RaisingExpectations



RECOMMENDATIONS OF THE EXPERT PANEL
ON INFERTILITY AND ADOPTION

SUMMER 2009

June 2009

The Honourable Deb Matthews
Minister of Children and Youth Services

Dear Minister:

As members of the Expert Panel on Infertility and Adoption that you convened in June 2008, we are deeply grateful for the opportunity to provide our advice and serve the people of Ontario in a meaningful way.

We salute the Premier of Ontario, the Honourable Dalton McGuinty, the Minister of Health and Long-Term Care, the Honourable David Caplan, you and your Cabinet colleagues for your political courage and non-partisan foresight in seeking new paths to ensure Ontario becomes the best jurisdiction in the world to build families. We are fully aware that seeking reform in the adoption and assisted reproduction systems is not a recipe for electoral success. These subjects are complex, controversial, often poorly understood and do not win elections.

You have provided us with an invaluable opportunity to recommend changes that reinforce Ontario's most important fundamental values - the dignity of individuals, the nurturing qualities of families and the right of all children to find loving, permanent families. We believe the Province's role in helping Ontarians build families has never been more important than it is right now in the 21st century. We feel this province can and should be the best jurisdiction in the world in which to build a family. Yet, there is a gap between that vision and current realities. We believe that it is entirely possible for your Government to close that gap.

As we began our work 12 months ago, most of us expected we would wind up making the case for investment in better adoption and assisted reproduction practices on the grounds of equity, fairness and justice. That justification persists – especially given the values of Ontarians.

But our thinking has changed. It is clear to us now, at the end of our considerations, that our proposals are cost-effective. Ontario cannot afford not to make investments now in order to forestall considerably larger public outlays in the future. Paying out a staged investment over a period of years in a possibly haphazard and ad hoc fashion will compound current problems with adoption and assisted reproduction in Ontario. We believe the case for immediate investment as a prudent cost saving measure is clear.

Our greatest enemy in addressing the challenges to the current adoption and assisted reproduction systems is indifference and ignorance. Over the past year, we have been struck by the passion, pathos and depth of emotion that emerges from encounters with Ontarians who fervently desire to have families. We have a new understanding of the profound joy that experience brings, and the profound despair and sadness of being unable to build a family. We have a new understanding of the courage and pain of children who long for "forever families".

Ontario has a unique opportunity – today – to lead in building families. We urge the Government to consider our recommendations, which we believe will pave the way to a new and more hopeful future for Ontarians who want to build families – and for the thousands of children who need them.

Our formal duties have ended but each of us is informally at your service in any way we can help to achieve this goal. We are deeply appreciative of the trust you have placed in us and the opportunity you have given us to work together to try to make Ontario a truly family-friendly province.

Yours sincerely,



David Johnston
Chair
Expert Panel on Infertility and Adoption

Disponible en français.

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EXECUTIVE SUMMARY

Families are the heart and soul of our society. They help give children – the next generation – the best start and provide support as they move through life. Strong families help build strong communities, a prosperous economy and a more secure future.

Ontarians build their families in different ways. Many – including heterosexual couples, same-sex couples, and single people – use adoption and assisted reproduction services. But barriers like cost, lack of information, system weaknesses, location, work constraints and stigma, prevent many Ontarians from accessing these services and keep many children waiting to be adopted.

For Ontarians who are successful in building their families through adoption or assisted reproduction services, the journey is not simple. It can take years, and the experience can be emotionally devastating and financially draining.

Everyone in Ontario knows someone who has struggled to build their family. Ontario's adoption and assisted reproduction services are not working as well as they could – and should – for children and families.

In 2008, the Government of Ontario established the Expert Panel on Infertility and Adoption to provide advice on how to improve Ontario's adoption system and improve access to fertility monitoring and assisted reproduction services.

The Numbers Tell the Story

- **1,600**
  Approximate number of children adopted into Ontario families each year through the province's three adoption services – public, private domestic and intercountry.
- **9,400**
  Approximate number of Crown wards in 2007-08.
- **822**
  Crown wards adopted in 2007-08.
- **1 in 6**
  Ontario couples who struggle with infertility in their lifetime.
- **1,500**
  Babies born in Ontario in 2006 through in vitro fertilization.

The Best Jurisdiction to Build a Family

In our view, Ontario has the opportunity to become a leader in adoption and assisted reproduction in Canada and the world. The Province can join a select group of countries that are setting the standard for family building.

Our Vision

Ontario should aim to be the best jurisdiction in the world to build a family.

Our Goals

1. To help more children find permanent homes and more Ontarians build families through adoption.
2 To help more Ontarians build families through high quality and safe fertility education, monitoring and assisted reproduction services.
3. To provide information and raise awareness about adoption, fertility and assisted reproduction services and make it easier for Ontarians to access these services.

That said, we have a long way to go.

The Problem Is the System, Not the People

During our deliberations, we talked to many professionals who work in adoption and assisted reproduction services. We talked to agencies, consumer organizations and individuals. We heard from service providers and Ontarians who used adoption and assisted reproduction services, adults who had been adopted or donor-conceived, foster parents and current and former Crown wards. We know that there are many dedicated, committed people working in both adoption and assisted reproduction services who want to do the best for children and families. We know that there are courageous adoptive parents and children who succeed in building strong families. The problem that prevents many more Ontarians from building their families is not the people, it's the system: the structures, policies, laws, regulations and costs.

When it comes to adoption services:

- Children who need families – particularly older children and youth – are often stuck in Ontario's child welfare system. Many of them have **court-ordered access** to their birth families that prevents them from being adopted.
- Families find it **difficult to get objective information** about the different types of adoption in Ontario.
- Families wishing to adopt are not always treated as **valued resources**.
- The adoption process is **complex and time-consuming**. Some families wait years to adopt and need more help and support to navigate the adoption process.
- It's not easy for families who adopt children with special needs to get the **support they need after the adoption is finalized** to help the adoption succeed.

- Adoption practices are built on **policies and legislation** that have not been updated to reflect today's realities.
- We have a **"patchwork" of public adoption services** that vary greatly across the province. Public adoption services are a very small part of child welfare services – only about 2% of the budget.[1] Faced with the demands for child protection and other child welfare services, the Province's 53 children's aid societies struggle to give enough attention to adoption.

When it comes to fertility monitoring and assisted reproduction services:

- Many Ontarians do not know about the **factors that may impact their fertility**.
- Clinics and fertility centres are **not required to be accredited** and people don't know where to go for the best care.
- The single greatest barrier to assisted reproduction services is the **cost**. The procedures are expensive: about $10,000 for a cycle of in vitro fertilization (IVF), including medications. Services are beyond the reach of most Ontarians.
- The high cost of assisted reproduction services is leading to decisions which result in an **unacceptably high rate of multiple births** in Ontario – this threatens mothers' and children's health and well-being and results in high hospital and other health care costs.
- Ontarians face other **barriers** accessing assisted reproduction services. Some live too far from the small number of clinics, others – such as single and same-sex people – face social and legal barriers and the stigma associated with infertility keeps many from seeking help.

The Solution? Empower Ontarians, Intervene Early and Improve Access

Instead of maintaining the existing barriers to adoption, we see a province where:

All children have the chance to have a safe, loving and permanent family, and adoption takes place as early in a child's life as possible.

All prospective adoptive families can access clear, accurate information about all forms of adoption – public, private domestic and intercountry – and are treated as a valuable resource.

Children who become Crown wards are able to maintain contact with people who are important to them, but that contact is not a barrier to being adopted.

Families – both parents and children – receive the supports they need even after an adoption is finalized.

Instead of maintaining the existing barriers to assisted reproduction, we see a province where:

Ontarians know how to protect their fertility.

Assisted reproduction services are safe and meet the highest, evidence-based standards.

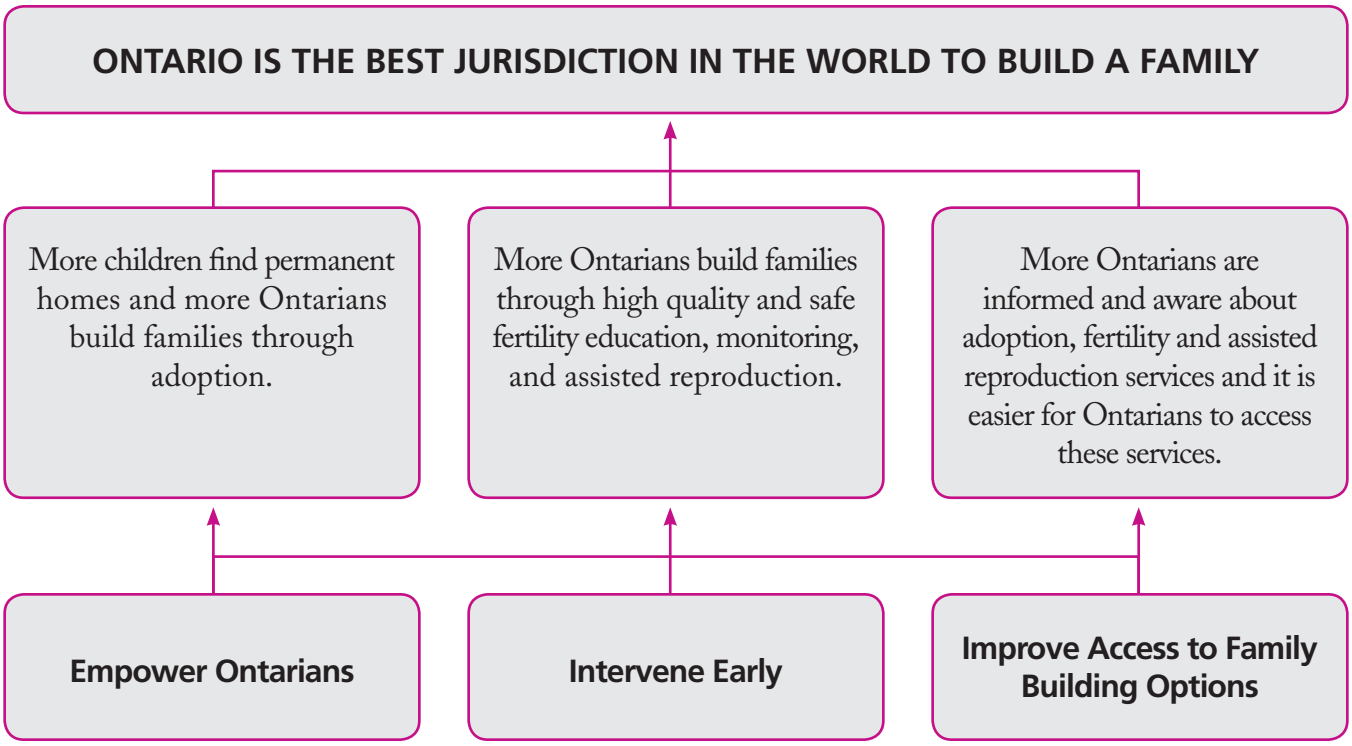
Cost is not a barrier to assisted reproduction.

All Ontarians who can benefit have access to assisted reproduction services.

Ontario has the information it needs to keep improving outcomes for all.

[1] This figure does not include CASs' infrastructure spending that supports adoption services.

To make Ontario the best jurisdiction in the world to build a family, the Province must pursue three key strategies:



1. Empower Ontarians

- Develop a multi-tiered public awareness campaign which supports people in making informed choices about family building.

2. Intervene Early

- Support concurrent permanency planning for Crown wards and re-position the system so that contact with birth families is not a barrier to adoption.
- Actively recruit adoptive families.
- Provide fertility education, monitoring and preservation services.

3. Improve Access to Family Building Options

- Create a provincial adoption agency – with a local presence – that offers services from system entry to post-adoption and that manages public adoption.
- Set consistent policy, standards and oversight for all adoption services.
- Overhaul Ontario's adoption legislation to address gaps and barriers in the public, private domestic and intercountry adoption systems.
- Provide funding to support permanency planning and for adoption subsidies and supports for former Crown wards with special needs.
- Publicly fund safe, evidence-based IVF.
- Reduce social and legal barriers to assisted reproduction.

- Require all IVF clinics and fertility centres in Ontario to be accredited and set targets for best practices, including decreasing multiple births.
- Better educate service providers so that Ontarians receive world-class adoption and assisted reproduction services.
- Collect data to improve services and outcomes.

Our report sets out a series of recommendations designed to empower Ontarians, encourage early intervention and improve access to services.

Ontario Cannot Afford to NOT Fix the Adoption System

The problems and barriers in adoption services are costing Ontario in lost opportunities for waiting children and families and in high social costs.

It costs at least $32,000 a year to keep a Crown ward in care. It costs significantly less to provide supports and subsidies to help adoptive families parent children.

The stated cost of keeping a child in care does not include the long-term cost to society of a child who grows up without a stable family. Former Crown wards are less likely to finish high school, and more likely to rely on social assistance and live in homeless shelters.

For the sake of the more than 9,000 Crown wards in the province – many of whom could be adopted – children in other jurisdictions waiting to be adopted, and the families anxious to adopt, the Province must act now. It must create an integrated, responsive adoption system that works for children and families.

Ontario Cannot Afford to NOT Fund Assisted Reproduction Services

Because of the high cost of assisted reproduction services, many Ontarians are making choices that are not good for their health, their children's health or the sustainability of the health care system. For example, the high cost makes it difficult for Ontarians to choose to transfer fewer embryos, which is a best practice in in vitro fertilization. As a result, the rate of multiple births from assisted reproduction in Ontario was 27.5% in 2006 compared to rates below 10% in other jurisdictions with controls on the number of embryos transferred.

Multiples are 17 times more likely to be born pre-term, to require a caesarian delivery and to need expensive care at birth and throughout their lives. As a result of its decision to not pay for comprehensive assisted reproduction services, Ontario is now spending hundreds of thousands of dollars a year dealing with the consequences.

It costs more to care for multiple births than it does to prevent them. Given the growing number of people using assisted reproduction services – people struggling with infertility, single people and same-sex couples – Ontario cannot afford to NOT fund assisted reproduction services.

A Question of Fairness and Equity

Ontario is committed to making a difference for Ontario families.

To become the best jurisdiction in the world to build a family, Ontario must ensure that all Ontarians – regardless of income, race, culture, sexual orientation, marital status or geography – have access to adoption and assisted reproduction services. Right now, many family building options are only available to people with higher incomes, people who live in major centers and people who are able to advocate for themselves.

We must move to actively support Ontarians in making informed decisions for family building options that are right for them, and to create responsive services that work for children and families.

Families are our future. Strong families build strong communities and a prosperous Ontario.

By acting now – by implementing the recommendations in our report – Ontario can become a world leader in family building and we will all reap the social and economic rewards.

ADOPTION RECOMMENDATIONS

1. CREATE A PROVINCIAL ADOPTION AGENCY

1.1 The Government of Ontario should **create a provincial adoption agency with a local service presence** to:

For Families

- Provide clear points of entry with current information about all adoption services: public, private domestic and intercountry.
- Facilitate referrals to private practitioners and licensees for families interested in adopting from the private domestic and intercountry services.
- Manage the service delivery of parental training (PRIDE) and homestudies (SAFE) for public adoption.
- Register families who want to adopt from the public adoption service, and guarantee the timely delivery of parental training and homestudies.

For Children

- Work collaboratively with children's aid societies to develop adoption plans for children in care.
- Recruit families for older Crown wards and Crown wards with special needs.
- Manage a central databank of Crown wards available for adoption and all families approved to adopt.
- Match children in care with an adoption plan with appropriate families.
- Make placement decisions, arrange for supervision of placements and oversee the finalization of public adoptions.

Post-Adoption

- Work with local community service agencies to develop post-adoption services.
- Create a central registry of community resources for adoptive families and provide referrals to community-based services.
- Support permanency through the provision of post-adoption subsidies and supports for children adopted from the public system.

Centre of Excellence

- Become a centre of excellence – a leader in the area of openness, including conducting research, educating professionals and developing supports to negotiate and maintain openness.

1.2 The government should set **service delivery timelines** for public parental training (PRIDE), homestudies (SAFE) and child welfare and criminal record checks, as required by the SAFE process. Specifically, guarantees should be established that parental training will commence within 60 days of initial contact with the provincial adoption agency, that homestudies will begin within 30 days after the completion of parental training and that child welfare and criminal record checks will take no longer than 30 days upon receiving the request.

Children's Aid Societies

1.3 The government should standardize **permanency planning practices** for all children in care.

1.4 As part of their responsibility for child welfare services, children's aid societies should collaborate closely with the provincial adoption agency and provide **transparent concurrent permanency planning, including planning for adoption** from the point of early contact with a child in care.

Obligations of the Provincial Adoption Agency

The provincial adoption agency should:

1.5 Operate in the **best interests of the child**.

1.6 Recognize prospective adoptive **families as a valuable resource** and support them to enter the adoption system, where appropriate.

1.7 Closely **collaborate** with government, children's aid societies, private practitioners, licensees, community-based service providers and other adoption stakeholders so that the adoption of children from the public system can occur in the best interests of the child.

1.8 Work with the Ontario Association of Children's Aid Societies to **develop a more flexible delivery model for PRIDE** (e.g., develop some components that could be offered online).

1.9 Develop a focused program to **find families** for older Crown wards and Crown wards with special needs.

1.10 Become **formally responsible for adoption planning** for Crown wards at the time of application for Crown wardship.

1.11 Provide adoptive families and birth families with **support to negotiate openness** and ongoing support to maintain openness.

1.12 Work with local community agencies to **help increase the availability of post-adoption supports** in communities across Ontario.

1.13 **Advocate for the creation of provincial programs and strategies** that support adoptive families (e.g., advocate for a provincial Fetal Alcohol Spectrum Disorder strategy).

1.14 Work with provincial bodies and other organizations to **raise awareness about the needs of all adoptive families** in community and provincial service planning, specifically, work collaboratively to influence education and training of courts, educators and other professionals.

2. DEVELOP TOOLS TO MANAGE THE ADOPTION SYSTEM

Openness and Court-ordered Access

2.1 The Government of Ontario should **remove barriers resulting from court-ordered access** to birth families while addressing the importance of contact or communication with birth families:

- Articulate a clear policy statement that contact or communication with birth families should not be a barrier to the adoption of Crown wards, and that adoption can occur for children with court-ordered access.

- Amend the *Child and Family Services Act* so that in the future Crown wards with court-ordered access are legally free for adoption.
- Tailor tools and mechanisms to better provide for contact or openness when it is in the best interests of the child.
- Undertake an immediate provincial review of all existing court-ordered access for current Crown wards: where access is not being exercised and/or does not continue to be in the best interests of the child, the case should be returned to court for reconsideration and, where some form of contact with the birth family continues to be beneficial for the child, consideration should be given to exploring the possibility of replacing the access order with an openness agreement or order.

2.2 The government should **create overarching policy and processes to support adoption with openness**:

- Clearly identify how and when court-ordered contact should be used and when it should not be used.
- Provide education for professionals in the court system, including those on the bench, about the importance of adoption for Crown wards, with a particular focus on adoption of older Crown wards.
- Provide a mechanism to clearly provide that the voice of children is heard in the decisions that impact their lives – including during any consideration of contact.
- Establish principles that birth families can be offered some form of contact in negotiation or mediation processes relating to children's futures, while providing a clear message that adoption will be pursued when it is in the best interests of the child.
- Increase the availability of alternative dispute resolution processes while collecting data to identify whether mechanisms are working.

Policy and Legislation

2.3 The government should immediately review all current adoption policies and move forward to **develop a policy framework** that will underpin public, private domestic and intercountry adoption.

2.4 The government should ensure that the policy development process is **informed by the knowledge and experience of a cross-section of external stakeholders** including, but not limited to, child welfare and adoption service providers, licensees and private practitioners, prospective and successful adoptive families, adopted youth and adults, birth parents, foster parents, current and former Crown wards.

2.5 The government should review the framework every five years to **ensure the policies remain evidence-based, current and consistent**.

2.6 The government should create **consistency within and between the three adoption services** and articulate provincial policy that:

- Clearly provides that race, culture, language, sexual orientation and family structure are not barriers to the timely adoption of children.
- Supports families to concurrently explore adoption between and within the private domestic, intercountry and public services, and to explore assisted reproduction services and adoption according to their own situations.

- Age should be only one of a number of factors considered when determining suitability of a family and/or a proposal for adoption.
- Supports equal leave for birth and adoptive parents under the *Employment Standards Act*.

2.7 The government should develop clear policy that demonstrates **support for relative adoption** including for relatives adopting intercountry.

Gaps and Barriers

2.8 The government should review intercountry adoption policy and overhaul legislation with the purpose of **safeguarding children and families, addressing barriers and legislative gaps**, as well as creating harmony between the *Child and Family Services Act*, *Intercountry Adoption Act*, with the Hague Convention and additionally, with the realities of non-Hague countries.

2.9 The government should enact **policy and/or legislative amendments** to:

- Include conflict of laws provisions in the *Child and Family Services Act* which recognize adoption consents and orders terminating parental rights made outside of Ontario.
- Address legislative gaps including those relating to guardianship and expenses and develop policy to assist Ontarians temporarily living outside the province who wish to adopt.

Advocacy

2.10 The government should **advocate** that the Government of Canada amend federal employment insurance rules to provide the same treatment for birth parents and adoptive parents.

2.11 To better support more timely intercountry adoption processes, the government should play an **advocacy role**:

- Within Ontario.
- With other provincial and territorial governments.
- With the federal government.
- With governments of other countries.

Oversight and Monitoring

2.12 The government should provide **clear oversight and monitoring** of Ontario's adoption system.

2.13 The government should set a provincial target to **double the number of Crown wards adopted within five years** and, within five years, review and establish new and ambitious targets.

2.14 The government should **set service standards and ensure that they are re-evaluated and reviewed** before the end of the five-year period.

2.15 The government should introduce a **graded licensing process** for intercountry adoption.

Data Collection and Reporting

2.16 The government should identify the data required to evaluate Ontario's adoption services and **establish clear reporting processes**.

2.17 The government should contract with a **trusted independent third party to collect and analyze longitudinal, anonymized data on outcomes** for children who are adopted.

2.18 This third party should collect **information about Crown wards who are not adopted**, including outcomes for children who are placed in kinship care and legal custody arrangements.

2.19 The government should make **accurate information about all adoption services available to all Ontarians**, including reporting on average costs, wait times, placement success and service standards.

Complaint Processes

2.20 The government should review and **enhance formalized complaint mechanisms** to be sure that all parties involved in adoption processes – adoptive and birth families, as well as children and youth – who are dissatisfied with the service they received, are heard.

3. PROVIDE ADEQUATE FUNDING THAT SUPPORTS THE REALITIES OF ADOPTION

3.1 The Government of Ontario should **fund permanency planning** to reward children's aid societies and the provincial adoption agency when children are placed for adoption.

3.2 The government should provide **adequate funding to support the provincial adoption agency to perform all identified duties**, including establishing a central and local presence.

3.3 The government should fund **special initiatives**, including:

- Parental training and homestudies for all families adopting from the public adoption service.
- The expansion of the Adoption Resources Exchange to four times a year in regional centres across the province.

3.4 The government should provide **funding for standardized and regular adoption subsidies** for the adoption of Crown wards aged two and older, as well as Crown wards under two with special needs. We recommend the use of needs-based criteria for subsidies ranging from 50% to 80% of the current foster care rate, and further recommend that the government set aside an additional funding pot for additional supports and future needs.

3.5 The government should increase the **ceiling of allowable adoption-related expenses** for income tax purposes to $30,000.

ASSISTED REPRODUCTION RECOMMENDATIONS

1. ALL ONTARIANS SHOULD KNOW HOW TO PROTECT THEIR FERTILITY

Education

1.1 The Government of Ontario should ensure that all **primary care practitioners are educated** about fertility and related issues, including: the impact of age on fertility, male and female infertility and the important risk factors that affect fertility; the reproductive needs of non-traditional families; and the complementary services available to enhance fertility or treat infertility.

1.2 All primary care practitioners – including naturopathic doctors and doctors of traditional Chinese medicine – should make **fertility education/counselling** a routine part of care for all patients, beginning in their 20s. This includes males and females, those in a relationship or single (including those who are not trying to start a family), regardless of sexual orientation.

1.3 The government should ensure that **printed and web-based educational materials** are developed and made available to primary care practitioners to share with their patients.

- Materials on fertility issues, including age-related fertility decline, should be shared with women and men who are 28 years of age or older.
- Materials on risk factors for infertility should be shared with women and men who are 28 years of age or older who present with these factors (e.g., sexually transmitted infections, obesity, anorexia, smoking).
- Materials that promote healthy behaviours and identify negative behaviours that may impact the chances of natural conception should be shared with all women and men who have identified that they would like to begin childbearing.

Counselling

1.4 The government should adjust the Ontario Health Insurance Plan **fee schedule** to allow physicians to identify counselling services that are provided specifically for infertility, so that practitioners can make the time for this in their busy practices, and the government can understand how many Ontarians are receiving this information.

Fertility Testing/Monitoring

1.5 All primary care providers, obstetrician/gynecologists or fertility specialists should offer **fertility testing/monitoring** to:

- Women age 28 and over who have been unable to conceive naturally after one year without using contraception.
- Women age 30 and older when they want to start a family (to estimate their ovarian reserve and the need for referral).
- Women age 30 and older who have been unable to conceive naturally after six months.

- The male partners of women who are undergoing testing.

Anyone who, based on fertility monitoring, appears to have a fertility problem should receive a **timely referral** to a fertility specialist (e.g., women under 30 should be referred after 12 months of trying to conceive naturally without success and women aged 30 and older should be referred after six months).

1.6 **Clinical practice guidelines** for fertility education and monitoring should be developed that include:

- Guidelines for fertility education.
- The important risk factors for female and male fertility.
- An algorithm that could help primary care practitioners assess patients' risk factors for infertility and the appropriate diagnostic tests to use.
- Criteria for diagnosing infertility in women and men.
- Single validated methods for measuring each of: the follicle stimulating hormone, antral follicle count and semen analysis tests to be used across the province.
- The specific test ranges or thresholds to use to make timely appropriate referrals to specialists.

1.7 The government should continue to **fund existing tests** (i.e., Follicle Stimulating Hormone, Antral Follicle Count, Semen Analysis tests), and introduce newer tests (i.e., Anti-Mullerian Hormone) that are more accurate and easier to use as they become available and are approved.

2. ASSISTED REPRODUCTION SERVICES SHOULD BE SAFE AND MEET THE HIGHEST, EVIDENCE-BASED STANDARDS

Accreditation

2.1 The Government of Ontario should identify a provincial body to provide a **mandatory accreditation program** for clinics and fertility centres in Ontario.

2.2 All clinics and fertility centres should be required to be **accredited** within five years in order to provide assisted reproduction services in Ontario. The cost of accreditation should be paid for by the Province.

Multiple Births

2.3 To maintain their accreditation, fertility clinics and centres must **reduce their annual multiple birth rate** to less than 15% within five years and to less than 10% within 10 years.

2.4 To help clinics meet this target, **clinical practice guidelines** should be developed that set out:

- When an intrauterine insemination procedure should be converted to an in vitro fertilization cycle.
- The number of embryos to be transferred based on the age of the woman and other clinical indications.

2.5 Providers should be given information to inform them of the negative impacts of multiple births and the **benefits of transferring fewer embryos** for children, mothers and families.

2.6 To control for multiple births and protect the safety of the children and women using assisted reproduction, clinical practice guidelines should be developed on the **safe prescribing of all fertility medications**.

2.7 As a condition of accreditation, clinics should be required to **collect and report** on:

- Success rates and other data to empower patients to make informed choices about their reproductive care.
- Their multiple birth rate and other specified data on the quality and safety of their services.

Safety

2.8 To support physicians in providing the best possible care, Ontario should collect aggregate and anonymized **data on the outcomes of**:

- Children conceived with assisted reproduction through the first five years of life.
- Patients using assisted reproduction services.

2.9 To reduce the risks for children, **intracytoplasmic sperm injection** should be provided only for individuals where:

- Severe male factor infertility is present, or
- There is demonstrated fertilization failure in a previous in vitro fertilization cycle.

2.10 **Clinical practice guidelines** should be developed by a panel of andrologists and reproductive endocrinologists that clearly defines "severe male factor infertility."

2.11 **Clinical practice guidelines** should be developed to identify:

- The qualifications necessary to provide assisted reproduction services in Ontario.
- Those circumstances where persons are not eligible for assisted reproduction services, to ensure the safety and well-being of Ontarians.

Timeliness

2.12 Ontario should examine the state of assisted reproduction technologies every five years and **update policies and practices** to reflect current capabilities.

Centre of Excellence

2.13 An academic **centre of excellence** for assisted reproduction should be created to work with the medical and research communities and service providers to:

- Conduct and facilitate research on assisted reproduction to protect the safety of Ontarians using services and ensure that provincial policies reflect current technologies and practices.
- Identify best practices within Ontario, Canada and other jurisdictions.
- Encourage knowledge transfer among service providers across the province to facilitate the best quality care for Ontarians.

3. ONTARIO CANNOT AFFORD **NOT** TO FUND ASSISTED REPRODUCTION

Funding

3.1 The Government of Ontario should **fund up to three cycles of in vitro fertilization** for women ages 41 years + 12 months and younger. The following ancillary services should be funded when provided for a funded cycle of in vitro fertilization:

- Intracytoplasmic sperm injection, when clinically indicated.
- The freezing and storage of embryos for women with any excess good quality embryos.
- Up to two frozen embryo transfers per fresh egg retrieval when a patient has good quality frozen embryos.

3.2 A patient must undergo **frozen embryo transfer** using good quality embryos before another publicly funded fresh in vitro fertilization cycle is provided.

3.3 Up to four cycles of **intrauterine insemination** should be funded for women ages 41 years + 12 months and younger. Sperm washing should be funded for intrauterine insemination procedures.

3.4 **Clinical practice guidelines** should be developed:

- That define and standardize how to assess the eligibility of embryos for freezing and storage.
- To identify parameters on the storage of embryos.

Fertility Medications

3.5 The government should develop an **awareness campaign** that:

- Focuses on educating employers and insurance companies about the benefits of including fertility medications in employer benefit plans.
- Profiles family-friendly Ontario companies that provide coverage for fertility medications.
- Highlights the need for coverage of other services that would be helpful for employees going through assisted reproduction, such as counselling, acupuncture, naturopathic medicine, massage and other complementary therapies.

3.6 The government should consider different options to help **control the cost of fertility medications**.

3.7 The government should introduce a **50% refundable tax credit** with a ceiling of $20,000 for Ontarians to help offset the costs of fertility medications.

Counselling

3.8 All Ontarians undergoing assisted reproduction services should be offered **one funded counselling session**.

3.9 The government should **fund any mandatory counselling** required by the federal government under the *Assisted Human Reproduction Act*. In the absence of federal legislation, all Ontarians undergoing third party reproduction should be required to participate in counselling as part of the informed consent process, and the government should cover the cost of this counselling.

3.10 All health care providers – including primary care practitioners – should be knowledgeable about **where to refer patients** who would need counselling services relating to fertility, infertility and using assisted reproduction services.

3.11 **Educational materials** on counselling – for fertility, infertility and assisted reproduction for all types of families – should be developed and made available to all professionals who may provide these types of services.

4. ONTARIANS WHO COULD BENEFIT SHOULD HAVE ACCESS TO ASSISTED REPRODUCTION SERVICES

Work Life

4.1 In a public awareness campaign, employers should be made aware of their responsibilities under the ***Human Rights Code*** to accommodate employees' special needs during the pre- and post-natal periods.

4.2 The definition of **personal emergency leave** in the *Employment Standards Act* should be interpreted to include assisted reproduction services.

Geographic Access

4.3 The Government of Ontario should extend the **Ontario Telemedicine Network** to all fertility clinics.

4.4 The government should ensure that the **monitoring tests** required for intrauterine insemination and in vitro fertilization (e.g., sonography, lab technician services) are available as needed in designated medical centres outside Southern Ontario.

4.5 The government should extend eligibility for the **Northern Health Travel Grant** to all people in Northern Ontario who have to travel for assisted reproduction services.

Legal Barriers

4.6 When the overdue review of the *Assisted Human Reproduction Act* is undertaken by the federal government, Ontario should **participate actively in this review**.

4.7 The Province should **join or support any Charter challenge** pertaining to the *Assisted Human Reproduction Act*.

4.8 A **provincial regulatory framework** for clinics and assisted reproduction services, including third party reproduction, should be developed under the equivalency provisions of the *Assisted Human Reproduction Act*.

4.9 An altruistic, province-wide **donor sperm, egg and embryo bank and surrogate database** should be established, operated at the clinic level, and regulated by and accountable to the government.

4.10 Ontario should ensure that the **guidelines on the safe insemination of women** using known and anonymous donor sperm protect the safety of women and children.

4.11 The government should review the process for **establishing parentage** to accommodate assisted reproduction services wherever possible, and to ensure that no intended parents are discriminated against on the basis of sexual orientation or reproductive needs.

4.12 Once they are finalized, the government should review and implement the **Uniform Law Conference of Canada's recommendations** on declaration of parentage.

Social Barriers

4.13 The government should ensure that social barriers to assisted reproduction are removed and legal barriers minimized for services to members of the **Lesbian, Gay, Bisexual, Transgendered and Queer communities**.

4.14 The government should ensure that barriers to assisted reproduction are removed from services for **single Ontarians**.

4.15 A public awareness campaign on infertility and assisted reproduction should focus on **reducing the shame and stigma** attached to infertility.

Fertility Preservation

4.16 All specialists caring for people with a medical condition or providing treatment for a medical condition that can affect fertility should be aware of the availability of services to help **preserve fertility** and make timely referrals to these services.

4.17 The government should **fund the freezing and storage of eggs, sperm and embryos** for fertility preservation.

4.18 Clinical practice **guidelines** should be developed on how long sperm, eggs and embryos can be stored at public cost.

HIV Discordant Couples

4.19 The government should develop a comprehensive approach to **reducing barriers to assisted reproduction services for HIV-infected people**.

4.20 Development of resources (including education programs) should be supported to allow **safe access** to these services in Ontario.

RAISING AWARENESS RECOMMENDATIONS

1. RAISING AWARENESS ABOUT FAMILY BUILDING OPTIONS IN ONTARIO

1.1 The Government of Ontario should develop a **coordinated public education and social awareness campaign** on family building to educate Ontarians about fertility, infertility, assisted reproduction and adoption, and about the resources and options for building or expanding their families.

1.2 The campaign should use a **multi-tiered approach** that is based on a provincial framework and implemented locally.

1.3 The multi-media campaign should utilize **partnerships with organizations outside of government**.

1.4 The government should develop **evaluation tools** to measure the success of the campaign and to shape the subsequent phases.

INTRODUCTION

Families are the heart and soul of our society. They help give children – the next generation – the best start and provide ongoing support as they move through life. Families help build strong communities and economies.

Ontarians build their families in different ways.

Many Ontarians turn to services – such as adoption and assisted reproduction – to help them become parents or add to their families.

Each year for the past five years, approximately 1,600 children were adopted into families in Ontario: more than 800 through public adoption, 650 through intercountry adoption and about 150 through private domestic adoption.

Over the same period of time, more Ontarians turned to assisted reproduction services to help them have children. Ontario clinics and fertility centres provide about 5,000 cycles of in vitro fertilization (IVF) and over 22,000 cycles of intra-uterine insemination (IUI) a year. In 2006, there were over 1,500 babies born in Ontario from IVF – and the demand for these and other assisted reproduction services is growing.

Parenting is one of life's great gifts. But it is a gift that is challenging to obtain or out of reach for many Ontarians.

- About one in six Ontario couples struggles with infertility in their lifetime.
- There are hundreds of families who are ready to adopt.
- Many single people and same-sex couples want to be parents.

Who Tries to Build Families through Adoption and Assisted Reproduction?

These stories were developed using an amalgamation of general themes. All characters and situations in these stories are fictitious.

Deborah and Kristoff were married in their 30s. When they decided to start a family, they felt there were children in their community who needed families, so they asked about adopting.

A few years after Eva and Rudy were married they tried to start a family. After many investigations, they were told that the cause of their infertility could not be diagnosed. They wanted to try assisted reproduction but could not afford the cost.

When Ruth and Emily wanted to start a family, they turned to intrauterine insemination with donor sperm and have had two successful pregnancies.

Maria was diagnosed with cancer when she was 26. There was a risk that her cancer treatments would affect her fertility, so she talked to her doctor about egg freezing so she might preserve her ability to have children in the future.

Terrell's niece, Laila, is in foster care in Ohio. Terrell and his wife Jasmine have been asked by Child Protective Services in Ohio if they would adopt Laila.

