 6 at 80.
34 Sentencing decisions may also be influenced by, amongst other things, policy and administrative decisions in the criminal justice and other systems (e.g. lack of available therapeutic programs or other supports and services) (consider Williams, supra note 6 at 88; R v S (R), 2014 ONSC 4279, 121 WCB (2d) 623 at paras 8-14; R v D (WAL), 2004 SKPC 40, 245 Sask R 98 [D (WAL)] at paras 87-89).
35 Williams, supra note 6 at 80, 87; Corrado, Kuehn & Margaritescu, supra note 27 at 55, 53.
earlier decision making points in the process.\textsuperscript{36} Where criminogenic risks and needs (e.g. individual level risk factors for criminality) are assessed without taking account of the role of social structures and systems in creating and perpetuating the circumstances experienced by marginalized individuals, intersecting oppressions and inequalities may be masked and the disadvantages experienced by the individual may be seen as “risk factors”.\textsuperscript{37}

Where the disadvantages or inequalities experienced by an individual are construed as risk factors, a link may be drawn between the individuals’ circumstances and the likelihood of criminal behaviour.\textsuperscript{38} In the context of remedial sentencing provisions this can mean that the circumstances the statute is aimed at addressing (oppression and inequality) and that the Court is mandated to consider, are seen as individual level risk factors which militate in favour of harsher sanctions (e.g. custodial sentences) to contain and reduce the (perceived) risk posed by the individual.\textsuperscript{39} The perpetuation of interlocking oppression and inequality may be particularly pronounced for minority groups (e.g. female or Aboriginal children) as assessments of risk are speculative and may be “morally laden subjective assessments” and reflective of “white, Western middle class judgement”.\textsuperscript{40}

The characterization of a child’s or family’s circumstances (experiences of interlocking oppression and inequality) as risk factors may similarly militate in favour of more intrusive State intervention or scrutiny in the child welfare context.\textsuperscript{41} For example, as Mosoff et al argue,

\textsuperscript{36} Corrado, Kuehn & Margaritescu, supra note 27 at 53; Minaker, supra note 5 at 300; Williams, supra note 6 at 80; consider also YCJA, supra note 2, Preamble.
\textsuperscript{37} Minaker, supra note 5 at 300; Williams, supra note 6 at 80, 87, 94, 95; Corrado, Kuehn & Margaritescu, supra note 27 at 53; regarding criminogenic risks and needs, see also Sarah McCormick, Michele Peterson-Badali & Tracey A Skilling, “Mental Health and Justice System Involvement: A Conceptual Analysis of the Literature” (2015) 21 Psychol Pub Pol’y & L 213 at 214; Michele Peterson-Badali et al, “Mental Health in the Context of Canada’s Youth Justice System” (2015) 19 Can Crim L Rev 5 at 11-12.
\textsuperscript{38} Minaker, supra note 5 at 300; Williams, supra note 6 at 80, 87; Corrado, Kuehn & Margaritescu, supra note 27 at 53; consider also Nicholas Bala et al, “Child Welfare Adolescents & the Youth Justice System: Failing to Respond Effectively to Crossover Youth” (2015) 19 Can Crim L Rev 129 at 140.
\textsuperscript{39} Williams, supra note 6 at 92, 80, 87; see also Corrado, Kuehn & Margaritescu, supra note 27 at 53; Minaker, supra note 5 at 300.
\textsuperscript{40} Corrado, Kuehn & Margaritescu, supra note 27 at 53; see also Minaker, supra note 5 at 300.
\textsuperscript{41} Mosoff et al, supra note 27 at 438.
“[p]oor, single mothers especially are constructed as a ‘‘risk class’…who can legitimately be intruded upon, scrutinized indefinitely and held to account for their daily activities’’. This increased scrutiny may be imposed also on families perceived as experiencing other or additional risk factors, such as intimate partner violence, caregiver mental health or addiction issues, child functioning issues, etc. The Courts have recognized that, as Justice O’Connell stated in *Children’s Aid Society, Region of Halton v. W. (A.)*, “[i]t is important not to judge the parent by a middle-class yardstick, one that imposes unrealistic and unfair middle-class standards of child care upon a poor parent of extremely limited potential, provided that the standard used is not contrary to the child’s best interests”. However, in some cases Courts nevertheless have found that child protection workers may have imposed “middle class standards” on caregivers in assessing their parenting capacities.

**Othering**

The ways the children and families that become engaged with the family law (child welfare) and criminal justice systems are seen, and how their issues or problems are framed, may be influenced by various (intersecting) characteristics and social positions. In assessing and making decisions about the children and families with whom they come into contact, child protection workers and judges (amongst others) may be influenced, often unconsciously, by perceptions and biases about marginalized individuals and groups. These often unconscious

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42 Ibid; consider also Sinha et al, supra note 30 at 822-23; D (D), supra note 22 at para 29.
43 Mosoff et al, supra note 27 at 440, 444; consider also D (D), supra note 22 at paras 29-33.
44 *Children’s Aid Society, Region of Halton v W (A)*, 2016 ONCJ 358, 268 ACWS (3d) 585 [W (A)] at para 292; consider also D (D), supra note 22 at para 14.
45 Eg W (A), supra note 44 at para 292; consider also D (D), supra note 22 at para 14; King et al, supra note 24 at 89.
46 See Minaker, supra note 5 at 296; Theresa Glennon, “The Developmental Perspective and Intersectionality” (2016) 88 Temp L Rev 929 at 930-31; Brown, Jones & Greiner, supra note 4 at 164; consider also Michael L Perlin & Alison J Lynch, “‘She’s Nobody’s Child/The Law Can’t Touch Her At All’: Seeking to Bring Dignity to Legal Proceedings Involving Juveniles” (2018) 56 Fam Ct Rev 79 at 87-88.
47 See Perlin & Lynch, supra note 46 at 87-88; Glennon, supra note 46 at 930-31; Rashmi Goel, “Delinquent or Distracted – Attention Deficit Disorder and the Construction of the Juvenile Offender” (2009) 27 Law & Ineq 1 at 38-39; Thomas A Mayes, “Understanding Intersectionality between the Law, Gender, Sexuality and Children” (2016) 36 Child Legal Rts J 90 at 101.
perceptions and biases may reflect dominant (majority) societal views and stereotypes about
minority groups, conceptions which may be embedded in social structures and systems and may
inform dominant notions of what constitutes “normal” or “acceptable” ways of being (e.g.
acceptable behaviour, normal mental states).48

The way an individual is perceived may affect how behaviours (e.g. delinquent acts) are
interpreted and whether they are attributed to individual (internal) factors or environmental
(external) factors.49 Attributions as to cause(s) of behaviour, may in turn affect the level of
responsibility ascribed to the individual for their actions.50 For example, where a child has been
found guilty of a criminal act and their behaviour is attributed to internal causes, they may be
seen to be more responsible for their actions (and more dangerous) and their sentence fashioned
accordingly.51

