

The resource includes activities and exercises that provide a complete physical activity workout for children in 20 minutes. Training is provided for child care staff and teachers to equip them with the tools to motivate and lead the children in structured physical activity 3-5 times per week. Rainbow Fun is also being integrated in to the curriculum of community college early childhood education programs.

The Daycare Resource Box is a toolbox resource that contains heart health promotion materials, activities and newsletters to use in programming with 3-12 year olds. The resource is distributed at train-the-trainer sessions. The Family Fit Kit is distributed to parents and caregivers through Parks and Recreation. It is designed for parents to increase family physical activity. In partnership with Parks and Recreation, the resource is being modified so that it is appropriate for ethnic-rationally diverse and low-income communities.

Objectives/benchmarks

Children and youth meet the Health Canada guidelines of 90 minutes of daily physical activity through a combination of 60 minutes of moderate intensity activity (e.g., brisk walking, bicycling) and 30 minutes of vigorous intensity activity (running, soccer, basketball).

Safety

► Free of violence, abuse, neglect

14. Child protection caseloads

Children's Aid Societies (CASs) in Ontario are not-for-profit, incorporated private agencies governed by a volunteer board of directors and funded by the Province. A primary mandate of CASs is to protect children from harm and to investigate allegations of abuse and neglect.

Apr. 2002 - Mar. 2003

Children served in the community/homes	51,661
Children served in CAS care	5,553
Children served total	57,214

Source: The data is compiled from the three Children's Aid Societies that currently serve Toronto. The Children's Aid Society of Toronto (CAST) accounts for about 57% of Toronto's child welfare cases; the Catholic Children's Aid Society of Toronto (CCAS) serves about 40% of the families involved with child welfare; Jewish Family & Child Service (JFCS) provides service to around 2% of the cases. As of Spring 2004, Native Child and Family Services (NCFS) is set to formally receive its child welfare mandate, and estimates are it will serve about 1-2% of the Toronto child protection cases.

Status/trends

Over the past decade, the child welfare sector has continued to experience significant changes. The number of children (children aged 0-16) and families served by the Toronto child welfare services continues to rise. In 1998, 28,070 children were served in their community/home by the Toronto CASs. By 2003, that figure has almost doubled, to 51,661 (see the following table). While the number of children served by child protection services in their homes increases, the number of children admitted to care has remained relatively stable over time and has actually decreased over the last three years. This reflects CASs primary service philosophy: to ensure that the safety of the child is paramount, while improving the home situation and strengthening families wherever possible.

Child protection workload: Toronto	Apr. 2000-Mar. 2001	Apr. 2001-Mar. 2002	Apr. 2002-Mar. 2003	% Increase: 2000-2003
Children served in the community/homes	45,276	48,728	51,661	↑ 14%
Children served in CAS care	5,380	5,421	5,553	↑ 3%
Children served total	50,656	54,149	57,214	↑ 14%

Key issues

The rise in the number of children and families served by child welfare is due, in part, to recent amendments to the child welfare legislation, the *Child and Family Services Act* (CFSA). More specifically, neglect and emotional abuse definitions were expanded. For example, the legislation stipulates that situations where children are exposed to or witness domestic violence/adult conflict are now to be investigated. The mushrooming of investigations of adult conflict investigations is evident in the review of numbers over time: in 2000/01 the number of investigations of these cases was 3,961; by 2002/03 the number had surged to 17,059 – nearly a five-fold increase.

An additional factor that has affected the rise in child welfare referrals is the Child Welfare Reform that commenced in 1997. Even prior to the change in legislation, there was an emphasis on community agencies and the public of their legal requirement to report allegations of suspected as well as known maltreatment of children by their parents or caregivers. That said, other key factors have also contributed to the rise in child welfare investigations. The cumulative cuts to education (\$350 million over five years) and the children's mental health sectors, along with the impact of the revamping of the social assistance program (Ontario Works), the lack of affordable housing and removal of rent controls in Toronto have all had adverse effects on children and challenged the family's ability to care for them.