Mark and Greg had been partners for four years when they decided to build a family. They had their first son, Lars, using donor eggs and a gestational carrier. When they wanted to have a second child, they found that the laws governing third party reproduction had changed.

When Janet and Philippe were diagnosed with male infertility, they tried for three years to build a family through assisted reproduction, eventually becoming pregnant with twins.

Lisa was in her early 40s. She was focused on her career and never expected to have children until she read an article about adoption, and thought she would make a good parent for an older child.

When she was in her early 30s, Nichelle was diagnosed with fertility problems. A young woman in her community became pregnant and asked Nichelle and Kofi whether they would be able to adopt the baby.

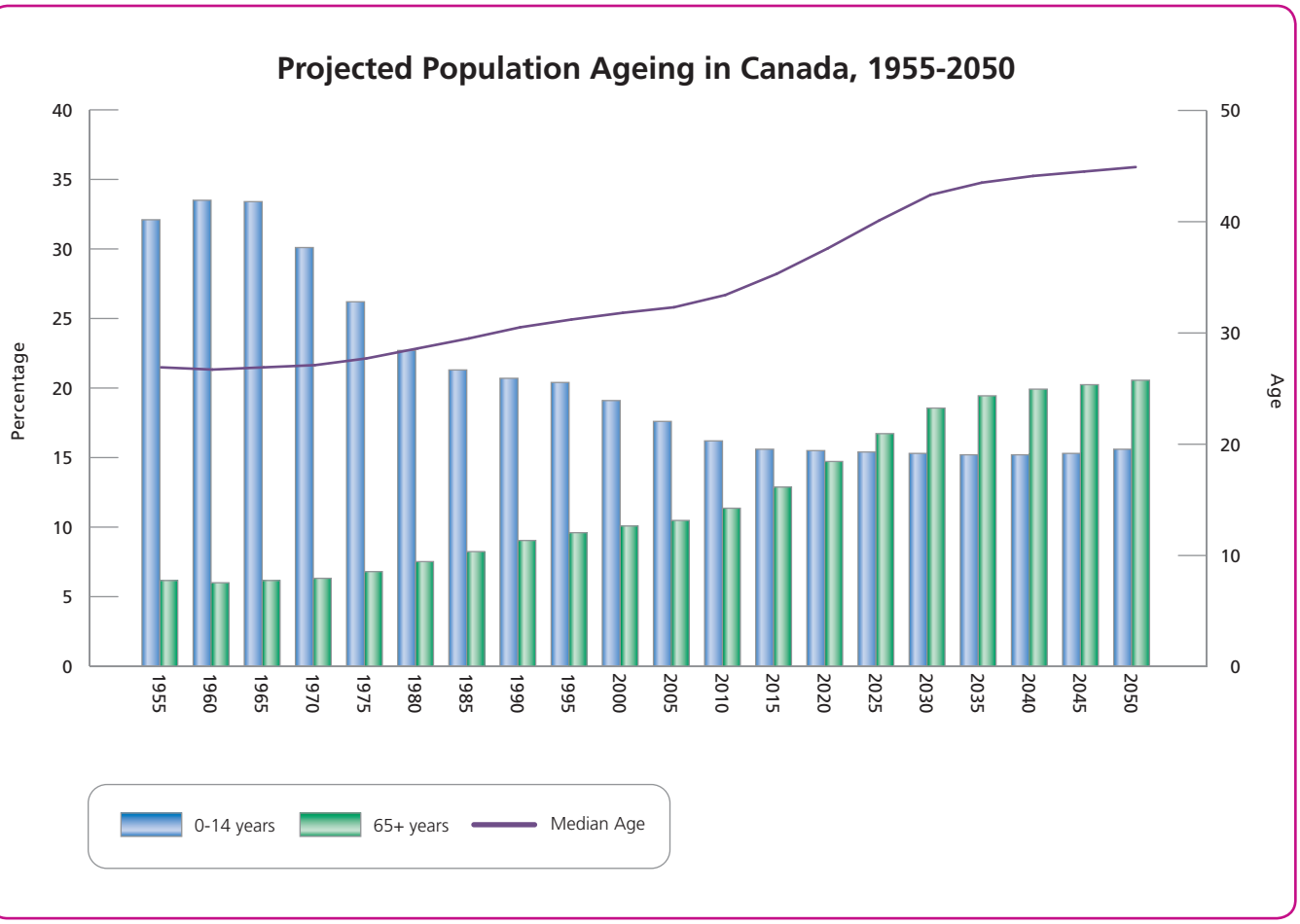
After trying for two years to start a family, Michael and Gwen had fertility tests. There was no diagnosed cause for their infertility except their age. They were told that their chances of conceiving through assisted reproduction were low so they looked into intercountry adoption.

Daniella and José first became foster parents to Jason when he was six years old. When he became a Crown ward at the age of nine, they wanted to adopt him and make him a permanent part of their family.

Families Are Our Future

Strong families mean strong communities, a healthy economy and a prosperous province. Children who have the best start in life and who grow up in stable families make Ontario stronger. They are more likely to be healthy adults and productive citizens, and contribute to their communities and the province's economy.

Children – and families – are important for our future. Ontario, like the rest of Canada, has an ageing population. In 2000, about one in eight Canadians (12%) was age 65 or older, while one in five (20%) was under age 15. By 2050, about one in eight Canadians will be under age 15 (12%) while over one in four (28%) will be 65 or older. This trend means that a much larger number of older people will be depending on fewer young people to provide the energy and resources to support them as they age.



Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2006 Revision and World Urbanization Prospects: The 2005 Revision*

To keep our province strong – socially and economically – Ontario needs more children and families.

In July 2008, the Government of Ontario appointed the Expert Panel on Infertility and Adoption to provide advice on how to:

- Improve access to infertility treatment and make fertility monitoring available to Ontarians so they know if they are likely to have problems conceiving a child.
- Improve Ontario's adoption system so that more children can become part of families more quickly.

About the Expert Panel

The Expert Panel is made up of 11 people. We were chosen both for our expertise and our personal experience with adoption, infertility and/or assisted reproduction. We include: reproductive endocrinologists, specialists in counselling, family medicine, complementary therapies and adoption; educators, lawyers and business people; people who have experienced infertility and/or used assisted reproduction first hand; and adoptive parents. For details, see Appendix F.

Our Methodology

We worked together over a year to understand the challenges that Ontarians face when trying to build families through adoption or assisted reproduction. We established two working groups: one on adoption and permanency and another on fertility monitoring and assisted reproduction.

Terms of Reference

Identify the principles that should guide Ontario's system of services and supports to family building.

Identify current issues and barriers that impede family building, including provincial and federal policies, practices, regulations and legislation.

Recommend ways to increase access to clinically effective and safe assisted reproduction technologies.

Recommend ways to support doctors and researchers to create a better system of reproductive care in Ontario.

Make recommendations to facilitate timely adoption and support adoption as a positive choice for family building.

Consider the role of employee benefits programs and the private sector in supporting family building.

Consider the most effective way of implementing the Government's commitment to make fertility screening available and recommend ways to educate the public about their fertility and family building options in Ontario.

Identify the potential impacts of better access to family building options.

We reviewed the literature on adoption, permanency, infertility and assisted reproduction, and we examined policies and programs in place in other jurisdictions. We received presentations from key organizations and individuals who were experts in their own right in their field.

We invited Ontarians who had experience with adoption, infertility and assisted reproduction in Ontario to complete an extensive online survey. We also developed online surveys for service providers, adopted adults, people who were donor-conceived and members of the public. We received about 2,500 responses to our online surveys. One hundred and six people who had used assisted reproduction and/or adoption services or were foster parents also agreed to participate in face-to-face or telephone interviews. Working with the Ontario Association of Children's Aid Societies, we conducted a survey of their member agencies about their adoption service provision. We also spoke to youth who are or were Crown wards to ask them about their views on adoption. For a summary of these discussions and surveys, see Appendix B.

We are grateful to all those who participated in our surveys, who took the time to share their knowledge and expertise and who provided information that informed our work.

Limitations

Although we believe our report represents a comprehensive view of both adoption and assisted reproduction services in Ontario, we acknowledge certain limitations. One year is a short time to review two such complex areas. We did not commission original research, although we tried to cover the most relevant literature. Time constraints prevented us from having a wider consultation, which we would have preferred. For example, the people who completed our online survey and participated in our key informant interviews may not be representative of the entire population, as they may be more computer literate or proactive in their views. Similarly, the information provided from children's aid societies (CASs) may not necessarily represent the position or experiences of all the agencies.

We fully recognize that the development of any policy or recommendations for First Nations, Métis, Inuit and urban Aboriginal children in Ontario must be a result of governments working in partnership with First Nations, Métis, Inuit and urban Aboriginal leadership, organizations, communities and service providers. We were not constituted to do this.

Our Approach

In our work, we focused on both the needs and well-being of children and the needs and well-being of all Ontarians – heterosexual couples, same-sex couples and single people – who face challenges in building families.

In all our deliberations, we put children first. Our recommendations are designed to ensure that:

- Children who are available for adoption find safe, nurturing, supportive homes – and families have the support and resources to help **children reach their full potential**.
- Babies born through assisted reproduction are **healthy** and given the **best start in life**.

We also focused on families as a valuable resource. Our recommendations are designed to:

- **Reduce the barriers** to family building.
- Make adoption services **more responsive** to families' needs.
- Ensure that Ontarians who seek out assisted reproduction services receive **safe care** that meets or exceeds the highest national standards.
- Give Ontarians who choose to adopt or use assisted reproduction services **clear information** about their choices, as well as help to navigate the adoption and assisted reproduction systems.

We believe that Ontarians have the right to choose how they want to build their families. Some will choose to adopt children from the public adoption service, while others may choose private domestic or intercountry adoption. Some will pursue assisted reproduction. Others will choose to remain childfree. **All choices are valid.**

Our report is dedicated to all Ontario families built through adoption and assisted reproduction. It is also dedicated to all the Ontarians who tried and were unable to build families or who are hoping to build families through adoption and assisted reproduction.

Family Building in Ontario

Our Vision

Ontario should aim to be the best jurisdiction in the world to build a family.
That said, we have a long way to go.

Although about 1,600 children are adopted through Ontario's three adoption services each year, there are many more who need permanent homes. Every year, a number of children whose families cannot provide the home life they need come into the care of CASs across the province and are made Crown wards. Many remain Crown wards for years and are not available for adoption, and many who are available for adoption do not find families. At the same time, many families who want children struggle to find information about different adoption services (i.e., public, private domestic and intercountry) and some wait years to be able to adopt.

Every year, tens of thousands of Ontarians turn to medical practitioners to help them build a family. Thousands more are not able to access these services because of barriers such as cost, lack of information, remote location, work constraints and the stigma of infertility.

Even when Ontarians are successful in building families through adoption or assisted reproduction, for many the journey is not simple or easy and the struggle to build a family can be heartbreaking. It can take years, and the experience can be emotionally draining and financially devastating. It can threaten people's sense of self and can destroy family and work relationships.

Goals

Our strategy is designed to achieve three goals:

1. To help more children find permanent homes and more Ontarians build families through adoption.
2. To help more Ontarians build families through high quality and safe fertility education, monitoring and assisted reproduction services.
3. To provide information and raise awareness about adoption, fertility and assisted reproduction services and make it easier for Ontarians to access these services.

Strategic Directions

To achieve our goals, we identified three key strategic directions:

1. **Empower Ontarians** – giving Ontarians the information they need to make informed decisions about family building.
2. **Intervene Early** – providing services and supports that are available early to help Ontarians build families, such as education and monitoring to prevent infertility where possible, services to preserve fertility, programs to actively recruit adoptive families, and repositioning the system so that planning for adoption can begin at an earlier stage and contact with birth families is not a barrier to adoption.
3. **Improve Access to Family Building Options** – making changes to existing services to make it easier for more Ontarians to use adoption and assisted reproduction services.

Guiding Principles

Our recommendations are guided by the following principles:

Affordability/Value for Money
The cost of building a family either through adoption or assisted reproduction should not be a barrier for Ontarians. Funding decisions should take into account the high health and social costs of not funding these services, such as the cost of keeping Crown wards in care and the costs associated with multiple births.

Child and Family Centred
Adoption and assisted reproduction services should be child and family centred. They should be designed and delivered in ways that meet the needs of children and families in Ontario.

Equity/Accessibility
All Ontarians should have equitable access to programs and services that help build families regardless of income or where they live in the province.

Freedom from Discrimination
All Ontarians should have opportunities to build families free from discrimination based on race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.

Health, Safety, Well-being and Dignity
The health, safety, well-being and dignity of every child in Ontario come first both in adoption and in assisted reproduction. Ontario's system of assisted reproductive care should be safe.

Informed Choice
Ontarians should have accurate information about assisted reproduction, fertility and adoption as positive choices so they can make informed decisions about building families.

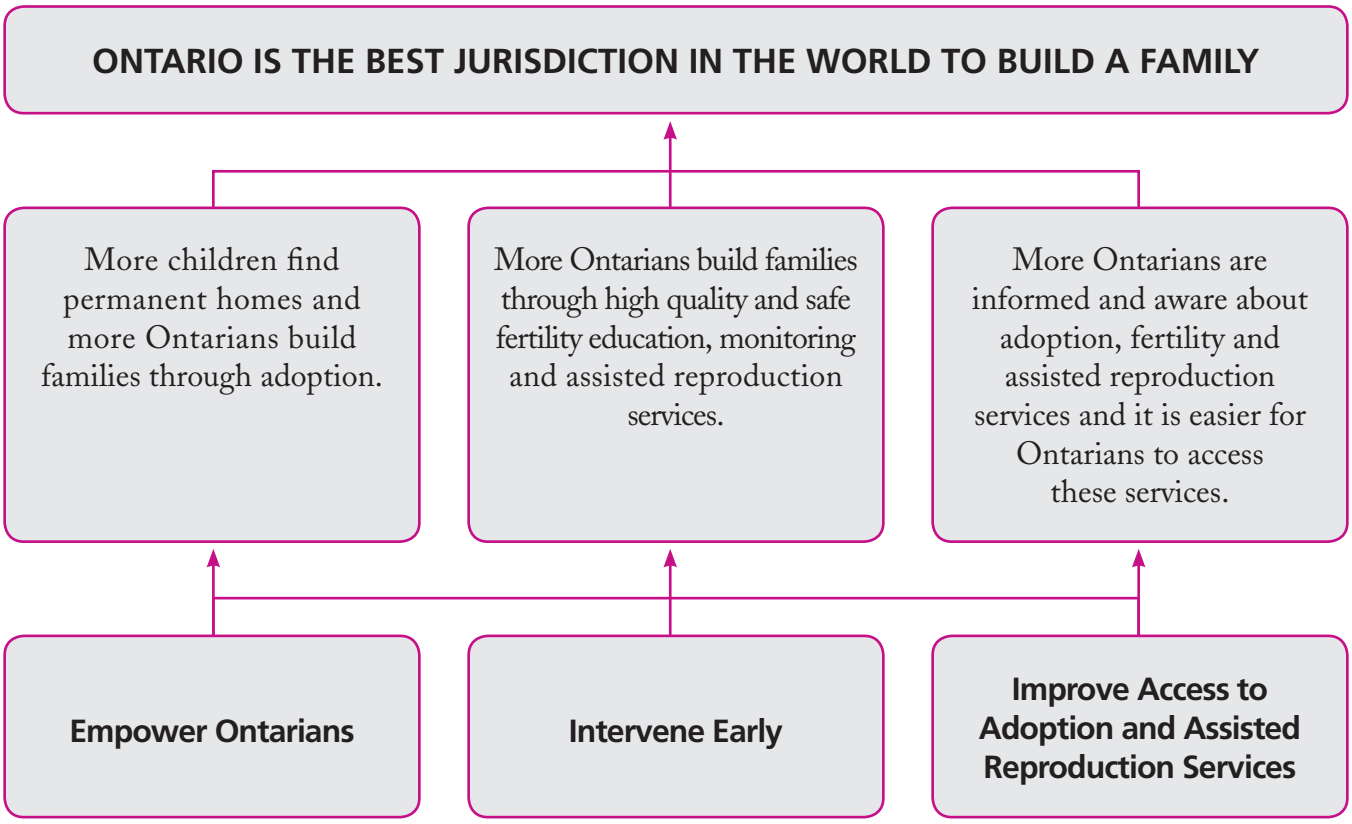
Quality/Accountability
Ontario's systems of adoption and assisted reproduction should be accountable for providing high quality, evidence-based services and achieving a balance between individual and collective interests.

Social Responsibility
Helping Ontarians build families makes good civic, social and economic sense for the province.

Timeliness/Evidence-based
Programs and services that help parents build – and children find – families should be timely and responsive to Ontarians' needs. They should incorporate current research on best practices in both reproductive technologies and adoption.

Voice
Children, youth and families should have a strong voice in the design of adoption and assisted reproduction services. The systems should reflect their needs, concerns, preferences and priorities.

As the following logic model illustrates, the initiatives and activities we recommend reflect our three strategic directions and will help achieve our goals and vision.



The following chapters address the services and supports that we see as crucial to making Ontario the best jurisdiction in the world to build a family.

FOREVER FAMILIES: ONTARIO'S ADOPTION SYSTEM

GOAL: TO HELP MORE CHILDREN FIND PERMANENT HOMES AND MORE ONTARIANS BUILD FAMILIES THROUGH ADOPTION

Adoption provides children who need permanent homes – from newborns to teenagers – with loving families. Without adoption, many children in this province would not have the stability, support, nurturing and attention that are so crucial to their physical, social and emotional development.

Adoption is also hugely beneficial for adults who want to make a lifelong commitment to a child by building what is often called a "forever family." Adoption gives many Ontarians the opportunity to become parents or add to their families. In Ontario, there are a number of options for family building including adoption through the public, private domestic or intercountry services.

Adoption is a legal process that builds families – providing children with a permanent home and parents to care for them in the present and guide them in the future.

A strong adoption system is good for the government and taxpayers of Ontario. Regulated and trusted adoption services help build strong families. Public adoption is far less expensive and has far better outcomes for children than long-term foster care.[1] Former Crown wards who age out of the system are less likely to finish high school, more likely to become parents themselves at a young age, more likely to be users of the mental health system, more likely to require social assistance, more likely to rely on homeless shelters, to experience poverty as adults and more likely to be in conflict with the law.[2] The long-term costs to society when children do not have permanent homes are staggering. The human costs, in terms of personal suffering and unfulfilled potential, are heartbreaking.

To reflect the importance of diversity and inclusiveness to Ontarians, throughout this chapter "family" refers to heterosexual couples, same-sex couples and single adults, with or without children.

Over the past year, we studied the research and literature on adoption, and heard from a wide variety of child welfare and adoption professionals, families waiting to adopt and those who had already adopted, current and former Crown wards, foster parents and adults who had been adopted. It became clear to us that the most troubling issues and concerns related primarily and, in many instances exclusively, to public adoption. For this reason, public adoption is our main focus in this chapter. However, we do address barriers and gaps relating to the private domestic and intercountry adoption services as well.

Some issues were raised repeatedly by many different stakeholders:

Many children in Ontario – from newborns to teens – are without permanent homes because **the system is failing them**.

Many families in Ontario who want to adopt children are prevented from adopting because **access to information and timely entry to mandatory parental training and homestudy programs are highly variable** across the province.

The current **fragmented system** of public, private domestic and intercountry adoption services is inefficient and ineffective – for families and children.

Public adoption services are decentralized, and as a result, **processes vary widely across the province**: for instance, some children's aid societies (CASs) do not look for family matches outside their own local boundaries, while others do.

More transparency is needed: adoption processes are too often both subjective and inconsistent. Adoptive families, birth families and others are often left in the dark as to why and how decisions are made.

Permanency is a fundamental goal for Crown wards **and adoption should be viewed as the most important form of permanency**.

Contact or communication with birth families should not be an insurmountable barrier to adoption – for many Crown wards, contact or communication with birth families continues to be a barrier to adoption.

> *"There are no guidelines posted, no rules posted … there is confusion about timelines, homestudies, concurrent adoption … and it seems that social workers are as confused as we are."*
>
> *– Interviewee*

Implementing and maintaining **openness without support is challenging** for adoptive families and birth families.

Adoption processes are not always timely, which creates emotional hardship for parents and children and delays bonding and attachment, which are crucial for healthy families.

Prospective and adoptive **families feel they don't have a voice** or anyone to turn to when the system is not working.

There Are Too Many Waiting Children

Every year, many dedicated and experienced professionals working in the province's three adoption services – public, private domestic and intercountry – help create or build about 1,600 families.[3] In addition, families are also created through relative adoption or by step parent adoption.

Yet, many more children are still waiting to be adopted and many more Ontarians would like to build their families through adoption – but problems in the system are keeping them apart. This is particularly

troubling with respect to public adoption: many children in the care of a CAS may have experienced neglect and/or abuse, or may have other risk factors such as prenatal exposure to drugs and/or alcohol. Children who live in foster care and group homes often experience multiple placements and numerous service workers.[4] For many of these extremely vulnerable children, change is the only constant. Finding stable, loving families for them can make an enormous difference in their lives – and in their ability to fulfill their potential and become productive members of society.

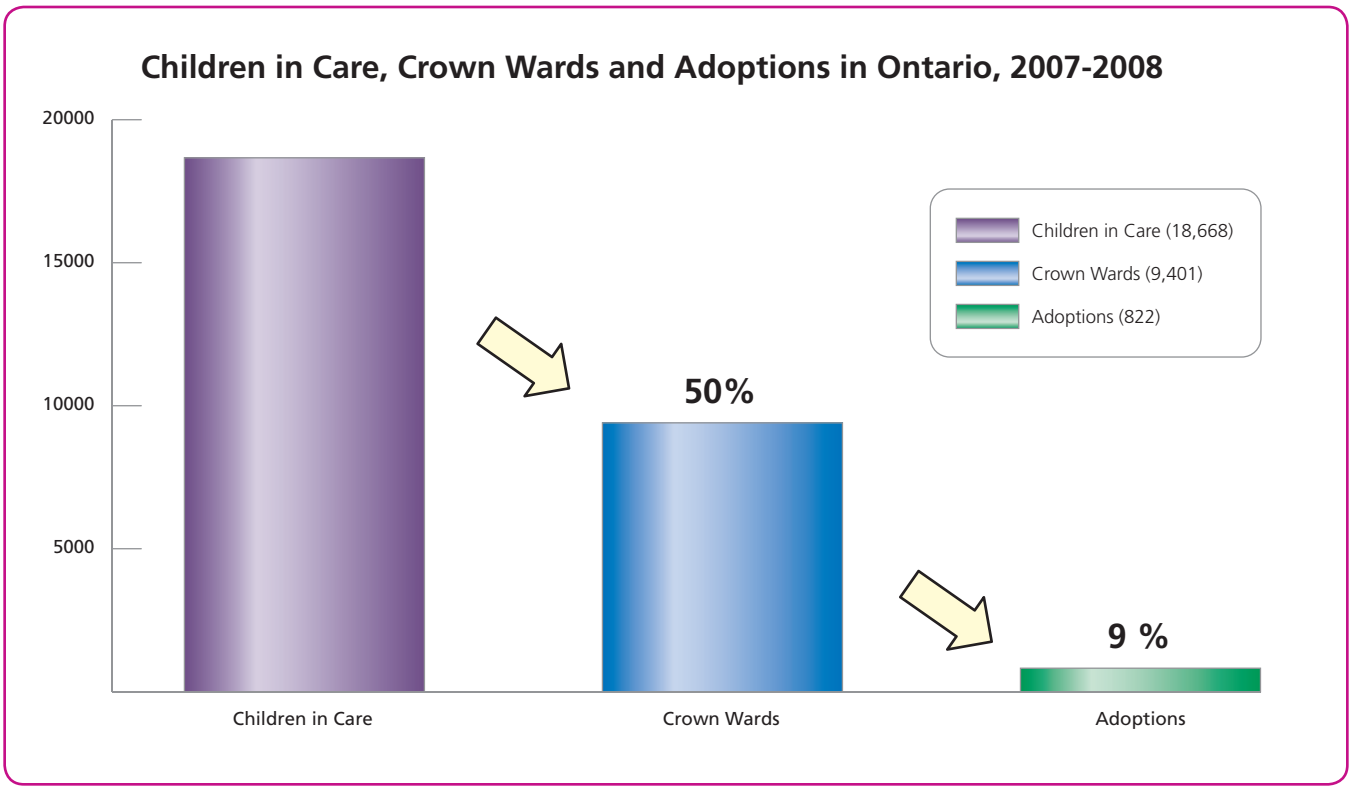
"There are kids in Ontario who have no permanent home, and that is 100% the result of how difficult the system is."
– Interviewee

CAS adoption service providers told us they don't have the resources they need to do the job they would like to do.

In our view, **the central systemic problem is that adoption is not the primary focus of CASs – nor should it be**. Child protection is, understandably, their main focus. Only about 2% of CAS funding is devoted to adoption and CAS workers themselves told us that the resources dedicated to adoption vary greatly from one CAS to the next.[5]

Furthermore, **there are significant policy and legal barriers** that prevent the adoption of many Crown wards. The numbers speak for themselves. In the child welfare system in 2007-08:

- There were 18,668 children in the care of a CAS.
- Of the children in care, approximately 50% (9,401) were Crown wards (meaning that a CAS has become the "legal parent" of the child).
- Only 9% (822) of the 9,401 Crown wards were adopted.[6]



Source: Ministry of Children and Youth Services

The price tag for growing up in care is too high, not just for the children themselves, but for all Ontarians. Foster care is designed to be a temporary solution for children in care, not an ultimate destination for thousands of Crown wards – the vast majority of whom will not be reunited with their birth families. For many children, foster care does not offer long-term permanency. In 2006, 35% of Crown wards who had been wards for more than two years had experienced three or more placements. Instability is emotionally costly for a child, and keeping a child in care is costly for all Ontarians. It is estimated that the provincial average annual cost to keep a Crown ward in public care is $32,000.[7] As youth in care told us, they are without stability, consistent adult guidance or certainty – even the certainty of knowing where they will be next. We cannot afford to be complacent about the fact that this is how thousands of children in Ontario are growing up – particularly when another, far more positive and less financially costly option exists.

A court may make a child a Crown ward when reunification with the birth family has proven unsuccessful or inappropriate. When a child has Crown ward status, the Crown (Province) has the rights and responsibilities of a parent. On behalf of the Province, CASs exercise these parental rights and responsibilities for the child.

One of the main barriers to changing public adoption is the current culture around adoption – negative attitudes about Crown wards and skepticism about the availability of families to adopt them. There is a widely held belief that families exploring adoption "are only interested in healthy, white infants" and that most of the children in the care of CASs have special needs, are over the age of three and, therefore, are "not adoptable." Adoption workers told us of tensions within agencies when child protection workers do not consider adoption as an option for the children whose cases they supervise, particularly if the children are older. Adoption workers also told us that, at times, courts appear to grant Crown wardship with court-ordered access (to birth families) – effectively preventing adoption – simply because they don't believe that there are any families in Ontario who would be willing to adopt children other than infants or toddlers.

Yet programs created specifically to place older children and children with special needs are, in fact, highly successful. For instance, the AdoptOntario website and databank, operated by the Adoption Council of Ontario (ACO), has had good success matching children with adoptive families. Of the 260 children posted on the website since January 2006, 130 (50%) were removed from the site for adoption placement.[8] The Adoption Resource Exchange (ARE), a public event where families interested in adoption can see video presentations and written profiles of waiting children and meet adoption workers from across the province, also has an impressive track record. The ACO told us that the approximate placement rate of children whose profiles are presented at the ARE is 75%.[9] It should be noted that most of the children listed on the AdoptOntario website and profiled at the ARE were older children and/or were children with special needs. We understand that virtually all were listed on the site because for a variety of reasons, their CASs had been unable to place them locally.

The success of programs in other jurisdictions also indicates that current biases about which children are adoptable, and which are not, are outdated and inaccurate. The "You Gotta Believe" campaign in New York state, the Homecoming Project in Minnesota and the Wendy's Wonderful Kids program right here in Ontario all prove that age and special needs are not insurmountable barriers to adoption.[10, 11]

Wendy's Wonderful Kids – finding families for "hard to place" children

Wendy's Wonderful Kids (WWK) is funded by the Dave Thomas Foundation for Adoption. WWK programs have had demonstrated success finding permanent, loving adoptive homes for "hard to place" children in public care across the United States, in British Columbia and right here in Ontario.

Innovative practices such as the "Adoption Register for England and Wales" demonstrate the potential of centralized, mandatory databanks. In 2007, the Adoption Register matched 199 children with families. Of the children matched, 49% were in a sibling group. The number of children placed through links made by the Adoption Register increased by 26% from the previous year, and at a time when the total number of children placed for adoption had fallen.[12]

We are deeply troubled by the fact that, despite proof of the effectiveness of programs and resources designed to match "hard to place" children with families, very few Crown wards are listed on the AdoptOntario website or profiled at the ARE.

The other significant barrier to improving public adoption is the **complexity of child welfare processes**. Ontario's current legislation creates two classes of Crown wards: those with court-ordered access (to birth parents or other birth family members) and those without court-ordered access.[13] Ontario's legislation stipulates that **Crown wards with court-ordered access may not be adopted**. Currently, of the Crown wards who have been wards for more than two years, almost 75% have court-ordered access. Of the Crown ward files reviewed in 2007, 99% of Crown wards did not have permanency plans that included returning home to the care of their birth families.[14] We believe court-ordered access has the effect of trapping Crown wards in the system rather than providing them with an opportunity for permanency in the form of adoption.

There Are Too Many Waiting Families

Accurate information does not exist on the number of families in Ontario who are waiting to adopt via any of the three adoption services. But we do know that last year, CASs completed more than 1,200 homestudies for families wanting to adopt, and many more families completed their homestudies and parental training privately.[15]

Ironically, the current adoption system in Ontario is not family-friendly. Adoptive families and prospective adoptive families told us repeatedly that it is exceedingly difficult to get accurate information about the different services in the province and about what to expect when moving through the system. There is no central clearinghouse for current research, information about adoption or about the services provided in the province. Moreover, processes are not transparent – the rationale behind many adoption policies and practices isn't clear, and at times the rules differ depending on which type of

"There is not one number you can call in the government and feel comfortable to ask questions and talk to people who are not biased. You can't ask these questions of your social worker because they could hold it against you."

– Interviewee

adoption is being pursued or which agency is providing the services. Prospective adoptive parents often feel "shut out" or become discouraged and sometimes give up on adoption altogether. However, the feedback we received from families was divergent and highlighted the variability and lack of standardization of adoption services across the province. Families' experiences clearly depended on a variety of factors: which of the three adoption services they used, the workers they encountered, their social and cultural backgrounds, and their own expectations about the process of adopting a child.

Adoption service providers gave us considerable insight into the system, both in terms of what is working and what is not. Licensees and practitioners told us that access to flexible, creative and personalized services was the greatest strength of the private domestic and intercountry adoption services, while weaknesses included the costs to adoptive families and the lack of collaboration between and across services. Public adoption workers told us that the strengths of their services included the strong focus on meeting the needs of the child, while the greatest weakness was the lack of resources.

These sorts of weaknesses make the adoption process more complicated and costly than necessary. They delay – or even prevent altogether – the placement of highly vulnerable children who clearly could benefit from early placement.[16, 17]

The Problem Is the System, Not the People

Given the numbers of waiting children and waiting families, it is clear that many more adoptions would occur in Ontario if adoption services worked better. In fact, we believe that with some significant adjustments to the system, **Ontario could double the number of Crown wards adopted within five years**.

In our view, the problem is not the *people* involved in adoption. The vast majority of adoption service providers, CASs, private practitioners and licensees want adoption services in Ontario to be the best they can be. They are trying to do what is right for the children waiting to be adopted, for the birth parents making adoption plans and for the prospective parents building their families through adoption. We also saw grassroots and community-based agencies – such as the ACO, the AdoptOntario program, the ARE committee, the Wendy's Wonderful Kids program, the London Coalition of Adoptive Families and the North American Council on Adoptable Children (NACAC) – working collaboratively with providers to improve adoption services in Ontario.

> *"It is a broken system, but has some very good people working in it."*
>
> *– Interviewee*

The central problem is the current "patchwork quilt" nature of adoption services in Ontario. Services are not structured in a way that makes sense for children or families – or even service providers. In fact, **there is really no "system" at all**. Service providers tend to operate in relative isolation, often with few connections between them. Adoption policies, legislation, guidelines and standards are not based on current research or best practices, are inconsistent across services and, in many cases, do not reflect the current realities of adoption – or the diversity of this province. Furthermore, insufficient information is collected about services and outcomes for children and families. Without evidence-based research, it is difficult to plan a comprehensive range of adoption services that anticipate and fully respond to children's, families' and service providers' needs.

Deborah and Kristoff married in their mid-30s and decided to build their family through adoption. At first, they had trouble finding information about the different options available in Ontario. Eventually they began to talk to other families who had adopted and found information on the Internet. They contacted their local CAS but found the first conversation – about how long they might have to wait and the kinds of needs a child might have – discouraging. However, they had become acquainted with other families who had adopted through the CAS so they asked to be considered as potential adoptive parents. They had to wait over a year to begin the required parental training and homestudy process. The delay surprised them because friends in a nearby community had applied to their local CAS to adopt at about the same time and had completed their homestudy and training within six months. To speed up the process, Deborah and Kristoff asked about completing their homestudy privately but were discouraged from doing so.

The year after Deborah and Kristoff were finally approved to adopt, the CAS called them about five year-old Kara, who was living with a foster family. She had been taken into care because of neglect. She was behind in her development. When she came into the care of the CAS at age four, she had not yet reached a number of key developmental milestones. For a year after she came into care, the CAS worked with Kara's birth parents to try to make it possible for her to return home. When the CAS eventually determined that her birth parents were not able to care for her, they applied to the court for Crown wardship.

During her time in foster care, Kara made great gains and showed signs of being very bright but, because of the lack of order in her early life, it was determined that she needed a family who could provide extra structure and stability.

Deborah and Kristoff were very anxious to adopt Kara. While they were concerned that they might not have all the skills necessary to provide the support she needed, the adoption worker reassured them that a permanent home was what Kara needed most. Deborah and Kristoff accepted the placement. Kara is now 15 years old, a straight-A student and an accomplished musician.

Kara continues to need extra structure and order in her life, but she is thriving. When she was nine, Deborah and Kristoff adopted another child through the CAS: a four year-old boy, Ethan.

Ontario Can Do Better – Ontario Must Do Better

The status quo is not acceptable. We envision a province where children who need homes find them as quickly as possible, and where families who want to adopt are able to access both information and services in a timely manner. We are convinced that many more adoptions would occur if the system worked better. Ontario can and should construct a world class system in which:

All children who need a safe, loving and permanent family have the best possible chance of finding one.

Age and special needs are not viewed as insurmountable barriers to adoption.

Choices made by families are respected – regardless of the adoption service they choose or their reasons for building their families through adoption.

"Before I was adopted I didn't belong. I yearned to belong! All I wanted was a mother. I wanted to be loved."
– Adopted adult

We clearly heard from youth that it is important to keep the channels of communication open with birth families or extended families where these contacts exist, but that such contact should not preclude them from being adopted.

All **prospective adoptive families are treated as valuable resources** and receive clear, accurate information about all forms of adoption.

Adoption **processes are streamlined and expedited**, so that children and adoptive parents are united as quickly as possible.

Contact or communication with the birth family, when in the best interests of the child, **is not a barrier to adoption**.

Adoptive families – **both parents and children – receive the supports they need** even after an adoption is finalized.

Information on services and outcomes is collected and continuously studied to keep improving adoption for children and families.

To provide a world class adoption system, Ontario must act now. We urge the government to:

1. Create a provincial adoption agency with a local service presence to:

- → Provide all interested **families with the information they need** to explore their potential to adopt.
- → Work with CASs to **make appropriate and timely adoption plans** for children in care.
- → Focus on **finding families** for older Crown wards and Crown wards with special needs.
- → **Match and place** Crown wards with families.
- → Provide birth families and adoptive families **support to negotiate and maintain openness** when in the best interests of the child.
- → Support families throughout the public adoption process and **help families after the adoption is finalized**.

2. Develop tools to manage the adoption system:

- → Set **policy and legislation** for all adoption services that reduce barriers to timely adoption.
- → Ensure that, when safe and appropriate, **contact or communication with birth families is not a barrier to adoption**.
- → Provide **consistent direction and oversight** and support the **independent collection of anonymized data** to monitor outcomes for children who are adopted.
- → Establish **complaint mechanisms** so that birth families, prospective adoptive families, adoptive parents and adopted children who are dissatisfied with the service they received can be heard.