The injustice and oppression experienced as a result of the intersection of various
characteristics by marginalized children and families, is often imbedded in the very systems that
are mandated to protect and assist them.52 Practices that, though likely not overtly
discriminatory, perpetuate inequality and oppression may permeate the family law (child
welfare) and criminal justice systems and affect decisions made along the service continuum,
including school personnel’s decisions to make reports to the CAS, police officers’ decisions
regarding arrests and diversion, child protection workers’ decisions regarding intervention and
service provision, and judges’ remand and sentencing decisions.53 Where decisions are affected

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48 Consider Glennon, supra note 46 at 930-31; Corrado, Kuehn & Margaritescu, supra note 27 at 53; Minaker, supra note 5 at 300; Goel,
supra note 47 at 38-39; Mayes, supra note 47 at 101; Lars Noah, “Pigeonholing Illness: Medical Diagnosis as a Legal Construct” (1999)
50 Hastings LJ 241 at 244-45; Aneshensel, Phelan & Bierman, supra note 15 at 3.
49 Clair White, “Incarcerating Youth with Mental Health Problems: A Focus on the Intersection of Race, Ethnicity, and Mental Illness”
(2016) 14 Youth Violence Juv Justice 426 at 430.
50 Ibid.
(2017) 54 Alta L Rev 831 at 841.
52 See Glennon, supra note 46 at 931; Cho, Williams Crenshaw & McCall, supra note 4 at 797; Minaker, supra note 5 at 292, 300.
53 Glennon, supra note 46 at 931; King et al, supra note 24 at 91, 100; Goel, supra note 47 at 38-39; Mosoff et al, supra note 27 at 438-
39; Corrado, Kuehn & Margaritescu, supra note 27 at 41, 53-55; Nichols & Braimoh, supra note 12 at 161-62.
by attributions made on the basis of (unconscious) perceptions and biases or stereotypes associated with the characteristics and social positions of the child or their family, interlocking oppression and inequality may be perpetuated, and marginalized individuals further disadvantaged.54

The Multifaceted Child: Overlooked Complexities

Characteristics and Demographics: A Picture of Interlocking Oppression and Inequality

Children who are engaged with the family law (child welfare) and criminal justice systems, particularly those with mental health issues, often face numerous challenges (e.g. trauma, poverty, cognitive impairments, etc.).55 Children who are taken into care by the CAS have been subjected (or, at least have been determined to have been subjected) to some form(s) of maltreatment or risk of harm (e.g. physical, sexual or emotional abuse, neglect).56 Research suggests that children who are exposed to maltreatment are at an increased risk of experiencing behavioural, mental health, and/or substance abuse issues and of becoming involved in the criminal justice system.57 Research also suggests that the occurrence and nature of the given (negative) outcomes actually experienced by maltreated children is often related to the interaction of a variety of factors (e.g. genetics, age, type, severity and chronicity of maltreatment, poverty, parental functioning issues).58

54 Consider Goel, supra note 47 at 37-39, 52; White, supra note 49 at 430, 438-39.
56 Scully & Finlay, supra note 55 at 2; Van Wert et al, supra note 22 at 50; Bala et al, supra note 38 at 135.
57 Van Wert et al, supra note 22 at 50, 58; see Chapter Two at 26-31 and related references.
58 Van Wert et al, supra note 22 at 50; Bala et al, supra note 38 at 135; as I describe below, the outcomes experienced by maltreated children may also be shaped by the provision, or failure to provide, adequate supports and services (consider Scully & Finlay, supra note 55 at 2, 25; Bala et al at 139; Van Wert et al at 59; Melissa Jonson-Reid & Richard P Barth, “From Maltreatment Report to Juvenile Incarceration: The Role of Child Welfare Services” (2000) 24 Child Abuse & Negl 505 at 519).
While each child is an individual with unique life experiences, the disproportionate prevalence of certain characteristics and environmental factors amongst children in care is notable. The majority of children in care experience mental health issues, and the rate of mental health issues is higher amongst this population than children who are not engaged with the CAS. Many children who are engaged with the CAS come from single parent families, and from households struggling with poverty, repeated moves, lack of social supports, and/or caregiver functioning issues (e.g. mental health or addiction issues).

Children of certain racial or ethnic backgrounds are, as Bryn King et al argue, “more likely to be referred for suspected maltreatment, to be substantiated as victims, to be placed in out-of-home care, and to remain in care for longer periods of time than White children”. For example, studies suggest that Aboriginal children are investigated at considerably higher rates than non-Aboriginal children and that they comprise a disproportionate number (an overrepresentation) of children in care. Research also suggests that Black children are more likely to be reported to CAS and to be investigated than White children and also are

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59 Consider Bala et al, supra note 38 at 134.
60 See Chapter One at 7 and related references.
62 King et al, supra note 24 at 89, 91; consider also Scully & Finlay, supra note 55 at 5; Joseph P Ryan et al, “Maltreatment and Delinquency: Investigating Child Welfare Bias in Juvenile Justice Processing” (2007) 29 Child Youth Serv Rev 1035 at 1037, 1047; Denise C Herz et al, Addressing the Needs of Multi-System Youth: Strengthening the Connection Between Child Welfare and Juvenile Justice (Washington DC: Center for Juvenile Justice Reform, 2012) at 16; it is beyond the scope of this Thesis to discuss the explanations for the overrepresentation of certain racial or ethnic minorities, in both the family law (child welfare), and criminal justice systems (e.g. racial bias, over-policing, intergenerational impact of colonialism) (see Sinha et al, supra note 30; Corrado, Kuehn & Margaritescu, supra note 27).
overrepresented (in comparison to the proportion of Black children in the general population) in terms of rates of substantiation, referral to ongoing services, and out-of-home placement. And, racial and ethnic disproportionality and disparity also has been observed in the criminal justice system and in rates of detention, with Aboriginal children and Black children being overrepresented in this system as well.

A disproportionate prevalence of mental health issues also has been observed in the criminal justice system, with children (with various backgrounds and demographics) who are engaged with this system experiencing considerably higher rates of mental health issues than do their counterparts in the general population. Many children who become engaged with the criminal justice system have experienced trauma and a disproportionate number are involved with the CAS (in many cases having been placed in group homes). Once these children, particularly those in group homes, have been involved with the criminal justice system, many tend to become enmeshed in a “vicious cycle” or “revolving door” that sees them repeatedly coming before the criminal Courts.