For example, Hulchanski's and colleagues' (2001) study found the lack of appropriate housing accounted for one out of five children entering CAST care. "A more recent study at the London CAS compared risks to children and increasing family cases from 1995 to 2001. The findings indicate more children are in need of child welfare services due to increasing risks and more stressed parents, not simply due to policy changes." Leschied and colleagues, 2003.

While the next table shows the overall number of children entering care has decreased in the last three years, the actual number of children staying in care has increased. This trend is mirrored across Ontario (Trocme et al., 2002). Children, when they do enter care, are averaging a longer time in care because their family problems are exacerbated by extenuating issues, such as housing and finance problems, coupled with the children presenting with more complicated and difficult challenges. For example, the number of children who are Crown wards (the Province is their permanent legal guardian) has risen substantially, and they now make up almost half the children in care. Of these children, nearly half require a modified or special school program.

Children in care	1998	1999	Apr. 2000-Mar. 2001	Apr. 2001-Mar. 2002	Apr. 2002-Mar. 2003	% Increase: 1998 - 2003
Admissions/re-admissions to care	1,879	1,985	1,999	2,010	1,975	↑ 5%
Discharges from care	1,632	1,841	1,921	1,943	1,870	↑ 15%

There are four broad, major categories of child maltreatment: physical abuse, sexual abuse, emotional abuse and neglect. The breakdown for investigations for 2002/03 is: physical abuse (30%); sexual abuse (6%); emotional abuse (18%) and neglect (46%). In Toronto, almost one-third of all child abuse investigations involve an alleged physical abuse of a child, and nearly half of all investigations are classified as neglect because of inadequate supervision, medical neglect or permitting maladaptive or criminal behaviour.

Objectives/benchmarks

One ramification of the increased emphasis by the provincial government on providing expanded child protection services is that it has limited CASs ability to provide outreach and prevention services. Current focus by the Toronto CASs is to continue to develop collaborative community partnerships in key areas: cultural diversity, domestic violence and service to at-risk populations, such as children under six and high-risk youth. 2004 initiatives include developing provincial outcome measures.

Crimes against children

Children under the age of 12 accounted for 5.2% of all victims of offences reported to Toronto police in 2002. This represents 909 boys and 944 girls.

- The number of children who are victims of crime and their overall proportion of all victims has changed only slightly over the past five years (from 1,951 persons in 1997 to 1,853 persons in 2002). In addition, the proportion of offences by type has remained relatively stable over the same period.
- More than half (56%) of the offences against children were non-sexual assaults. In 2002, there were 685 cases of non-sexual assault against boys and 352 against girls. Non-sexual assaults accounted for 75% of offences against boys and 37% of those against girls.
- Sexual assault, meanwhile, accounted for 22% of all offences against children. In 2002, Toronto police reported 318 cases of sexual assault against girls and 97 against boys. Sexual assault accounted for 33% of offences against girls but only 10% of those against boys.

Offences against victims 0 - 11 years by sex, 2002.

	males	% of all offences	females	% of all offences	total	% of all offences
All	909	100.0	944	100.0	1,853	100.0
Sexual assault	97	10.7	318	33.7	415	22.4
Non-sexual assault	685	75.4	352	37.3	1,037	56.0
Robbery	51	5.6	10	1.1	61	3.3
Other	76	8.4	264	28.0	340	18.3

Source: Toronto Police Service Board, annual statistics

Prepared by Toronto Community and Neighbourhood Services: Social Development and Administration Division

Action to end physical punishment of children

The 1998 Ontario Incidence Study of Child Abuse and Neglect found that the rate of reported physical abuse doubled between 1993 and 1998, and that 72% of physical abuse cases were cases of physical punishment. One objective of the Early Child Development Family Abuse Prevention project is to reduce the use of physical punishment through four strategies:

- developing a Toronto Public Health position statement against the use of physical punishment
- advocating for change in federal legislation that allows parents and teachers to use physical punishment with children
- running a media campaign on positive discipline and the harms of physical punishment
- educating service providers on promoting positive and effective discipline with families.

► Safe environment

15. Air quality and respiratory health

In 2003, Ontario’s environment ministry issued five smog advisories for Toronto for a total of 12 smog alert days. While smog can exist every day, a smog alert is called when there is a strong likelihood that there will be widespread and persistently elevated levels of smog within the next 24 hours. In other words, a smog alert is called when Ontario’s Air Quality Index (AQI) is expected to reach a value of 50 or greater over an extended area and time.