3. Provide adequate funding that supports the realities of adoption:

- → Create funding **incentives for permanency planning**.
- → Provide funding to support the provincial adoption agency to perform **all identified adoption functions**.
- → Guarantee funding to **support ongoing adoption subsidies** for older Crown wards and Crown wards with special needs.

Limitation to these recommendations:

We fully recognize that any recommendations for First Nations, Métis, Inuit and urban Aboriginal children in Ontario must be a result of government working in partnership with First Nations, Métis, Inuit and urban Aboriginal leadership, organizations, communities and service providers.

We understand that it will be necessary for the government to work in partnership with these groups to determine whether and how our report has implications for child welfare for First Nations, Métis, Inuit and urban Aboriginal children.

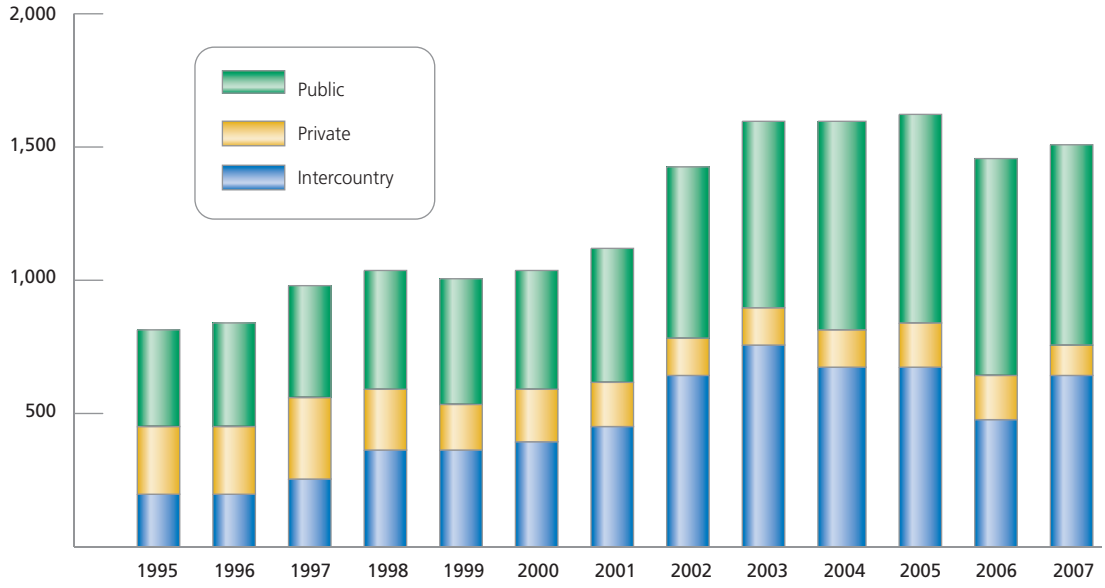
ADOPTION IN ONTARIO NOW – THE BASICS

Ontarians who want to build or add to their families through adoption have three options: public, private domestic and intercountry adoption. All three are regulated by the provincial government and, in all instances, the best interests of the child are deemed paramount.[18]

Patterns of adoption in Ontario have changed significantly over time and continue to change. Over the past decade, for instance, there has been a decrease in the number of private domestic adoptions and a slight increase in intercountry and public adoptions. In Ontario, as in many other jurisdictions, there are many fewer newborn babies available for adoption than there were several decades ago, and more families are choosing to adopt from countries like China and, more recently, Ethiopia.[19]

Each year for the past five years, **approximately** 1,600 children were adopted into families in Ontario through one of these three services. The largest number – more than 800 a year – are public adoptions, followed by about 650 intercountry adoptions and 150 private domestic adoptions.

Adoptions in Ontario (1995-2007)



Source: Adoptions and Crown Wards (ACW) Information System, Ontario Ministry of Children and Youth Services and Citizenship and Immigration Canada, Facts and Figures.
Note: The ACW system is updated on an ongoing basis following receipt of final adoption orders from Provincial Courts. This data has been supplemented with intercountry adoption statistics from Citizenship and Immigration Canada.

The Ontarians Who Choose to Adopt and Why

> *"The fact that I was a lesbian was never something I considered to be a barrier to wanting to have a child."*
>
> *– Interviewee*

Ontarians – heterosexual and same-sex couples, and single people, with and without children – choose to build or add to their families through adoption for many different reasons. Some want to help a child in need. Some try assisted reproduction services before trying to adopt. Others turn immediately to adoption. Some families adopt a child who is already biologically related to them. Some are foster parents who have been caring for a child they have come to view as a member of their forever family.

Regardless of why they want to adopt, families do not take the decision to adopt lightly. Families told us that they thought long and hard about adoption and that the decision was life-changing. In every instance, we heard that they wanted to be sure that adoption was in the best interests of the child – whether they were adopting from the public, private domestic or intercountry services.

In her early 30s, Nichelle was diagnosed with fertility problems. She and her partner, Kofi, were devastated and, at first, they didn't tell anyone they knew because of the stigma of infertility. Eventually, they did talk to their family and friends about it. When a young woman in their community became pregnant, she asked Nichelle and Kofi whether they would be able to adopt the baby. They agreed. They were referred to a private practitioner who helped them complete their homestudy and parental training, and a licensee who arranged counselling for the birth mother and looked after all the legal aspects of the adoption. A few days after Alika was born, she was placed into Nichelle's and Kofi's family. Alika's birth mother continues to be part of her life. Nichelle says that she believes their adoption experience was much easier than for many people because they knew the birth mother. However, the process and paperwork were complicated, the experience was an emotional rollercoaster and the costs were higher than expected.

The Children Who Need Permanent Homes

Children adopted by Ontario families generally fall into one of four groups:

Public	Private Domestic	Intercountry	Relative
Ranging in age from newborns to teens, these children are generally available for adoption as a result of having been taken into the care of a CAS and have been made Crown wards by the court. A smaller number of birth parents voluntarily place their children for adoption with CASs each year (approximately 5% of public adoptions).	Usually newborns or infants whose birth parents, for personal reasons, want to make an adoption plan for their child. Children who, through a court procedure, are adopted by a parent's partner.	Usually toddlers or young children from outside Canada whose birth parents are not able to provide a safe, stable home. These children are usually in the care of an orphanage or are otherwise in the care of the state.	Ranging in age, these children live either in Ontario or outside the province and are adopted by biological relatives living in Ontario.

Who Provides Adoption Services in Ontario?

Private domestic and intercountry adoption services are facilitated by about 38 individuals or agencies (licensees) licensed by the government under the *Child and Family Services Act* (CFSA) or the *Intercountry Adoption Act* (IAA). Intercountry licensees are required to be knowledgeable about country-specific adoption programs and must ensure that all legal requirements are met, both in Ontario and in the child's home country.

Ontario requires that all prospective adoptive families complete a parental training (PRIDE) and homestudy process (SAFE). In addition to CAS workers who have been approved to complete parental training and homestudies, there are 110 *adoption practitioners* in the province who have been approved to conduct parental training and homestudies privately. Approved adoption practitioners are social workers or other professionals with significant experience in adoption and/or child welfare.

Adoption Legislation in Ontario

The rules for adoption by Ontario residents are set out in two pieces of legislation, the *Child and Family Services Act* (CFSA) and the *Intercountry Adoption Act* (IAA).

Public adoption services are part of the broader child welfare service system. Each of the 53 CASs across the province has been mandated by the government to provide child welfare services, including child protection and adoption. CASs are not-for-profit agencies with locally elected boards of directors, are subject to regulation by the government and largely funded by the province. Six Ontario CASs are Aboriginal and three are faith-based agencies (two Catholic, one Jewish).

Many important decisions about how to deliver child welfare services are made independently, at the local level. Adoption is only one of the possible "permanency placements" for children in the care of CASs. Other options available include legal custody, kinship care, Customary care and foster care.[20]

How Much Does Adoption Cost?

A key difference between Ontario's three adoption services is the cost to adoptive parents. Because the child welfare system is publicly funded, there are few if any costs for families adopting Crown wards – the primary costs would be for any independent legal advice families may seek.

Families adopting from the private domestic and intercountry adoption services are responsible for all the costs associated with adoption, including the parental training (PRIDE) and the homestudy process (SAFE), the services of the adoption licensee, legal fees and administrative costs. In private adoption, families also pay for the cost of counselling for the birth parent(s). In intercountry adoption, families pay fees charged by the licensee, as well as travel expenses to meet the child and bring the child home.

Adoptive famiiles told us that the cost of a private adoption can range between $20,000 and $30,000, while intercountry adoptions can cost up to $60,000.

To offset these costs, families can claim adoption expenses on their personal income tax, including fees

"There was probably about $60,000 that could have gone into the mortgage. But it was worth it for our children."

– Interviewee

paid to a licensed adoption agency, court costs, legal and administrative expenses, as well as reasonable travel and living expenses to complete an intercountry adoption. Both the federal and Ontario governments offer a non-refundable adoption tax credit.

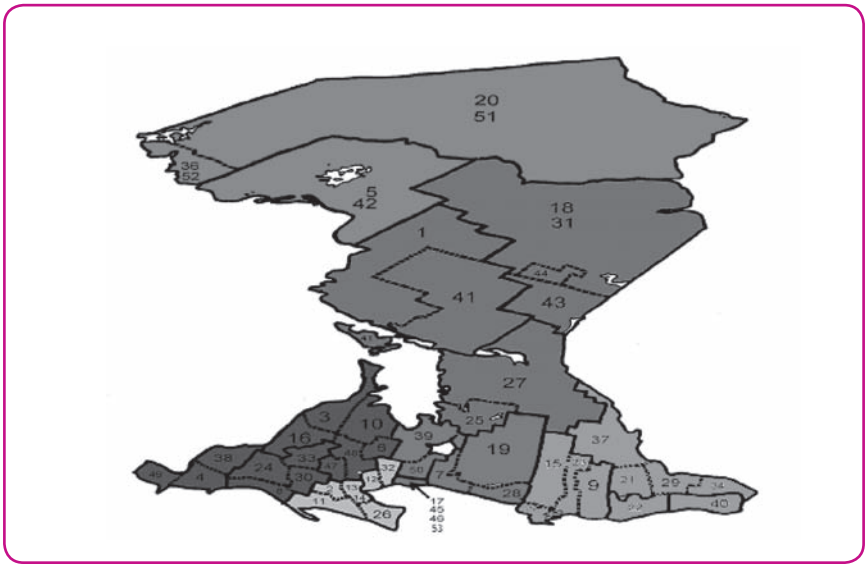
In summary, the three adoption services in Ontario are:

Public	Private Domestic	Intercountry
Facilitated by CASs. Most of the cost of public adoption services is paid for by the government.	Facilitated by licensees – government is responsible for approving all proposed adoptions. The cost of these services is paid for by the adoptive families and ranges from $20,000 to $30,000, including the costs for mandatory parental training and homestudy processes.	Facilitated by licensees – government must approve applicants under the IAA before their application is forwarded to another country. The cost of these services is paid for by the adoptive families and ranges from $30,000 to $60,000, including the costs for mandatory parental training and homestudy processes.

THE WAY FORWARD

During our review of adoption services in Ontario, three consistent themes emerged: the system isn't coordinated, service delivery isn't consistent, and service delivery isn't as sensitive as it could be to the needs of children and families. We are particularly concerned by the fact that there is so much variability in the adoption service delivery provided by CASs and we believe the main explanation is that adoption is not the primary focus of the CASs – nor should it be.

We do not believe that it is possible to fix or revamp public adoption services as they currently exist in Ontario. The measure of success of any public adoption service is the number of children available for adoption who find forever families – and, by that measure, the current system simply does not work. This is not surprising, given its decentralization and lack of standardization. Dispersing responsibility for the adoption of Crown wards to 53 separate CASs without clear, unifying standards or policy direction is neither effective nor efficient. The current decentralization of public adoption services in Ontario is illustrated by the regional and local divisions of the 53 CASs as noted below.



CASs are primarily responsible for delivering a range of prevention and child protection services. Understandably, assessing risk and preventing harm to children – truly life and death matters – are the main day-to-day focus of CASs. But the result, in a world of limited resources, is that adoption often gets lost amidst competing claims and is not always a high priority service. Adoption services represent only a small fraction of the child welfare services that CASs deliver on behalf of the province and in 2007-08, accounted for only about 2% of the more than $1.3 billion spent per year on child welfare services in Ontario.[21]

Child welfare services delivered by Ontario's 53 mandated CASs include:

Prevention services designed to strengthen families, including crisis intervention, counselling and other services to prevent child abuse and neglect.

Child protection services, including investigating reports of neglect or abuse and taking children into care under court supervision.

Providing care programs for children, including foster care and providing support for birth parents to help them regain the care of their children.

Permanency planning for children who become wards of the province, including planning for adoption.

The child protection focus of CASs makes it difficult for prospective adoptive parents to get the information they need about adoption. Many told us they felt they were initially viewed as potential threats rather than valuable resources for children in need of loving families. Furthermore, CASs tend to look within their own borders when searching for families to adopt Crown wards in their care. Sometimes this works, but often it does not – and using geography as the most significant criterion in determining the suitability of an adoptive match is not in the best interests of the child.

Finally, there is clearly a fiscal component to adoption. Quite apart from the immeasurable benefits to children and families, **it simply costs less in the long-term than keeping children in public care**.[22, 23] Where it is possible and desirable to seek adoptive placements, it is cost-effective to do so as aggressively and as early as appropriate.

All of this will only be possible with a strong, central agency dedicated solely to adoption – and accountable for ensuring that children and families across the province have equal access to adoption services that are delivered in a timely manner. It is simply not acceptable to let children languish in care because of an outmoded, ineffective and decentralized way of delivering adoption services. Their lives are worth more and we owe it to them – and to the families who are eager to provide loving homes – to create a new path forward.

1. CREATE A PROVINCIAL ADOPTION AGENCY

We urge the government to create a new, centralized provincial adoption agency (PAA) with a local service presence to:

- → Provide all interested **families with the information they need** to explore their potential to adopt.
- → Work with CASs to **make appropriate and timely adoption plans** for children in care.
- → Focus on **finding families** for older Crown wards and Crown wards with special needs.
- → **Match and place** Crown wards with families.
- → Provide birth families and adoptive families with the **support to negotiate and maintain openness**, when in the best interests of the child.
- → Support families throughout the public adoption process and **help families after the adoption is finalized**.

What It Would Look Like: Provincial Adoption Services with a Local Service Presence

A PAA with a local service presence, answering to government, would serve as a clearinghouse for information on all three of Ontario's adoption services and help families interested in adoption to access the services they need. The agency would also manage public adoption service delivery, including matching children available for adoption with potential adoptive families, placing children with families and supervising placements. The agency would be responsible for supporting adoptive families through the public adoption process – from entry point to post-adoption services – and for providing subsidies to families who adopt Crown wards with special needs.

Services in English and French

We recognize that to adequately provide services in Ontario, capacity in both English and French must be developed. Local service provision means responding to the needs of members of the community, and the agency would actively offer services in French in those parts of the province that require it.

CASs would continue to have responsibility for children in care. But locally-based PAA adoption workers would work together with CAS child protection workers on concurrent adoption planning for children in care, where appropriate, from early in the permanency planning process, particularly when the CAS is applying for Crown wardship of a child.

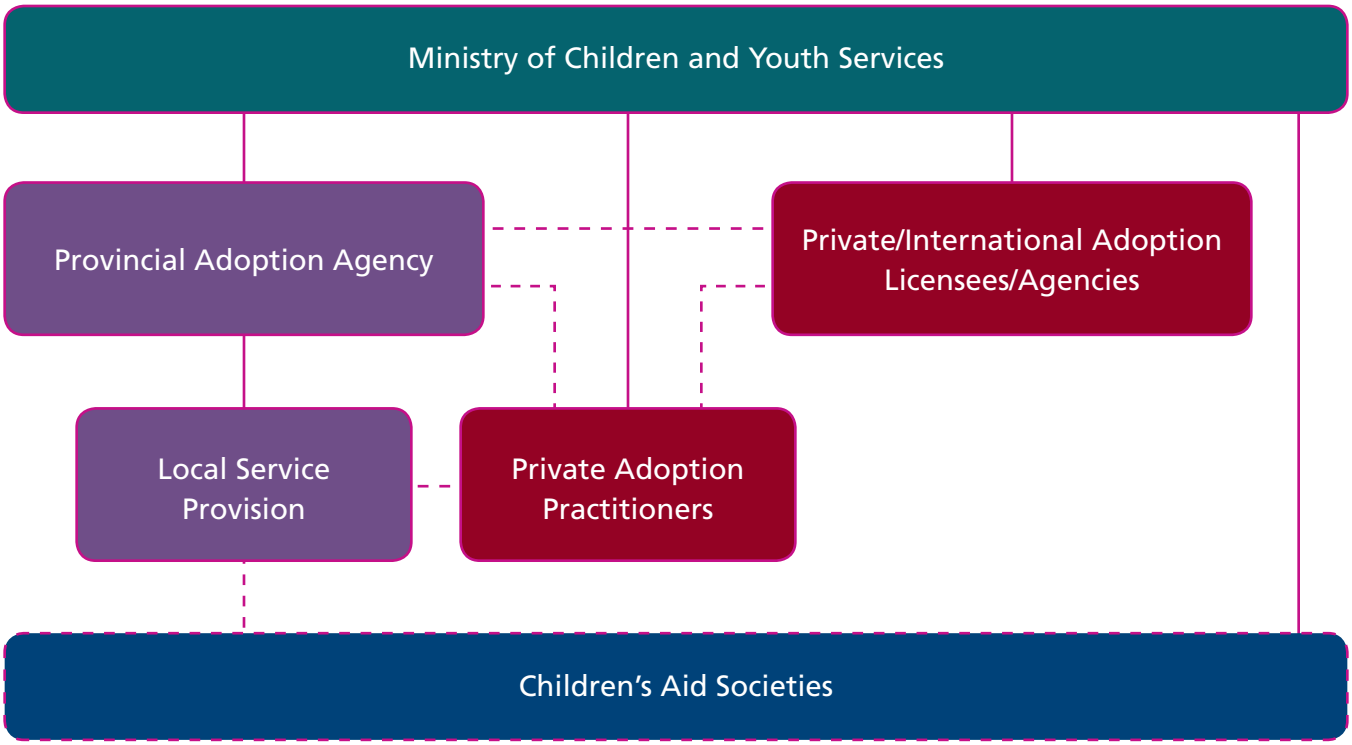
The PAA would also work with CASs to regularly review the plans of Crown wards in non-permanent situations, such as short-term foster care, to determine whether adoption might be an appropriate option for those children.

To facilitate system entry for prospective adoptive parents and timely adoptions of Crown wards, the PAA would establish both a central and local service presence in order to work efficiently with families, as well as CASs.

How and where local services would be provided is an implementation detail. In building its service delivery model, the agency would evaluate needs across the province and place services accordingly.

Private domestic and intercountry adoption services would continue to be offered by private practitioners and licensees and would continue to be licensed and monitored by government. Families who enter the system through the PAA, and who wish to adopt from the private domestic or intercountry services, would be referred to private practitioners and licensees in their area. A priority of the PAA would be to develop collaborative relationships with private practitioners and licensees in order to build a stronger, more integrated provincial system.

Given its provincial scope, and because its sole mandate would be to support adoption, the PAA would provide the time, resources and focus on adoption lacking in the current system. The agency would become a centre of excellence – a leader in the area of openness, including conducting research, educating professionals and developing supports – to help children, adoptive families and birth families understand, negotiate and maintain openness. With its strong local presence, the agency could develop close working relationships and networks with community service providers to support families before, during and after adoption. We envision a system as illustrated below:



As we considered the role of the PAA, we identified nine key functions in the adoption process. Yellow chevrons describe family-related functions and blue chevrons describe child-related functions.



System Entry



The Problem: Information Is Hard to Find and the Way into the System Is Not Clear

Grassroots organization tries to close the information gap

The Adoption Council of Ontario (ACO), a non-profit organization, was formed in 1987 to help Ontarians interested in adoption by providing information, resources and programs. A website, helpline, resource library, newsletter and 'how-to-adopt' seminars are just some of the services ACO provides.

We are impressed with what this organization has been able to accomplish and provide with limited resources.

Families – including those who have successfully adopted, those who are waiting to be matched with a child and those who explored, but did not pursue adoption – told us that it is very difficult to get clear, detailed, objective information about Ontario's three adoption services, the differences between the services, the children available for adoption from each, the cost of adoption, intercountry adoption options – such as information about the countries that Ontarians typically adopt from – and the time it takes to adopt. Some families reported that they chose one adoption service over another based on misperceptions, myths and word of mouth information. For example, some people chose intercountry over public adoption because they heard that public adoption is very complicated and can take many years. Finally, we consistently heard that where families lived in the province had a direct impact on their ability to access services.

Some families reported feeling that some private domestic and intercountry licensees were in competition with each other and, therefore, it was difficult to determine which direction to choose. Others told us that meeting with individual intercountry agencies to research options added fees to an already costly process.

And we repeatedly heard from families pursuing public adoption that, instead of being treated as a valued resource for waiting children, agencies worked to screen them out of – rather than into – the adoption process. Many families told us that they were not welcomed nor provided with the opportunity to explore whether or not public adoption was the right choice for them. This approach could be due to a lack of resources within CASs to embrace all prospective adoptive families and it could also be because many families initially inquire about adopting healthy infants. Some CASs told us that, at first contact with prospective adoptive families, they try to describe the realities of the needs of many of the children in their care.

This may well have the unintended result of "scaring off" families calling about healthy infants but who, with more complete information, might be more than willing to adopt a toddler, an older child or a

child with special needs. The "screening out" approach might be a natural outcome of a child protection orientation: approaching adoption using a child protection lens is completely understandable given how much child protection work CASs are engaged in on a daily basis.

The Solution: Harness the Energy and Excitement of Families Wanting to Adopt by Providing a "Front Door" to Important Adoption Information

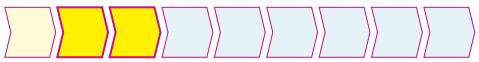
Families who choose adoption generally start the information gathering process with some trepidation, but also considerable energy and enthusiasm. They are excited about the prospect of building a family through adoption. We believe it is in the best interests of children to harness these families' excitement by focusing resources to welcome potential adoptive families into the system, and by providing them with opportunities to gather important information to help them make informed choices.

Taking a more welcoming approach to prospective families does not mean putting children's interests second. It simply means ensuring that all potential adoptive families get the information and support they need to explore adoption – regardless of the service they wish to use or the characteristics of the child they seek to adopt.[24, 25]

The current reality of public adoption in Ontario is that there are more children legally free for adoption than families who have completed the mandatory requirements and are ready to adopt. We anticipate that if our recommendations are implemented, the number of children free for adoption will grow considerably and the need to welcome families into the system will become even more pressing.

A provincial agency would provide a "one-stop" entry point to all three services in Ontario's adoption system (although families could continue to access private practitioners and licensees directly if they so desired). The faster and more easily families can get information and services, the more family-friendly adoption services will be.[26]

Parental Training and Assessment/ Supporting and Promoting Families



The Problem: Accessibility, Portability and Timeliness of Parental Training and Assessment Varies Widely Across the Province

To be approved to adopt in Ontario, families must successfully complete a parental training program (PRIDE) and a homestudy assessment (SAFE), which are designed to be portable across all three adoption services. Training helps families understand the rewards, along with some of the challenges, when building a family through adoption, and homestudies provide adoption workers with a detailed picture of a family and its suitability for a particular child. Families adopting from the private domestic and intercountry services pay private practitioners to complete PRIDE and SAFE, but both are offered free of charge to families adopting from the public service.

In some areas of the province, families adopting from the public service wait up to two years before they can begin their parental training or homestudy process. In other areas, wait times are much shorter. In many parts of the province, fulfilling the homestudy requirements – particularly obtaining child welfare and criminal record checks – takes an inexplicably long time, regardless of the adoption service used.

Some families who completed parental training and homestudy assessments with private adoption practitioners told us that, upon subsequently contacting some CASs, they were asked to redo some or all of the processes – despite the fact that PRIDE and SAFE were specifically designed to be portable across all three services. Additionally, some CASs reported that their agencies have a policy not to provide a copy of a prospective adoptive family's SAFE homestudy to them.

The Solution: Standardize Wait Times and Ensure Parental Training and Homestudies Are User-friendly and Portable

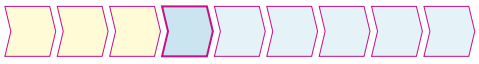
We believe the Province should establish standard wait times for entry into public PRIDE and SAFE programs, in the best interests of both children and families. It seems both desirable and reasonable to offer a province-wide guarantee that PRIDE be started no more than 60 days after parents register with the PAA, and that SAFE be started no more than 30 days after completing PRIDE. We further recommend that the government establish provincial guarantees that child welfare and criminal record checks required for SAFE would be completed within 30 days of receipt of the request.

Both PRIDE and SAFE were designed to be portable across all three services and we believe this would be easier to enforce with a PAA. While updating may be necessary in some instances, requiring prospective adoptive families to redo training and homestudies creates an unnecessary – and costly – barrier to adoption.

The PAA would coordinate and monitor access to PRIDE and SAFE provided for families wanting to adopt from the public service, which must continue to be free of charge to families. By pooling resources, planning for PRIDE and SAFE provincially and working collaboratively to find more efficient ways to deliver PRIDE, the PAA would ensure that families can complete both programs within the reasonable time limits set forth in provincial standards. For example, the PAA would work with the Ontario Association of Children's Aid Societies, which owns the license for PRIDE in Canada, to look at how e-learning could make PRIDE more accessible and user-friendly for families.

Another crucial function of the PAA would be to create a provincial registry of families interested in public adoption. Once families complete SAFE and PRIDE, the PAA would enter their names in a registry listing all Ontario families qualified to adopt. Such a databank would help improve the speed of matching, as well as increase the pool of qualified families for any particular child who is legally free for adoption.

Concurrent Planning



The Problem: Adoption is Rarely Considered as Part of Permanency Planning for Children in Care

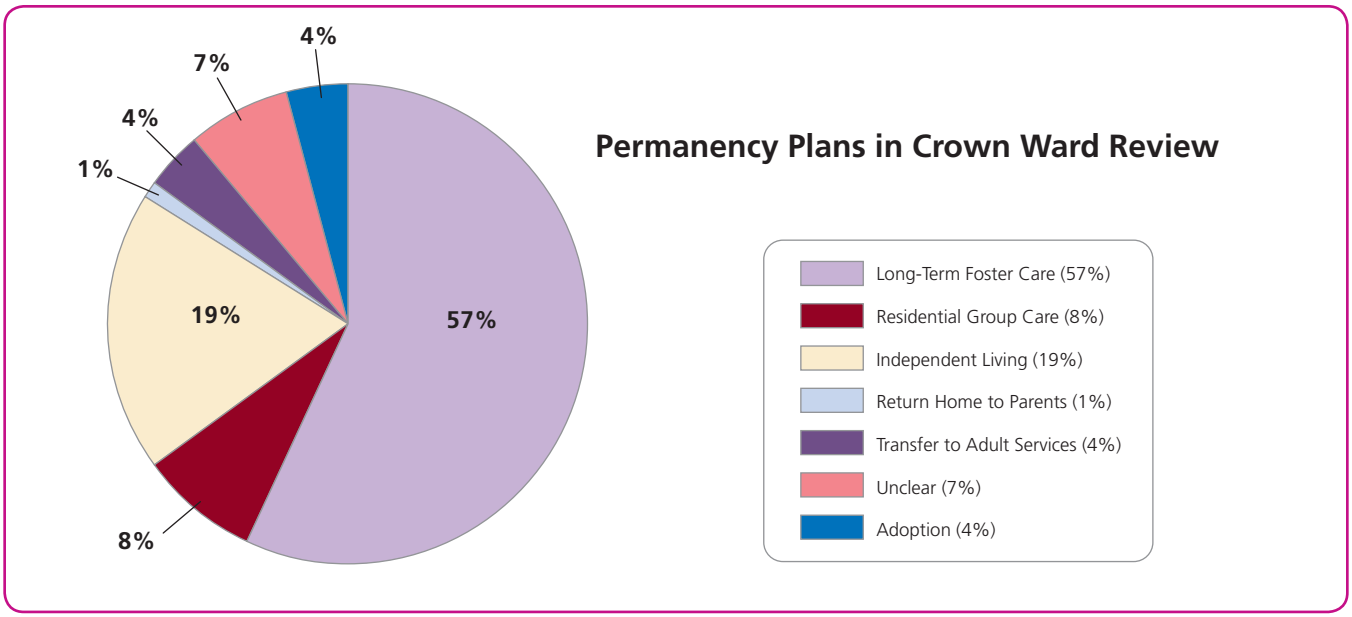
Whether children are to be adopted via the public, private or intercountry services, time is of the essence. The sooner a child can start to bond with and attach to a family, the more successful the adoption will be.[27,28] The longer a child remains in foster care or in other non-permanent arrangements, the more often a child moves – or the older he or she gets – the harder it may be to adjust to a permanent family.[29, 30, 31]

We cannot overstate the importance of concurrent planning for children in care. While the overarching goal of the child welfare system is to strengthen families and keep children out of care, an equally important goal should be to find permanent homes for children who come into care when it is clear that reunification with birth parents is not in their best interests. Permanency is critical for children's social and emotional development. The literature consistently demonstrates that timely adoption placements are vital for children by producing better chances of bonding quickly with their new family and better outcomes later in life.[32, 33, 34]

One of the roles of CASs is to develop permanency plans for children in care. However, as of March 31, 2008:[35]

- Only 4% of the province's 5,548 Crown wards who had been wards for two or more years had a permanency plan that included adoption.
- For fully 65%, the permanency plan was to remain in long-term foster care or residential group care.
- The plans for only 1% included a return home to parents and for 7% were unclear.

To us, these statistics demonstrate an urgent need to focus more attention on adoption as a permanency option. We support the goal of returning a child to his or her birth parents when it is in the child's best interests – but the reality is that the overwhelming majority of Crown wards who have been wards for two or more years are very unlikely to return to their birth families. The system should be reoriented to help more of them find adoptive families and provide them with a future out of provincial care.



Source: Ministry of Children and Youth Services, Crown Ward Review, 2008

The Solution: Adoption Planning Should Start Much Earlier

It is critical to focus on the importance of early permanency planning for children in care – no matter the age or special needs of the child, nor how long the child has been in care. Concurrent permanency planning, including adoption, must be a key component of child welfare services from a point of early contact with a child.[36, 37, 38] Planning from the moment a child comes into care helps to earlier identify the child's needs.

We believe that working together, CASs and the PAA would facilitate more timely adoptions. **This collaboration would start at an early stage and be formalized as part of the application for Crown wardship**. At the point of Crown wardship, while guardianship of the child would stay with the CAS, the responsibility for adoption planning would shift to the PAA.

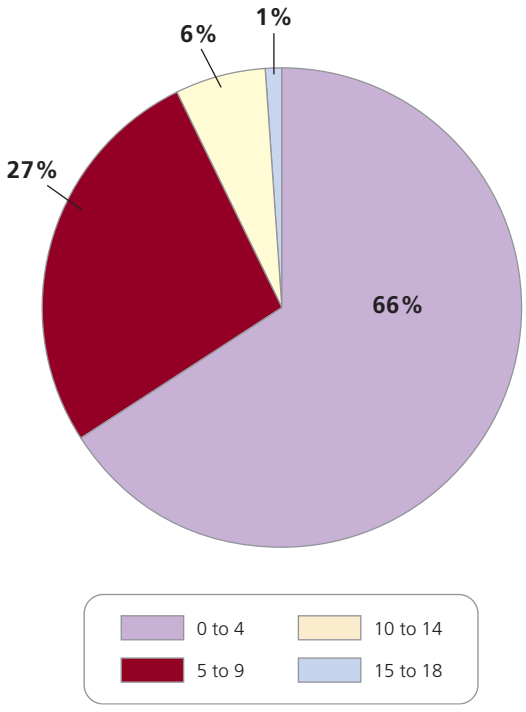
Concurrent permanency planning is equally important for older children and youth.[39] While many families who first consider adoption often want to adopt newborns or toddlers, some decide they are willing to adopt older children and youth. We heard clearly from Crown wards themselves that, rather than giving up on adoption when a child turns 12 or 13, concurrent permanency planning for older children and youth, focusing on preparing them to "age out" of care, should still include planning for the potential for adoption.

With its sole focus on adoption and a mandate to deliver services locally, the PAA would work closely with CASs to help develop appropriate, timely adoption plans for children in care. While working with 53 different CASs would be complex, it is not impossible. The agency would build on collaboration practices already in place in some CASs. We recommend that CASs provide transparent concurrent permanency planning, including planning for adoption, from the point of early contact with a child. Further, to support collaboration and reduce variability in service delivery, government should also work with CASs to standardize practices related to permanency planning for children in care.

Finding and Recruiting Families

The Problem: Ontario Struggles to Find Families for Older Children and Children with Special Needs

Public Adoptions by Age (2003-2007)



In Ontario, approximately two-thirds of all public adoptions involve children aged four or younger. However, almost nine of every 10 Crown wards in Ontario are over age six.[40]

Not all prospective adoptive parents want to adopt an older child, and some older children and youth do not want to be adopted. And while some CASs very consciously dedicate time and resources to finding families for older children, it is not a consistent focus across the province. Those children and youth who do want to be adopted should have that option and their chances should not depend on where they live in Ontario.

Source: Adoption Crown Ward Database, Ministry of Children and Youth Services

The Solution: Build on the Success of Innovative Programs that Prove Age and Needs Do Not Have to be Barriers to Adoption

> *"You can love a child at any time, regardless of age."*
>
> *– Youth dialogue*

Programs in some jurisdictions (e.g., New York, Minnesota, California) have much more success in finding adoptive families for older children. Ontario can learn from them. For example, programs that do a good job of matching older children with families have workers dedicated to the task who actively recruit families. Some jurisdictions find families who will provide foster care for children when they first come into care and will adopt them if they become Crown wards. This is an effective way to provide stability and permanency for children.[41]

We believe that the PAA should focus on proactively recruiting families who meet the needs of the full range of Crown wards waiting for families: older children, those with special needs, sibling groups and those of all races, cultures and religions. Having a registry of waiting families would increase the potential number and quality of matches available for waiting children.

The Homecoming Project

Five years ago, the Homecoming Project set out to increase the success of teen adoption in Minnesota. Partnering with adoption professionals and involving waiting teens, the project worked to counter myths, pilot new practices and encourage system change. The efforts seem to have paid off – more than 30 teens have found permanent homes over the five years, a much higher rate than the state average. And an additional 12 teens have made permanent connections with families.

NACAC, 2009

Promoting Children



The Problem: Ontarians Do Not Know Enough about Waiting Children

Myths about public adoption persist. Many people in Ontario believe "it's very difficult to adopt" because "there are no kids available." Others, who are aware of public adoption services, discount them because they believe that "the kids have been irreparably damaged by their experiences." Still others are scared off by the concept of openness – which often means no more than a yearly letter and pictures sent to a birth family via an adoption worker – because they worry that "birth parents could turn up on the doorstep at any time."

It's difficult, if not impossible, to counter these misperceptions and vigorously promote children available for adoption without a unified, province-wide effort.

The Solution: Build On and Expand Mechanisms that Have Proven Successful in Promoting Waiting Children

Promoting waiting children via newspapers, magazines, web-based and interactive information forums can help recruit adoptive families that match their individual needs. Websites have been used to find more families and complete more adoptions in many jurisdictions including Alberta and across the United States.[42, 43]

Adoption Resource Exchange – Bringing Families to Children

Twice a year, families interested in adoption can attend the Adoption Resource Exchange (ARE) where they can see video presentations of many children waiting for adoption in Ontario.

One of the roles of the PAA should be to fund and manage a central web-based databank, and to support the expansion of the ARE so that it is held four times a year rather than two in different areas of the province. We believe that when it is in their best interests and does not compromise their safety, all children waiting for adoption in Ontario should be promoted in as many creative ways possible. We hope that with its province-wide focus and mandate to plan adoption for Crown wards, the PAA would ensure that waiting children from all parts of Ontario benefit from being promoted through these tools.