Interlocking Oppression and Inequality: Systemic Perpetuation

Individual and environmental factors may act to insulate children from experiencing the risks associated with challenges and disadvantages (e.g. childhood trauma) or they may act as aggravating factors, increasing children’s vulnerability and the likelihood they will experience...
negative outcomes (e.g. aggression, engagement in the criminal justice system). The nature of the outcomes experienced by children who have been maltreated may be shaped by the intersection of various individual and environmental factors (e.g. genetics, gender, socioeconomic status, treatment provision). As Melissa Van Wert et al note, “[t]he accumulation and interaction of negative influences at the individual, family, neighborhood, and societal levels are generally considered more detrimental to child development than any single risk or disadvantage”.

Children who are engaged with the family law (child welfare) and criminal justice systems often face multiple challenges and disadvantages, including trauma (e.g. abuse, neglect), childhood functioning issues (e.g. mental health issues, learning difficulties), poverty, multiple housing disruptions, lack of social supports, etc. The prevalence and extent of the challenges and disadvantages experienced by these children may be compounded and exacerbated (or ameliorated) by the child and family’s characteristics and social positions (e.g. race, sexual orientation, socioeconomic status, access to resources). For example, King et al found that “Black children reported for maltreatment-related concerns in Ontario in 2013 also experienced a number of socioeconomic risk factors in excess of their White counterparts”, with Black families being “less likely to be working full time or living in their own home, but more likely to receive social assistance or other benefits, experience severe economic hardship, and live in

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69 See Van Wert et al, supra note 22 at 50; consider also Cairney, Veldhuizen & Wade, supra note 5 at 51-53; Mayes, supra note 47 at 91.
70 See Van Wert et al, supra note 22 at 50; Goel, supra note 47 at 28; Corrado, Kuehn & Margaritescu, supra note 27 at 41; consider also Cairney, Veldhuizen & Wade, supra note 5 at 51-53; Mayes, supra note 47 at 91.
71 Van Wert et al, supra note 22 at 50.
72 Smith et al, “Role Specialization and Service Integration”, supra note 55 at 139; Tonmyer et al, supra note 55 at 493; Bala et al, supra note 38 at 130, 134-35; Scully & Finlay, supra note 55 at 25-26, 2-3; Van Wert et al, supra note 22 at 50; Smith et al, “Child Welfare Organizations: Placement Decisions”, supra note 61 at 574; Jud, Fallon & Trocmé, supra note 61 at 983, 987, 988; Filippelli et al, “Infants and Ongoing Services”, supra note 61 at 3, 10; Filippelli et al, “Infants Investigated”, supra note 61 at 4; Fallon et al, “Opportunities for Prevention”, supra note 61 at 11, 12; Stoddart et al, supra note 61 at 2, 6, 7; Mosoff et al, supra note 27 at 440.
73 King et al, supra note 24 at 101-02; Sinha et al, supra note 30 at 823, 828-29; Corrado, Kuehn & Margaritescu, supra note 27 at 41; consider also Mayes, supra note 47 at 91; Van Wert et al, supra note 22 at 50; White, supra note 49 at 438; Goel, supra note 47 at 34; Brown, Jones & Greiner, supra note 4 at 164.
overcrowded housing”. In other words, the context in which children and families become engaged with the family law (child welfare) and criminal justice systems, and their experiences in these systems, may be shaped by the “intersectional impact” of various factors, including poverty, racism, and sexism.

Consequences of Failing to Recognize the Individual is More Than the Sum of Its Parts

While certain patterns are discernable, not all maltreated children face the same challenges and disadvantages, and individual children will respond differently to the intersection of different individual and environmental factors. Personalizing the issues experienced by maltreated children, and acknowledging them only at the individual level (e.g. diagnosis of a mental “disorder” within the child), ignores and perpetuates societal discrimination and the interlocking oppressions and inequalities in which children’s lives are embedded. This narrow focus excludes from consideration the structural and systemic factors that condition the experiences of the child (and family), and that create or heavily contribute to the circumstances that bring the child (and family) to the attention of the legal system.

In order to be able to understand and to adequately address the needs of children with mental health issues who are engaged in the family law (child welfare) and criminal justice systems, it is important to consider and address cumulative individual and environmental factors. Thus while, for example, psychotropic medications may help to alleviate the negative

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74 King et al, supra note 24 at 101; “[s]evere economic hardship” was defined as “running out of money for food, utilities, or housing” (Ibid). It is beyond the scope of this Thesis to discuss the structural and systemic factors relating to the higher rates of poverty amongst various marginalized groups (see ibid at 102).
75 See ibid at 101-03; Sinha et al, supra note 30 at 822-23, 828-29; Corrado, Kuehn & Margaritescu, supra note 27 at 41, 53; Goel, supra note 47 at 40, 52; White, supra note 49 at 438; Brown, Jones & Greiner, supra note 4 at 164.
76 Consider Mayes, supra note 47 at 91; Van Wert et al, supra note 22 at 50; Goel, supra note 47 at 51-52.
77 Consider Minaker, supra note 5 at 292, 293; Williams, supra note 6 at 95; Goel, supra note 47 at 51-52; Corrado, Kuehn & Margaritescu, supra note 27 at 53; Scully & Finlay, supra note 55 at 25.
78 See Goel, supra note 47 at 51-52; Minaker, supra note 5 at 292, 300-02; Mosoff et al, supra note 27 at 461, 438-39; Corrado, Kuehn & Margaritescu, supra note 27 at 53.
79 Consider Corrado, Kuehn & Margaritescu, supra note 27 at 53, 41; Van Wert et al, supra note 22 at 59; Mosoff et al, supra note 27 at 461, 438-39; Mayes, supra note 47 at 104-05, 92; Glennon, supra note 46 at 936; Cho, Williams Crenshaw & McCall, supra note 4 at 787-88; Nichols & Braimoh, supra note 12 at 159; Sinha et al, supra note 30 at 829.
“symptoms” experienced by a child with a mental health issue, addressing the matter solely with individual medical interventions (pursuant to the medical model) may not address the root causes of the mental health issue or assist in addressing the other challenges the child may be facing. In other words, in order to treat the “whole child” it is important to acknowledge and address not only single issues (e.g. a mental “disorder”), but also the existence or absence and intersection of the various other factors (e.g. trauma, poverty, sexual orientation) that may engender and shape the lived experiences of the child.

Thomas A. Mayes illustrates the need to account for various considerations with a number of case scenarios, including: “an LGBTQ [lesbian, gay, bisexual, transgender, or questioning] child with a physical disability is placed in a family foster home that is physically accessible; however, the family foster home does not have the resources to address the needs arising from the child’s sexual orientation or gender identity”, and “an LGBTQ child is set to be placed in an adoptive home of the child’s same race based on the child’s close identification with her heritage; however, the prospective adoptive family holds heterosexist views”. As Mayes goes on to ask, ultimately, which of these “children’s needs are met and which needs go unmet? Who answers this question? Fundamentally, why is this even a permissible question to ask?”

Unfortunately, the needs of many children with mental health issues who are engaged with the family law (child welfare) and criminal justice systems go unmet, often compounding and further exacerbating the disadvantages experienced by this extremely vulnerable population.