Importance

Children are more sensitive than adults to the effects of air pollution because they breathe faster and often spend more time active outdoors, and closer to ground level. For sensitive people such as asthmatics, even a small increase in pollution levels can make symptoms worse.

Air pollution has been linked to hospitalizations and early deaths. Studies in the U.S. have also raised the possibility of a link between air pollution and lung cancer.

Status/trends

Smog advisory days			
2000	2001	2002	2003
3	20	18	12

The number of smog advisory days over the last three years continues to be much higher than in previous years.

Key issues

With climate change and the increasing number of hot sunny days in the city, the number of smog alert days (also known as smog advisory days) is likely to increase. The main source of air pollution in Toronto is the burning of fossil fuels such as oil, gasoline, diesel and coal.

Services, supports and initiatives

Through the “20/20 The Way to Clean Air” social marketing campaign, Toronto Public Health is working in collaboration with health units in the Greater Toronto Area (GTA) to provide residents with resources to help reduce home energy use and vehicle use by 20%. This campaign offers participants a free 20/20 Planner – a practical step-by-step guide to reducing energy at home and on the road. The goal of this campaign is to lower energy use, thereby reducing health impacts from air pollution and climate change.

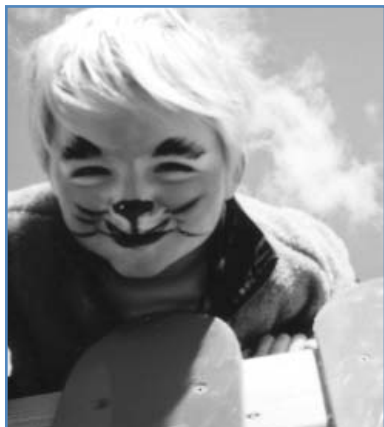


In support of the Call to Action on Physical Activity, in June 2003 Toronto Public Health released a report on air pollution and physical activity. The report identified the times of day when levels of pollutants are lowest in Toronto, to provide guidance on when and where to exercise. Given the importance of physical activity to well-being, the study promotes regular physical activity year round, while advising the public to modify physical activity outdoors on days when air quality is poor. TPH is also collaborating with Health Canada and Environment Canada in a new personal exposure study in Toronto, to ensure that advice provided during smog events is effective in reducing exposure to air pollutants, with a focus on children.

Toronto Public Health continues to implement a variety of public education and outreach initiatives on smog and air quality year round. Smog alert days provide heightened awareness for the public and staff who work with high-risk groups such as children. Toronto Public Health also participates in the annual Smog Summit and in developing and implementing the 2003 GTA Idle-free campaign.

Objectives/benchmarks

Ideally, Toronto would experience zero smog alerts per year, indicating that the levels of air pollutants that trigger smog alerts have decreased.



Playground safety

In 2003, the City continued to address the issue of playgrounds built using chromated copper arsenate (CCA)-treated lumber. All 217 of the City's play structures containing CCA-treated wood were tested for arsenic. Both wood surface samples and soil samples were collected. As a result of this investigation, 58 play structures were targeted for remediation through sealing, or through sealing and soil replacement. This remediation work was completed in 2003. Monitoring of playgrounds that were remediated, plus those approaching the remediation guideline, is ongoing.

Respiratory hospitalizations

In 2001, there were 2,965 hospitalizations of children aged 0-14 for respiratory disease (asthma, croup, bronchitis and pneumonia) compared to 2,824 hospitalizations in 2000 and 3,244 in 1999. A child will be counted more than once if they were hospitalized on more than one occasion in the same year, and this is a possibility for many of the respiratory diseases. Trends in hospitalization are influenced by many factors, including hospital admission policies and access to care, and do not necessarily reflect changes in morbidity.

Bronchitis was the most common cause of respiratory hospitalizations among infants (53%), while asthma was the most common cause among children aged 1-14 (44.5%). Respiratory hospitalizations only partially reflect the full extent of respiratory illness in the community. Studies estimate that only one in ten children who report having asthma are hospitalized.