Lisa was a single woman in her early 40s. She was very successful in her career in human resources and just assumed she would never have children. One day, she read an article about older children in Ontario waiting to be adopted. She thought she would make a good parent for an older child and she was particularly interested in Bryan, a 14-year-old featured in the article. Her attraction to him was his interest in art, which she shared. However, upon contacting the CAS, the worker she spoke with told her that he was the responsibility of a different CAS so she would not be able to adopt him. But Lisa was a good advocate for herself. After privately completing her parental training and homestudy, she contacted the other CAS.

The adoption worker she spoke with was skeptical about her ability to parent Bryan on her own. Because he was 14, he would also have a say in choosing his adoptive family. To get to know Bryan and to convince the CAS that she was serious, Lisa visited him every weekend. Over a period of about eight months, they developed a good relationship and Bryan became convinced that he wanted to be adopted by Lisa. His worker agreed that their similar interests had helped strengthen their bond. Once Bryan moved into his new home, Lisa took adoption leave to help him settle into the community, and she was then able to work flexible hours for several months so she could be there when he came home from school each day.

Matching Children with Families

The Problem: Regional Boundaries Are Barriers to Adoption

"There is an adoptive home for all children waiting for adoption in Ontario. The right family just needs to be found."
– AdoptOntario program staff

It is the job of all adoption workers, private practitioners and licensees to find the family that best matches each individual child. The best match is important for the child and for the family.

However, during our consultations we heard that many CASs are hesitant to consider families outside of their local area when trying to match waiting children. This practice may be due, in part, to the way CASs are funded and to a desire to keep children closer to significant people in their lives. It may also be due to the fact that CAS workers feel they know more about prospective adoptive families in their own regions. Regardless of the reasons, however, both families and CAS service providers report that this practice results in children, particularly older children, remaining in care for longer periods of time – even when there is a family waiting for them. In addition, policies about placing children in families with a similar cultural background are applied differently across the province, thereby delaying adoptions.

Having fewer choices results in fewer matches and increases the likelihood of not making the best possible match. Clearly, this is not in the best interests of any child.

Provincial Matching

A major barrier we identified in the public adoption system was the lack of inter-agency matching of children and families. We intuitively believed that many more appropriate matches between children and families could be made by moving to a provincial matching system and we set out to find out whether statistics confirmed this belief.

Limiting the number of possible options for children waiting for families seriously hinders the ability to match children with families who may appropriately share their interests and meet their needs. In fact, according to the statistical model constructed for the panel, moving toward a province-wide matching system could result in an overall match increase of at least 25% – or 200 adoptions – for all current Crown wards without court-ordered access.

This model, which used a hypothetical collection of data – assigning unique "scores" for each family and child to reflect the probability of a match – showed significant match improvements for older Crown wards. Specifically, we could expect the number of matches to almost double for Crown wards between the ages of 6-12 and 13-18.

The Solution: Province-wide Matching of Children and Families

It is important to match children and families based on interests, needs and compatibility. The net must be cast as widely as possible or children will remain in care for longer periods of time and, inevitably, many will never be adopted. Similarly, prospective adoptive families who are living in areas with few waiting children may also wait much longer to be matched and/or may eventually be lost to the system when no matches are proposed.

We understand that it can be important for waiting children to remain physically close to important people in their lives, and we wholeheartedly support efforts to place children with adoptive families who have similar cultural backgrounds when it is in the child's best interests. However, we believe these factors should not prevent children from being matched with families who otherwise would meet their needs and are ready to provide permanent homes.

Because of its wider mandate and focus, the PAA would take a broad view and consider families from across Ontario when matching children. It would also work to ensure that policies about matching children with families with similar cultural backgrounds are applied consistently across the province. More choices would mean better matches.

Facilitating Placements and the Provision of Subsidies

The Problem: The Benefits of Openness Are Not Well Understood and Permanency for Children with Special Needs is Not Adequately Supported

Openness

In "open" adoptions, when it is in the best interests of the child, adoptive families – including adopted children – may continue to have some form of direct or indirect communication with birth families, such as letters, e-mails, phone calls or visits.

Openness

When contact or communication with birth parents or birth family members is safe for the child, openness can be positive for children – particularly older children.

In some cases, openness can give adoptive families ongoing access to important family medical information.[44] In many cases, openness promotes a sense of identity, increases self-esteem, and allows children to feel a greater sense of security about themselves and their role within the adopted family.[45]

For older children, openness often preserves attachment to birth parents and/or family members and, in some cases, helps to lessen feelings of loss for the child associated with severing significant relationships, as well as feelings of disconnection from racial, cultural and biological roots.[46, 47]

Openness can also be important for some birth families. Some birth parents want to be reassured that their child is growing, developing and prospering in their adoptive home.[48]

Private domestic adoption practitioners and licensees have promoted openness for many years. More recently, public adoption services, both in Ontario and in other jurisdictions, have come to recognize that secrecy in adoption is a trend of the past and that, in many cases, when contact or communication is safe for the child, openness can be positive for children – particularly older children.[49] Adoption policy and legislation in a number of Canadian jurisdictions and in the United States, Australia and the United Kingdom, all now support openness in adoption – both openness in terms of unsealing records from past adoptions for adopted adults and birth parents, and promoting openness in adoptions moving forward.

Despite this trend, we learned that openness and how it may be implemented is not yet widely understood by some adoption workers and many adoptive families. We have heard that many CASs find the current tools, including openness orders and agreements, to be very complex – so complex, in fact, that some have established a policy *not* to use them. The complicated tools, coupled with concern about safety for children and fears about how openness may infringe on the "right to parent," make some CASs and adoptive families reluctant to consider openness in public adoptions.

Adoption Subsidies

A second issue related to placement success in many public adoptions concerns adoption subsidies. As the child welfare system is currently structured, most children with special needs receive substantial additional financial support to address those needs while they are in care. This support may be cut off, however, if the child is adopted. We heard from some very dedicated foster parents who said they would like to adopt children currently living in their homes, but primarily due to the significant needs of the children, simply could not afford to do so. Others worried that adoption was not in the best interests of a child if it resulted in a loss of critical services and supports. Perversely, as the system is currently structured, a child with special needs has a better chance of having those needs met by remaining in care – a "solution" that overlooks their basic human need for permanency and emotional attachment, and the Province's own need for fiscal responsibility. Simply put, **it costs more to keep children with special needs in care than it does to provide adoption subsidies for these children**.[50, 51]

Currently, adoption subsidies for children with special needs are provided to some families by some CASs. However, the practice varies greatly across the province. Primarily due to the way public adoption services are funded, CASs are limited in their ability to provide subsidies for all children who require them and to provide them on an ongoing basis. The current time-limited subsidy agreements in Ontario mean that prospective adoptive families cannot count on ongoing financial assistance to help support a child's special needs.

The Solution: More Education about and Support for Openness, as well as Reliable Adoption Subsidies

Education about Openness

We recognize that openness is complex, that openness plans change over time, and that negotiating and maintaining openness is particularly complicated for many public adoptions. We also understand that openness is not in the best interests of all children at all times, and we have heard the concerns about putting the children's best interests in front of the needs of birth parents or adoptive families. We believe that openness is an important ingredient necessary for making adoption work for more children. A key role for the PAA would be to provide education about, and support for, openness. The PAA would become a "centre of excellence" and develop the expertise to facilitate support for adoptive and birth families to negotiate openness and manage the provision of ongoing support to maintain openness.

> *"I was scared when the CAS talked about openness, until I learned it meant sending a letter and photo every year to my child's birth family. I'm now happy to do that because I'm so grateful to them for my son, and proud to let them know how he's doing. I think it will also be easier for him as he grows up to know that I haven't slammed the door on his birth family."*
>
> *– Interviewee*

Reliable Subsidies

The government should remove the financial incentives keeping children in public care and, instead, create incentives to find permanent families for Crown wards. A provincial system of ongoing adoption subsidies should be created for children over the age of two, and children of any age who have special needs. Based on the experience of other jurisdictions that have introduced adoption subsidies, we believe that more Ontarians would adopt children with special needs if there was ongoing financial support to meet the identified special needs.[52, 53] There would also be fewer breakdowns of adoptive placements if families adopting children with special needs received the services they needed to help them parent.[54, 55]

We recommend that the government create a provincial system of ongoing adoption subsidies to be administered by the PAA, in order to provide greater consistency and equity across the province. Additional detail about subsidies is provided on page 80.

Post-Adoption Supports

The Problem: Some Adoptive Families Need More Help and Support After the Adoption is Finalized

The finalization of an adoption is a legal event. It does not necessarily mean that all families are perfectly equipped to attach to and grow with the children whom they adopt, nor are the children always fully equipped to adjust to life with an unfamiliar structure and a new set of rules. Sometimes, continued support is needed and adoptive families often look to their communities for help.[56, 57, 58]

> *"When adopting an older child, we have to remember that there will inevitably be unwanted habits and attitudes entrenched, and it takes a special person who has a great deal of time and a lot of energy to break them down, start up and build again… The adoptive parent or parents really need to have a support system. This could be financial, emotional, etc…"*
>
> *– Adopted adult*

Many families told us that it is not uncommon for adopted children to come into contact with professionals – such as teachers, counsellors and mental health professionals – who are not fully aware of the needs or challenges faced by both adopted children and families. Families told us that they had trouble finding the services and supports they need, and that they feel they are "on their own" once an adoption has been finalized.

Families raising adopted children often find it particularly difficult to access services and support that are sensitive to or knowledgeable about the needs and circumstances of their children.

The Solutions: Education and Training for Professionals, Building Support Networks and Developing Services for Families

Education and Training

More must be done to provide education and training for a wide spectrum of professionals – from teachers to community service providers to the court system, family doctors and others – about the experiences and needs of adoptive families, including parents and children. The PAA would be in a good position to work with government, provincial bodies and other organizations to raise awareness about the realities of adoption and of the needs of all adoptive families in policy development and service planning, and to work collaboratively to influence the education and training of professionals. For example, the PAA would work with the courts to provide education about adoption generally – and outcomes for older children specifically – and work with educators on adding adoption as a curriculum component to help teachers to incorporate and welcome adoption into the classroom at all grade levels.

At the local level, the agency would build relationships and create networks so that when adoptive families need help, they would be referred to services that are attuned to the needs of adopted children.

Building Support Networks and Developing Services

Adoptive families told us they find it helpful to talk about their joys, experiences and challenges with other adoptive parents. Grassroots efforts facilitated by not-for-profit organizations like the ACO and the NACAC provide opportunities for support and mentorship. The PAA would promote dialogue and manage the creation of a registry of organizations and support networks that could easily be accessed by adoptive families seeking support.

Community Networks – Mobilizing to Develop Community Support

A number of grassroots networks have sprung up in Ontario, often with few financial resources. Many of these groups connect families – those who have adopted older children, children with special needs or children from the same birth country, to name a few.

Fetal Alcohol Spectrum Disorder (FASD)

FASD is a disability resulting from prenatal exposure to alcohol. An estimated nine in every 1,000 babies born in Canada are affected by the disability (Health Canada, 2005). According to the 2007 Crown ward review, **approximately 4% of Crown wards in Ontario who have been Crown wards in Ontario for two years or more are identified as impacted by FASD**. Many academics and professionals working with children in care believe these numbers to be overly conservative due, in part, to difficulties accessing and gaining accurate diagnoses of the disorder.

Furthermore, we believe that the PAA should be an advocate for the creation of provincial programs and strategies that support adoptive families. For example, Ontario is the only province in Canada that does not have a provincial strategy for Fetal Alcohol Spectrum Disorder (FASD). We heard that FASD touches a number of adoptive families, regardless of the service from which they have adopted. A provincial FASD strategy should be developed to provide improved and better coordinated supports, services and diagnoses for children with FASD, while raising public awareness and knowledge about the issue. As part of its role in supporting families post-adoption, the PAA could play a key role in contributing to the development of such a strategy.

Implementation Plan

Developing a detailed implementation plan for the creation of a provincial adoption agency (PAA) is beyond our mandate. However, we do suggest the following:

- Members of the board of directors of the PAA should be appointed by Orders-In-Council.
- A memorandum of understanding should define the agency's mandate and performance indicators.
- The agency should be adequately funded on a multi-year basis, permitted to retain any surplus funds from year-to-year and be a leader in accountability and transparency.
- The agency should utilize, to the greatest extent possible, the skilled and dedicated professionals currently providing public adoption services across the province.
- Staff should be employees of the agency (i.e., not government employees).
- An implementation strategy should be developed that employs a two-year transition period to move responsibility for adoption from CASs to the new PAA.
- Adequate funding should be provided to address the additional costs to the system during the transition period.

WHAT STEPS SHOULD ONTARIO TAKE TO OFFER COORDINATED, CONSISTENT AND SENSITIVE SERVICE DELIVERY?

To help Ontario offer coordinated, consistent and sensitive service delivery, we recommend:

1. Create a Provincial Adoption Agency

1.1 The Government of Ontario should create a **provincial adoption agency with a local service presence to**:

For Families

- Provide clear points of entry with current information about all adoption services: public, private domestic and intercountry.
- Facilitate referrals to private practitioners and licensees for families interested in adopting from the private domestic and intercountry services.
- Manage the service delivery of parental training (PRIDE) and homestudies (SAFE) for public adoption.
- Register families who want to adopt from the public adoption service and guarantee the timely delivery of parental training and homestudies.

For Children

- Work collaboratively with children's aid societies to develop adoption plans for children in care.
- Recruit families for older Crown wards and Crown wards with special needs.

- Manage a central databank of Crown wards available for adoption and all families approved to adopt.
- Match children in care with an adoption plan with appropriate families.
- Make placement decisions, arrange for supervision of placements and oversee the finalization of public adoptions.

Post-Adoption

- Work with local community service agencies to develop post-adoption services.
- Create a central registry of community resources for adoptive families and provide referrals to community-based services.
- Support permanency through the provision of post-adoption subsidies and supports for children adopted from the public system.

Centre of Excellence

- Become a centre of excellence – a leader in the area of openness, including conducting research, educating professionals and developing supports to negotiate and maintain openness.

1.2 The government should set **service delivery timelines** for public parental training (PRIDE), homestudies (SAFE) and child welfare and criminal record checks, as required by the SAFE process. Specifically, guarantees should be established that parental training will commence within 60 days of initial contact with the provincial adoption agency, that homestudies will begin within 30 days after the completion of parental training, and that child welfare and criminal record checks will take no longer than 30 days upon receiving the request.

Children's Aid Societies

1.3 The government should standardize **permanency planning practices** for all children in care.

1.4 As part of their responsibility for child welfare services, children's aid societies should collaborate closely with the provincial adoption agency and provide transparent **concurrent permanency planning, including planning for adoption** from the point of early contact with a child in care.

Obligations of the Provincial Adoption Agency

The provincial adoption agency should:

1.5 Operate in the **best interests of the child**.

1.6 Recognize prospective adoptive **families as a valuable resource** and support them to enter the adoption system where appropriate.

1.7 Closely **collaborate** with government, children's aid societies, private practitioners, licensees, community-based service providers and other adoption stakeholders, so that the adoption of children from the public system can occur in the best interests of the child.

1.8 Work with the Ontario Association of Children's Aid Societies to **develop a more flexible delivery model for PRIDE** (e.g., develop some components that could be offered online).

1.9 Develop a focused program to **find families** for older Crown wards and Crown wards with special needs.

1.10 Become **formally responsible for adoption planning** for Crown wards at the time of application for Crown wardship.

1.11 Provide adoptive families and birth families with **support to negotiate openness and ongoing support to maintain openness**.

1.12 Work with local community agencies to **help increase the availability of post-adoption supports** in communities across Ontario.

1.13 **Advocate for the creation of provincial programs and strategies** that support adoptive families (e.g., advocate for a provincial Fetal Alcohol Spectrum Disorder strategy).

1.14 Work with provincial bodies and other organizations to **raise awareness about the needs of all adoptive families** in community and provincial service planning, specifically, work collaboratively to influence education and training of courts, educators and other professionals.

2. DEVELOP TOOLS TO MANAGE THE ADOPTION SYSTEM

Creating a PAA, a front door to all of Ontario's adoption services, is a radical change. But simply establishing an agency to centrally and locally deliver services is not enough. No system functions well without clear policy and legislation, consistent rules and standards, and good information about the effectiveness of the services.

To create an integrated, fully functioning and world-class adoption system, the government must:

- → Set **policy and legislation** for all adoption services that reduce barriers to timely adoption.
- → Ensure that, when safe and appropriate, **contact or communication with birth families** is not a barrier to adoption.
- → Provide **consistent direction and oversight**, and support the **independent collection of data** to monitor outcomes for children who are adopted.
- → Establish **complaint mechanisms** so that birth families, prospective adoptive families, adoptive parents and adopted children who are dissatisfied with the service they received can be heard.

The current fragmented system of public, private domestic and intercountry adoption services is inefficient and ineffective – for families and children. An integrated, fully-functioning adoption system is needed.

Set Policy and Legislation to Reduce Barriers

Policy and Legislation Shape Practice

Ontario's policies and legislation for the three adoption services appear, at times, to have been developed in silos and are not always evidence-based. The rationale for some policies is unclear, some are not clearly articulated, some are not applied consistently across the three services, and some do not reflect the realities of the changing world. Regular effort is needed to develop and update policy to support the public, private domestic and intercountry services.

> *"I am astonished that there is no public information in terms of laws for adoption. This should be made publicly available and some explanation to those laws should be given…"*
>
> *– Interviewee*

Evidence-based policy and legislation are the foundation of a sound, ethical and fair adoption system that better serves children and families. Policies should be founded on the belief that all three types of adoption are valid choices and are supported by the Government of Ontario.

All current adoption policies should be reviewed immediately with the purpose of developing a policy framework that underpins adoption from all three services – public, private domestic and intercountry. The framework and policies should then be reviewed on an ongoing basis (i.e., at least every five years) to ensure they remain evidence-based, current and consistent. The policy development process must be informed by the knowledge and experience of a cross-section of external stakeholders including, but not limited to, child welfare and adoption service providers, licensees and private practitioners, prospective and successful adoptive families, adopted youth and adults, birth parents, foster parents, and current and former Crown wards.

We have chosen to highlight some of the policies and legislative issues that we feel most clearly serve as barriers to the timely placement of children with families and require the government's immediate attention. The list is not exhaustive.

Public Adoption Issues

Contact or Communication with Birth Families

Court-ordered Access

A court order for Crown wardship terminates parental rights. Birth parent access to the child automatically terminates upon Crown wardship unless a further order for access is made by the court. A court cannot make a further order for access unless satisfied that there is a meaningful and beneficial relationship between the child and the person seeking access, **and** the access order would not impair the child's opportunity to be adopted. A Crown ward cannot be placed for adoption if the subject of any court-ordered access.

Court-ordered access may be granted to ensure that a Crown ward can continue to have contact or communication with a member or members of his or her birth family – this may include birth parents, siblings, grandparents, aunts or uncles, or other people significant to the child.

Court-ordered access has long been viewed as having the effect of keeping many children trapped in the child welfare system. We note that approximately 75% of children who have been Crown wards for more than two years have court-ordered access, and the permanency plan for a large majority of them (65%) is foster or residential care.[59]

Despite well-intentioned efforts on the part of the government – including amendments to the CFSA in November 2006 – to make it clear that an order for Crown wardship automatically terminates any outstanding access orders, **a significant obstacle to the adoption of Crown wards continues to be court-ordered access**.

Not much has changed in 19 years

The chief obstacle to adoption for some 70% of children in long-term foster care is an access order which the court has awarded to birth relatives, allowing visits to the child.

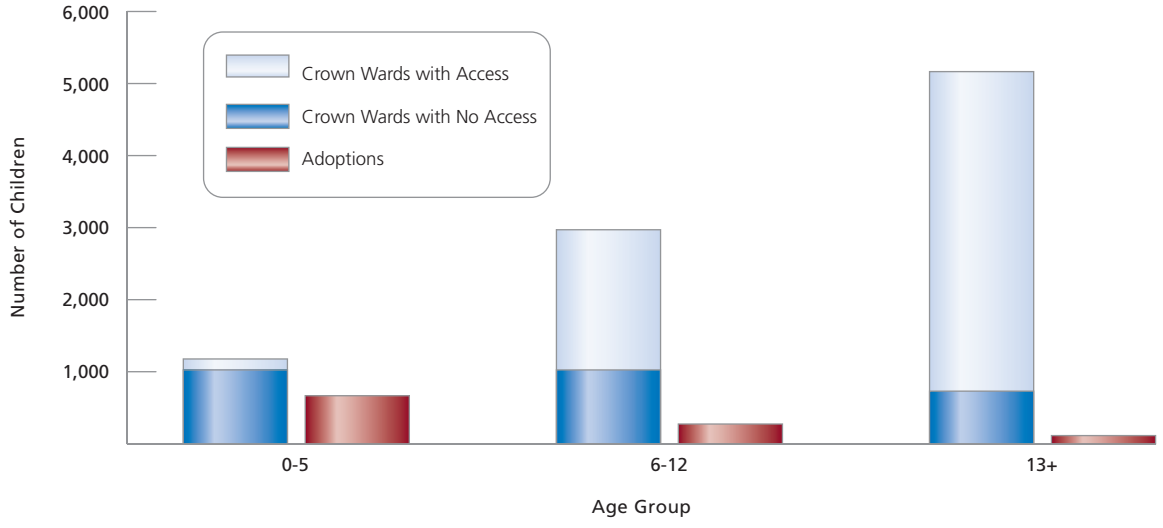
Under Ontario law, no child who is a Crown ward who has an outstanding access order may be adopted…unless a court procedure is instituted to remove the access order.

Why can we not resolve the legal question of access orders, so that children being made Crown wards today will not live in limbo until the age of 18?

The Toronto Star – ***January 23, 1990***

We understand that the intent of the 2006 changes was to make more Crown wards legally available for adoption. However, despite significant legislative changes, CAS adoption workers have told us that courts have been slow to adjust to the new policy direction – continuing to grant court-ordered access even if it is clear the child is not likely ever to return home to the birth parents, and would benefit from adoption. In a non-scientific call for information from CASs (see appendix B), since November 2006, the number of Crown wards with court-ordered access appears to have decreased slightly. However, we do not view this decrease as indicative of a complete culture change in the system.

Age Group by Placement Type (as of March 31, 2008)



Source: OACAS, "Ontario's Children in Care: facts from Children's Aid Societies," (Oct. 2008)

Openness Orders and Agreements

At the same time that the November 2006 legislative changes regarding court-ordered access were made, openness orders and agreements were introduced. If a plan for adoption has been made for a Crown ward and no access order is in effect, at any time before the adoption is finalized the CAS may apply to the court for an openness order. For a court to make an order, all parties – the CAS, adoptive parents, birth parents and the child, if over the age of 12 – must consent. Openness *agreements* may be made by adoptive families with a birth family member or significant person in the child's life. Openness agreements can be entered into at any time, before or after an adoption is finalized.

We understand that the intent behind openness orders is to provide some level of comfort that contact or communication between children and birth families will be protected when adoptions occur. However, we have heard that many CASs find openness orders to be very complex – so complex, in fact, that some have established a policy not to use them.

The Legislative Changes Are Not the "Right" Changes

The legislative changes regarding access and openness are not solving the problem they were intended to solve:

- The potential of an openness order or agreement in the future is not enough to convince courts to sever court-ordered access between children and birth parents at the time of Crown wardship, particularly if the court believes that an adoption in the future is not likely (e.g., if the child is older).
- There is a disconnect between access and openness, in that a CAS may only apply to the court for an openness order if no access order is in effect. However, Crown wards with court-ordered access would seem to be those who would be most appropriately served by openness orders.
- There does not appear to be any mechanism to "convert" contact or communication prescribed in an access order to contact or communication prescribed in an openness order.
- A culture exists within the current system that discourages using an openness order as a tool when working with birth parents (e.g., the offer of an openness agreement or order in exchange for not contesting the termination of an access order).

We support maintaining contact or communication with birth families, when safe and appropriate, because we recognize that it is vital for some children. However, we strongly believe that contact or communication does not need to be a barrier to adoption.

Lessons from Other Jurisdictions

We have learned from other jurisdictions that there are ways to prevent court-ordered access from becoming a barrier to adoption. The experience in British Columbia is that terminating court-ordered access upon adoption placement – and replacing the access with an openness agreement – is largely successful. In the 13 years of experience with these agreements, it is reported that there has been a high level of compliance and the agreements have worked well.

We recommend that the government look to these other jurisdictions in order to inform and to support the articulation of a clear policy statement in Ontario that **contact or communication with birth families should not be a barrier to the adoption of Crown wards,** and **adoption can occur for children with court-ordered access**.

We recognize this policy shift would require amendments to the CFSA so that, in the future, **Crown wards would be legally free for adoption – whether there is court-ordered access or not.**

Adoption in British Colombia

We learned of adoption practices in British Columbia that informed our recommendations. First, children with court-ordered access can be adopted. In British Columbia, at the time of adoption finalization, the order for access is either terminated by the court and, with the agreement of the parties, converted to an openness agreement, or the court-ordered access is built into the adoption order. Second, the Province has put into place a practice to develop openness that works. Birth and adoptive families can either negotiate a "semi-disclosed" openness agreement which the government registers and facilitates, or a "fully-disclosed" openness agreement which the families negotiate themselves. These practices mean that more children in care can be considered for adoption, while also maintaining important contact with birth families, when in the child's best interests.

Additional Barriers to Consider

We recognize that making children with court-ordered access legally free to be adopted would address one problem for some children, but may have unintended consequences for others. We want to acknowledge that it may be more difficult to find adoptive families for Crown wards with contact or communication prescribed by the court, due to the additional complexities that any formalized order brings to adoption. We believe that the difficulties experienced by CASs when trying to understand and implement openness orders have already illustrated how any form of contact or communication ordered by a court can be a barrier to adoption. We believe that **tools and mechanisms to better provide for openness when it is in the best interests of the child** (e.g., openness agreements or some other form of court-ordered contact or communication specifically tailored to the adoption) should be developed.

The Way Forward

To immediately address the importance of maintaining contact or communication with birth parents and the current barriers still in place due to the large number of Crown wards with court-ordered access, the government should **undertake an immediate provincial review of all existing court-ordered access for current Crown wards**. We note that approximately 75% of children who have been Crown wards for more than two years have court-ordered access, and the permanency plan for 65% of those is foster or residential care.[60] Where access is not being exercised and/or does not continue to be in the best interests of the child, the case should be returned to court for re-consideration as to whether access continues to be in the best interests of the child. Where some form of contact or communication with the birth family continues to be beneficial for the child, consideration should be given to exploring the possibility of replacing the access order with an openness agreement or order.

To support an overarching policy for openness, the government would also need to:

- Clearly identify how and when court-ordered access should be used and when it should not be used.
- Provide education for professionals in the court system, including those on the bench, about the importance of adoption for Crown wards, with a particular focus on adoption of older Crown wards.
- Provide a mechanism to clearly provide that the voice of children is heard in the decisions that impact their lives – both at the stage of Crown wardship and during any consideration of contact or communication.

- Support a culture that birth families can be offered some form of contact or communication in negotiation or mediation processes relating to the child's future, while providing a clear message that adoption will be pursued when it is in the best interests of the child.
- Increase the availability of alternative dispute resolution processes which are less adversarial and time-consuming than the court system.

Child Welfare Transformation

The following comments relate only to adoption-related aspects of child welfare transformation.

In 2005, the Government of Ontario introduced a series of changes to child welfare policy. To increase the use of adoption as a permanency option for children in care, the ministry supported four strategies:

1. Amendments to the CFSA to allow communication with birth families after an adoption through openness agreements or orders.
2. The development of common homestudy and parental training tools.
3. An electronic database and website to assist matching more children with families.
4. The provision of support, where needed, after an adoption is finalized.

The components of transformation relating to adoption have been implemented in different ways across the province. We believe that the fact that there are 53 CASs interpreting the government's vision may, in part, explain the great variability in implementation.

We heard that the development of common parental training and homestudy processes was a significant step forward, but that the goal of full portability has not yet been achieved. Similarly, although a website and electronic database were created through the AdoptOntario program, too few profiles of children and families are being placed on either.

Permanency options, such as kinship care and legal custody, were introduced and we have heard that, in particular, kinship care has been embraced by some CASs. However, we are concerned that, while a range of options is important in order to best meet the diverse needs of children in care, adoption has become only one permanency option, lost among many, despite the inherent security, stability and legal certainty that only adoption can provide.

Monitoring and tracking processes related to adoption were not adequately thought through and implemented after the transformation reforms. As a result, it is unusually hard to track success. Clear goals and measures need to be established to determine if transformation is working. These goals and measures need to be transparent, independently validated and monitored, and reported publicly.

Finally, we are convinced that more needs to be done to ensure that contact with birth families is not a barrier to adoption. We do not believe that openness orders or agreements as they exist today can function as they were intended. We are also convinced that stable and secure funding for adoption subsidies and post-adoption supports is critical to making more adoptions happen. Currently, CASs scramble to find funding internally, with the predictable consequence of significant variability across the province. We believe that rolling out complex ideas across 53 autonomous agencies is a challenge to adoption success.

The focus of the government must be to develop a system and a culture that supports adoption with openness and satisfies the needs of all parties – the court, service providers, adoptive families, birth families – and, most importantly, is in the best interests of the child.

We believe that tools to support openness developed in the context of a system that supports adoption (e.g., support from the PAA, concurrent permanency plans, earlier identification and matching of families with children), can be used to facilitate more timely adoption processes and result in better outcomes for children.

We are confident that these steps will help promote the adoption of more Crown wards – both those with court-ordered access and those without, and will make the adoption of Crown wards much less complex in the future.

Race, Culture and Family Structure

The public and intercountry services are supported by very different policies on racial-cultural adoption placements for children.[61] Given the nature of intercountry adoption, many children are placed with families from a different race or culture. This differs starkly from public adoption services, where there is great variability in the emphasis CASs place on racial and cultural matching, and many different iterations of what factors matter when matching children with families (e.g., physical appearance, cultural practices).

With some exceptions, primarily for First Nations, Métis, Inuit and urban Aboriginal children, we believe that when too much importance is placed on finding the "exact" racial or cultural match, without consideration for other equally important needs children may have, children remain in care for longer periods of time.

A practice instituted in Ontario and in other provinces in Canada between the late 1950s and mid-1970s, "the '60s scoop era," to remove First Nations, Métis and Inuit children from their home communities and adopt them out to non-First Nations, Métis and Inuit families, is a subject of great concern for First Nations, Métis and Inuit leadership of today.

We understand that it will be necessary for the government to work in partnership with First Nations, Métis, Inuit and urban Aboriginal leadership, organizations, communities and service providers to determine whether and how our report has implications for child welfare care for First Nations, Métis, Inuit and urban Aboriginal children.

We support efforts to match children with families of the same race, culture and language if it is clearly in the best interests of the child. However, these policies should be informed by current evidence. In our view, placement should not be unduly delayed and no child should go without a stable, permanent home simply because an adoptive family who can meet a great majority of a child's needs is not of the same race, cultural or linguistic background as the child.[62]

We also found variability across the province in attitudes about matching children with single and same-sex families (in the intercountry service, policy on this issue is determined in the child's country of origin and, in private domestic adoption, the birth parent selects the adoptive parent). Again, we believe that policy supporting decisions about family structure should be informed by current evidence.

Based on our review of the literature, children's adjustment to adoption depends on age and length of time in care. Children adopted into non-traditional families – that is, families of mixed race, different culture, language or family structure – had similar outcomes to those adopted into more traditional families.[63, 64, 65]

We believe that Ontario must develop consistent policies for racial, cultural and linguistic matching, and family structure placements, to reduce variability across the province.

Issues in All Three Adoption Services

Planning for Adoption

> *"We know we will become parents one way or another by applying to all three systems."*
> *– Interviewee*

Rules that keep families from pursuing more than one type of adoption at the same time (e.g., obtaining approval to adopt from China, and concurrently exploring adoption through a CAS) or from exploring a second adoption while the first is in the process stage (e.g., while waiting to be matched with a child from China, exploring the possibility of adopting a second child) are barriers to adoption. We understand that these policies were originally designed to prevent families from having more than one placement within an 18 month period.

In part because of the uncertainty about the time required for adoption from all services, the ability for prospective adoptive families to concurrently explore all options, particularly when planning for more than one child is essential. We believe the system should be much more open to families exploring different adoption options at the same time – while still allowing enough time between adoptions for families and children to bond. Policies on planning for adoption should be clear, evidence-based and responsive to current service structures.

Assisted Reproduction Services and Adoption

> *"We had to ask ourselves, how badly do we want to be parents? The day after our first failed IVF we called an adoption agency."*
> *– Interviewee*

We heard often about the "unwritten" policy that families may not explore assisted reproduction services and adoption at the same time. We understand how important it is for families to be physically and emotionally ready for adoption – particularly after unsuccessful assisted reproduction treatment. However, having an informal policy prohibiting exploring assisted reproduction services concurrently with exploring adoption is driving behaviour underground. Families have told us that with adequate support, they are more than capable of making good decisions about their ability to explore assisted reproduction services and adoption at the same time. In addition, we believe that as families are exploring the adoption process, the adoption service providers and practitioners trained to complete parental training and homestudies can help families identify what is right for them, along with what they need to be the best parents for children.

Employment Leave for Adoptive Parents

In several other provinces, employment standards legislation allows adoptive parents to take the same amount of protected employment leave as biological parents. This is not the case in Ontario. Here, the combination of pregnancy and parental leave for biological parents equals a 52 week entitlement of unpaid, job-protected leave, while adoptive parents are only entitled to 37 weeks of parental leave. Federal employment insurance benefits also make a distinction between adoptive and birth parents.

> *"You need to create a bond that isn't naturally there when you adopt rather than give birth. There are so many companies that are willing to recognize that, but the government doesn't. I think that the laws and regulation around adoption are created without empathy or knowledge of what it is really like to be in that situation."*
>
> *– Interviewee*

There is no justification for this differential treatment. We accept that included in the 52 weeks leave for birth parents is time for the birth mother to heal from physical impacts of birth. However, adoptive parents need consideration of the time it takes them to form bonds with their adopted children.

Ontario's *Employment Standards Act* should be amended to provide equal leave to adoptive and birth parents. We also recommend that the Government of Ontario advocate that the Government of Canada amend federal employment insurance rules to provide the same treatment for birth parents and adoptive parents.

Michael and Gwen were diagnosed with infertility problems in their late 30s. When their doctor advised them that their chance of conceiving through IVF was quite low, they looked into adoption. They read on the Internet that intercountry adoption would be faster than public adoption so – despite the cost – they contacted an adoption agency that specialized in intercountry adoptions from China.

They had completed their homestudy and training, and were in the process of applying to be matched with a child when China changed its adoption rules. They learned that it was now taking longer to adopt from China, and they were worried about meeting China's age requirements. The adoption agency advised them to try adopting from Ethiopia, but if they chose to do so, they would have to withdraw their application for China. Michael and Gwen found the changing rules and requirements difficult. They were frustrated because they could not get clear information on how long it would take or how much it would cost. And there always seemed to be more paperwork and more fees.

Almost three years after they first began to explore adoption, Gwen and Michael were both relieved and excited when they heard that they had been matched with siblings: two year-old Sunil and six month-old Crishantha. Michael and Gwen traveled to Ethiopia to complete the adoption and pick up their children.

When they returned home, Michael took parental leave. Gwen and Michael have developed deep bonds with their children and have no regrets. Still, the experience has taken its toll. They estimate that they have spent approximately $40,000 to complete the adoptions. While the process to complete the adoptions has at times been overwhelming, the couple has connected with a group of families who also adopted children from Ethiopia. They are finding that support very helpful.

Issues in Private Domestic and Intercountry Adoption

Guardianship

Currently, for voluntary adoptions, the CFSA provides for the transfer of responsibilities for the child's care and custody to the licensee or CAS placing the child, once all consents required under the legislation have been obtained and the period during which consents could be revoked has expired. There is a barrier to private domestic and intercountry adoption because the CFSA does not clearly address situations where consents have been dispensed with. Policy and related legislative work is needed: to clarify guardianship issues where foreign consent is executed; where parental rights have been terminated and guardianship has been granted to an entity or to the adoptive family in the child's country of residence; or where a child is a permanent ward of an authority outside of Ontario (i.e., extra-provincial or foreign).

Expenses

We understand that the policy intent underpinning allowable expenses related to private domestic and intercountry adoption is to provide a mechanism for adoptive families to pay for all the costs of the adoption both domestically and where necessary, in the child's country of origin. However, today's reality is that the regulation prescribing expenses is too restrictive and does not reflect true intercountry adoption processes.

To better support the current reality of intercountry adoption, the legislation should respect expenses that can be lawfully paid for in another country. There should be a requirement of full disclosure of the costs incurred to complete the adoption.