80 See Chapter Four at 155-57 and related references; Introduction at 9-11 and related references.
81 Consider Goel, supra note 47 at 51-52; Minaker, supra note 5 at 300; Mayes, supra note 47 at 104-06, 98, 92; Glennon, supra note 46 at 936; Van Wert et al, supra note 22 at 59; Corrado, Kuehn & Margaritescu, supra note 27 at 41, 53.
82 Mayes, supra note 47 at 106, 90; consider also Glennon, supra note 46 at 936.
83 Mayes, supra note 47 at 106.
Intersectional Analysis: Providing a Means to Protect Children with Mental Health Issues

An intersectional perspective recognizes the multiplicative effects of the intersection of various characteristics, and related social positions. Where an intersectional analysis is undertaken, underlying dominant (majority) perceptions and biases are questioned, the role of social structures and systems (e.g. the family law (child welfare) and criminal justice systems) in creating and sustaining marginalization and subordination are emphasized, and the interlocking oppressions and inequalities experienced by children and families are illuminated. Attention is drawn to the broad and overarching systemic issues (e.g. racism, patriarchy, economic inequality) that impact the lives of children and families and construct the “risk factors” that they experience (e.g. poverty, violence, family dysfunction, inadequate education). This analysis allows for a deeper and more contextual understanding of the complex needs of the children (and families) engaged with the family law (child welfare) and criminal justice systems, and exposes the potential of various services and systems (e.g. mental health, education) to more adequately meet those needs.

With early intervention and adequate supports and services, some of the trauma and consequences (e.g. less education, economic issues, poorer health, criminal activity) that arise from the compounding of disadvantages and the failure to meet the needs of the children (and families) engaged in the family law (child welfare) and criminal justice systems, may be

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85 Brown, Jones & Greiner, supra note 4 at 179; Cho, Williams Crenshaw & McCall, supra note 4 at 787, 795; Cairney, Veldhuizen & Wade, supra note 5 at 56; MacKinnon, supra note 6 at 1020-21; Mayes, supra note 47 at 92.
86 Cho, Williams Crenshaw & McCall, supra note 4 at 795-97; MacKinnon, supra note 6 at 1020-21; Minaker, supra note 5 at 292, 297-300; Cairney, Veldhuizen & Wade, supra note 5 at 63; Mayes, supra note 47 at 106.
87 Minaker, supra note 5 at 299-300.
88 Ibid at 302-04; Mayes, supra note 47 at 92; Glennon, supra note 46 at 931-32; Goel, supra note 47 at 4; Corrado, Kuehn & Margaritescu, supra note 27 at 54; King et al, supra note 24 at 102; Scully & Finlay, supra note 55 at 25.
avoided.\textsuperscript{89} Part of adequately meeting the needs of children with mental health issues who are engaged with these systems is the provision of appropriate mental health services and supports which address distressing mental states \textit{and} their underlying causes.\textsuperscript{90} However, in order to truly protect and promote the well-being of these children, the cumulative challenges they face must be holistically addressed.\textsuperscript{91} It is only once all of the cumulative needs of the children who are engaged with the family law (child welfare) and criminal justice systems are fully addressed, that either system may be said to truly be meeting their statutory mandates and obligations to protect children and promote their well-being.\textsuperscript{92}

\textbf{Summary: Intersectionality and Meeting Children’s Multifaceted Needs}

Intersectionality explores how various characteristics interact and produce cumulative effects that marginalize some and empower others, and how social structures and systems create and perpetuate these interlocking oppressions and inequalities. An intersectional analysis recognizes that the challenges and disadvantages experienced by marginalized individuals may be multiplicative and may be rooted in the systemic issues (e.g. racism, economic inequality) that construct the “risk factors” that bring many children and families to the attention of the family law (child welfare) and criminal justice systems (e.g. poverty, family dysfunction, mental health or addiction issues). Recognizing that the challenges faced by a child (and a family) may be

\textsuperscript{89} Boyle & Georgiades, \textit{supra} note 17 at 217-18; Goel, \textit{supra} note 47 at 4, 28, 52; Van Wert \textit{et al.}, \textit{supra} note 22 at 59; Scully & Finlay, \textit{supra} note 55 at 2, 25; Glennon, \textit{supra} note 46 at 940; Sinha \textit{et al.}, \textit{supra} note 30 at 829; \textit{D (WAL)}, \textit{supra} note 34 at para 42.


\textsuperscript{91} Van Wert \textit{et al.}, \textit{supra} note 22 at 59; Corrado, Kuehn & Margaritescu, \textit{supra} note 27 at 54; Bala \textit{et al.}, \textit{supra} note 38 at 131; consider also McCormick, Peterson-Badali & Skilling, \textit{supra} note 37 at 219; Davis, Peterson-Badali & Skilling, \textit{supra} note 90 at 18, 20-22.

\textsuperscript{92} Consider Mayes, \textit{supra} note 47 at 106; see also CYFSA, \textit{supra} note 1, ss 1, 35(1); \textit{YCJA}, \textit{supra} note 2, s 3.
interlocking and multiplicative allows for a broader understanding of needs and of the various supports and services required to adequately meet those needs.

The multifaceted needs of children with mental health issues who are engaged in the family law (child welfare) and criminal justice systems cannot be met adequately where a narrow focus, such as the individualistic focus embraced by the medical model (and, in many cases, by the family law (child welfare) and criminal justice systems), is adopted. Where, for example, a child is labelled as having a “mental disorder” and the cause is attributed to the child’s biology, the “illness” is addressed by individual medical intervention (namely psychotropic medication). While this may alleviate some of the negative “symptoms” of the “illness”, the characterization of a distressing mental state as an isolated, individual (medical) issue, masks the broader social disadvantages (e.g. poverty, racism) that may impact upon the child’s mental health. Where the interlocking oppressions and inequalities experienced by these children are overlooked or ignored, their needs may not be adequately met and they may be further disadvantaged. In order for the family law (child welfare) and criminal justice systems to protect children and promote their well-being, the intersecting challenges faced by the children engaged with these systems must be recognized, and addressed with adequate supports and services. Only then, will these systems stop perpetuating the disadvantages experienced by the children in their care and instead start meeting their statutory mandates and obligations to this vulnerable population.
Conclusion

Vicious Cycles: The Failure to Protect Children with Mental Health Issues and the Systemic Perpetuation of Interlocking Oppression and Inequality

The Problem

Children engaged with the family law (child welfare) and criminal justice systems are amongst the most vulnerable in society.\(^1\) Academic studies have shown that many of these children face multiple complex and intersecting challenges and disadvantages, including maltreatment (e.g. emotional, sexual and/or physical abuse, neglect), trauma, social marginalization and subordination (e.g. poverty, racism, sexism), caregiver functional issues (e.g. mental health or addiction issues), and instability (e.g. multiple placements).\(^2\) Academic studies also suggest that a significant and disproportionate number of these children experience mental health issues, and only a small number of them receive adequate supports and services.\(^3\) Researchers have found that the failure to meet their needs may expose these children, as well as society more generally, to severe and long lasting consequences (e.g. ongoing mental health issues, repeated engagement with the criminal justice system).\(^4\) Given the high prevalence of mental health issues amongst the children engaged with the family law (child welfare) and criminal justice systems and the often negative outcomes they experience, the relationship between the law and the failure to adequately protect these children needs to be better understood.