Data source: Hospital In-Patient Data for 1999-2001, Provincial Health Planning Database (PHPDB). Extracted by Toronto Public Health: October 2003, Health Planning Branch, Ontario MOHLTC

Completely smoke-free homes

According to the Rapid Risk Factor Surveillance System for the period July 2001-June 2003, 74.2% (± 3.4 %) of households with children age 0-14 were completely smoke-free. Completely smoke-free homes are those where no household member smokes regularly inside the home and visitors are not allowed to smoke.

The current level of completely smoke-free homes is encouraging but also allows for considerable improvement. A recent British study showed that an absolute ban on smoking in the home decreased urinary cotinine levels in children while, restrictions that did not eliminate smoke exposure in the home completely had very little beneficial effect.

The benefits of eliminating second-hand smoke around infants and children include decreased risk of SIDS, decreased risk of children developing bronchitis and pneumonia, decrease in the risk of developing asthma, allergies and fewer middle ear infections and related hospitalizations.

It is important for parents to be role models for their children. Children from households where neither parent ever smoked are far less likely to become smokers. Parents who quit smoking when their children were young lowered risk by about 40 percent; having just one parent quit cut risk by 25 percent.

Car seat safety

According to Toronto Police Service, of all child care seats that are inspected by the police (through an appointment or through a clinic) 80% are deemed to be improperly used. This includes improper installation and incorrect car seat selection for the particular child based on height and weight requirements.

16. Hospitalizations due to injuries

In 2001, there were 1,247 hospitalizations of children aged 0-14 for all types of injuries compared to 1,359 in 2000 (see limitations).

Data source: Rapid Risk Factor Surveillance System (RRFSS), July 2001-June 2003, Health Information & Planning, Toronto Public Health and the Institute for Social Research, York University

Hospitalizations due to injuries include causes such as poisoning, traffic collisions, cycling collisions, falls, assaults, burns, adverse effects of therapeutic drugs and medications, suicide and self-inflicted injuries. A vast majority of childhood injuries do not require hospitalization. Thus injuries resulting in hospitalizations are only a fraction of the total number of injuries treated in emergency rooms, the community or at home.

Data source: Hospital In-Patient Data for 2001, Provincial Health Planning Database (PHPDB). Extracted by Toronto Public Health: October 2003, Health Planning Branch, Ontario MOHLTC



Limitations

- excludes injuries due to surgical and medical procedures
- causes are based on the most responsible diagnosis (i.e., diagnosis associated with the longest duration of treatment) during a given hospital stay
- hospitalization data includes multiple admissions for a single individual. Multiple admissions likely occur more frequently for chronic diseases. Therefore hospitalization data provide only a crude measure of the prevalence of a disease or injury
- data is influenced by factors that are unrelated to health status such as availability and accessibility of care, the practice patterns of providers, and administrative policies and procedures. This may influence comparisons between areas and over time
- data is collected based on location of hospital, but is generally analyzed by the residence of the patient. Hospital discharge records are the most comprehensive and accessible source of morbidity information. The cause is the primary reason for the hospital stay (i.e., most responsible diagnosis).

Importance

For the most part, injuries are both predictable and preventable. Ontario spends billions of dollars each year in direct and indirect costs related to unintentional injuries. Injury hospitalizations are just one part of these costs. Many more people with injuries are treated in emergency rooms than are admitted to hospital. An unknown number of injuries are treated in other settings and go unreported. These are not captured in the statistics presented here.

When a child is injured, there is the added burden of a parent needing to take time away from employment to care for the injured child and possibly increased child care costs as the child recovers from his or her injury. In addition to economic costs associated with childhood injuries, there are numerous intangible personal and social costs such as pain, grief and/or reduced quality of life as a result of these injuries.

Status/trends

Trends in hospitalization are influenced by many factors, including hospital admission policies and access to care, and do not necessarily reflect changes in morbidity.

In 2001, for infants under one year of age, injuries (see limitations) represent only 1% of all hospitalizations (excluding newborns). This increases to 8% for ages 1-4, 15% for ages 5-9 and 21% for ages 10-14. Within each age group, unintentional falls account for the greatest proportion of hospitalizations, while the second and third leading causes of hospitalizations vary among the age groups.