In addition, the category of lawful expenses should be expanded to include those expenses which are incurred in third party assisted reproduction where adoption by the intended parents is necessary. These would include the cost of medical procedures and testing and other expenses permitted by legislation and regulation. Further, consistent with rules in some other provinces, consideration should be given to expanding the category of lawful expenses in private domestic adoption to include certain pregnancy and birth-related medical expenses where no other source of coverage exists, and provided that any such payment is unconditional.

Issues in Intercountry Adoption

Of importance to intercountry adoption in Ontario is the *Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption* (Hague Convention). The Hague Convention is an international agreement designed to protect the interests of adopted children, standardize adoption processes between countries and prevent the trafficking of children. The convention provides a framework to Ontario's regulation of intercountry adoption.

Intercountry adoption is complex and made more difficult in Ontario by the fact that the policy underpinning the service is unclear and the process to complete an adoption is governed by one of two pieces of legislation, the CFSA or the IAA. It is further impacted by whether the adoption is from a country that is a signatory of the Hague Convention.

The safeguarding of children and families in the process, and the timeliness of intercountry placements are goals that should inform policy. We recommend that the government should review and overhaul intercountry adoption policy and legislation with the purpose of addressing barriers and gaps, as well as

creating harmony between the CFSA, the IAA and the Hague Convention and, additionally, with the realities of non-Hague countries.

The following discussion highlights some of the policies and legislative issues that serve as barriers to intercountry adoption.

The New Reality of Intercountry Adoption

Like in public adoption, older children adopted intercountry can also adjust to a new permanent home. For reasons in part due to systemic changes to intercountry adoption in recent years, more and more children adopted intercountry are not newborns or infants. In fact, it is becoming more common that, by the time all the processes have been followed to ensure the children are free to be adopted, they are in fact closer to age three. However, we heard from licensees and families adopting intercountry that the government is reluctant to approve homestudies stating a family is willing to adopt a child or matches for children over the age of three. It is important that the government review its policies for intercountry adoption and consider that, as in public adoption, age should be only one of a number of factors that is considered when determining suitability of a family and/or a proposal for intercountry adoption.

The Hague Convention

The *Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption* (Hague Convention) was implemented to address unethical adoption practices and that effort is lauded and supported. However, it should be noted that in some cases, the requirements put in place have had the unintended consequences of creating additional barriers and delays to the early placement of children resulting in many staying in institutional care longer.

While we want to ensure that ethical practices in intercountry adoption continue, we want the policies of the provincial government to recognize current intercountry adoption realities, including the reality that children are increasingly older and that relative adoption is complex.

Relative Adoption

There is significant variation in policy about relative adoption in Ontario. On one hand, in public adoption, recent policy direction confirmed within the government's 2005 transformation agenda clearly supports the placement of children in care with relatives. In practice, CASs look to kin first as a permanency and/or adoptive placement for a child. On the other hand, support for relative intercountry adoption varies depending on the legislative framework (e.g., CFSA or IAA) that covers it, and there is no clear policy support for it. Many intercountry adoptions involve Ontarians hoping to adopt a young relative living in another country whose parents are unable or unavailable to provide care for the child. However, often the very relatives who would be treated as distinct in public or private domestic adoption actually experience additional challenges when attempting an intercountry adoption.

The CFSA exempts certain relatives – grandparents, aunts, uncles, great-aunts, and great-uncles – from a number of regulatory requirements in relation to adoption placement (e.g., no requirement to complete the parental training and homestudy process). The IAA on the other hand, treats all potential adoptive families the same, whether related or unrelated to the child.

We recognize there are a number of issues to address when considering relative adoption intercountry, including the consideration of relative adoption by other bodies (e.g., Hague Convention, federal government) and the inconsistencies resulting from implementing two different pieces of legislation in Ontario to govern intercountry adoption. However, we also recognize that Ontario has a diverse population and that there are Ontarians who, for personal reasons, wish to build or add to their families by adopting a relative child from their country of origin.

We believe that the government should develop clear policy that demonstrates support for relative adoption – including for relatives adopting intercountry. Issues that must be addressed include:

- Broadening the category of relatives and spouse (e.g., spouse of a deceased parent of a child).
- Barriers to adoption for Ontarians wishing to adopt a relative child from a country with which no Ontario licensee has an established program (e.g., it can be difficult or expensive to find an Ontario licensee willing to establish a program with a country for one adoption).
- Clear identification of the authority in legislation and processes for relative adoption (e.g., there is no authority under the CFSA for the government to approve relative adoptions, but federal immigration requires approval from the government).

Jasmine and Terrell are in their early 40s and have one son, Tyson, who is 12 years old. They have a combined income of $58,000. Terrell received a call from Child Protective Services in Ohio. His sister, in Ohio, has a daughter, Laila, who is five years old. The child's father is unknown. Terrell's sister has a history of drug use and is unemployed. Laila has been in and out of care with the Child Protective Service for two years. The Service is planning to go to court to terminate Terrell's sister's parental rights. Before Laila, who is now in foster care, is placed into an adoptive home of unrelated people, under Ohio policy, the Service is bound to search out family members who may be willing to care for this child. Terrell's sister will not oppose the court proceedings if Terrell and Jasmine are able to adopt Laila. Ohio's Child Protective Service wants to know if Terrell is interested in taking his niece, when they can be ready to adopt and if they can come to court in a month.

Jasmine and Terrell were not sure where to start. After a week of phone calls and Internet searches, they were told that they needed to hire a private adoption practitioner to complete a homestudy for them. The cost of the homestudy was about $2,500. They also needed to complete parental training which cost an additional $1,400. They wondered how they would find the money to pay these unexpected costs. They also learned that it would take about three months to process these two requirements.

Because the United States and Canada are both signatories to the Hague Convention, and the adoption is one which will be finalized in the United States, Jasmine and Terrell need the services of an Ontario licensee, licensed under the IAA and accredited under the Hague Convention – an additional expense for them. They were also told that, on behalf of the Ontario government, the Ministry of Children and Youth Services must review their homestudy before a letter of approval can be issued, and that other steps must be taken to satisfy the Hague Convention rules, including obtaining approval of the Ontario government for the proposed adoption of this child. Finally, they were told there will be additional time required to complete the immigration sponsorship process to obtain a visa for Laila to come into Ontario. Talking to Child Protective Services in Ohio, Terrell and Jasmine were told that the court may not want to wait the six to eight months required to bring Laila to Ontario. The court in Ohio is impatient: Laila has been in foster care too long already and the court termination hearing has already been adjourned three times.

Legislative Gaps

The Hague Convention rules govern adoptions from many countries around the world, but not all. The IAA is the legislation which implements the Hague Convention in Ontario. As the central authority for the Hague Convention in the Province, the government is required both to approve families as suitable to adopt and, later, to approve the proposed adoption.

The IAA provides procedures to follow in Ontario when adoptions are to be finalized in the child's country of origin – whether the adoption is from a country which is a signatory to the Hague Convention or not. Problems occur when the Hague Convention applies to adoptions which are to be finalized in Ontario. The CFSA does not contain any procedures to be followed to ensure that the requirements of the Hague Convention can be met. This legislative gap has resulted in confusion about the procedures to follow to finalize such adoptions.

The lack of harmonization between the IAA, the CFSA and the Hague Convention results in legislative gaps that create unnecessary complexity, expenses and delay for families and children.

Conflict of Laws

Adoption legislation in most other provinces and states has "conflict of laws" rules which recognize situations where legal requirements in one jurisdiction differ from those in another. While the CFSA clearly contemplates a child being brought to Ontario with a view to the adoption being finalized here, there are serious deficiencies in that it fails to address issues that arise when the rules in the child's home jurisdiction do not match Ontario's. For example, Ontario has specific rules about obtaining consents to adoption, when they become valid, whose consent is required, and what can be lawfully paid for in relation to adoption. In many cases, these rules differ from those in the child's home country. The CFSA simply doesn't take these differences into account, leaving Ontario families vulnerable when they go to court in Ontario seeking an adoption order with foreign documentation that may not satisfy provincial rules.

In some cases, a child may have been surrendered by a parent to an orphanage or found abandoned. The parental rights in respect of such a child have been transferred by a court or by the operation of the country's laws to an orphanage or person with authority to consent to the child's adoption. The CFSA does not automatically recognize such an order or accept the consent of the orphanage or authorized person as sufficient to allow the adoption to be finalized here, even though the foreign adoption authority and the ministry approved the adoption.

The laws of other provinces and states recognize foreign adoption consents and orders terminating parental rights as valid and sufficient if they are in compliance with the rules of the foreign jurisdiction. We recommend the government promptly amend the CFSA to include such "conflict of laws" provisions.

Ontarians Temporarily Living Outside of the Province

There is a policy gap for Ontarians who are living or working temporarily outside of Ontario and who wish to pursue an intercountry adoption. In the United States, the Secretary of State is authorized to play a role in assisting citizens involved in intercountry adoption and there are regulations and guidelines that address the adoption-related challenges faced by citizens living abroad. We believe that, included in its mandate to help more Ontarians build families through adoption, the government should develop policy informed by that mandate and include Ontarians temporarily living outside the province who want to adopt.

Intercountry Adoption – Government Role

Recommendations in this report address some of the barriers and gaps encountered when adopting intercountry.

We share the belief that intercountry adoption is an important family building choice for Ontarians. We believe that clear government support for intercountry adoption should be demonstrated, particularly given that it comprises one-third of adoptions in Ontario each year. To better support families in their choice to adopt intercountry, we believe that increased and ongoing policy attention must be paid.

In addition, an effective and efficient intercountry adoption service that reflects present day realities of Ontarians requires that the government recognize the impact of other jurisdictions' policies on Ontario and play an active role in supporting Ontarians to adopt intercountry.

For example, federal policy and legislation impacts intercountry adoption: Canadian immigration authorities in visa posts do not always give deference to the high level of screening which is required in Ontario prior to an intercountry adoption placement approval. They impose additional scrutiny on these adoptions, often resulting in children being separated from their adoptive families, or adoptive families themselves being separated while one parent stays in the child's country of origin to care for the child pending approval to complete the adoption. Waiting for visa approval is an expensive and stressful experience for families. The delay compromises the bonding and attachment between the child and family.

The government must link with key decision makers within the purview of the provincial government, with other provinces, with the federal government, and with governments of other provinces and countries, and must advocate on behalf of Ontarians building their families through intercountry adoption both within and across governments (federal and other countries).

While we understand that the Ontario government cannot directly affect the policy and legislation of other jurisdictions, we believe that concerted inter-governmental linkages are important to inform policy within Ontario and with other levels of government, and to support Ontarians to adopt intercountry to best meet the needs of the child. We are asking that the barriers or delays in the intercountry adoption process, to the extent that these are within the control of Ontario, be minimized.

The government should put a concerted effort into developing current, relevant policy for intercountry adoption and develop mechanisms to address the intersections within and between jurisdictions to improve policy and legislation in Ontario and by the federal government.

Direction, Oversight and Monitoring

Consistent Direction and Oversight

In reviewing how the adoption system as a whole functions in Ontario, we learned that the government is much more directly involved in providing day-to-day direction and guidance to licensees that provide private domestic and intercountry adoption services than to the public adoption sector.

The government approves homestudies for families wishing to adopt intercountry, and placement plans for private domestic and intercountry adoption. In our view, in contrast, the government plays a more "hands off" role with public adoption services. As an example, we repeatedly heard from CASs that a clearer explanation of the intent of policy changes is needed. We also noted that many guidelines and standards that inform adoption practice are outdated. The last comprehensive set of guidelines for public adoption service providers dates back to 1985 and, for private domestic and intercountry licensees and private practitioners, to 2000.

We suggest that consistent direction and oversight of all adoption services is required to decrease variability in public adoption across the province, to ensure accountability of private domestic and intercountry adoption, and to ensure that adoption is provided in the best interests of the child.

Provincial Targets and Standards

To truly improve service delivery, it is important to set a provincial target for the number of public adoptions that should be finalized each year. We believe that if the government commits to implementing the adoption-related recommendations in this report, it can expect that **the number of Crown wards adopted would double within five years** (i.e., current annual number of public adoptions is about 800 – by 2014, the annual number of adoptions would be 1,600). We suggest that this target is achievable based on the experience in the United States: the number of adoptions increased dramatically after the introduction of significant policy changes codified under President Clinton in the federal *Adoption and Safe Families Act*. In the United States, "Adoption 2002" reforms resulted in a doubling of the number of children adopted between 1995-2000. Policies to support these results included:

Provincial target

To establish the target of doubling Crown ward adoptions within five years, we looked at the number of current Crown wards (minus the number of First Nations and Aboriginal Crown wards) by age and placement. We compared these numbers to the national American placement rates for the same age cohorts and predicted what similar placement rates would be for Ontario.

- Support for permanent state subsidies for adoptions of children with special needs.
- Financial incentives for states which increased their number of adoptions.
- Standardization of rules for terminating parental rights (e.g., if a child is in care for 15 of the last 22 months, the process to terminate parental rights must be started).

Service delivery standards should also be set. For example, when we discussed the provincial agency on page 48, we noted the important role that the government needs to play in setting standards for the availability of parental training and homestudies and for completing child welfare checks and police checks.

All targets and service standards should be re-evaluated and reviewed before the end of the five-year period and, when appropriate, new and ambitious targets should be set.

Timeliness of Court Processes

We repeatedly heard from child welfare workers that court processes can be very slow, time-consuming and costly, and they obviously have a direct impact on how quickly children become Crown wards. This in turn directly affects the ability to move them into permanent arrangements, including adoption.

Some broad steps have already been taken to try to address this problem. The government has supported the development of alternative dispute resolution processes, including mediation, to ease some of the burden on the courts. But there's little information available about how these processes are actually working across the province.

We recommend that the government prioritize solutions to this problem and consider setting service standards in this area as well. In its broad system oversight role – both of the child welfare system and the court system – the government should explore how alternative dispute resolution processes can be used to move children through the Crown wardship process as efficiently as possible, while collecting data to see whether mechanisms like alternative dispute resolution are working.

Licensing

As we mentioned, the government is responsible for licensing private domestic and intercountry adoption service providers. We fully support regulation and the process of licensing private adoption service providers, however, we question the current requirements to renew all licenses annually. Given the reality of the intercountry adoption process – where the processing of an adoption from start to finish often takes several years – and the significant responsibility of licensees – we believe that the government should make the best possible use of its resources and licensing should be on a graded basis similar to the hospital accreditation process. New agencies and agencies requiring more support would receive licences of a shorter duration. Those with a proven track record and consistently strong performance would receive longer term licences. Whatever the term of the licence, we envision that regulation of the agency would continue during the term by ongoing support and consultation, and by oversight and monitoring that could include the requirement of periodic reporting and inspection of records.

Data on Service Provision and Outcomes

Throughout our review of adoption services in Ontario, we were continually frustrated by the lack of data on service provision. Even the limited information reported to the government is full of gaps. For example, the Crown Ward Review only provides information on children who have been Crown wards for two or more years. It tells us little about what is being done to facilitate adoptions for Crown wards waiting for a permanent home and nothing about Crown wards who have been wards for less than two years.

We were also surprised to find that information is not collected about how well children do after their adoptions are finalized. This means the field does not have information about the matches that work best for children or the types of supports families need after an adoption is finalized. Without this information, services cannot be continually improving.[66]

For data collection and reporting on children in care, Crown wards, adoptions and other permanency arrangements, Ontario could learn from practices in the United States where anonymized data is collected by each state and reported centrally.[67] Independent data collection is necessary in and of itself to promote transparency and confidence in the data collection process. The public has increased confidence in data collected by an independent third party with expertise in privacy, security and data collection across human services.

The government should identify the data required to evaluate Ontario's adoption services and establish clear reporting processes. We recommend that the government contract with a trusted independent third party to collect and analyze longitudinal, anonymized data on outcomes for children who are adopted. Additional information should be collected about Crown wards who are not adopted – including children who are placed in kinship care and legal custody arrangements.

Service Delivery Information Available to All Ontarians

We believe that to increase accountability, all Ontarians should have clear, unbiased information on all adoption services regulated by the Province. This information should be clearly posted on the government's website and include a brief description of the licensing requirements for private domestic and intercountry licensees, approval processes for private practitioners and service standards for the delivery of adoption services. In addition, there should be information from each of the three services about approximate costs and time to complete adoption. The likelihood of having a child placed should also be posted. Finally, information about complaint mechanisms and processes must be clearly identified.

Establish Mechanisms so that People Who Are Dissatisfied with the Services they Received Can Be Heard

It is important to establish a counter-balance to the considerable power a PAA would have. We also conclude that as the government is responsible for regulating private domestic and intercountry services, more formal mechanisms are needed to establish service provider accountability.

We recognize that there currently are some mechanisms in place like the Child and Family Services Review Board that provide service recipients a voice, but they are not adequate.

The government should review and enhance formalized complaint mechanisms to be sure that all parties involved in adoption processes – adoptive and birth families – as well as children and youth who are dissatisfied with the service they received, can be heard.

Child and Family Services Review Board

The CFSA gives the Child and Family Services Review Board the mandate to hear an application from a foster parent or other person requesting a review of a CAS's decision to refuse an application to adopt a particular child.

The Board also has the mandate to review a CAS's or licensee's decision to remove a child who has been placed with a person for adoption.

WHAT ADDITIONAL STEPS SHOULD ONTARIO TAKE TO IMPROVE ADOPTION SERVICES IN ONTARIO?

To ensure that Ontario has a world class adoption system, we recommend:

2. Develop Tools to Manage the Adoption System

Openness and Court-ordered Access

2.1 The Government of Ontario should **remove barriers resulting from court-ordered access** to birth families while addressing the importance of contact or communication with birth families:

- Articulate a clear policy statement that contact or communication with birth families should not be a barrier to the adoption of Crown wards, and that adoption can occur for children with court-ordered access.
- Amend the *Child and Family Services Act* so that in the future Crown wards with court-ordered access are legally free for adoption.
- Tailor tools and mechanisms to better provide for contact or openness when it is in the best interest of the child.
- Undertake an immediate provincial review of all existing court-ordered access for current Crown wards: where access is not being exercised and/or does not continue to be in the best interests of the child, the case should be returned to court for re-consideration; where some form of contact with the birth family continues to be beneficial for the child, consideration should be given to exploring the possibility of replacing the access order with an openness agreement or order.

2.2 The government should **create overarching policy and processes to support adoption with openness**:

- Clearly identify how and when court-ordered contact should be used and when it should not be used.
- Provide education for professionals in the court system, including those on the bench, about the importance of adoption for Crown wards, with a particular focus on adoption of older Crown wards.
- Provide a mechanism to clearly provide that the voice of children is heard in the decisions that impact their lives – including during any consideration of contact.
- Establish principles that birth families can be offered some form of contact in negotiation or mediation processes relating to children's futures, while providing a clear message that adoption will be pursued when it is in the best interests of the child.
- Increase the availability of alternative dispute resolution processes while collecting data to identify whether mechanisms are working.

Policy and Legislation

2.3 The government should immediately review all current adoption policies and move forward to **develop a policy framework** that will underpin public, private domestic and intercountry adoption.

2.4 The government should ensure that the policy development process is **informed by the knowledge and experience of a cross-section of external stakeholders** including, but not limited to, child welfare and adoption service providers, licensees and private practitioners, prospective and successful adoptive families, adopted youth and adults, birth parents, foster parents, current and former Crown wards.

2.5 The government should review the framework every five years to **ensure the policies remain evidence-based, current and consistent**.

2.6 The government should create **consistency within and between the three adoption services** and articulate provincial policy that:

- Clearly provides that race, culture, language, sexual orientation and family structure are not barriers to the timely adoption of children.
- Supports families to concurrently explore adoption between and within the private domestic, intercountry and public services, and to explore assisted reproduction services and adoption according to their own situations.
- Age should be only one of a number of factors considered when determining suitability of a family and/or a proposal for adoption.
- Supports equal leave for birth and adoptive parents under the *Employment Standards Act*.

2.7 The government should develop clear policy that demonstrates **support for relative adoption** including for relatives adopting intercountry.

Gaps and Barriers

2.8 The government should review intercountry adoption policy and overhaul legislation with the purpose of **safeguarding children and families, facilitating timely placements, addressing barriers and legislative gaps**, as well as creating harmony between the *Child and Family Services Act*, *Intercountry Adoption Act*, with the Hague Convention and additionally, with the realities of non-Hague countries.

2.9 The government should enact **policy and/or legislative amendments** to:

- Include conflict of laws provisions in the *Child and Family Services Act* which recognize adoption consents and orders terminating parental rights made outside of Ontario.
- Address legislative gaps including those relating to guardianship and expenses and develop policy to assist Ontarians temporarily living outside the province who wish to adopt.

Advocacy

2.10 The government should **advocate** that the Government of Canada amend federal employment insurance rules to provide the same treatment for birth parents and adoptive parents.

2.11 To better support more timely intercountry adoption processes, the government should play an **advocacy role**:

- Within Ontario.
- With other provincial and territorial governments.

- With the federal government.
- With governments of other countries.

Oversight and Monitoring

2.12 The government should provide **clear oversight and monitoring** of Ontario's adoption system.

2.13 The government should set a provincial target to **double the number of Crown wards adopted within five years** and, within five years, review and establish new and ambitious targets.

2.14 The government should **set service standards and ensure that they are re-evaluated and reviewed** before the end of the five-year period.

2.15 The government should introduce a **graded licensing process** for intercountry adoption.

Data Collection and Reporting

2.16 The government should identify the data required to evaluate Ontario's adoption services and **establish clear reporting processes**.

2.17 The government should contract with **a trusted independent third party to collect and analyze longitudinal, anonymized data on outcomes** for children who are adopted.

2.18 This third party should collect **information about Crown wards who are not adopted**, including outcomes for children who are placed in kinship care and legal custody arrangements.

2.19 The government should make **accurate information about all adoption services available to all Ontarians**, including reporting on average costs, wait times, placement success and service standards.

Complaint Processes

2.20 The government should review and **enhance formalized complaint mechanisms** to be sure that all parties involved in adoption processes – adoptive and birth families, as well as children and youth – who are dissatisfied with the service they received, are heard.

3. PROVIDE ADEQUATE FUNDING THAT SUPPORTS THE REALITIES OF ADOPTION

We must all recognize that public adoption is cost-effective, particularly relative to the cost of keeping Crown wards in care.

→ Create funding **incentives for permanency planning**.

→ Provide funding to support the provincial adoption agency to perform **all identified adoption functions**.

→ Guarantee funding to **support ongoing adoption subsidies** for older children and children with special needs.

In addition, to support families who choose private domestic or intercountry adoption, the government should:

→ **Increase the ceiling of allowable adoption expenses** that can be claimed on income tax to $30,000.

Creating Funding Incentives for Permanency Planning

The way the government currently funds CASs does not necessarily support permanency planning. When children are moved out of care and into permanent homes, a portion of the base funding for the CAS responsible for those children is discontinued. Inadvertently, this funding formula may create disincentives for adoption and incentives for keeping children in care.

A funding formula is needed where both the PAA and CASs are supported to work collaboratively and see the rewards for doing so. We believe it's crucial that incentives for pursuing permanency planning from an early stage and for working closely with the PAA be built into every CAS's funding.

Provide Adequate Funding to Support the Provincial Adoption Agency to Perform All Identified Functions

To perform all duties as outlined in this report, and to continue free access to public adoption, the PAA would require adequate funding. This includes sufficient resources for: establishing a central and local presence; staffing needed to provide the range of duties required throughout the adoption process; providing ongoing subsidies and facilitating community capacity to develop a range of post-adoption supports; funding parental training and homestudies for all families adopting from the public service; and expanding the ARE to occur four times a year in regional centres across the province.

Our preliminary analysis indicates that a PAA can be established within the existing resources that are currently designated for public adoption services, and that the establishment of the PAA would therefore be cost neutral for the Province.

Providing Funding for Subsidies and Post-adoption Supports

While subsidies and other financial supports are provided to some families who adopt through a CAS, once again there is considerable variability regarding if, and for how long, subsidies are provided. And whether or not a subsidy can even be considered depends on where the child lives in the province and which CAS is responsible for that child. Consequently, the "system" of subsidies is more like the luck of the draw.

In the United States, in 1997, increased federal funding for adoption subsides resulted in a statistically significant increase in the number of finalized adoptions.

"There needs to be more support for foster parents who want to adopt the children they have bonded with."

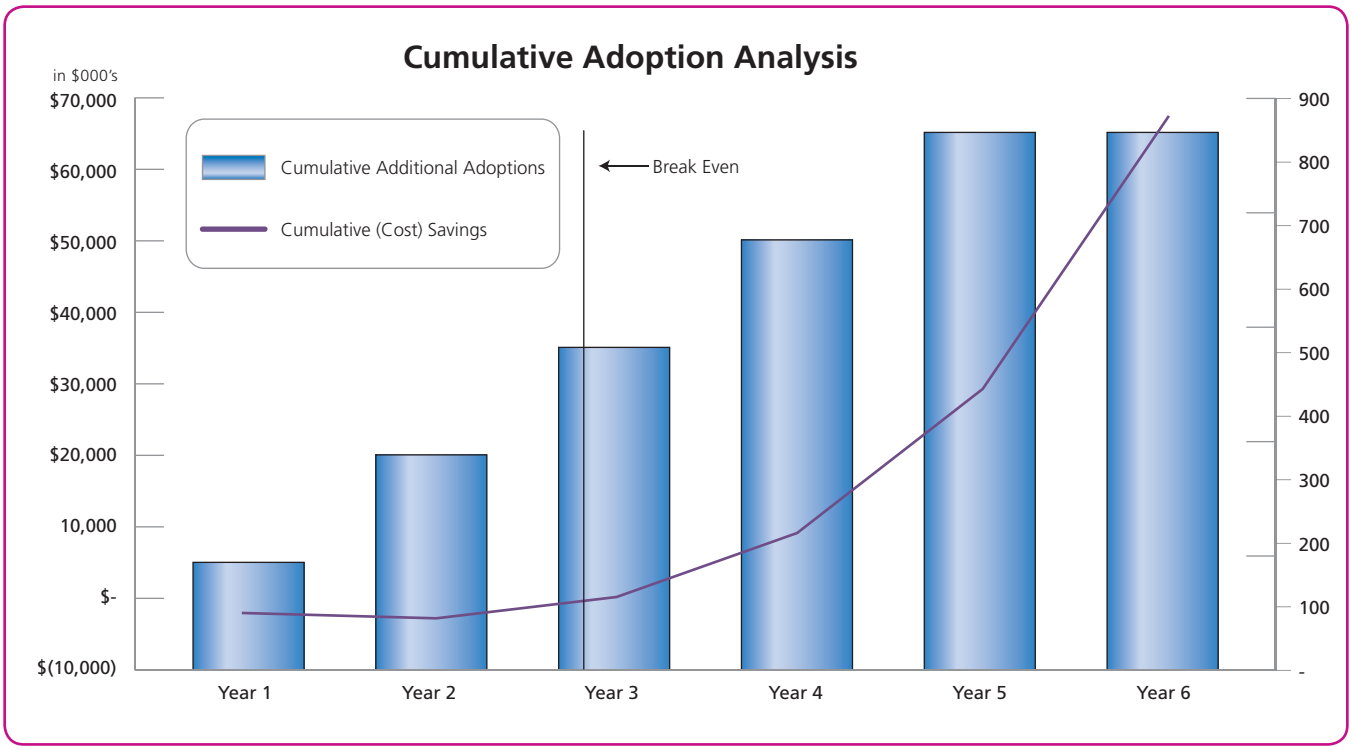
– Interviewee

Evidence from other jurisdictions, both in Canada and across the United States, demonstrates that post-adoption subsidies and other financial supports are very important tools to facilitate adoption placements for children over the age of two and children of any age who have special needs.[68, 69] In some cases, when subsidies are available, children who have been in long-term placements

with foster families are adopted. As described earlier in this report, we heard stories of foster families who adopted their foster children with special needs – at the expense of funded services and supports – in order to give them permanency and a forever family. But adoption should not be an "either/or" scenario. Children with special needs should not have to sacrifice services and supports in order to become members of permanent families.

In Alberta and in many U.S. states, all families who adopt a child from public care receive a monthly subsidy – regardless of the child's needs. Ontario is out of step. It is urgent that we develop a provincial subsidy system.

A costing analysis, completed to provide us with confidence that providing subsidies in Ontario would result in cost savings to government, illustrates that the "break even" on subsidies can be accomplished in less than three years. The cumulative savings over five years, assuming we reach our goal of doubling adoptions over that timeframe, would result in savings to the child welfare system of over $28 million. It should be noted that these savings are a conservative estimate, in that they do not take into consideration the money saved in cost avoidance measures related to long-term costs to society when children do not have permanent homes.



We believe that subsidies should be needs-adjusted and based on specific criteria to ensure equity. We recommend that they should correspond to 50% to 80% of the child's current foster care rate. Furthermore, a funding pot should be set aside to provide for additional supports (e.g., significant medication costs) and future needs. Subsidies should be made available retroactively for adoptions taking place from the day our report is released. We believe that reliable, ongoing subsidies would result in significant cost savings for the child welfare system based on our analysis of current system costs.

Daniella and José became foster parents to Jason when he was six years old. Jason had been severely neglected, and FASD was suspected but not diagnosed. It took time for Jason to form a bond with Daniella and José and to overcome some of his developmental delays, but he made good progress. Jason lived with Daniella and José for most of the next three years – except for two brief periods when he moved back with his birth family.

When Jason became a Crown ward at the age of nine, Daniella and José wanted to adopt him. He was already part of their family – their other children loved him – and they wanted to make the relationship permanent. But when they talked to their CAS worker, they realized it might not be so easy. As long as Jason was a foster child, the family received approximately $1,200 a month to help with his care, along with an additional special subsidy to cover the costs of tutoring that Jason needed because of his learning disabilities. If they adopted him, they would lose the foster care subsidy. Other subsidies and supports might be available, but only on a year-by-year basis, and could be stopped at any time. While they wanted to adopt Jason, they weren't sure they could give him the same level of care and support as they could as foster parents.

Tax Relief for the Cost of Adoption

Private domestic and intercountry adoptions are expensive for families. A private domestic adoption can cost between $20,000 and $30,000, including the cost of PRIDE and SAFE. An intercountry adoption is reported to cost up to $60,000.

In 2008, Ontarians who adopted could claim up to $10,592 in eligible adoption-related expenses on their provincial income tax, in the form of a non-refundable tax credit that serves to reduce the amount of taxes owed to the government. Claimable expenses include fees paid to an adoption agency, court and legal costs, and travel and living expenses incurred when adopting from another country. This credit can reduce Ontarians' provincial taxes by a maximum of about $640 (based on a tax rate of 6.05%). A similar federal non-refundable tax credit allows for a reduction in taxes of about $1,600 (based on a tax rate of 15%).

Given the current costs of private domestic and intercountry adoption, we believe that the provincial $10,592 ceiling is too low and recommend that the provincial government increase the ceiling for allowable adoption expenses to $30,000. This would allow for a reduction in provincial taxes owing of a maximum of $1,815.

The estimated cost to the province of increasing this ceiling is less than $1 million annually.

HOW CAN ONTARIO BETTER SUPPORT THE REALITIES OF ADOPTION?

To ensure that Ontario better supports the realities of adoption, the adoption system must be adequately funded. We recommend:

3. Provide Adequate Funding that Supports the Realities of Adoption

3.1 The Government of Ontario should **fund permanency planning** to reward children's aid societies and the provincial adoption agency when children are placed for adoption.

3.2 The government should provide **adequate funding to support the provincial adoption agency to perform all identified duties**, including establishing a central and local presence.

3.3 The government should fund **special initiatives**, including:

- Parental training and homestudies for all families adopting from the public adoption service.
- The expansion of the Adoption Resource Exchange to four times a year in regional centres across the province.

3.4 The government should provide **funding for standardized and regular adoption subsidies** for the adoption of Crown wards aged two and older, as well as Crown wards under two with special needs. We recommend the use of needs-based criteria for subsidies ranging from 50% to 80% of the current foster care rate, and further recommend that the government set aside an additional funding pot for additional supports and future needs.

3.5 The government should increase the **ceiling of allowable adoption related expenses** for income tax purposes to $30,000.

CONCLUSION

Adoption is a valuable form of family building in Ontario, providing children with stability and long-term family connections and support, and providing choices for families who want to parent.

Ontario has the capacity to be a leader in adoption. With vision and efforts by government and support from service providers and others dedicated to adoption, the current patchwork of adoption services – public, private domestic and intercountry – can be stitched together to create a world-class system of services that benefits all Ontarians.

We know conclusively that children in public care who do not return home and who age out of care have a much more difficult time later in life. Children who grow up in care without the stability, nurturing, acceptance and certainty that only a permanent family can provide, face extraordinary, ongoing challenges. It is tragic that thousands of children in this province are currently facing such a future – particularly considering that it is, in many cases, avoidable. For many of these children, adoption would provide a completely different kind of future. We heard repeatedly, both from interviewees and in the literature, that children, even those with significant challenges, thrive once they have forever families. It isn't always easy, but as adoptive families recognize, it is absolutely worthwhile.

We encourage the government to demonstrate its support of the belief that the lives of Crown wards are as valuable as the lives of all other children in this province. Children in public care should have the same opportunities for permanency and family connections. The way forward is clear: to vigorously and aggressively improve their chances of finding permanency through adoption.

We encourage the government to help more children find permanent homes and more Ontarians build families through adoption. Our goal is to provide an adoption system that both anticipates and is more responsive to the needs of children and families – including adoptive and birth families. We believe that acting on our recommendations would:

- Find **families for many more children** who need them.
- **Eliminate existing barriers** – legislative, organizational, and attitudinal – to adoption.
- **Streamline and expedite processes** so that children and adoptive families are united as quickly as possible.
- Through openness, **support contact or communication with birth families** when it is safe and in the best interests of children.
- **Respect choices** made by families – regardless of the adoption service they choose.
- Result in a system that treats **adoptive families as a valuable resource** and provides the support they need even after an adoption is finalized.
- Provide adoption **services that are continually improving**.
- **Double the number of Crown wards adopted** within five years.

We know that Ontario has the capacity to build a system that reflects our vision and exceeds our goals. We believe that within five years, the picture of adoption in this province could look entirely different and far more positive than it currently does. Radically changing the adoption system will result in more permanent homes – and better lives – for children in care. In our view, the future of extremely vulnerable children is a matter of utmost importance for any government, and we are grateful to this government for providing us the time, resources and scope to consider how best to help children needing "forever families" and help Ontarians seeking to build families through adoption.

CARE TO PROCEED: INFERTILITY AND ASSISTED REPRODUCTION IN ONTARIO

GOAL: TO HELP MORE ONTARIANS BUILD FAMILIES THROUGH HIGH QUALITY AND SAFE FERTILITY EDUCATION, MONITORING AND ASSISTED REPRODUCTION SERVICES

We believe that all Ontarians should have the opportunity to build a family. Infertility is a medical condition that prevents some Ontarians from doing so. These medical problems often require medical treatment(s) to overcome infertility. Right now in Ontario, one in eight couples is struggling with infertility. **One in six couples has experienced infertility at some point in their lives.** Both male and female infertility are on the rise. And many other Ontarians – same-sex and single people and people with illnesses like cancer or HIV – need help to start a family.

Infertility is a medical condition that often requires medical treatment. Infertility has wide-reaching consequences for individuals, families and society.

Access to assisted reproduction services should be free from any discrimination.

Every year, tens of thousands of Ontarians turn to assisted reproduction and other services like acupuncture and naturopathic medicine to help them conceive. Thousands more never seek help.

People who have experienced fertility problems or who have sought help told us about the barriers they face.

- It's **difficult to get information**: many people didn't know about the factors that affected their fertility.
- They are not sure **where to go for help**. Some facilities and practitioners offering assisted reproduction services are not accredited. **Are the treatments safe**? Where should they go to get the best care?
- The **procedures are too expensive**. Many treatments are beyond the reach of most Ontarians.
- There **isn't enough emotional support** to help them deal with the grief over fertility problems, the stress fertility issues place on relationships or the challenges of treatments.
- Many people have **trouble accessing services** because of where they live.
- For same-sex and single people, and people with HIV, **social and legal barriers** can keep them from getting the services they need.
- The **fertility needs of young cancer patients** are often forgotten by treating cancer specialists.
- There is still a sense of failure or **stigma** about infertility that keeps many people silent and in pain.

Ontario can do better. Ontario must do better. The status quo is not acceptable. We see a province where all Ontarians have the information they need to protect their fertility, where they are confident that they are receiving safe, high quality care, and where other barriers – such as cost, geography and stigma – do not keep them from getting the services they need.