The State has a legal obligation to protect children from harm, including a failure to provide needed medical treatment, and can intervene with parental rights (e.g. to raise and make

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\(^1\) See Introduction at 7-9 and related references; Chapter One at 41-42 and related references; Chapter Four at 133-34 and related references; Chapter 5 at 169-70, 172 and related references.

\(^2\) See Introduction at 8 and related references; Chapter One at 41-42 and related references; Chapter Five at 169-72 and related references.

\(^3\) See Introduction at 7, 8 and related references; Chapter One at 44 and related references; Chapter Five at 174 and related references.

\(^4\) See Introduction at 4, 9-11 and related references, Chapter One at 28-29, 39 and related references; Chapter Four at 148, 153 and related references.
decisions for their children) where it is considered necessary to safeguard a child’s life or health.\(^5\) The prevalence of mental health issues amongst children (and families) engaged with the family law (child welfare) and youth criminal justice systems and the relevance of certain mental states is recognized in the governing statutes. The *Child, Youth and Family Services Act, 2017*\(^6\) (“CYFSA”) and the *Youth Criminal Justice Act*\(^7\) (“YCJA”) and *Criminal Code*\(^8\) contain provisions which authorize psychological assessments of children and establish parameters for determining which mental states may be legally relevant (e.g. for findings of “in need of protection” or fitness to stand trial on criminal charges).\(^9\) However, despite the prevalence of mental health issues amongst children engaged with the family law (child welfare) and criminal justice systems, and despite the State’s obligation to protect children from harm and the inclusion of legislative provisions aimed at addressing mental health issues, a significant proportion of these children still are not getting the mental health or other supports and services they need.

**Legislative Definitions: The Root of the Problem**

A review of the jurisprudence and literature reveals ongoing issues with diagnosis and treatment and the limited use of the statutory mental health provisions, and highlights the failure to identify children with mental health issues, the tendency to incarcerate these children, the lack of available services and supports, and the (over) use of psychotropic medications to treat and to restrain children.\(^10\) At the root of these problems is the way mental health issues are characterized and defined in the legislation governing both child welfare and criminal justice proceedings. While problematic in both systems, the way mental health issues are characterized

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\(^5\) See Introduction at 12 and related references; Chapter Four at 132-33 and related references.

\(^6\) *Child, Youth and Family Services Act, 2017*, SO 2017, c 14, Sched 1 (“CYFSA”).

\(^7\) *Youth Criminal Justice Act, SC 2002*, c 1 (“YCJA”).

\(^8\) *Criminal Code, RSC 1985*, c C-46.

\(^9\) CYFSA, supra note 6, ss 98, 74(2)(f)-(j), 164, 171; YCJA, supra note 7, ss 34, 42, 140, 141; *Criminal Code, supra* note 8, ss 2, 16(1), 672.11.

\(^10\) See Chapter Three at 93, 113-23 and related references; Chapter Four at 146-48, 153-57 and related references; Chapter Two at 74-75 and related references; Chapter One at 23-24, 34-36 and related references; Introduction at 5-7, 8-9 and related references.
and defined and the criteria that must be met in order for them to be considered legally relevant, differs as between these different areas of law.

The child welfare legislation, the CYFSA, provides that for “in need of protection” findings, “emotional harm” is defined as being “demonstrated by serious, (i) anxiety, (ii) depression, (iii) withdrawal, (iv) self-destructive or aggressive behaviour, or (v) delayed development”.\(^{11}\) The CYFSA further provides that in the context of committal or emergency admission to a secure treatment program, “mental disorder” means “a substantial disorder of emotional processes, thought or cognition which grossly impairs a person’s capacity to make reasoned judgments”.\(^{12}\) For criminal law purposes (e.g. fitness to stand trial, defence of mental disorder), “mental disorder” is defined in section 2 of the Criminal Code as “a disease of the mind”.\(^{13}\) Pursuant to the jurisprudence, “disease of the mind’ embraces any illness, disorder or abnormal condition which impairs the human mind and its functioning, excluding, however, self-induced states caused by alcohol or drugs, as well as transitory mental states such as hysteria or concussion”.\(^{14}\)

Where a child’s mental state meets the statutory definition, a number of other legislative criteria also must be met before the “emotional harm” or “mental disorder” may affect the disposition in the case.\(^{15}\) For example, where a child is found to have suffered or to be at risk of likely suffering “emotional harm”, to be found “in need of protection” the Court also must find that the harm results from the “actions, failure to act, or pattern of neglect” of the parent or that the parent failed to provide services or treatment or (where the child is incapable of consenting)

\(^{11}\) CYFSA, supra note 6, s 74(2)(f); Chapter Two at 52-54 and related references; Chapter Three at 81-83 and related references.

\(^{12}\) CYFSA, supra note 6, s 157; Chapter Two at 56-58 and related references; Chapter Three at 85-92 and related references.

\(^{13}\) Note also YCJA, supra note 7, ss 2(2), 140, 141(1).

\(^{14}\) Cooper v R (1979), [1980] 1 SCR 1149, [1979] SCJ No 139 (SCC) at para 51; Chapter Two at 60-62 and related references; Chapter Three at 98, 99-101 and related references.

\(^{15}\) See Chapter Two at 51-52, 55, 59-60, 69-70 and related references; Chapter Three at 80-81, 85, 88-89, 98, 99-101 and related references.
to consent to treatment to remedy, alleviate or prevent the harm.\(^\text{16}\) For committal or admission to a secure treatment program, the child must be found to have a “mental disorder” and various additional enumerated criteria (e.g. attempt to cause serious bodily harm, least restrictive method of treatment) also must be met.\(^\text{17}\) Similarly, for a “mental disorder” to be relevant for purposes of being found unfit to stand trial or not criminally responsible by reason of mental disorder (“NCRMD”), the “mental disorder” must be found to have impaired the child’s cognition in specified ways (e.g. rendering them unable to understand the proceedings, rendering them unable to appreciate the nature and quality of the criminal act or to know that it was wrong).\(^\text{18}\)

Whether the statutory definition and related criteria are found to be met can have a significant impact on the child’s life course. A finding that a child is “in need of protection” may mean the difference between a child remaining with a parent or being permanently removed from their care.\(^\text{19}\) A finding that a child may lawfully be committed or admitted to a secure treatment program may severely restrict a child’s liberty and make the difference between whether and how the child’s mental health issues are addressed.\(^\text{20}\) Similarly, a finding that a child is unfit to stand trial, NCRMD, or eligible for a particular sentence (e.g. intensive support and supervision program (“ISSP”)), may mean the difference between accessing treatment and supports or incarceration.\(^\text{21}\) The way that mental health issues are defined and characterized in the legislation is highly determinative as to what outcomes children experience. This is due to

\(^\text{16}\) CYFSA, supra note 6, s 74(2)(f)-(i); a child may also be “in need of protection” where they suffer from a “mental, emotional or developmental condition that, if not remedied, could seriously impair the child’s development” and their parent fails to provide treatment or (where the child is incapable of consenting) to consent to “treatment to remedy or alleviate the condition” (CYFSA, s 74(2)(j)); Chapter Two at 70, 55 and related references; Chapter Three at 80-81, 84 and related references.