Analysis of injury hospitalization rates of children, birth to six years of age, for 1998 to 2000 combined, reveals that for the most part, Toronto children have lower rates of injury hospitalization compared to the rest of Ontario. However, in the area of scald burns, Toronto children (birth to six years) are admitted to hospital at a higher rate than children in the rest of the province. These rates could be a reflection of many things, including differing admission policies and community support for injury treatment and recovery between Toronto and the rest of Ontario.



Key issues

Many factors affect how children are injured including:

- Growth and development - As children grow, their developing capabilities put them at risk for various types of injury. As their mobility and skill level increase so does their access to potentially hazardous situations. Preventing an injury to an infant can be different than preventing an injury to an older child.
- Location of injury - In the early years, children spend a great deal of time at home. As children get older, they begin to spend more time away from home, in child care settings, at school and at public recreational facilities.
- Reliance on actions of others - Children rely on others to create safe environments and to practice safe behaviours to prevent injuries. As a child grows, he or she will become increasingly involved in practicing injury prevention behaviours, but will still rely on others as role models for such behaviours.
- Reliance on government decision-makers - Governments are responsible for enacting laws, standards and regulations to assist parents and care givers in providing safer environments for their children. In addition, the enforcement of these laws, standards and regulations is just as crucial for providing safe environments.

Services, supports and initiatives

Toronto Public Health has received funding, under the Early Years Plan, for the Early Child Development (ECD) Injury Prevention Project. This project is addressing injuries occurring to children, birth to six years of age, in residential environments.

The ECD Injury Prevention Project in Toronto is working to prevent scald burns to young children through a number of initiatives:

- advocating for changes to the National and Ontario Building Codes to reduce the temperature of hot water at faucets in residential dwellings to 49°C
- raising the awareness of families about the temperature of their hot water by providing hot water temperature indicator cards
- ensuring information on the risks associated with hot water temperature above 49°C and ways to reduce the risk of scald burn injury are included in educational resources.



As well, other activities of the ECD Injury Prevention Project will focus on increasing the knowledge and skills of parents, caregivers and other service providers pertaining to childhood injury prevention. These activities include a health communication campaign and other advocacy activities.

As part of its Injury Prevention/Substance Abuse Prevention (IP/SAP) program, Toronto Public Health (TPH) currently plans, delivers and collaborates on a wide variety of injury prevention initiatives targeted to children and their families. These initiatives focus on increasing knowledge and raising awareness of injuries and how to prevent them, preparing children and their parents to develop personal safety and injury prevention plans and habits, and developing skills and strategies to prevent or minimize harm due to injuries. Examples of these programs are Child Passenger Safety initiatives, Bike Safety initiatives, Injury Prevention Week and the At Home Alone program.

The IP/SAP program has identified falls and motor vehicle/pedal crashes as the key priority injury prevention issues to address in the 5-14 year old age group. For injury prevention programming to be successful, it must be comprehensive, coordinated and include multiple strategies focused on environmental modification/engineering as well as on education, legislation and enforcement. Therefore, the primary strategies used by Toronto Public Health to prevent childhood injuries are policy development, advocacy, social marketing, education skills-building and community action/mobilization.

Objectives/benchmarks

Toronto Public Health, through the ECD Injury Prevention Project and the IP/SAP program, is developing a comprehensive approach that focuses on increasing parental/caregiver capacity to prevent injuries. Establishing strategic partnerships in the community to develop a comprehensive and co-ordinated approach to address unintentional injuries in children is crucial.

Internet safety

The Child Exploitation Section of Toronto Police Service, Sex Crimes Unit contacted Microsoft to discuss the possibility of working together. This contact has led to the development of a network database called CELTS-Child Exploitation Tracking System. This database allows Toronto Police to coordinate with police across the rest of the country and to commence multi-jurisdictional investigations. Toronto Police Service and Microsoft are continuing to explore new software to help identify children at risk on the Internet as well as suspects who may be preying on children.

Safety for children is a key component of the Toronto Public Library's electronic services for children through:

- filtering children's workstations
- Kids' Space: a children's web portal, that guides children to age-appropriate sites
- Families on the Net: training sessions on Internet safety for children and their families.