To be the best place to create a family, Ontario must act now.

1. **All Ontarians should know how to protect their fertility.**
2. **Assisted reproduction services should be safe and meet the highest, evidence-based standards.**
3. **Ontario cannot afford to NOT fund assisted reproduction services.**
4. **All Ontarians who could benefit should have access to assisted reproduction services.**

Janet and Philippe were graduate students in their mid-20s when they met and married. They wanted to finish their education and work for a few years before starting their family. When they started trying to conceive, Janet was in her early 30s. After six months of trying without success, they were concerned. They talked to their family doctor who advised them to keep trying for another six months. Seven months later, Janet returned to the doctor who referred the couple to a specialist. After several months of investigations and cycle monitoring, the specialist diagnosed a male infertility problem.

The doctor recommended in vitro fertilization (IVF) as the best treatment. But when the couple learned that it would cost $10,000 per cycle and that their employers' health plans didn't cover the treatments or the drugs, they decided to try several cycles of intrauterine insemination (IUI) with washed sperm instead – because they would only have to pay for the sperm washing. When the IUI wasn't successful, the couple decided to try IVF. They also contacted an agency to ask about adopting a child, but were told that they would have to wait until they had finished all their fertility treatments before they could begin the adoption process.

Because of the high cost of treatments, Janet and Philippe could only afford two IVF cycles. To pay for it, they used money they were saving to buy a home. They still had to borrow money. During the treatments, Janet had to have her cycles closely monitored. She was often late for work. She didn't feel comfortable discussing her medical problem with her manager, so she tried to work around it. This was very stressful for her. The drugs that Janet had to take to stimulate her ovaries were very hard on her, both physically and emotionally. The financial pressure, combined with the effects of the drugs and the couple's sense of shame and failure, took a toll on their marriage. They were stressed and tense with each other. They found it very difficult to talk about their situation with each other or with others. Many members of the family and close friends did not know what they were going through.

Because they knew they could only afford two IVF cycles, the couple asked to have more than one embryo transferred. During the second IVF cycle, Janet became pregnant. When they discovered that they were going to have twins, they were elated. However, the multiple pregnancy was very difficult for Janet. She developed hypertension and gestational diabetes. She had to be hospitalized late in her pregnancy. Her babies were born at 32 weeks. Each weighed less than 2,500 grams and their lungs were under-developed. They had to spend almost two months in a neonatal intensive care unit.

Janet and Philippe are delighted to have their babies – a girl and a boy–- home now, but they are aware that their children may have health problems later in life because of being born prematurely. They wonder if some of the family's stress and health problems could have been avoided if they had sought help earlier or if the cost of treatments had not been such a big factor in their choices.

1. ALL ONTARIANS SHOULD KNOW HOW TO PROTECT THEIR FERTILITY

Five Principles for Monitoring Fertility:

1. Involve partner where possible.
2. Provide initial advice and basic investigations in the primary care setting.
3. Know that fertility declines dramatically with age.
4. Encourage timely referral to fertility specialist teams.
5. Provide access to infertility support groups and counsellors.

Canadian Fertility and Andrology Society, Guidelines for First Line Physicians

Knowledge IS power. The more people know about their health, the better able they are to make informed decisions – to improve their health, to manage their fertility and to seek help early, when it's most likely to be successful.

Age is the single most important factor affecting the ability to conceive. Both male and female fertility decrease with age. Lifestyle factors – such as smoking, alcohol and the use of some recreational drugs – affect fertility as do an unhealthy weight, some medical treatments and other health conditions.

Fertility monitoring can help people to make informed choices about their fertility, including when to start a family and when to seek help with fertility. It can also facilitate timely referrals to fertility specialists.

To give people the information they need to protect their fertility and make informed decisions, we recommend:

- → All primary care practitioners, including doctors of naturopathy and traditional Chinese medicine, should be encouraged to make **fertility education/counselling** a routine part of care for all patients beginning in their 20s – male and female, in a relationship or single (including those who are not trying to start a family), regardless of sexual orientation.
- → All primary care providers, gynecologists and other specialists should give special consideration to age when **diagnosing fertility problems** in women beginning at age 28 up to age 30, who have been unable to conceive naturally after one year, and include their male partners in assessments.
- → All primary care providers, gynecologists and other specialists should offer **fertility testing/ monitoring to women** who are age 30 and older who want to start a family, **and their male partners**, so as to facilitate timely referrals to fertility specialists.
- → All primary care providers, gynecologists and other specialists should **consider a referral to an infertility specialist** to women age 30 and older who have been unable to conceive naturally after six months.
- → The government should fund and support the development of **clinical practice guidelines** for fertility education and monitoring, including an algorithm to assist practitioners in assessing their patients for fertility problems.
- → The Ministry of Health and Long-Term Care (MOHLTC) should continue to **fund existing tests for ovarian reserve and semen analysis tests**, standardize these tests province-wide, and introduce newer tests that are more accurate and easier to use as they become available and are approved.

Why Should Ontario Invest in Fertility Education and Monitoring?

Many Ontarians are Unaware of How to Protect Their Fertility

Currently, about one in eight Ontario couples is struggling to build a family. Female infertility – problems producing eggs, blocked Fallopian tubes or endometriosis – is responsible for about 51% of fertility problems. Male infertility, including low sperm counts and abnormally-shaped or slow-moving sperm, accounts for another 19%. About 18% of infertility is a combination of male and female factors, and 12% is unexplained.[70]

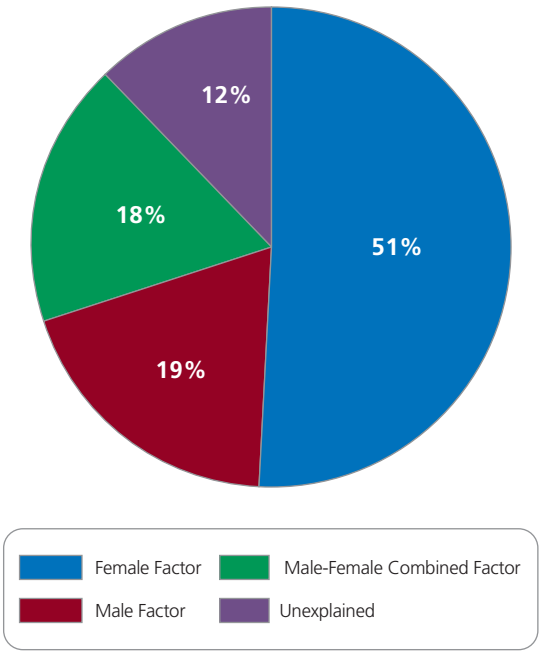
A woman's fertility can be affected by many factors, including:

- Her age.
- Sexually transmitted infections (STIs) or pelvic inflammatory disease.
- Endometriosis or polycystic ovarian syndrome (PCOS).
- Cigarette smoking or heavy use of alcohol and some recreational drugs.
- Unhealthy weight.
- Environmental toxins, radiation, certain chemicals and pesticides.
- Past use of intrauterine devices (IUDs) for birth control.
- Presence of other conditions, such as high blood pressure, diabetes, liver or kidney disease, thyroid disease, pituitary growths and tuberculosis.
- Cancer treatments (i.e., chemotherapy, radiation).
- Abdominal or pelvic surgery.[71]

A man's fertility can be affected by many factors, including:

- His age.
- STIs.
- Cigarette smoking or heavy use of alcohol.
- Use of prescription medications, over-the-counter and recreational drugs and anabolic steroids.
- Occupational hazards that expose men to toxins or high temperatures.

Reasons for Infertility



Source: Center for Disease Control and Prevention, 2006 Assisted Reproductive Technology Success Rates: National Summary and Fertility Clinic Reports

For most women, fertility begins declining around age 30 – even for women with healthy lifestyles. This is because:

- Every woman is born with all of the eggs she is ever going to have. Each month, for every egg that is released and available for fertilization, many eggs mature and most are absorbed into the body. Most women will ovulate about 400 times in their lifetime.
- Eggs get older as women age, making conception more difficult and increasing the chance for chromosomal abnormalities, which often causes miscarriage.

Many women are not aware of how they can be proactive in protecting their reproductive health.

- Treatment for cancer.
- Any injuries or health conditions that affect the male reproductive organs, such as varicocele, injuries to the testicles, testicular cancer, hormone problems, vasectomy, impotence, birth defects and autoimmune disorders.[72]

> *"I did not realize that age played such a significant role in fertility, and infertility hadn't even crossed my mind."*
>
> *– Interviewee*

It is important for primary care practitioners to discuss the relevant factors for infertility with their patients. Ontarians should know how to best protect their fertility, but also be aware that no amount of prevention can reverse age-related fertility decline. Where there are no other fertility problems, leading a healthy lifestyle (e.g., maintaining a healthy weight, not smoking) may help to increase the chances of conceiving, but it cannot change the fact that fertility declines with age.

More and Earlier Fertility Education Will Help

Early fertility education can help Ontarians to make informed decisions about their reproductive health and childbearing decisions. Also, the sooner that Ontarians are aware they may have a problem with fertility, the sooner they can be referred for treatment.

The goals of a provincial fertility education and monitoring program should be to ensure that:

- All Ontarians can receive fertility education.
- When fertility monitoring indicates a possible problem, Ontarians are referred quickly to a specialist.
- Health care resources are used wisely.

One of the best ways for Ontarians to learn about any risks that might affect their fertility is to talk to their family doctor, nurse practitioner, naturopathic doctor or other primary health care provider. Primary care providers can and should play a key role in fertility education and monitoring. Primary care providers see patients at all ages. Women in their teens, 20s and early 30s are more likely than men to go for regular checkups. In 2006, 33% of 28 year-old women saw a family doctor for a general assessment compared to 13% of 28 year-old and 17% of 35 year-old males.[73] Family doctors should be supported in incorporating fertility counselling into routine preventive health care.

Family doctors can help to educate their patients on ways to protect their fertility. Other providers also can do this. For example, the practices of naturopathic medicine, traditional Chinese medicine and homeopathy focus on treatments designed to balance hormones, increase blood flow and preserve fertility.

According to our survey of Ontarians who have used infertility services, only about one in four said that their doctor initiated a discussion about fertility with them before they were trying to start a family. Few received any fertility counselling before they experienced fertility problems. Those who did usually had a health problem that affected their fertility, such as pelvic inflammatory disease, obesity or PCOS.

> *"I thought that people with health conditions and in their late 30s had problems, and that young, healthy people did not have fertility issues. We are both very healthy and didn't think it would happen to us."*
>
> *– Interviewee*

Right now in Ontario, we are concerned that fertility is discussed and assessed too late. By the time many people have "the talk" with their primary care givers, they are already over 30 or experiencing trouble conceiving. Under the current OHIP fee schedule, physicians can bill for fertility counselling under a common counselling code. But there is no distinct billing code number, so there is no way to track how many Ontarians are receiving fertility counselling.

That said, Ontarians should also be given enough time to try to conceive naturally. After a year of trying to conceive naturally, about 90 percent of couples will conceive.[74] A good fertility monitoring program would give younger Ontarians time to conceive naturally before referring them on to a fertility specialist.

We've heard that single heterosexual people, lesbian women and gay men are less likely than heterosexual couples to receive fertility education and monitoring. This gap in preventive care is an issue because – like the rest of the population – a proportion of single heterosexual people, lesbian women and gay men will have fertility problems.

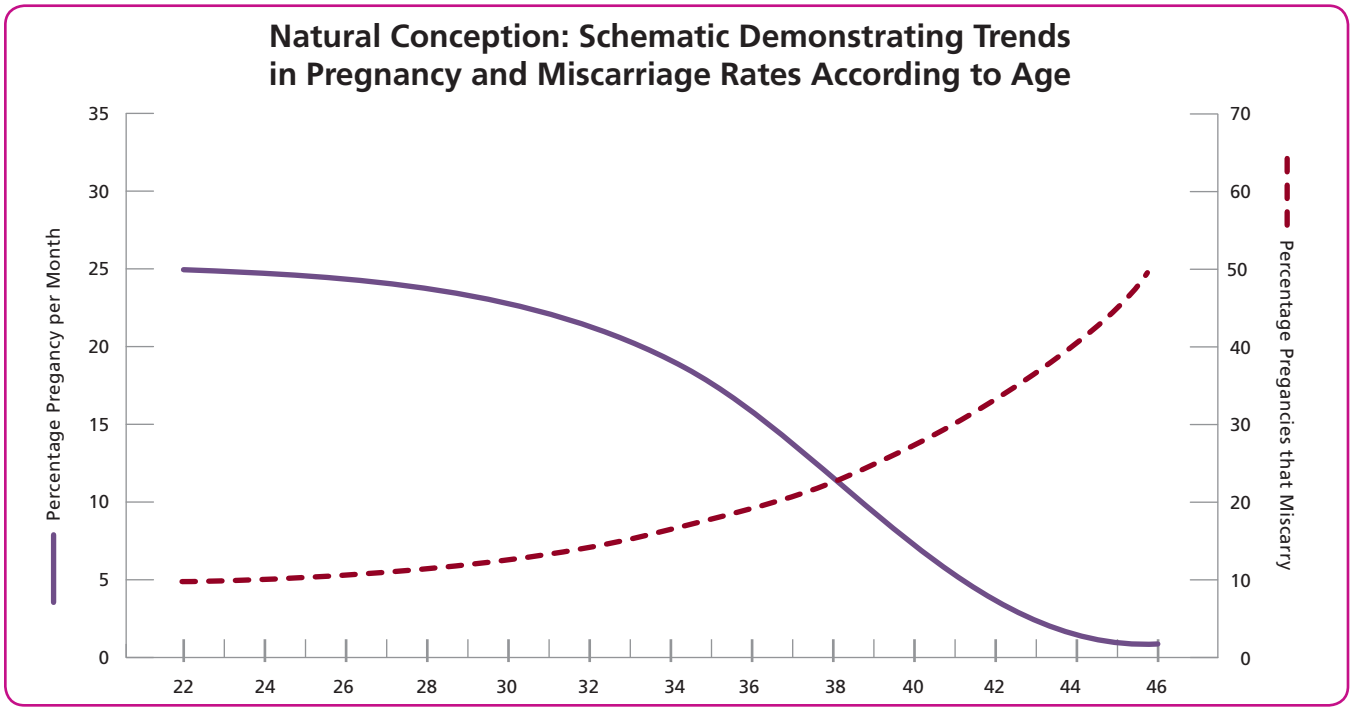
The Government Made a Commitment

The Government of Ontario has made a commitment to make fertility monitoring available to women earlier in life. But women are not the only ones who suffer from infertility. We recommend that men as well as women be educated about fertility and that men be offered fertility monitoring when their partners are being monitored or assessed.

Why is Age Important for Fertility Education and Monitoring?

When it Comes to Fertility, Age Matters

Age is the single most important factor affecting the ability to conceive. Both female and male fertility decline with age – although at different ages and at different rates.[75]



Source: Reproductive Ageing: Guidelines for First Line Physicians for Investigation of Infertility Problems (Canadian Fertility and Andrology Society, 2004).

Although the concept of a biological clock is not new, many women think they can beat the clock by staying in good physical shape ("But I'm a young 40!"). This is not the case: ovaries continue to age regardless of how fit or active women are, or how careful they are about what they eat. Although the rate at which fertility declines is different for every woman, as the ovaries age both the number and quality of eggs deteriorate.[76]

Most women start becoming less fertile around age 30 and the process speeds up at age 35.[77] In their 20s, women have a 20 to 25% chance of conceiving with their own eggs in a given month.[78] By age 40, they have a 5% chance. By age 45, if she has not yet had any children, a woman's chance of getting pregnant with her own eggs is virtually zero.[79]

> *"It never occurred to me that it could be a male issue."*
>
> *– Interviewee*

Men start becoming less fertile around age 40 as sperm count and sperm quality deteriorate.[80] The risk of miscarriage, stillbirth and fetal abnormalities increases with the father's age.[81] A 35 year-old woman trying to conceive with a 40 year-old man is twice as likely to miscarry as a woman of similar age who conceives with a man under 40.[82] When the father is over 40, the risk of having a child with birth defects, such as Down's syndrome, abnormalities of the extremities and nervous system, and multiple malformations, doubles.[83]

When it Comes to Fertility Treatments, Age Matters

Age is also a factor in the success of assisted reproduction. The chances of becoming pregnant, carrying to term and giving birth decrease with age, even with assisted reproduction.[84] The younger women are when they seek treatment, the more likely that treatments will be successful. Currently, the average age of women seeking treatment is over 35 years.[85] Assisted reproduction can only partly compensate for age and age-related decline in fertility,[86] thus a good fertility education and monitoring program would facilitate the early referral of people who want help to fertility specialists.

Fertility Monitoring Should be Evidence-based and Cost-effective

Most Ontarians will be able to build a family on their own and will not need fertility monitoring. Most Ontarians will not want to go through fertility testing without good reason. To ensure health resources are used wisely, fertility monitoring should be offered only when there is evidence – such as the person's age or past health problems – that testing is appropriate.

We recognize that primary care practitioners should always be able to make clinical decisions that best support their patients. We also recognize that decisions about undertaking testing and treatment always rest with the individual.

That is why we are recommending education for everyone in their 20s and testing/monitoring for all women in Ontario who are age 28 and older (and their male partners) who have not been able to get pregnant after one year of trying to conceive naturally.

Because a woman's fertility declines more quickly over age 30, we are also recommending that all women age 30 and over who want to start a family have the opportunity to have their fertility monitored right away – and NOT be encouraged to try to conceive for a year before being tested. We estimate that providing fertility monitoring tests (see below for the tests to be used) to these women and their partners – where appropriate – would cost the Province approximately $1.6 million per year.

> *"My doctor thought it was too early for concern. I was 32."*
>
> *– Interviewee*

Furthermore, we believe that women age 30 and over should be referred to a fertility specialist if they have tried to conceive naturally for six months without success.

In our opinion, by providing education and fertility monitoring, more Ontarians will be aware of potential fertility problems they may encounter when trying to conceive, and the people who need assisted reproduction services will have a greater chance of success because they will be younger.

To be able to talk to their patients about fertility and provide high quality, consistent fertility monitoring services, primary care providers will need evidence-based clinical guidelines.

Which Monitoring Tests Should Ontario Use?

There are tests currently available to estimate ovarian reserve, the Follicle Stimulating Hormone and Antral Follicle Count. The semen analysis test is used to estimate fertility potential in the male partners of women undergoing testing. These tests are currently funded through OHIP, but are used to help diagnose infertility once people have already identified that they are having trouble conceiving.

About Fertility Screening Tests

The **Follicle Stimulating Hormone** (FSH) blood test, taken on day one, two or three of the menstrual cycle, measures the level of a protein in a women's blood that stimulates follicles (egg sacs) to produce and release eggs. The level of this hormone increases as a woman's egg count (ovarian reserve) declines. Birth control pills and other hormones can affect the accuracy of this test, so it doesn't work for women who are taking the pill or hormone birth control.

The **Antral Follicle Count** (AFC) uses an ultrasound camera inserted into a woman's vagina to measure the actual number of follicles growing at that moment in her ovaries. The accuracy of this test depends on the skill of the person doing the ultrasound as well as timing. The test must be conducted during the first five days of a woman's menstrual cycle.

The **Anti-Mullerian Hormone** (AMH) test measures the level of a hormone in a woman's blood and is a good way to assess egg supply. The level of AMH in a woman's blood is unaffected by birth control pills and other hormones. This test is not yet licensed for use in Canada.

Semen Analysis measures the quantity and quality of a man's sperm, including how much semen a man produces, the number of sperm in each semen sample, as well as the movement and shape of the sperm – all of which reflect on male fertility potential. The analysis must be conducted within one hour after the man provides the semen sample.

Alone, Current Tests Do Not Show the Whole Picture

Currently approved and funded tests to estimate ovarian reserve and fertility potential are limited in what they can assess. The tests for female ovarian reserve can help estimate how many eggs a woman has, but they are not able to determine the quality of those eggs or whether a woman will have trouble conceiving or carrying to full-term. The tests do not work if a woman is taking birth control pills or other hormones. They work best on women who are older or more likely to experience a sharp decline in ovarian reserve.

The test available to assess men's fertility is more helpful in identifying men who may experience infertility.

Current Tests Are an Essential Part of the Whole Picture

Despite the limitations, these are the tests that are currently licensed for use in Canada. These tests are effective when used along with the other diagnostic assessment tools available to physicians (e.g., hysterosalpingogram is used to image and assess the uterus and the Fallopian tubes) to diagnose fertility problems. They can also be used to get a better understanding of fertility potential when used in a fertility monitoring program on the appropriate people.

We are aware that more accurate tests to identify overall fertility potential are being developed and we encourage Ontario to adopt these tests as soon as they are approved for use in Canada.

Tests Should be Provided and Interpreted Consistently

All three tests – the follicle stimulating hormone, antral follicle count and semen analysis – are currently being used across the province, but with not enough consistency on how to conduct the tests and how to interpret the results. Laboratories and providers need standards, guidelines and training to ensure that tests will be conducted and interpreted in the same way across the entire province.

WHAT STEPS SHOULD ONTARIO TAKE TO IMPLEMENT FERTILITY EDUCATION AND MONITORING?

To help Ontario implement a comprehensive, evidence-based fertility education and monitoring program, we recommend that:

1. All Ontarians Should Know How to Protect Their Fertility

Education

1.1 The Government of Ontario should ensure that all **primary care practitioners are educated** about fertility and related issues including: the impact of age on fertility, male and female infertility, and the important risk factors that affect fertility; the reproductive needs of non-traditional families; and the complementary services available to enhance fertility or treat infertility.

1.2 All primary care practitioners – including naturopathic doctors and doctors of traditional Chinese medicine – should make **fertility education/counselling** a routine part of care for all

patients, beginning in their 20s. This includes males and females, those in a relationship or single (including those who are not trying to start a family), regardless of sexual orientation.

1.3 The government should ensure that **printed and web-based educational materials** are developed and made available to primary care practitioners to share with their patients.

- Materials on fertility issues, including age-related fertility decline, should be shared with women and men who are 28 years of age or older.
- Materials on risk factors for infertility should be shared with women and men who are 28 years of age or older who present with these factors (e.g., sexually transmitted infections, obesity, anorexia, smoking).
- Materials that promote healthy behaviours and identify negative behaviours that may impact the chances of natural conception should be shared with all women and men who have identified that they would like to begin childbearing.

Counselling

1.4 The government should adjust the Ontario Health Insurance Plan **fee schedule** to allow physicians to identify counselling services that are provided specifically for infertility so that practitioners can make the time for this in their busy practices and the government can understand how many Ontarians are receiving this information.

Fertility Testing/Monitoring

1.5 All primary care providers, obstetrician/gynecologists or fertility specialists should offer **fertility testing/monitoring** to:

- Women age 28 and over who have been unable to conceive naturally after one year without using contraception.
- Women age 30 and older when they want to start a family (to estimate their ovarian reserve and the need for referral).
- Women age 30 and older who have been unable to conceive naturally after six months.
- The male partners of women who are undergoing testing.

Anyone who, based on fertility monitoring, appears to have a fertility problem should receive a **timely referral** to a fertility specialist (e.g., women under 30 should be referred after 12 months of trying to conceive naturally without success; women aged 30 and older should be referred after six months).

1.6 **Clinical practice guidelines** for fertility education and monitoring should be developed that include:

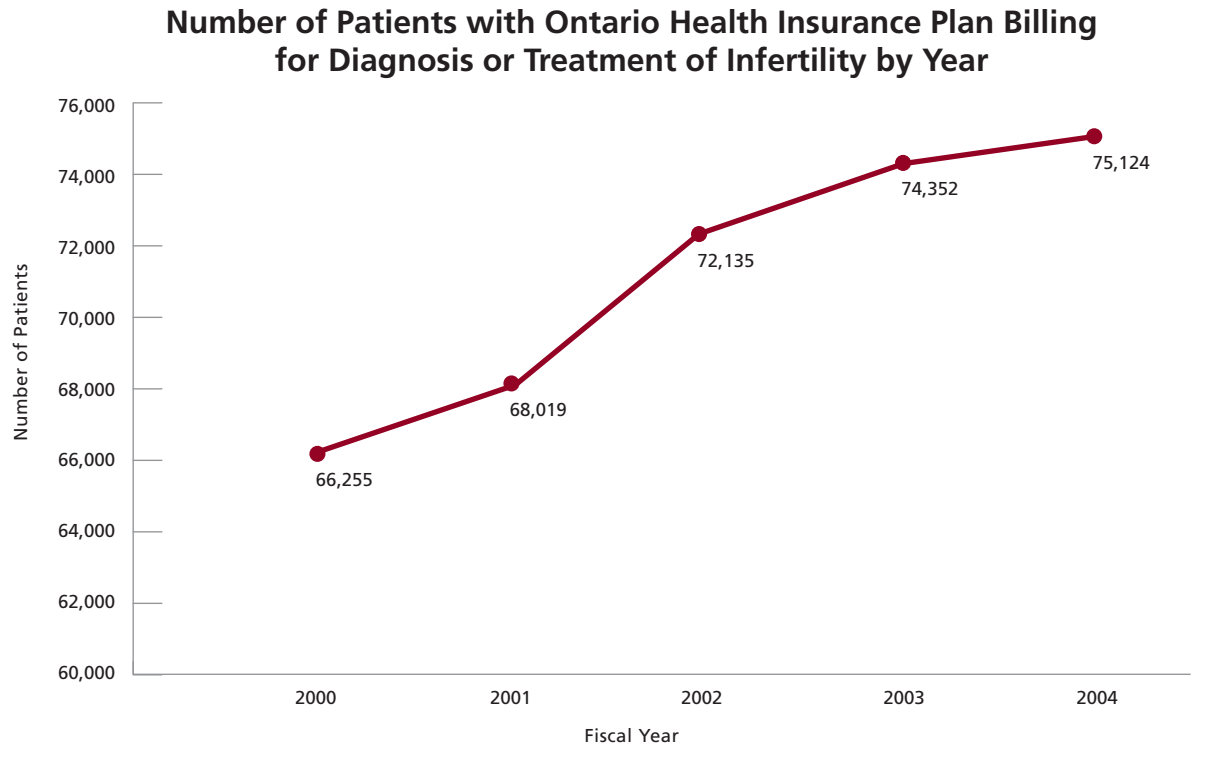
- Guidelines for fertility education.
- The important risk factors for female and male fertility.
- An algorithm that could help primary care practitioners assess patients' risk factors for infertility and the appropriate diagnostic tests to use.
- Criteria for diagnosing infertility in women and men.

- Single validated methods for measuring each of: the follicle stimulating hormone, antral follicle count and semen analysis tests to be used across the province.
- The specific test ranges or thresholds to use to make timely appropriate referrals to specialists.

1.7 The government should continue to **fund existing tests** (i.e., Follicle Stimulating Hormone, Antral Follicle Count, Semen Analysis tests) and introduce newer tests (i.e., Anti-Mullerian Hormone) that are more accurate and easier to use as they become available and are approved.

2. ASSISTED REPRODUCTION SERVICES SHOULD BE SAFE AND MEET THE HIGHEST, EVIDENCE-BASED STANDARDS

Each year, tens of thousands of Ontarians turn to medical procedures, such as in vitro fertilization and intrauterine insemination – to help them build their families.



Source: Canadian Institute for Health Information, Provincial Health Planning Database, Ontario Ministry of Health, 2006.

Assisted reproduction services are provided in 14 specialized clinics and several fertility centres and private physician offices in Ontario. Most of the 14 are private, free-standing clinics located in the Toronto, London and Ottawa corridor. Three receive some funding from MOHLTC, two of these are public clinics located in hospitals and the other is not located in a hospital.[87]

The clinics and physicians' offices that provide assisted reproduction services are not required to be accredited and information about their practices and success rates is not easily available – so it is difficult for Ontarians to make an informed choice about where to go for care or to be confident that their care is safe.

Assisted reproduction can be a safe and effective way to build a family. However, the way services are currently used in Ontario means that there are risks – both to the women and the babies conceived using assisted reproduction – when the procedures result in multiple births (e.g., twins, triplets or more). The good news is these risks can be avoided.

IVF Clinics in Ontario



To ensure Ontarians have access to assisted reproduction services that are safe and meet current clinical best practice guidelines, we recommend:

- → All IVF clinics and fertility centres in Ontario **be accredited** in accordance with provincial standards.
- → To be licensed to provide assisted reproduction services, all clinics be required **to reduce their annual multiple birth rates** to less than 15% within five years (as compared to the present rate of 27.5%).
- → Ontario follow children born through assisted reproduction, and the Ontarians using these services, to **assess the impact of services** on their long-term health and well-being.
- → Policies and practices be **re-examined and updated at least every five years** to ensure that they reflect current technologies, evidence and capabilities.

What Assisted Reproduction Services Do Ontarians Use?

There is a wide range of assisted reproduction services available to help people build families, including drug treatments to induce or regulate ovulation, surgery to clear blocked tubes or remove fibroids from the uterus, intrauterine insemination, in vitro fertilization, technologies like egg retrieval that help people preserve their fertility, counselling, and complementary therapies, such as acupuncture.

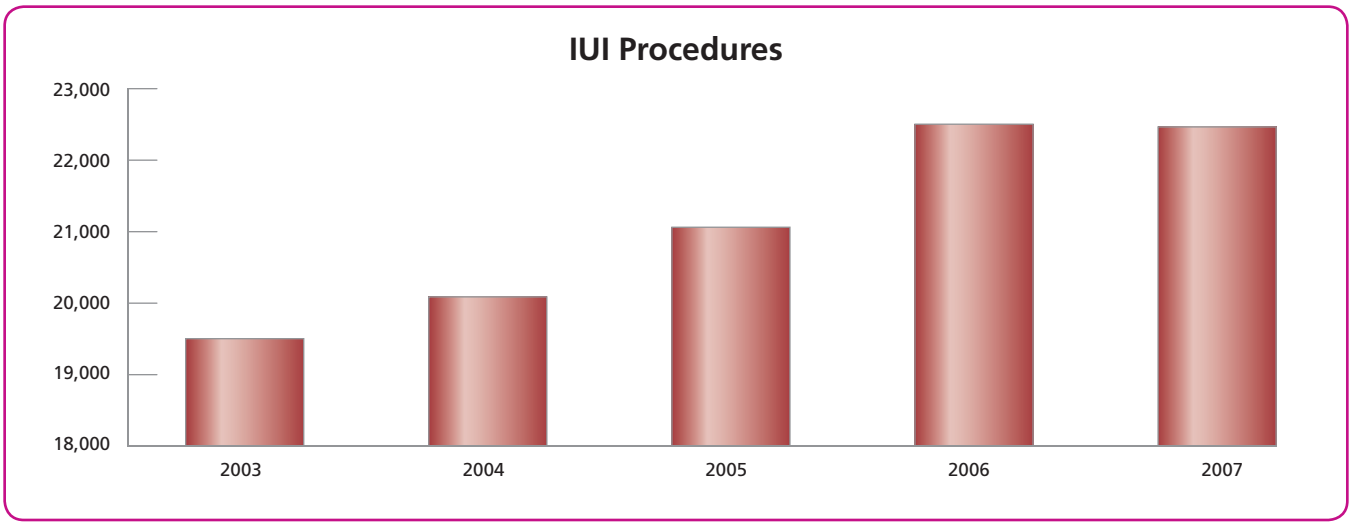
In our work, we focused specifically on treatments and other services where there were issues related to safety, appropriate use, cost and/or access, including:

- Intrauterine insemination (IUI) – with or without controlled ovarian stimulation (COS).
- In vitro fertilization (IVF) – with or without intracytoplasmic sperm injection (ICSI).
- The freezing and storing of eggs, sperm and embryos to preserve fertility.

Intrauterine Insemination

In IUI, washed and filtered sperm are injected into the uterus when a woman is ovulating. IUI is used mainly when:

- Men have problems with their sperm (e.g., low sperm count, poor motility) or have problems with sexual relations.
- Heterosexual couples have unexplained fertility problems.
- Women (including single women, women who are part of a heterosexual or homosexual couple) are using frozen donor sperm.
- Women have "hostile cervical mucous" (i.e., cervical mucous doesn't allow the sperm to pass into the uterus).



Source: Adapted from information provided by the Ministry of Health and Long-Term Care from fiscal year 2003-07.

IUI may be used alone or with controlled ovarian stimulation (COS). COS involves the woman taking medication to help her produce more than one egg in a menstrual cycle and then timing the insemination to her ovulation. COS can increase the chances of conceiving through IUI by making more eggs available for fertilization by the sperm. IUI requires frequent blood tests and ultrasounds to identify when the woman is ovulating. It may also require sperm washing, a process that uses a centrifuge to separate the best sperm from seminal fluid.

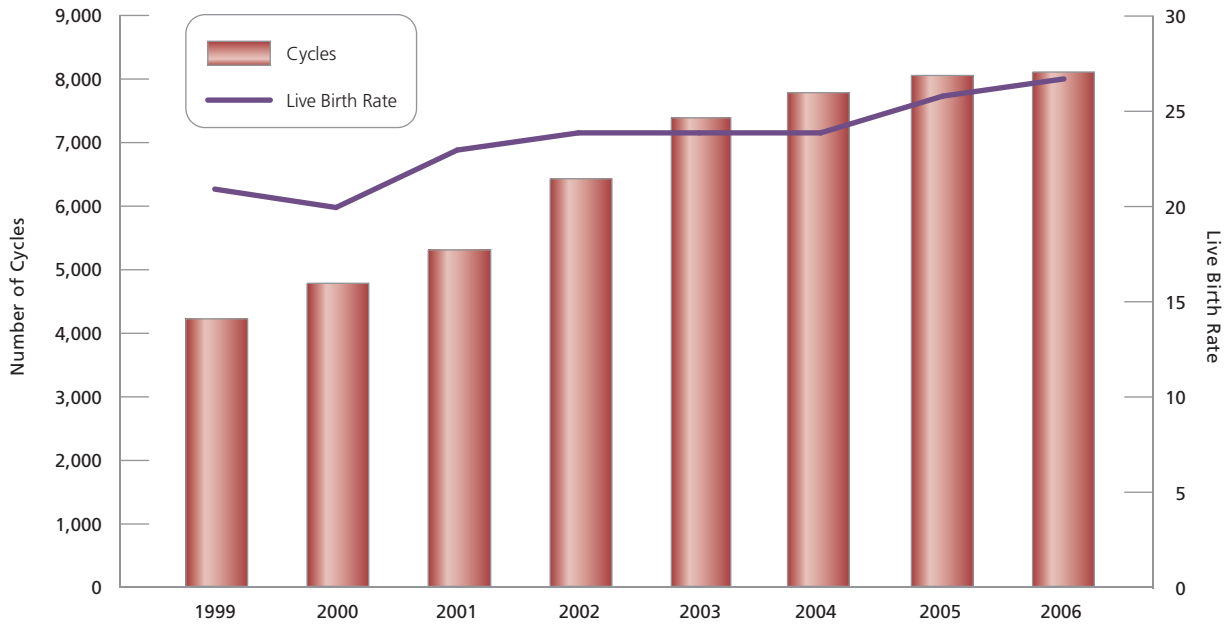
The use of IUI is increasing over time: over 22,000 IUI procedures were done in Ontario in 2007.

Advantages of IUI	Disadvantages of IUI
Does not involve surgical or other procedures nor require women to take much time away from work (i.e., minimally invasive).	Lower success rate per cycle of treatment than IVF.
Relatively inexpensive (most costs covered by OHIP).	Because it is inexpensive, used even when IVF would be more effective.
Effective option for women who do not have fertility problems but who require donor sperm.	Cannot be used for women who have blocked tubes.
	When COS is used, there is a high risk of multiple conceptions (i.e., doctors cannot control the number of eggs that are fertilized).

In Vitro Fertilization

IVF is a process by which a woman's eggs are fertilized outside of the body. With IVF, the woman usually takes medication to help her produce more eggs (COS). The eggs are then removed from the woman's ovaries and fertilized in the lab using either her partner's or a donor's washed sperm. One or more of the resulting embryos are then transferred to the woman's uterus.

Number of Cycles and Live Birth Rates for Canada, 1999-2006



Source: Canadian Fertility and Andrology Society

IVF is used for cases of both male and female factor infertility and for people who require donor eggs. As with IUI, a woman going through IVF must have frequent blood tests and ultrasounds in order to monitor the effects of the drugs and to schedule the procedures at the right time in her cycle.