\(^\text{17}\) CYFSA, supra note 6, ss 164(1), 171(2); Chapter Two at 58-59 and related references; Chapter Three at 85, 88-89 and related references.

\(^\text{18}\) Criminal Code, supra note 8, ss 16(1), 2; see also YCJA, supra note 7, ss 2(2), 140, 141(1); Chapter Two at 59-60, 69 and related references; Chapter Three at 98, 99-101 and related references.

\(^\text{19}\) See Chapter Four at 133-34, 149 and related references; Chapter Three at 81-84 and related references.

\(^\text{20}\) See Chapter Three at 85-91 and related references; Chapter Two at 58-59 and related references.

\(^\text{21}\) See Chapter Three at 98-109 and related references; Chapter Two at 72, 75-76 and related references.
the way the legislation is drafted and the way it is implemented in practice by the Courts, Boards (e.g. the Child and Family Services Review Board), and the CAS.

For a child’s mental state to be potentially legally relevant, it must come to the attention of the Court. In proceedings regarding committal or emergency admission to a secure treatment program, the child’s mental state will be put in issue by the applicant (e.g. the child’s parent, child protection worker, CAS) and will be central to the Court’s or Board’s decision.22 Similarly, in child protection proceedings involving allegations of “emotional harm” or “mental, emotional or developmental condition”, the issue of the child’s mental state will have been put before the Court by the applicant (the CAS). This will occur where a child protection worker has recognized that a child may have a mental health issue, and it is believed (and plead) that the child is “in need of protection” as they have suffered or are at risk of suffering “emotional harm” and/or they suffer from a “mental, emotional or developmental condition”.23

The involvement of the CAS with a given child and family generally begins when someone reports possible maltreatment of the child.24 Child protection workers make critical decisions regarding investigating and substantiating maltreatment allegations and what, if any, intervention is provided (e.g. service referrals, out-of-home placement).25 Research suggests that these critical decisions are influenced by the legislation to a limited degree and by a variety of other factors, including the allocation of public resources, organizational structure, case characteristics and clinical considerations, and personal knowledge and experience.26 Research also indicates that the decisions child protection workers make can have lifelong implications

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22 See Chapter Three at 85, 88-89, 114 and related references.
23 See Chapter One at 43, 44-45 and related references; Chapter Three at 80-81 and related references; Chapter Four at 136-37, 138, 142-48 and related references.
24 See Chapter Four at 135-36 and related references; Chapter One at 40 and related references.
25 See Chapter Four at 136-38 and related references; Chapter One at 40-45 and related references.
26 See Chapter Four at 138-44 and related references; Chapter One at 40-43 and related references.
and effects for children and families (e.g. whether a child will get needed services, whether a child will be permanently removed from their familial home, the likelihood a child will become engaged with the criminal justice system) and that (lack of) identification by child protection workers of children with mental health issues is a significant problem in terms of getting children needed services.  

The (lack of) identification of children with mental health issues also has been identified as a significant problem in the criminal justice system. For example, in *R. v. D. (W.A.L.)* (“*D. (W.A.L.)*”) Justice Whelan noted that in the approximately four years twin adolescent brothers suffering from Fetal Alcohol Spectrum Disorder (“FASD”) had “interacted with the Justice System, [the boys] have repeatedly been treated without regard for their Primary Disabilities and this likely had a deleterious effect”. Researchers have indicated that the “lack of use” of the provisions in the *YCJA* related to mental health issues (e.g. ISSP orders, assessments) appears to be due, in part, to a failure to screen for mental health concerns amongst the population to whom the provisions are intended to apply.

**Problems in Practice: Implementing the Medical Model**

Where a child’s mental state is put in issue, it will be legally relevant where the legal test established in the applicable legislative definition and related criteria are met. The determination as to whether a child’s mental state is of the kind contemplated in a given legislative definition and whether the other criteria are met is a legal question which is

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27 See Chapter Four at 133-34, 136-38, 146-49, 151-53, 155-57 and related references; Chapter One at 43-45 and related references.
28 See Chapter Three at 114-15 and related references.
29 *R v D (WAL)*, 2004 SKPC 40, 245 Sask R 98 [*D (WAL)*] at para 43; Justice Whelan also noted that there had been a lack of consistent supervision and support for the boys, despite the involvement of numerous government departments (social services, health and education, justice and corrections), starting, in some cases, before the boys were born (para 44); Chapter Three at 114-15 and related references.
30 See Chapter Three at 115 and related references.
31 *CYFSA*, supra note 6, ss 74(2)(f)-(j), 157, 164, 171; *Criminal Code*, supra note 8, ss 2, 16(1); Chapter Two at 69-70 and related references.
determined by the trier of fact (i.e. the Court, or a Board). However, medical evidence, usually from an expert qualified to make clinical or psychiatric diagnoses, is often relied upon and may be highly influential on the ultimate disposition in a case.

The legislative definitions and related criteria in the CYFSA and YCJA (by incorporation of the provisions in the Criminal Code) are underpinned by a conceptualization of mental health issues that reflects the medical model and embraces the paradigm’s individual focus and medical orientation. Pursuant to the medical model, distressing or problematic mental states or behaviours are characterized as “symptoms” of a mental “illness” or “disorder” which is inherent in the individual (i.e. biological) and requires rectification by individual (medical) intervention (generally pharmacotherapy, possibly accompanied by psychotherapy).

The legislative definitions similarly are premised on the characterization (diagnosis) of certain mental states or behaviours as problematic (disorders), occurring within the individual and requiring individual (medical) intervention.

Viewing mental health issues through a definitional lens premised on the medical model places the focus on the individual child, eliciting analyses that turn on an assessment of the individual child’s words and behaviours and are guided or directed by the opinion of medical professionals. For example, in Children’s Aid Society of Sudbury & Manitoulin (Districts) v. C. (C.), a fourteen-year-old girl who was “troubled”, ran away and engaged in impulsive and potentially harmful behaviour (including using drugs and alcohol and blacking out, and hanging out at an alleged escort service where she said she had been raped), was found not to have a

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32 See Chapter Two at 68-69, 70 and related references; Chapter Three at 109-10 and related references.
33 See Chapter Three at 109-12 and related references; Chapter Two at 71-72 and related references.
34 See Chapter Two at 62-65 and related references.
35 See ibid at 68-69, 70-73 and related references; Chapter Three at 112-13 and related references.
36 See Chapter Two at 71-74, 76 and related references; Chapter Three at 81-92, 98-101, 105-08, 126-28 and related references; Chapter Five at 173, 164-67 and related references.
“mental disorder” for purposes of committal. In that case, the psychiatrist who diagnosed the child as having adjustment disorder, opined that she was cognizant and understood the implications of her actions. In Weechi-it-te-win Child & Family Services v. F. (D.K.) a girl who was found, based on affidavit evidence, to be “unable to look to her own safety”, to lie, run away, and occasionally consume “alcohol to the point where her very life is in jeopardy”, was found (without need for an expert opinion) to have a “mental disorder” for purposes of committal to a secure treatment program.

By focusing on the existence or absence (as demonstrated by observed words and behaviours) of a “disorder” within a given child, the environmental factors that may impact upon a child’s mental health are obscured and unacknowledged and individual (medical) intervention (namely pharmacotherapy) seen as appropriate “treatment”. For children in care, this narrow focus and the related failure to provide adequate supports and services, often enmeshes these children in a “vicious cycle” wherein their mental health or behavioural issues are exacerbated, they are moved repeatedly between placements (generally group homes), and they experience ongoing engagement with the criminal justice system and increasingly severe penalties. Once embroiled in the criminal justice system, the challenges experienced by children with mental health issues are often compounded (rather than alleviated) by the application of the narrow individualistic analysis prompted by the legislative definitions and related criteria. For example, where the challenges and disadvantages experienced by these children (e.g.

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37 Children’s Aid Society of Sudbury & Manitoulin (Districts) v C (C) (1999), 101 ACWS (3d) 304, 1999 CarswellOnt 4865 (WLNext Can) (ONCJ) [C (C)] at paras 4, 5, 25, 35, 36, 33, 23, 39; Chapter Three at 88 and related references.
38 C (C), supra note 37 at paras 6, 22, 23.
40 See Chapter Two at 73-76 and related references; Chapter Three at 122-23 and related references; Chapter Four at 156-57, 143-44 and related references; Chapter Five at 173-76, 165-67 and related references.
41 See Chapter One at 28-33 and related references; Chapter Three at 85-88, 90-92, 100-01, 114-17, 128 and related references; Chapter Five at 171, 173-74 and related references; Chapter Four at 148, 152-53 and related references.
42 See Chapter Five at 164-69 and related references.
maltreatment, mental health issues) are assessed at the individual level without taking the cumulative impact of environmental factors into account, they may be conceived of as “risk factors” and be seen as justifying the imposition of harsher sanctions (e.g. custodial sentences) to contain and reduce the perceived risk posed by the child.43

**Problematic Consequences: Children with Mental Health Issues being Locked-Up, Drugged, and Falling Through the Cracks**

Children who are engaged with the CAS, particularly those with mental health issues, are significantly overrepresented in the criminal justice system and in custody facilities.44 These children, especially those living in group homes, are more likely to face criminal charges, be detained pre-trial, and sentenced to custody than are their counterparts in the general population.45 Of the children incarcerated, a significant number have inadequately addressed mental health and child welfare needs.46 In many instances, a lack of collaboration and communication between the family law (child welfare), criminal justice, and other systems, may contribute to the overrepresentation of children in care in custody facilities, and to the failure to provide these children with needed mental health and other supports and services.47 The fragmentation across service sectors and systems and a lack of available resources or lack of knowledge about availability, can affect child protection workers’ referral decisions (e.g. whether to make a referral, type of service referral), and can constrain the dispositions the Court can make.48

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43 See *ibid* at 164-67 and related references.
44 See Introduction at 7-8 and related references; Chapter One at 31-33, 34-36 and related references; Chapter Three at 103, 116-17 and related references.
45 See Chapter One at 29-36 and related references; Chapter Three at 103, 116-17 and related references.
46 See Chapter One at 34-35, 28-29 and related references; Chapter Five at 170-71, 174 and related references.
47 See Chapter One at 33-39 and related references; Chapter Three at 123-26 and related references; Chapter Four at 153-55 and related references.
48 See Chapter One at 33-34, 42-44 and related references; Chapter Three at 105-09, 117-21 and related references; Chapter Four at 139-41, 147, 153-54 and related references.
For example, in *R. v. M. (B.)* the Court lamented the fact that there was “no placement…in terms of a suitable residence or other supports appropriate” to the circumstances of an adolescent with FASD who was involved with the CAS, had experienced repeated engagement with the criminal justice system, and had apparently never received supports or services to address his mental health or other needs.49 *D. (W.A.L.)* similarly involved adolescent boys (twins) with FASD, who had been engaged repeatedly with the criminal justice system, and whose needs had not been adequately addressed despite the involvement throughout their lives of numerous government departments, including social services, education, and justice and corrections.50 In *D. (W.A.L.)*, the Court was obliged to convene repeated conferences (and issue subpoenas) to coordinate amongst various agencies in an effort to ascertain and arrange needed supports and services for the boys and establish which agency would be responsible for overseeing implementation.51 Despite the Court’s efforts, the “commitment was not” what Justice Whelan “had hoped” (though the “services offered” were said to represent “progress in the living circumstances of these Young Persons, that, with further cooperation, and attention from the Review Board, might be built upon”).52

In *R. v. S. (R.)*, the Provincial Director would not consent to an adolescent’s participation in an intensive rehabilitative custody and supervision (“IRCS”) program, based on the belief that the boy would agree only to minimal treatment and would not agree to take medication.53 Justice Forestell characterized these reasons as “troubling” and noted that it was unrealistic, in light of his cognitive limitations, to expect the boy to appreciate fully his treatment needs or answer

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49 *R v M (B),* 2003 SKPC 133, [2003] SJ No 602 [M (B)] at paras 1, 5-7, 11, 25; the sentencing (probation) order under review in *M (B)*, was set aside in *R v M (B)*, 2003 SKCA 135, 60 WCB (2d) 337; Chapter Three at 119-20 and related references.

50 *D (WAL),* *supra* note 29 at paras 3, 42-44.

51 *Ibid* at paras 12-14, 16, 36-39, 49, 84-87; Chapter Three at 119 and related references.

52 *D (WAL),* *supra* note 29 at para 13.