Currently, in 50% to 70% of cases, IVF is used with intracytoplasmic sperm injection (ICSI), which involves using specialized tools to select a high quality sperm and inject a single sperm directly into each egg. Although ICSI is only recommended in cases where men have severe male factor infertility, more Ontarians opt to use ICSI because it improves the chances of fertilization. This increases the chances of having an embryo that will implant and grow, and of having embryos available to freeze.

Some people who go through IVF will freeze and store excess embryos and use them the next time they want to try to get pregnant. Freezing and storing embryos means the woman does not have to go through the drug treatment and egg retrieval process again. In 2006, 8,278 cycles of IVF – with or without ICSI – were started at clinics across Canada. Over half of these cycles – 4,321 – were done in Ontario.

Advantages of IVF	Disadvantages of IVF
For people with certain indications, IVF is the only option for building a family through assisted reproduction services. Can reduce risk of multiple births (because the number of embryos transferred can be controlled).	Invasive and requires women to take time off work. High cost causes people to transfer more than one embryo (which increases the multiple pregnancy rate) or to use ICSI when it is not necessary. Expensive.

Advantages of ICSI	Disadvantages of ICSI
ICSI is the only way to overcome severe male factor infertility or male sterility.	Increased risk of sex chromosomal abnormalities in male children. Expensive, as it must be done as part of IVF (not covered by OHIP).

Advantages of Freezing and Storing Embryos	Disadvantages of Freezing and Storing Embryos
Woman will not have to go through as many egg retrievals and fewer fertility medications are required. Reduces the risk of multiple births by using frozen embryos and implanting one or two frozen embryos each time. Cost of a frozen embryo transfer is lower than the cost of a fresh embryo transfer.	Ethical issues that arise if all frozen and stored embryos are not used by the woman. Cost (not covered by OHIP) – so use of these services is very low.

The Freezing and Storing of Eggs, Sperm and/or Embryos to Preserve Fertility

Eggs, sperm and embryos can be frozen and stored to preserve fertility for people who are going through treatments for illnesses that might affect their fertility, such as women and men having radiation therapy, surgery or chemotherapy for cancer.

The two most effective methods of preserving fertility are sperm and embryo freezing. Eggs are more viable when they are fertilized and frozen as embryos.[88] However, some women who want to preserve their fertility may not have a partner to provide the sperm, and they may choose to either have their eggs frozen or use donor sperm.

More Ontarians Are Using Complementary Therapies

Many Ontarians are turning to complementary therapies, such as acupuncture, naturopathy and traditional Chinese medicine – either with, or as an alternative to, assisted reproduction. Naturopathic and traditional Chinese medicine are regulated professions in Ontario and both offer treatments that are intended to promote overall health and well-being, promote fertility and treat infertility.

> *"I did acupuncture to get my body in order and feel better and use it as a stress release. This helped me feel like I was getting healthy again."*
>
> *– Interviewee*

According to our online survey, almost half of the people who responded used some kind of complementary services. The most common was acupuncture, followed by naturopathic and traditional Chinese medicine. Many others reported using massage and other forms of physical therapy. Respondents reported that they used acupuncture mainly to reduce stress, help them relax and improve their mental and physical health while undergoing assisted reproduction services.

Accreditation Is an Effective Way to Ensure Safety and Quality of Care

At the current time, IVF clinics and fertility centres are not required to be accredited – although reproductive endocrinologists, nurses, most counsellors and other health professionals who provide assisted reproduction services are all members of regulated professions and are required to meet the standards of practice set out by their regulatory colleges. Clinics can be accredited by Accreditation Canada on a voluntary basis. Not all Ontario clinics are accredited. Without mandatory provincial accreditation, there are no common provincial standards for clinic operations, the services they should offer nor the prices that clinics should charge for their services.

It Is Unclear Who Will Accredit the Clinics

In 2004, the Canadian Government passed the *Assisted Human Reproduction Act* (AHRA) which sets out rules for assisted reproduction services. Most of the regulations for the Act have not yet been drafted or enacted but, when they are, they will apply to all assisted reproduction clinics in Canada. As we were writing our report, the Government of Quebec had challenged this law, arguing that provinces and territories should be responsible for regulating assisted reproduction clinics – as they are for all other aspects of their health care systems. The Quebec Court of Appeal upheld the Quebec challenge. Several other provinces joined Quebec in this challenge, as it has now been appealed to the Supreme Court of Canada. A decision is expected imminently.

> As an Expert Panel, we support Quebec's position. We believe that Ontario should be responsible for regulating its assisted reproduction services, and that the costs of accrediting clinics should be borne by the Province.

This means that, if the Supreme Court overturns the Quebec Court of Appeal judgement and the law is upheld, Ontario clinics will be regulated based on federal standards and the federal government will be responsible for covering the costs associated with licensing and regulating the clinics. Regardless of the court decision, we believe that Ontario should take an active role in the accreditation process to ensure that clinics and practitioners are providing safe, high quality care for Ontarians.

Accreditation Will Provide More Information About Success Rates

Assisted reproduction is still a relatively young science and clinical practice. It is only 31 years since the first baby was born using IVF. Since then, knowledge, procedures and success rates have improved significantly. For example:

- The number of live births per IVF cycle started – the stronger measure of success – has improved. In Ontario, women under age 35 now have a 30.6% chance[89] of having a baby with each cycle of IVF.
- ICSI has been developed as an effective treatment for severe male infertility or male sterility.
- Women who go through IVF using a fresh embryo the first time and a frozen embryo the second have the same success rate as women who have two fresh embryos implanted on the first cycle.[90]
- Although still experimental, eggs can be matured in vitro and either used or frozen for future fertility.

While the overall success rates for assisted reproduction have improved, the success rates of individual clinics vary and depend on a number of factors, including the age of the women being treated and the skill of the practitioners and embryologists. Currently, clinics voluntarily submit their clinic-specific data (e.g., success rates, multiple rates) to the Canadian Fertility and Andrology Society (CFAS). The data

for all Canadian clinics are combined and used to educate providers and the public on the status of IVF in Canada. The information reported is for all of Canada. There is very little information available for Ontario to learn about what services are offered in the province and how each of our clinics is doing.

This means that there is little information for Ontarians seeking assisted reproduction services about what is available, where it is available and which clinic is best for them. There is currently no consistent, clinic-specific information about success rates to help people make an informed decision about which clinic is right for them. This clinic-specific data would help to support Ontarians in making choices about assisted reproduction services that are best for them, help physicians to exchange knowledge and be used to hold clinics accountable to high standards of safety and quality.

Accreditation Is Essential to Protect Ontarians

We believe that Ontario should require all IVF clinics and fertility centres to be accredited in order to provide assisted reproduction services. Regardless of the Supreme Court of Canada's decision on the AHRA, the government should identify a provincial body to accredit clinics and centres and hold them to the highest standards. This will help to protect the health and well-being of Ontarians using assisted reproduction services.

How Safe is Assisted Reproduction?

Assisted Reproduction Can Affect Children's and Mothers' Physical Health

Assisted reproduction has been shown to be safe for women and their children. In 2006, there were over 1,500 babies born in Ontario from IVF. Babies born through all assisted reproduction now represent about 1% to 2% of live births in Ontario.

Canada and Ontario have not consistently followed children born through assisted reproduction to assess the impact of the procedures on their long-term health and well-being. However, we do know that when children are part of a multiple birth or born to older mothers, they are more likely to have health problems than babies who are naturally conceived or than single babies. Multiples are also more likely to experience developmental delays.

Despite slightly greater use of health services, children born through assisted reproduction do not have any significant developmental delays compared to children conceived spontaneously. Being born through assisted reproduction does not appear to affect children's motor or cognitive development.

We also know that children conceived using IVF-ICSI for severe male factor infertility have a higher rate of sex chromosomal abnormalities than those conceived naturally or by IVF alone.[91] These abnormalities may affect the normal development of the genitals in boys.[92] We believe that it is important for Ontario to collect information on the development of children born through assisted reproduction to provide more information on the long-term impacts of these procedures.

Women who use assisted reproduction also face risks including the effects of fertility drugs (e.g., ovarian cyst formation) and a low risk associated with the egg retrieval (e.g., infection or bleeding). Women who take fertility drugs but do not get pregnant also have a greater chance of developing breast cancer or uterine cancer later in life.

Independent of the use of assisted reproduction, the risks of pregnancy increase with age. Women over age 35 are more likely to miscarry and experience complications during their pregnancy.[93] They are also more likely to have gestational diabetes or high blood pressure or require caesarean delivery.[94] Children who are born to women over age 35 are more likely to require special medical care when they are born.[95]

The Greatest Risk is Multiple Births

The single greatest risk to both children's and mothers' health associated with assisted reproduction is from multiple births. There is a much higher incidence of multiple births with assisted reproduction than with unassisted pregnancies.

The multiple birth rate from:

- IUI is **21-29**%.
- IVF is **27.5**%.

Twins occur naturally in 2% of spontaneously conceived pregnancies.

When COS is used with IUI, about one in four births (21% to 29%)[96] will be multiples (e.g., twins, triplets). Of the 1,500 IVF-related births in 2006, 70% were singletons and 30% were multiple births (two or more babies).[97] According to the Canadian Institute for Health Information, the use of fertility treatments results in a multiple birth about one-third of the time.[98] In fact, Ontarians using assisted reproduction are 10 times more likely to have a multiple birth than those who do not. Babies born through assisted reproduction represent about 1% to 3% of all singleton (one baby only) births in Canada, 30% to 50% of twin births and more than 75% of higher order multiple births.[99]

Multiple Births Put Children at Risk

We recognize that there are healthy twin and triplet babies born in Ontario each year. However, we believe that the chance of poor health outcomes for multiples is so high that Ontario must act to help provide the best start in life for children born from assisted reproduction.

The risks of hospitalization and other health problems are much greater for children who are part of a multiple birth than for singletons. More than 50% of twins and 90% of triplets are born prematurely (< 37 weeks gestation) and have a low birth weight (< 2,500g).[100] Premature infants are often born with immature lungs, which can lead to a chronic lung disease that will affect their health for the first 10 years of their lives.[101] Babies born with low birth weight (i.e., <2,500 grams) are more likely to die during the first year of life and are at higher risk of having learning disabilities, developmental disabilities, and visual and respiratory problems than children who are born a healthy weight.[102] With better medical technologies, more pre-term babies are surviving. However, they are more likely to have health problems throughout their lives than full-term babies.

Multiple Births Put Mothers at Risk

Multiple births are hard on mothers. Women pregnant with multiple children are three to seven times more likely to have complications, such as anemia, hypertension, and gestational diabetes.[103] They are also more likely to go into premature labour and to require a Caesarean section.[104] After the babies are born, they are more likely to experience problems like endometriosis, bleeding, infections and mental health problems (e.g., depression, social isolation) than mothers of singletons.[105]

Multiple Births are Costly for the Health Care System

Because both babies and mothers are at risk of complications, the financial cost of multiple births is high – during pregnancy, at delivery and later in life.[106] Women who are pregnant with twins or other

multiples require more prenatal visits. They are more likely to be hospitalized during a pregnancy and more likely to need a Caesarian section, which is a more costly delivery than a vaginal delivery. Babies who are part of a multiple birth are more likely to remain hospitalized longer after birth and need neonatal intensive care services. Babies with long-term health problems and development delays also cost the system more over their lifetime.

On average, low birth weight twin babies will cost the health care system about one million dollars each over their lifetime.

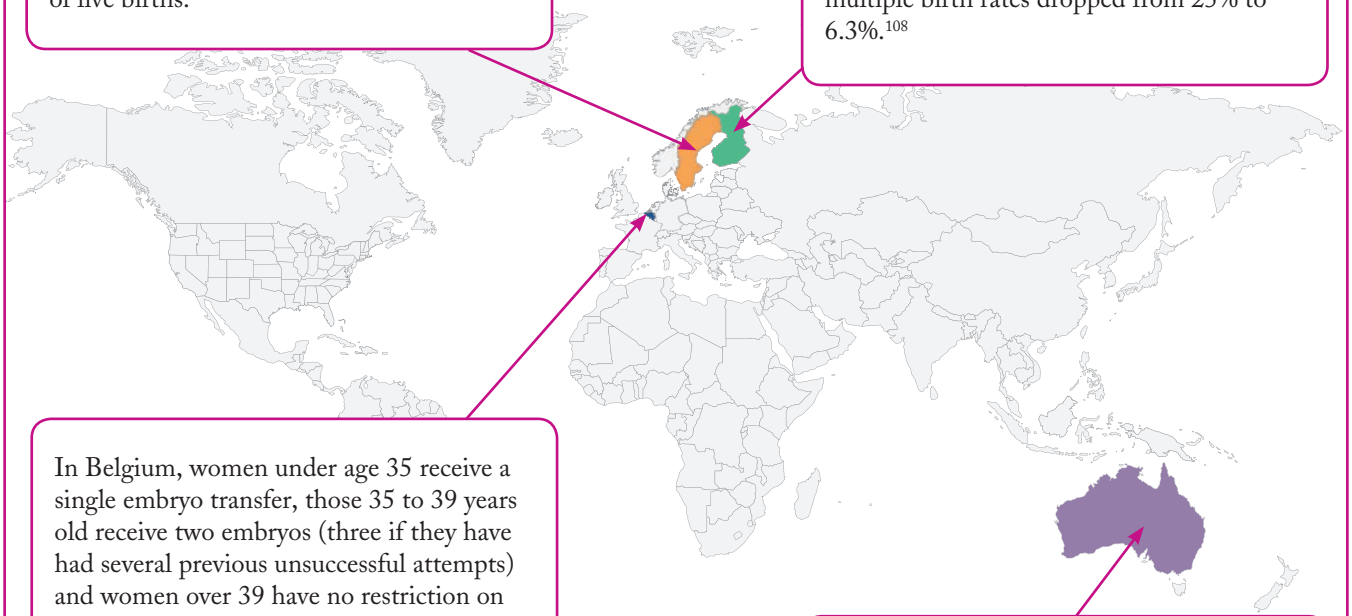
Limiting the Number of Embryos Transferred Cuts the Risk of Multiple Births

Concern over the high rate of multiple births – and their effect on children's and mothers' health – has led many jurisdictions to limit the number of embryos transferred. In IVF, policies limiting the number of embryos transferred are now preferred practice.

It Works in Other Jurisdictions

In Sweden, only patients with a low risk of twin pregnancy can have two embryos transferred – and only after they have been informed of the risks associated with a multiple pregnancy – and 70% of all IVF cycles are now single embryo transfer.[109] In 2008, Sweden's IVF twin birth rate was 5% and triplet births decreased from 3% to 0.5%, with no effect on the overall number of live births.[110]

In Finland, two embryos are transferred only when the couple has a history of unsuccessful IVF cycles, embryo quality is low or the woman is older than 37 with a long history of infertility and no top quality embryos.[107] Between 1997 and 2003, the proportion of single embryo transfers increased from 11% to 60%, the delivery rates remained at about 34% and the multiple birth rates dropped from 25% to 6.3%.[108]



In Belgium, women under age 35 receive a single embryo transfer, those 35 to 39 years old receive two embryos (three if they have had several previous unsuccessful attempts) and women over 39 have no restriction on the number of embryos transferred. This policy has resulted in almost a complete avoidance of triplet births and a twin birth rate of 7%, with no decrease in success rates.[111]

Australia is making greater use of single embryo transfers and has seen the number of multiple births drop from 20% to 11% in seven years.[112]

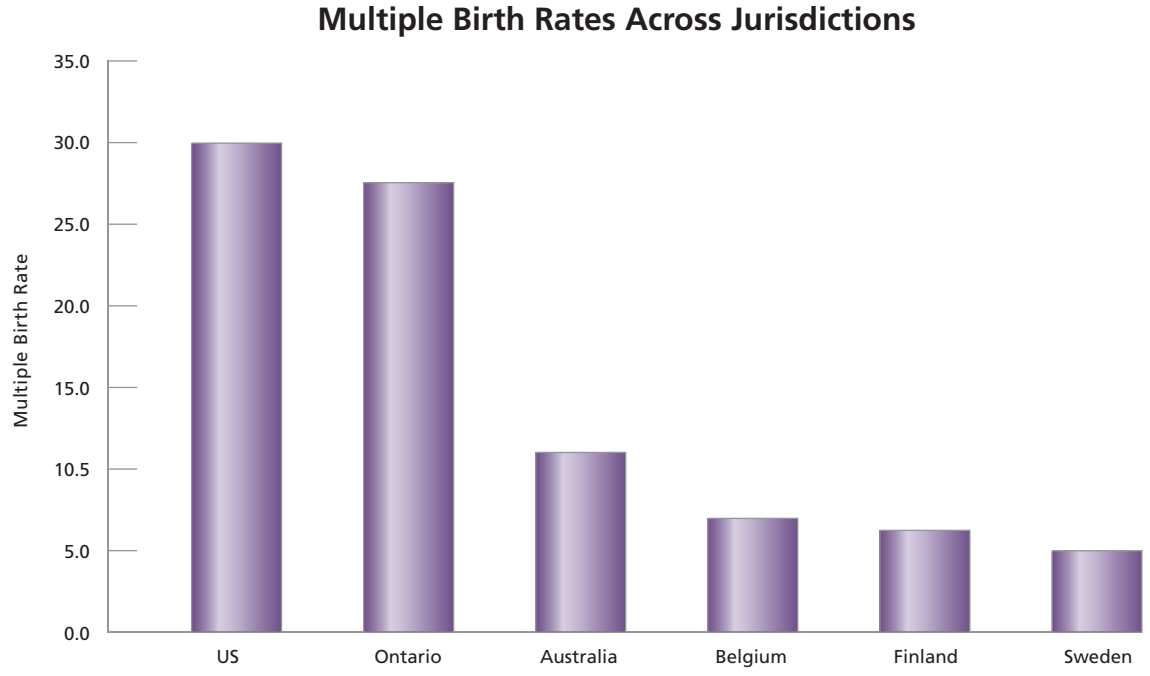
Ontario Can Do More to Reduce Multiple Births

In guidelines developed by the Society of Obstetricians and Gynecologists of Canada, IVF programs are encouraged to develop embryo transfer policies that minimize multiple births while maintaining pregnancy and birth rates.

Woman's Age	Prognosis	Recommendation – Fresh Cycles
Under 35 years	Excellent Favorable	**Single Embryo Transfer** **No more than two** embryos transferred.
35-37 years	Favorable Other	**One to two** embryos transferred in first or second cycle. **No more than three** embryos transferred.
38-39 years	Favorable Other	**Two** embryos in first or second cycle. **No more than three** embryos transferred.
Over 39 years	Favorable Other	**Three** embryos transferred. **No more than four** embryos transferred.
Exceptional Cases (regardless of age)	Very poor/multiple failed attempts	Transfer of more embryos than recommended above (physician discretion).

Note: "Excellent/favorable" prognosis is defined as undergoing first or second cycle, previous successful pregnancy, good quality embryos.
Note: In donor egg cycles, the age of the egg donor should be used to determine the number of embryos to transfer.

Despite these guidelines, the number of single embryo transfers done in Ontario remains low (just over 2% of cycles) and our multiple birth rate is 27.5% – much higher than in Australia (11%), Sweden (5%) and Belgium (7%).



A successful policy that would reduce the number of multiple births resulting from assisted reproduction requires the support of physicians, counsellors and other providers. It is essential that these providers are aware of the health, psychological and emotional impacts of multiple births on children, women and families.

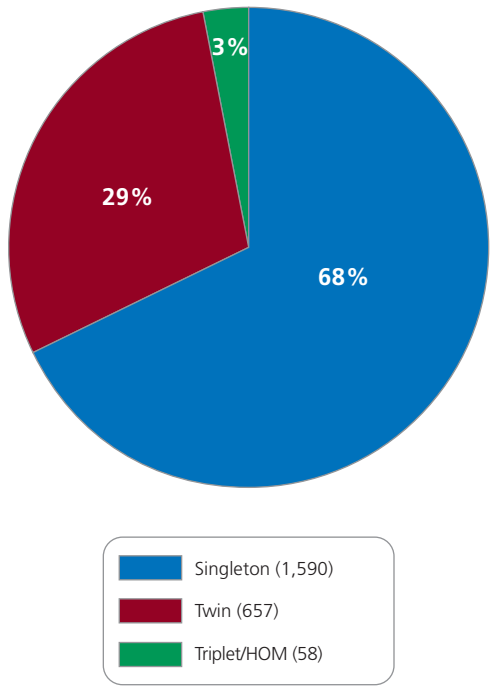
Although the vast majority of our multiple births (95%) are twins (indicating that Ontario physicians are not transferring a large number of embryos) – we can and must do more to protect the health of women and children.

Ontario Should Do More to Reduce Multiple Births

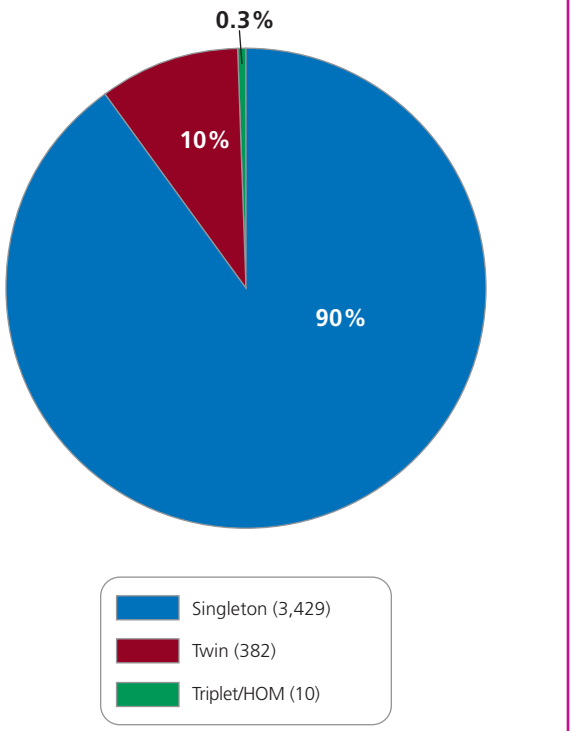
We believe that to protect the health and well-being of the children born from assisted reproduction, the Government of Ontario should require – as a condition of accreditation – clinics and fertility centres to reduce their multiple birth rates. The examples set by other jurisdictions lead us to believe that a reduction in multiple birth rates to 15% within five years and 10% within 10 years is possible in Ontario. The government should work with the appropriate medical organizations to develop the guidelines and other supports the clinics and fertility centres will require to achieve this goal.

By following our recommendations, we estimate that Ontario would reduce the number of low birth weight babies born from assisted reproduction by 2,625 over the next 10 years. We feel strongly that this recommendation should only be implemented in conjunction with our recommendations on funding (please see page 118). The success of this recommendation depends on the public funding of IVF and the education and support of providers and patients.

Live Births Under Current Scenario, 2019



Live Births Under Funding Scenario, 2019



There Are Other Ways to Limit Multiple Births

IUI Procedures Also Contribute to Multiple Births

As discussed earlier, whenever an IUI procedure is done along with controlled ovarian stimulation (COS), it is very difficult to limit the risk of a multiple pregnancy. The current multiple birth rate from IUI is similar to the multiple birth rate of IVF. The only way to reduce the chance of a multiple birth is to monitor the number of eggs produced and convert the procedure to an IVF cycle if there are many eggs produced.

In order to reduce the chance of a multiple birth from IUI, we believe that the government, in collaboration with the appropriate medical organizations, should ensure that guidelines are developed on when to convert a funded IUI procedure to a funded IVF cycle.

The Use of Fertility Medications Contributes to Multiple Births

Some Ontarians who experience fertility problems do not require IUI or IVF. Many people require fertility medications alone to overcome these issues. Fertility medications often lead to multiple births because they stimulate the production of many eggs in a single month. We believe that injectable fertility medications should never be prescribed without cycle monitoring.

There Are Other Ways to Protect the Safety of Women and Children

In addition to reducing multiples, there are other ways that the safety and well-being of the children, women and men using assisted reproduction can be protected.

It Is Important to Know When to Start – and When to Stop – Treatment

It is not always safe for some women to get pregnant, with or without assisted reproduction services. Certain factors (e.g., a woman's age, clinical history) may mean that it is not in the best interests of a woman's health for her to begin or continue assisted reproduction services. Similarly, there should be safe practice guidelines regarding when to stop treatments. It may be difficult for patients who have had treatments fail to make this choice – and therefore physicians should be provided with guidelines that will support them in protecting the health of their patients.

It Is Essential to Have the Right People Delivering Care

Fertility services are offered by different providers. IVF is offered in the 14 IVF clinics in Ontario, while other services (e.g., IUI) are offered in fertility centres or by community gynaecologists. We believe that all providers should be held to standards and guidelines.

To protect the safety of Ontarians using assisted reproduction, it is essential to hold the providers of these services to the highest standards. We believe that Ontario should ensure that only appropriately qualified people are permitted to provide the full range of assisted reproduction services.

There are many other providers who support people using assisted reproduction services (e.g., family doctors, acupuncturists, naturopathic doctors who specialize in fertility, counsellors). It is essential that all of these providers are given accurate, appropriate, current information so they are best able to support their patients. We believe that Ontario should support these providers by providing them with this information so the people who are using their services know they are receiving high quality, professional care.

Technologies Are Always Changing

Our report and all of our recommendations are based on the research and technologies available today. As with other medical technologies, there are fast-paced advances in assisted reproduction services that mean the way that providers deliver care is constantly changing. In order to provide safe, high quality reproductive services, it is essential that Ontario examine the state of these technologies at least every five years and update policies and practices to reflect current capabilities.

Facilitating Best Practices in Assisted Reproduction

To create a world-class system of assisted reproduction services in Ontario, it is essential that the Province have the tools to measure success and identify where we need to improve. Ontario must also be aware of the newest technologies and practices. We believe that by creating an academic centre of excellence for assisted reproduction, the government would ensure that providers, clinics and centres are held to the highest standards and supported to provide world-class care. This centre of excellence should be responsible for conducting research, highlighting best practices in assisted reproduction within Ontario and across the world, and reporting advances in technologies to ensure public policies are timely.

WHAT STEPS SHOULD ONTARIO TAKE TO FACILITATE ACCESS TO SAFE, HIGH QUALITY ASSISTED REPRODUCTION SERVICES?

To ensure that assisted reproduction services in Ontario protect the health and well-being of all people involved, we recommend that:

2. Assisted Reproduction Services Should Be Safe and Meet the Highest, Evidence-based Standards

Accreditation

2.1 The Government of Ontario should identify a provincial body to provide a **mandatory accreditation program** for clinics and fertility centres in Ontario.

2.2 All clinics and fertility centres should be required to be **accredited** within five years in order to provide assisted reproduction services in Ontario. The cost of accreditation should be paid for by the Province.

Multiple Births

2.3 To maintain their accreditation, fertility clinics and centres must **reduce their annual multiple birth rate** to less than 15% within five years and to less than 10% within 10 years.

2.4 To help clinics meet this target, **clinical practice guidelines** should be developed that set out:

- When an intrauterine insemination procedure should be converted to an in vitro fertilization cycle.
- The number of embryos to be transferred based on the age of the woman and other clinical indications.

2.5 Providers should be given information to inform them of the negative impacts of multiple births and the **benefits of transferring fewer embryos** for children, mothers and families.

2.6 To control for multiple births and protect the safety of the children and women using assisted reproduction, clinical practice guidelines should be developed on the **safe prescribing of all fertility medications**.

2.7 As a condition of accreditation, clinics should be required to **collect and report** on:

- Success rates and other data to empower patients to make informed choices about their reproductive care.
- Their multiple birth rate and other specified data on the quality and safety of their services.

Safety

2.8 To support physicians in providing the best possible care, Ontario should collect aggregate and **anonymized data on outcomes** of:

- Children conceived with assisted reproduction through the first five years of life.
- Patients using assisted reproduction services.

2.9 To reduce the risks for children, **intracytoplasmic sperm injection** should be provided only for individuals where:

- Severe male factor infertility is present, or
- There is demonstrated fertilization failure in a previous in vitro fertilization cycle.

2.10 **Clinical practice guidelines** should be developed by a panel of andrologists and reproductive endocrinologists that clearly define "severe male factor infertility."

2.11 **Clinical practice guidelines** should be developed to identify:

- The qualifications necessary to provide assisted reproduction services in Ontario.
- Those circumstances where persons are not eligible for assisted reproduction services, to ensure the safety and well-being of Ontarians.

Timeliness

2.12 Ontario should examine the state of assisted reproduction technologies every five years and **update policies and practices** to reflect current capabilities.

Centre of Excellence

2.13 An academic **centre of excellence** for assisted reproduction should be created to work with the medical and research communities and service providers to:

- Conduct and facilitate research on assisted reproduction to protect the safety of Ontarians using services and ensure that provincial policies reflect current technologies and practices.
- Identify best practices within Ontario, Canada and other jurisdictions.
- Encourage knowledge transfer among service providers across the province to facilitate the best quality care for Ontarians.

3. COST IS THE SINGLE GREATEST BARRIER TO BUILDING A FAMILY THROUGH ASSISTED REPRODUCTION

A few years after Eva and Rudy were married, they tried to start a family but were unsuccessful. They did not have a regular family physician, so it took some time for them to find someone who would refer them to a specialist. The fertility clinic was several hundred kilometers from their home, so every visit cost them in travel and accommodation, as well as in lost work time – she from her cashier's job in a local supermarket and he from his job at a gas station. They were diagnosed with a combination of female and male infertility, and the specialist recommended IVF. Rudy had some health benefits from his work, but they did not cover either the treatments or the medications they would need. Although they desperately wanted to have children, they decided they simply could not afford the treatments. Three years later, they are now on a waiting list for adoption with their local children's aid society. While they are looking forward to adopting, they are concerned that assisted reproduction is only an option for families with higher incomes.

Currently in Ontario, publicly-funded assisted reproduction services include IUI for all women and up to three cycles of IVF for women whose two fallopian tubes are completely blocked or absent (not as the result of voluntary sterilization). Complete blockage of the fallopian tubes accounts for only 20% of the need for IVF treatments. Even for these insured patients, the costs of treatment can still be out of reach.

Despite the fact that infertility is a medical condition, most assisted reproduction services – including ancillary services such as sperm washing for IUI and ICSI for male factor infertility – are NOT covered by our universal health insurance plan.

As a result, Ontarians who need to use assisted reproduction to build their families face high costs: up to $6,000 (not including medications, lost work time or travel costs for people in communities that do not have a clinic) for each cycle of IVF. These costs put assisted reproduction – particularly IVF – out of the reach of most Ontarians. According to the Infertility Awareness Association of Canada, the real need for IVF treatment is much higher than the number of people actually using IVF. Because of the cost, many people who could benefit from IVF are not accessing these services.

Even for those who can afford IVF, the process can be financially devastating. The average cost of a single cycle of IVF is $10,000 including medications – almost 14% of the median family income in Ontario.

But the lack of public funding for assisted reproduction isn't just hard on individuals – it is hard on our health care system – because it is contributing to high rates of multiple births. The low number of single embryo transfers done in Ontario is driven, in part, by a lack of patient choice. Faced with costs of over $10,000 per IVF cycle (including medications), many Ontarians are willing to risk having more embryos implanted and using ICSI, even when it is not clinically indicated, in order to have a greater chance of getting pregnant and taking home a baby. Many cannot afford to do otherwise.

However, as we discussed in the previous section, multiple births cost the system tens of thousands of dollars more than singleton births to care for the women during pregnancy and delivery and for the

babies at birth – not to mention the long-term health and social costs. In our view, Ontario cannot afford to NOT fund assisted reproduction services. At the same time, we believe that health care resources should be used wisely and the publicly-funded health care system should only fund assisted reproduction when there is a reasonable chance of success.

We recommend that:

- → The government **fund up to four cycles of intrauterine insemination**, including sperm washing, for women age 41 years +12 months and younger.
- → Ontario **fund up to three cycles of in vitro fertilization – including ICSI** when clinically indicated, the freezing and storage of embryos, and **frozen embryo transfer** – for women age 41 years + 12 months and younger.
- → Women who have two or more good quality frozen embryos be required to undertake publicly-funded **frozen embryo transfer** before another publicly-funded fresh IVF cycle is provided.
- → **Clinical practice guidelines** be developed by a panel of andrologists in consultation with fertility specialists to assess conditions which indicate "severe male factor infertility" and require ICSI.

3.1 Ontario Cannot Afford to NOT Fund Assisted Reproduction Services

What Is the Cost of Assisted Reproduction Services?

> *"We didn't want to get into debt, and then have a baby and not be able to pay for daycare or education for the child. I would have done IVF if it wasn't so expensive. I took it off the table because of the cost."*
> *– Interviewee*

For many Ontarians, there is no public funding for assisted reproduction services. This means that in 2009, for every cycle of IVF, people must pay about $6,000 for treatment alone – around $8,000 if ICSI is also required. Even for patients whose treatment is covered under OHIP, costs range from $1,500 to $5,000 per cycle (depending on whether they go to a public or private clinic). Ontarians who need IUI, a funded service, must still pay hundreds of dollars for sperm washing and administrative fees. These amounts do not include all of the other costs necessary for treatment – medications (which may cost just as much as IVF itself), travel, accommodation and time off of work – which add thousands more to the cost.

Service	Range of Cost for Insured Patient		Range of Cost for Uninsured Patient
	Public Clinic	Private Clinic	
Administrative Fee	$0-$1,200	$0-$400	$0-$475
IVF Treatment	$0	$3,000-$4,050	$4,800-$6,000
Embryo Thawing and Transfer	$650-$1,250		$950-$1,250
ICSI	$1,000-$1,500		
Embryo Freezing/Storage for One Year	$500-$875		
Semen Analysis	$200-$350		

Note: Prices are representative of the clinics who report their fees online only.

Cost Is Leading to Unhealthy Choices

The high cost of assisted reproduction leads people to make choices that may not be good for their health, the health and well-being of their children or the sustainability of the health care system. Cost is contributing to inappropriate treatment and higher rates of multiple births. For example:

- Many people choose to try IUI because it is covered under OHIP – even when IUI is not the best treatment option for their diagnosis.
- As women age, the success rates for assisted reproduction services decrease. Some people may waste valuable time trying to conceive using IUI simply because they cannot afford more appropriate procedures, such as IVF.
- Because doctors cannot control the number of eggs that are fertilized using IUI, this procedure results in a high number of multiple births, which mean greater health risks for the mother and children, and higher costs for the health care system.
- Many couples who use IVF also risk multiple births because of the cost. To increase their chances of success, couples who can only afford one or two IVF cycles may not be willing to have just one embryo transferred.
- These cost-driven choices can lead to long-term health problems for children.

Only 80 of 3,758 women in 2006 (2.2%) and 112 of 4,022 (2.8%) in 2007 who received IVF agreed to have a single embryo transfer. The unwillingness to have a single embryo transfer is due to a number of factors, including:

- The cost of IVF treatment in Ontario, which means that patients want to increase the likelihood of becoming pregnant each time.
- Patients having the option of reducing a multiple pregnancy (i.e., selective fetal reduction).
- Many people considering twins an ideal and benign outcome of treatment.

The Cost Is Driving Some People to Leave Ontario for Care

Cost is also a key factor in Ontarians' decision to seek care outside the country. A number of people who responded to our online survey reported that they chose to purchase assisted reproduction services from clinics in other countries. The main reasons for leaving the province for assisted reproduction services were lower costs and higher success rates.

Not Funding Assisted Reproduction Is a False Economy

It Costs More to Care for Multiple Births than to Prevent Them

The cost of treatment makes it very difficult for Ontarians to accept single embryo transfer. As a result, the health care system is now spending hundreds of thousands of dollars a year dealing with the consequences of an unacceptably high rate of twins being born.