53 *R v S (R)*, 2014 ONSC 4279, 121 WCB (2d) 623 [S (R)] at para 9; Chapter Three at 107 and related references.
hypothetical questions about medication.\textsuperscript{54} However, with the Provincial Director’s refusal, the IRCS order was not considered.\textsuperscript{55} In \textit{R. v. M. (S.)} (“\textit{M. (S.)}”), a thirteen-year-old girl who was in the care of the CAS and living in a group home, had been detained for approximately two weeks, and given anti-psychotic medication to control her behaviour because there were no forensic facilities available to perform the assessment ordered by the Court under the \textit{YCJA}.\textsuperscript{56}

In many instances, the mental health needs of children in care, particularly those living in group homes, are “addressed” through the use of psychotropic medications.\textsuperscript{57} These medications can have significant side effects, including drowsiness, lethargy, and drug dependence.\textsuperscript{58} In some cases, like that of \textit{M. (S.)}, psychotropic medications have been administered (involuntarily) to children in care (or in the “care” of the criminal justice system) because of their sedative effects, being used as “chemical restraints” to control the behaviour of “difficult” children.\textsuperscript{59} While the use of psychotropic medications may alleviate some of the “symptoms” of distressing mental states or behaviours in a relatively quick and cost effective manner, this individual medical intervention (premised on the medical model) fails to acknowledge or address the various environmental or social (i.e. external) factors that may impact upon a child’s mental health (e.g. trauma, placement instability, inequality).\textsuperscript{60}

The use of individual medical interventions (psychotropic medications) to address individual “disorders” is in keeping with, and reflective of, the individualistic focus and medical orientation adopted in the legislative definitions and the medical model that underpins them.

\textsuperscript{54} \textit{R v S (R), supra} note 53 at paras 10-14.
\textsuperscript{55} \textit{Ibid} at para 8.
\textsuperscript{56} \textit{R v M (S)} (2004), 61 WCB (2d) 63, 2004 CarswellOnt 5138 (WLNext Can) (ONCJ) [\textit{M (S)}] at paras 2, 3, 11, 21, 22, 24-27; Chapter Three at 117-18 and related references.
\textsuperscript{57} See Chapter Three at 122-23 and related references; Chapter Four at 155-57 and related references.
\textsuperscript{58} See Chapter Two at 74 and related references; Chapter Four at 155 and related references.
\textsuperscript{59} \textit{M (S), supra} note 56; Chapter Three at 122 and related references; Chapter Four at 155-56 and related references.
\textsuperscript{60} See Chapter One at 26-30 and related references; Chapter Two at 74 and related references; Chapter Four at 155-57 and related references; Chapter Five at 173-74, 162 and related references.
Viewing children’s mental health issues as individual illnesses or disorders, and relying exclusively on individual medical interventions, overlooks and masks the other complex challenges and disadvantages faced by children with mental health issues who are engaged with the family law (child welfare) and criminal justice systems, and the cumulative effect these factors may have on the child’s mental health. In the result, the complex needs experienced by these children are not acknowledged or addressed, and the interlocking oppressions and inequalities they face perpetuated and compounded.

**Intersectionality: A Way Forward**

In order to understand the complex needs of children and families engaged with the family law (child welfare) and criminal justice systems, the cumulative effects of the intersection of various individual and environmental factors (e.g. (dis)ability, sexual orientation, maltreatment, poverty) must be considered, and the role of social structures and systems (e.g. the family law (child welfare) and criminal justice systems, the CAS) in creating and sustaining the marginalization and subordination, and the interlocking oppressions and inequalities, experienced by these children and families must be recognized. This analysis allows for a deeper and more contextual understanding of the complex cumulative and overlapping needs of the children and families who are engaged with the family law (child welfare) and criminal justice systems, and exposes how various services and systems can meet these needs more adequately.

Adequately meeting the complex needs of children with mental health issues requires the engagement of various professionals and agencies (e.g. child welfare, mental health, education,
criminal justice). Further research is needed regarding the lack of collaboration and communication across service sectors and systems, and the systemic barriers that continue to support and perpetuate these divisions. Critical analysis is required to better understand the role of the law in creating and compounding the gaps that allow children with mental health issues to “fall through the cracks”, and how the law could be used to help bridge these gaps and encourage the use of a more holistic and integrated approach. The adoption of a more holistic approach would see various professionals and agencies working collaboratively to fully assess the intersectional challenges faced by these children, and to develop and implement coordinated plans to provide them with the supports and services necessary to adequately meet their needs.

The implementation of such an approach at the outset of a child’s involvement with the legal system (e.g. when the CAS determines there is a protection issue, when the police come into contact with a child as a result of alleged criminal behaviour) could interrupt the “vicious cycle” in which so many of these children become ensnared.

For example, in D. (W.A.L.) if the various departments and agencies that had been involved with the twin boys from an early age had worked together to fully assess and holistically address the boys’ various needs (e.g. educational, psychological, supervisory), perhaps the boys could have avoided acquiring secondary disabilities and the related ongoing engagement with the criminal justice system and time in custody. When they did become involved with the criminal justice system, if professionals from that system had worked collaboratively with other departments and agencies (e.g. social services, education, health) to holistically address the boys’ various needs, perhaps the boys dissent into repeated engagement

65 See Chapter One at 25, 37-39 and related references; Chapter Three at 123-26 and related references; Chapter Four at 157, 153-54 and related references; Chapter Five at 175-76, 162, 169-73 and related references.

66 See Chapter Four at 157 and related references.

67 See supra at 183, 187 and related references.
with the criminal justice system could have been curbed. In either case, earlier intervention and the provision of adequate services would have facilitated the chances of a successful outcome for the boys, and could have spared the boys from a number of consequences that were costly both for them and for society more generally (e.g. educational disruption, the need for services for their FASD and secondary disabilities).

The Problem: As It Now Stands

Children engaged with the family law (child welfare) and criminal justice systems, particularly those with mental health issues, are not getting adequate supports and services to meet their needs. At the root of the problem are the medical model underpinnings of the statutory provisions that define and characterize the mental health issues (i.e. mental states and behaviours) that may be legally relevant in child welfare and youth criminal justice proceedings. In practice, the individual focus and medical orientation adopted in the legislation translates into the conceptualizing of children’s mental health issues as an individual medical issue, requiring individual medical intervention (namely pharmacotherapy). This narrow approach masks and overlooks the complex cumulative challenges and disadvantages that shape the lives of children with mental health issues who are engaged with the family law (child welfare) and criminal justice systems, and the role of these legal systems in compounding and perpetuating the marginalization and subordination experienced by these children. In order to meet their statutory mandates and obligations, and adequately protect children with mental health issues, the family law (child welfare) and criminal justice systems must adopt and implement conceptualizations and analyses that acknowledge and address the interaction of various individual and societal-

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68 Ibid.
69 Ibid.
level factors, and the cumulative and multiplicative effects they may have on children’s lived experiences and mental health.
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