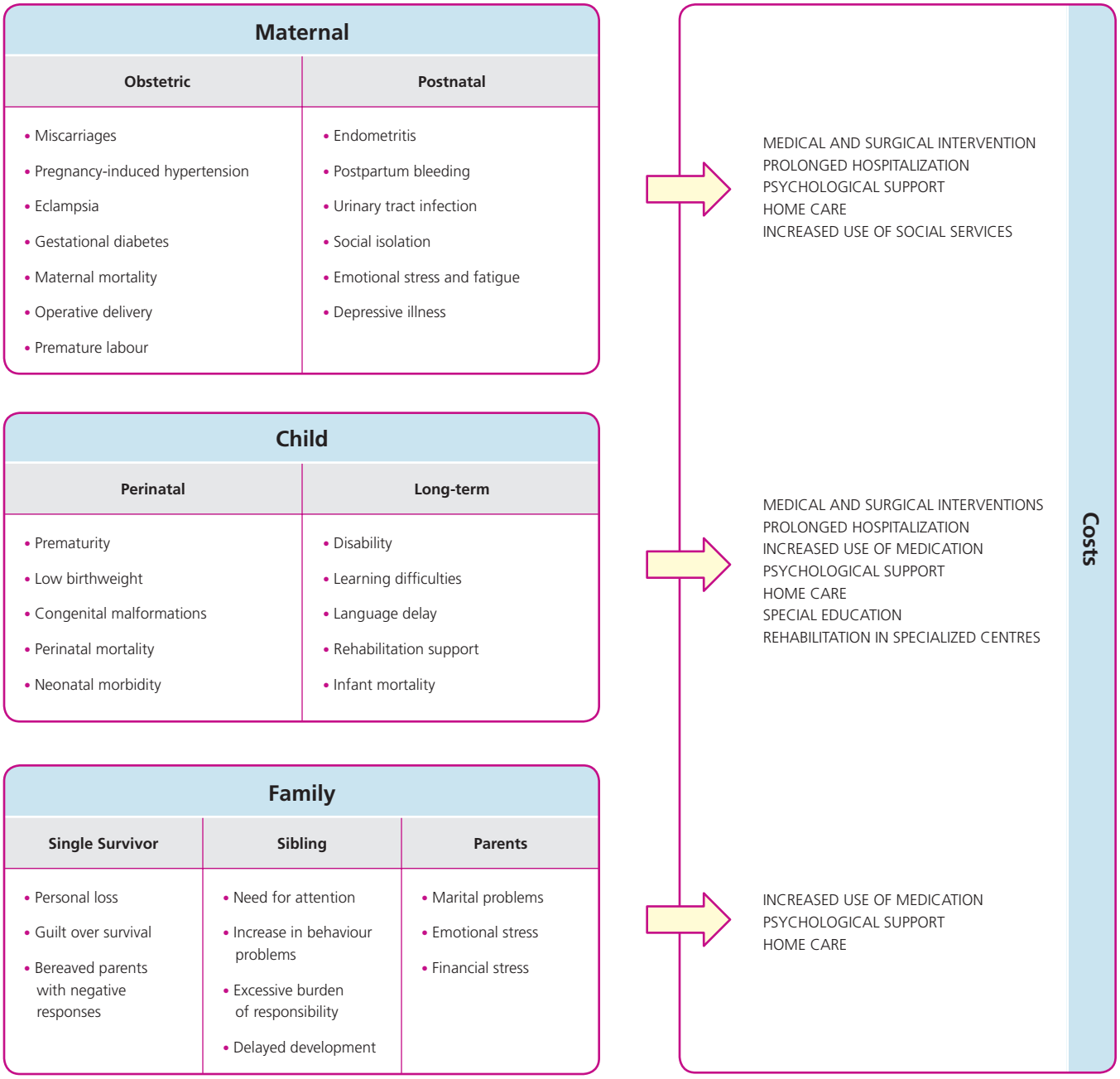
Hospital Costs (Delivery and Post-natal)		Cost Difference
Vaginal Delivery - $2,700	Caesarean Delivery - $4,600	+ $1,900
Caring for a Normal Birth Weight Baby - $795	Care for a: • Low birth weight baby - $12,354 • Baby weighing less than 750 grams at birth - $117,806	+ $11,559-$117,011
	Admitting a baby to the neonatal intensive care unit - $9,700	+ $9,700

The average hospital cost to care for multiple births is consistently higher than caring for singletons.[113] Multiples are 17 times more likely to be born pre-term,[114] and being pre-term is a key factor in how much a child will cost the health care

system.[115] Multiple births are more likely to require caesarean delivery, which is more expensive than a vaginal delivery. Also, multiple births are more likely to have low birth weights and require specialized, intensive care at birth.

These high costs can continue through life as a number of multiple birth children struggle with neurological problems such as cerebral palsy, as well as physical and developmental disabilities.[116] On average, over the lifetime of a low birth weight baby, health care and education costs exceed $1 million.[117]

Implications of Multiple Births



Modified from original source: Omebelet, W, De Sutter P, Van der EJ, Martens G. Multiple gestation and infertility treatment; registration, reflection and reaction - the Belgian Project. Human Reproduction Update 2005; 11(1)

Ontario is Out of Step with Other Jurisdictions When it Comes to Funding Assisted Reproduction

Ontario is out of step with a number of other jurisdictions that fund IVF – including Belgium, Netherlands, Sweden, Denmark, Finland and Australia – all of whom have lower rates of multiple births than Ontario. The decision to fund IVF is usually driven by the desire to reduce multiple births and their health and social costs. By paying for procedures like IVF, countries have been able to reduce the risk of people having twins or triplets while still containing health costs and maintaining the number of live births. The Government of Quebec has recently announced that it will soon fund three cycles of IVF and other associated medical services for its citizens.[118] In the meantime, Quebeckers will continue to have access to a 50% tax credit for offsetting the costs of assisted reproduction.

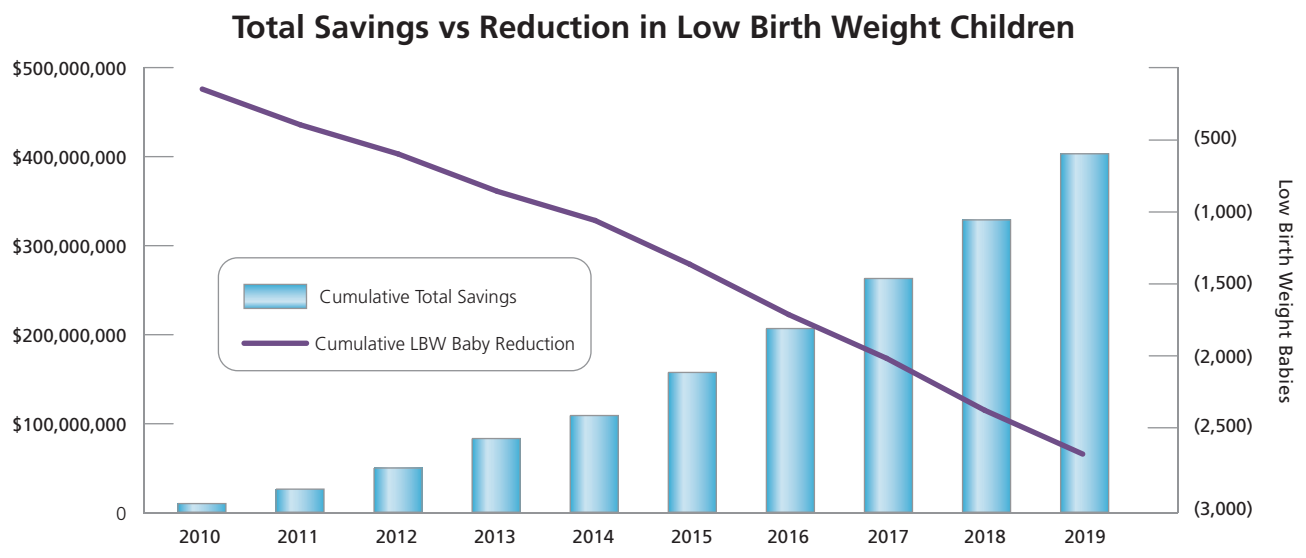
Ontario Has an Opportunity to Join the World Leaders

Reducing multiple births is an essential step in protecting the health of Ontarians and ensuring the best use of public spending on healthcare. We feel strongly that these recommendations must be implemented with a government commitment to fund IVF. As demonstrated in other jurisdictions, public funding is the key component of a successful strategy to reduce multiple births. We believe that it is the right thing to do and that it makes good economic sense.

Funding IVF Makes Good Economic Sense

Paying for Assisted Reproduction Services Will Reduce Hospital and Other Health-Care Costs

Funding IVF will reduce hospital and other health care costs and improve the health of mothers and babies across the province. We estimate that by following our recommendations, Ontario could save $400-$550 million over the next 10 years by reducing multiple births born from assisted reproduction. The Province would see another $300-$460 million (2009 dollars) in savings that would have been spent on these children over their lifetimes.[119] The savings in health costs could be used to offset the costs of providing assisted reproduction services.

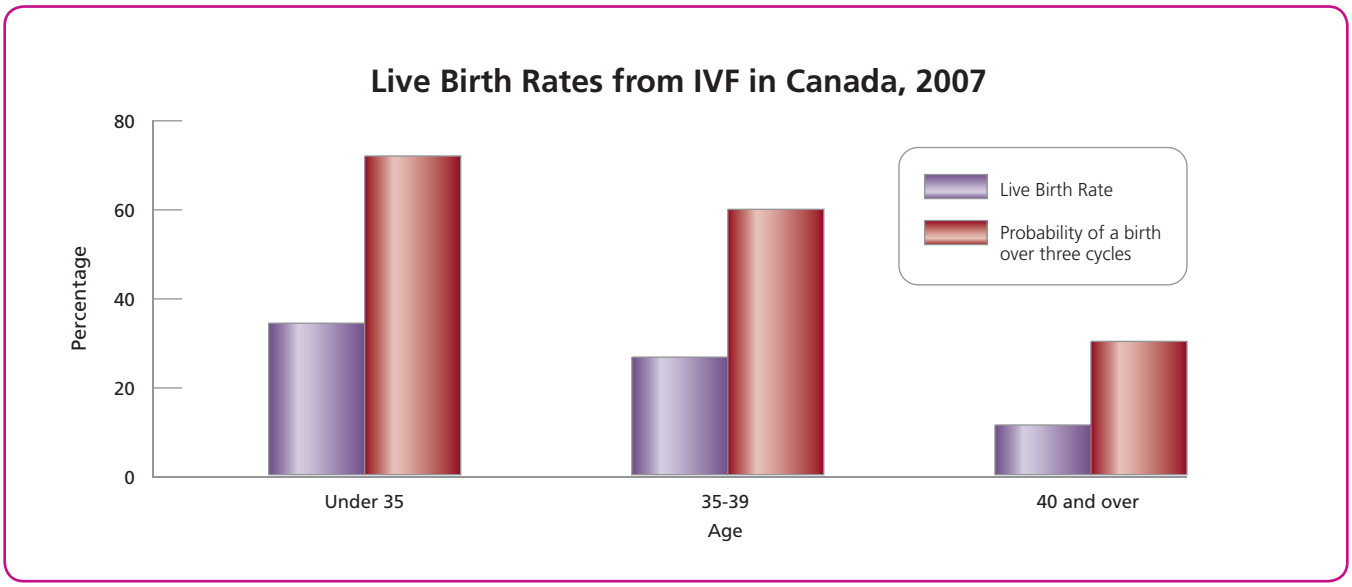


Babies born from assisted reproduction make up 1% to 2% of all live births in Ontario, but – because of the high rate of multiple births – they account for 20% of all the babies admitted to the neonatal intensive care unit (NICU) each year. It is very expensive to care for babies who require NICU services. There has been an increasing need for NICU beds in Ontario over the past few years. In 2008, MOHLTC announced $7 million in funding to provide 28 new NICU beds over the next two years.[120] By following our recommendations and reducing the multiple birth rates of clinics and fertility centres, some of the high costs of increasing the number of NICU beds across the province would be avoided.

The reality of an ageing Ontario population also means that having more babies makes economic sense. By funding assisted reproduction services, we estimate that, over the next 10 years, Ontario would have 7,042 more babies born than if the current situation remains unchanged. More importantly, these babies would be more likely to be single, healthy babies – giving them the best beginning in life.

There Should Be Limits on Funding

While we support public funding for assisted reproduction, we do not want to place an unreasonable burden on the public health care system. We believe assisted reproduction services should be publicly funded only when safe and there is a reasonable chance they will be successful.



Source: www.ivf.ca, "Birth Rates and Cycle Probabilities"

Age Matters for Successful Treatment

The success rate with assisted reproduction – that is, the proportion of people who will become pregnant and take home a baby – is affected by the age of the woman, her eggs and, possibly, her partner. IVF can make up for about half the births lost by postponing pregnancy from age 30 to 35,[121] but only one-third of the births lost by the time women are between the ages of 35 and 40.[122] Women who are over 42 have less than a 7% chance of becoming pregnant.[123] The lower success rates are largely dependent on the number and quality of a woman's eggs – which deteriorate with age. The success of IUI – which is also dependent on the quality of eggs – also declines with age. Currently, most women who use assisted reproduction services are already 35 or older.[124] Ontarians who need assisted reproduction services should seek treatment as early as possible.[125]

We believe that Ontarians should have access to assisted reproduction – when there is a reasonable chance of success and when the risks of pregnancy and delivery are lowest. In looking at the success rates of assisted reproduction in Ontario, the current data show that IVF rarely works for women age 42 and older.[126] Considering the pregnancy-related risks, it also appears that women age 42 and older are at greater risk during pregnancy and delivery. This data should be reviewed periodically to account for changes in technologies. However, to limit the financial burden on the health care system and ensure safety, we believe, at this time, that publicly funded IVF and IUI should be available only to women under the age of 42 years.

More Cycles Do Not Mean More Success

Jurisdictions that do fund IVF often limit their funding to women up to a certain age, based on the evidence of low success rates for women in their 40s, and limit their funding to a certain number of IVF cycles, based on the fact that more cycles don't necessarily lead to more success.

The following table lists the limits or restrictions that other jurisdictions put on public funding for assisted reproduction.

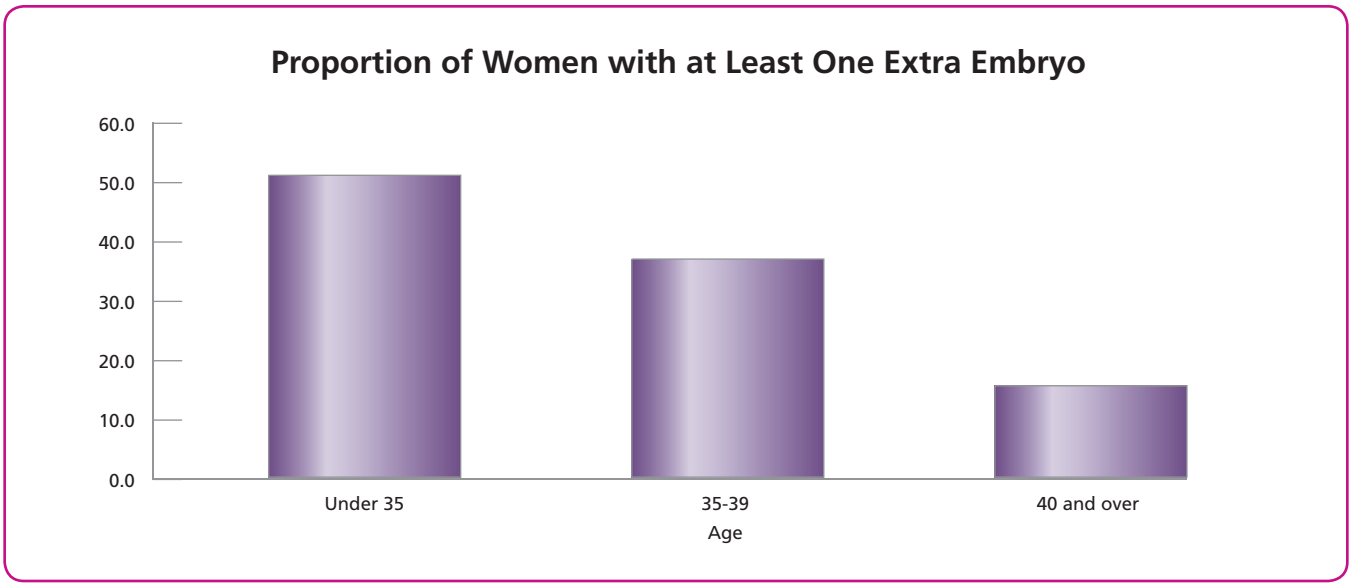
Jurisdiction	Funded Services	Restrictions
Sweden	One to three cycles of IVF/ICSI depending on the county.	Single embryo transfer unless prognosis is poor. Age limit of 38 for women to be eligible for publicly-funded IVF.
Denmark	Maximum of three cycles of IVF/ICSI.	Woman must be childless. Limit on the number of embryos that can be transferred based on age. Age limit of 40 for women to be eligible for publicly funded IVF.
Finland	Maximum of three to four cycles of IVF/ICSI at public clinics.	No limit on the number of embryos but customary practice is maximum one to two embryos – three in exceptional circumstances.
Belgium	Maximum of six cycles of IVF/ICSI in a lifetime.	Limit on the number of embryos based on age and # of cycles. Age limit of 42 for women to be eligible for publicly funded IVF.
Australia	Unlimited number of IVF/ICSI cycles. Up to 80% of costs are covered.	Limit on the number of embryos that can be transferred based on age. Age limit on women who are eligible for publicly funded IVF – set by clinics and ranges from 43 to 51.

For women under age 42, there is a very good chance – as high as 71% for women under 35 years – that they will have at least one live birth after three cycles of IVF.[127] If a woman has not been able to get pregnant after three cycles of IVF, her chances of becoming pregnant are less with each additional procedure.[128]

Similarly, for people using IUI, more procedures do not necessarily equal more success. A woman who undergoes four cycles of IUI without success is less likely to conceive with more cycles.[129]

We believe that, to be responsible, publicly-funded access to assisted reproduction should be limited to a maximum number of cycles. We believe that three funded cycles of IVF and four cycles of funded IUI procedures are appropriate.

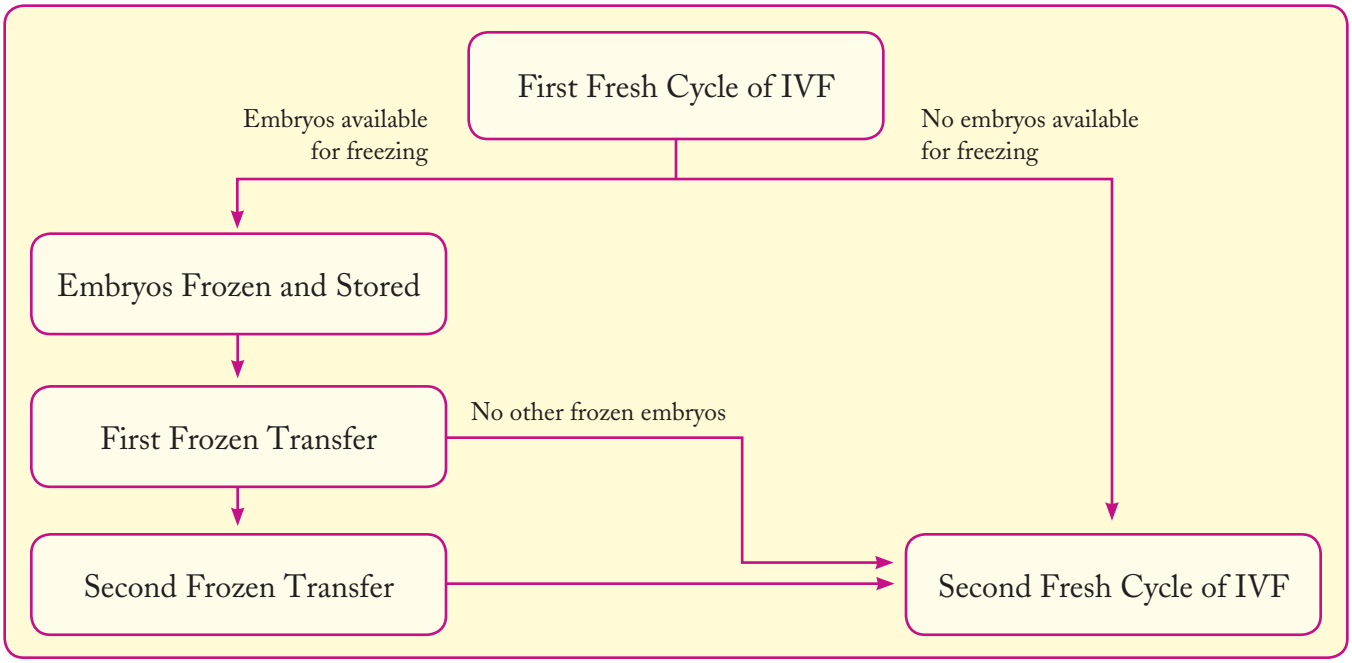
The Use of Frozen Embryos will Reduce Costs



It costs a lot less to freeze and store good embryos, then thaw and transfer them, than it does for a fresh IVF cycle. The chances of a woman becoming pregnant using a frozen embryo are quite high. To reduce the cost to the health care system and give Ontarians more opportunities to have a healthy baby through assisted reproduction, people must be willing to have fewer embryos transferred in each cycle. We believe that the costs of freezing and storing any extra embryos from an IVF cycle and costs of a frozen embryo transfer should be covered by the government. This will make it easier for Ontarians to agree to transfer fewer embryos in each cycle – because they know they will have up to two frozen embryo transfers to increase the chances of conceiving with each IVF cycle.

Women with extra, good quality frozen embryos should be required to have up to two frozen embryo transfers before the system will pay for another fresh IVF cycle.

All clinics would be expected to follow evidence-based guidelines on how to identify good quality embryos that would be eligible for freezing and transfer. Provincial guidelines should be developed to guide IVF clinics.



ICSI Is the Only Way to Overcome Severe Male Factor Infertility

While we do want to limit the unnecessary use of ICSI, it is the only way to overcome severe male factor infertility. It is an essential procedure that should be funded to ensure that assisted reproduction services are available to all Ontarians, regardless of the source of the fertility problem. ICSI should only be used in the situations as described in the previous section.

The Physician Perspective

The Chair of the Ontario Medical Association Section on Reproductive Biology conducted a survey of the section members early this year to provide a physician perspective on funding of assisted reproduction services in Ontario to the Expert Panel.

According to the survey, the fertility specialists of Ontario believe that infertility is a medical condition that deserves the same funding as other conditions. The survey results indicated:

- Almost unanimous consensus that funding should be provided for IVF – with strong support for some conditions on that funding and a maximum number of cycles.
- Support for age restrictions on funding.
- Support for funding to be tied to the number of embryos transferred, with many providers supporting the Society of Obstetricians and Gynaecologists of Canada's guidelines with input from the Canadian Fertility and Andrology Society.
- Support for funding of frozen embryo transfer to facilitate a reduction in the number of embryos transferred.
- Strong support for the funding of ICSI for male infertility, when recommended by a physician.

According to the survey results, there is strong support among physicians for increased public funding for assisted reproduction services.

A Proposed Approach to Funding Assisted Reproduction

Ontario has the opportunity to become a leader in the support of assisted reproduction in Canada and join a group of countries that are setting the standards for the world.

We believe that Ontario should fund safe assisted reproduction. Not only is this the right thing to do, but it will also protect the health and well-being of the children, women and men who use the services and save the Province money by reducing the financial burden that high-risk pregnancies and multiple births have on the health care system.

That said, we recognize that we do not have the resources or expertise to construct a specific model to deliver funding for these services. However, we believe that, to be effective, a funding model for assisted reproduction should limit costs to patients, be flexible and allow clinics to maintain some autonomy – while also ensuring clinics are accountable to patients and government. We recommend that the government consider a flexible course of care model that would give Ontarians access to assisted reproduction services and include other necessary services (e.g., counselling).

We appreciate that there needs to be careful thought given to the number of fertility specialists that would need to be trained to meet increased demand that public funding would create. And clinics would need time to increase their capacities to serve more people and give them the opportunity to manage their costs to ensure that they are able to offer these services efficiently. It is essential that there is collaboration between the government, the Ontario Medical Association and providers in moving to public funding of IVF.

WHAT STEPS SHOULD ONTARIO TAKE TO FUNDING ASSISTED REPRODUCTION SERVICES?

Funding assisted reproduction services will be cost-effective and help to protect the health and well-being of the Ontarians using the services. Therefore we recommend that:

3. Ontario Cannot Afford NOT to Fund Assisted Reproduction

Funding

3.1 The Government of Ontario should **fund up to three cycles of in vitro fertilization** for women ages 41 years +12 months and younger. The following ancillary services should be funded when provided for a funded cycle of in vitro fertilization:

- Intracytoplasmic sperm injection, when clinically indicated.
- The freezing and storage of embryos for women with any excess good quality embryos.
- Up to two frozen embryo transfers per fresh egg retrieval when a patient has good quality frozen embryos.

3.2 A patient must undergo **frozen embryo transfer** using good quality embryos before another publicly funded fresh in vitro fertilization cycle is provided.

3.3 Up to four cycles of **intrauterine insemination** should be funded for women ages 41 years + 12 months and younger. Sperm washing should be funded for intrauterine insemination procedures.

3.4 **Clinical practice guidelines** should be developed:

- That define and standardize how to assess the eligibility of embryos for freezing and storage.
- To identify parameters on the storage of embryos.

3.2 There Are Other Costs that Limit Access to Treatment

The cost of procedures is not the only expensive part of assisted reproduction. Many Ontarians need medications – either in combination with assisted reproduction procedures or alone – to help them overcome fertility problems. Also, counselling, which helps people make informed choices about assisted reproduction can be difficult to access for a number of reasons, including cost.

We recommend that:

→ The government consider a number of options for helping to **control the costs of fertility medications**.

→ The government introduce a **50% refundable tax credit** to help offset the costs of fertility medications.

→ A public awareness campaign **target employers** and highlight the benefits of supporting employees who use assisted reproduction services.

→ The government fund one session of **counselling services** for all Ontarians using assisted reproduction services.

Fertility Medications Are Out of the Reach of Most Ontarians

Fertility medications can make up almost half of all costs in a cycle of IVF.

Many Ontario Employers Do Not Cover Fertility Medications

About 9.8 million Ontarians have some form of drug coverage through work or through private drug plans.[130] For employers, offering extended health and drug coverage is one way to attract and retain employees.

The insurance companies that manage drug plans do include fertility medications in the list of drugs that can be covered. However, it is up to individual employers to decide whether or not they will purchase that coverage for their employees. Many employer drug benefit plans have a maximum that an employee can claim for drug coverage (e.g., up to $15,000 per year) and/or some limits on the drugs that are covered. Many plans do not include fertility drugs – employers tell us that this is because they think it will be too expensive.

Based on what we've learned, it appears that coverage for fertility medication is not a priority for many Ontario employers. At the current time, there appears to be a perception by some employers and

"*As increasing numbers of women enter the workforce, and the importance of a company's image as family-friendly becomes an ever greater selling point to talented upwardly mobile young adults, we appear to have the convergence of many positive messages about the benefits and realities of infertility coverage.*"

Infertility Coverage is Good Business
Joseph C. Issacs
Fertility and Sterility, May 2008

employees that infertility is the result of the employee's choice to delay childbearing, rather than a medical condition. This may be due to the highly personal nature of the issue and the unwillingness of many people who experience the problem to discuss it openly or to advocate for coverage in the workplace. According to our survey, many people do not want to discuss their assisted reproduction treatments with their employer and fear that taking the time off work required for appointments will affect their jobs and/or their opportunities for promotion.

Covering Fertility Medications Improves Employee Retention in the U.S.

According to a recent survey of employers in the U.S., those who provide fertility benefits generally experience improved retention and recruitment of valued employees, higher staff morale and reasonable related costs.[131] Among those companies that do offer this coverage for employees:

- 72% did so to be recognized as a "family-friendly" employer and attract valued employees.
- 68% wanted to increase morale and retain valued employees.

For these companies, providing coverage for fertility medication costs was a business decision designed to improve their image and attract and maintain a positive and loyal workforce.

Employer Education Can Make a Difference

When employers are aware that covering fertility medications could help them compete for and retain good employees – and that the costs can be manageable – they may be more likely to include the medications in their plans. We believe that one component of a public awareness campaign should be focused on making employers aware of the advantages of including fertility medications in employee benefit plans.

What Role Should Government Play in Funding Fertility Drugs?

Some of the options for offsetting the costs of fertility medications that we considered were:

- → A 50% refundable infertility tax credit.
- → Including fertility medications in the Ontario Formulary.
- → Providing public funding for fertility medications prescribed in fertility clinics.

The Ontario government already has a number of mechanisms in place to offset the cost of expensive medications for its citizens, including providing medications free of charge for people being treated in hospitals, and covering the cost of drugs for people with low incomes and people whose drug costs exceed a certain portion of their income. Quebec is now using a tax credit to help families offset the cost of fertility drugs.

We urge the government to consider all of its options for offsetting the financial burden of fertility medications on Ontarians trying to build their families. Because the cost of fertility medications is out of reach for many Ontarians, we believe that finding a way to offset these costs is invaluable to facilitating access to assisted reproduction. We believe that a 50% refundable tax credit, similar to the approach taken by Quebec, should be used to offset the costs of fertility medications for Ontarians. We found it very difficult to cost this recommendation as there is little information available on the number of people who require fertility medications in the province. Referring to other jurisdictions, we estimate that this recommendation could potentially cost the Province approximately $2 million per year and would go a long way in helping Ontarians access assisted reproduction services.

Counselling Should be Offered – and Funded

Counselling is Important to Many People

The descriptions of assisted reproduction services may sound straightforward, but the experience is not. The ups and downs of the treatment process are very difficult. People are very hopeful at the beginning of a cycle only to have their hopes dashed if a procedure fails. Ontarians who have been through assisted reproduction find the process extremely stressful. They say it affects every relationship in their life: with their partner, their family and their friends.

For many people, counselling helps them cope with the psychological stress of treatment, including the sense of grief and loss over not being able to have a baby on their own, the stigma and sense of failure associated with infertility, and pressures on relationships.

> *"[Infertility] eroded my self confidence, it made me question my value and my value to my partner."*
>
> *– Interviewee*

Not Many People Have Access to Counselling Services

Only 37% of people who responded to our online survey reported receiving counselling in any form and only half of the people who were interviewed said they sought counselling. Few respondents used counselling because these services are either not available or they are too expensive.

We recognize that for many people using assisted reproduction – but not all – having professional emotional support is important. At the same time, there are many people – for example, same sex couples who are using assisted reproduction as family planning services – that do not feel they need "infertility counselling". We believe it is very important that these services are available and appropriate for any Ontarians who wish to use them.

When Should Counselling Be Mandatory?

Counselling can help people going through assisted reproduction understand the physical or emotional risks of treatment. For those who are considering freezing and storing eggs or embryos, counselling can help them explore the ethical issues. For those who are using third party reproduction, it can provide an opportunity to talk about the ethical and emotional issues and about having and raising a child who is not genetically related to them.

We believe that, as part of the informed consent process, the Government of Ontario should mandate and fund counselling services for all third party reproduction.

At the current time, Victoria, Australia is the only jurisdiction that has made counselling mandatory for all people going through assisted reproduction: it is considered an essential part of informed consent. Currently in Ontario, each clinic has its own counselling policies and counselling services are not consistently available.

Like Australia, the federal AHRA makes counselling mandatory as an important part of the informed consent process. This means that some counselling will be required by law for all people using assisted reproduction services. The regulations that will outline the details of mandatory counselling have not been publicly announced yet. To reduce financial barriers to treatment, we believe that any counselling services made mandatory under federal legislation should be funded by the Province.

WHAT STEPS SHOULD ONTARIO TAKE TO FUNDING ASSISTED REPRODUCTION SERVICES?

There are other financial costs to accessing assisted reproduction services in Ontario which should not be allowed to act as a barrier to accessing treatment. We recommend that:

3. Ontario Cannot Afford NOT to Fund Assisted Reproduction

Fertility Medications

3.5 The Government of Ontario should develop an **awareness campaign** that:

- Focuses on **educating employers** and insurance companies about the benefits of including fertility medications in employer benefit plans.
- Profiles family-friendly Ontario companies that provide coverage for fertility medications.
- Highlights the need for coverage of other services that would be helpful for employees going through assisted reproduction, such as counselling, acupuncture, naturopathic medicine, massage and other complementary therapies.

3.6 The government should consider different options to help **control the cost of fertility medications**.

3.7 The government should introduce a **50% refundable tax credit** with a ceiling of $20,000 for Ontarians to help offset the costs of fertility medications.

Counselling

3.8 All Ontarians undergoing assisted reproduction services should be offered **one funded counselling session**.

3.9 The government should **fund any mandatory counselling** required by the federal government under the *Assisted Human Reproduction Act*. In the absence of federal legislation, all Ontarians undergoing third party reproduction should be required to participate in counselling as part of the informed consent process, and the government should cover the cost of this counselling.

3.10 All health care providers – including primary care practitioners – should be knowledgeable about **where to refer patients** who would need counselling services relating to fertility, infertility and using assisted reproduction services.

3.11 **Educational materials** on counselling – for fertility, infertility and assisted reproduction for all types of families – should be developed and made available to all professionals who may provide these types of services.

4. ONTARIANS WHO COULD BENEFIT SHOULD HAVE ACCESS TO ASSISTED REPRODUCTION SERVICES

We believe that all Ontarians should have opportunities to build families free from discrimination based on socio-economic status, geography, reproductive health needs, marital status or sexual orientation. In our surveys and interviews, Ontarians told us about many other barriers that must be removed if Ontario is going to be the best jurisdiction to build a family.

To ensure that all Ontarians have access to assisted reproduction, **we recommend**:

Time off work:

- → Employers be made aware of their responsibilities under the **Human Rights Code** regarding pre-and post-natal care.
- → **Personal emergency leave** under the *Employment Standards Act* be interpreted to include assisted reproduction services.

Geographic barriers:

- → The impact of distance from a fertility clinic be minimized by extending access to the **Ontario Telemedicine Network** to all fertility clinics and maintaining access to the **Northern Health Travel Grant** for Ontarians living in the north.

Access to third party reproduction:

- → Ontario develop **policies and legislation with regard to donor sperm, eggs, embryos and gestational carriers** that will protect everyone's rights and make these services safely available to Ontarians who need them.

Stigma and discrimination:

- → All clinics, staff and other health care providers be educated about the rights of all Ontarians to build families **free from stigma and discrimination**.

Concurrency in using assisted reproduction and adoption services:

- → Families be supported to **explore infertility and adoption** options concurrently, according to their own situations.

Timely access to fertility preservation services:

- → All specialists caring for people with cancer and other medical conditions whose treatment can affect fertility be aware of the availability of services to help **preserve fertility** and make timely referrals to these services.
- → Ontario fund the freezing and storage of eggs, sperm and embryos for **fertility preservation**, where medically indicated.

Capacity to provide fertility treatments for people with HIV:

- → Ontario develop a **comprehensive approach** regarding the reproductive needs of HIV-infected individuals.

4.1 Treatments Affect Work Life

Treatment Takes Time

> *"You have to choose between work and having a family. You can't work at full capacity and pursue and advance your career when you are doing the treatments. It is too stressful. You just do enough work to get by and go unnoticed. You are certainly not giving 100%."*
>
> *– Interviewee*

Fertility investigations and treatments take time. Women must have their hormone levels and cycles monitored daily for several days. The process of egg retrieval and transferring embryos takes more time. If a woman has to go through several cycles, the impact on her work life can be career limiting. If the baby is born pre-term or low birth weight – or there are complications from the pregnancy or birth – the parent(s) may require more time off work.

In our surveys, we heard about employers and individual managers who were extremely supportive. We also heard about people who felt they lost their jobs or were overlooked for promotions because they were trying to deal with a medical problem.

Policy Under the Human Rights Code Requires Employers to "Accommodate" Special Needs in the Pre- and Post-natal Periods

Not all employers may be aware of their obligations under the Ontario Human Rights Code. The Code, which sets out employers' responsibilities, has a policy on pregnancy and breastfeeding. The policy states that employers must accommodate special needs during the pre- and post-natal period, and acknowledges that this may include infertility treatment. Employers can accommodate their employees in a number of different ways, including providing a flexible work schedule to accommodate medical appointments.

> *"Lost hours is lost income."*
>
> *– Interviewee*

The policy is designed to protect women from discrimination in the workplace related to pregnancy and to make women aware of their right to equal treatment in employment and accommodation. We believe that many employers and most women may not be aware of their obligations and rights under the Code.

Personal Emergency Leave Provides Some Flexibility

Currently, employees who work in companies with at least 50 employees have the right to take up to 10 days of unpaid job-protected leave each year for illness, injury or other emergencies. As assisted reproduction services are necessary medical treatments, we believe that they should be eligible for personal emergency leave in the *Employment Standards Act*.

4. Ontarians Who Could Benefit Should Have Access to Assisted Reproduction Services

4.1 In a public awareness campaign, employers should be made aware of their responsibilities under the **Human Rights Code** to accommodate employees' special needs during the pre- and post-natal periods.

4.2 The definition of **personal emergency leave** in the *Employment Standards Act* should be interpreted to include assisted reproduction services.

4.2 The Distance from Clinics Is a Barrier

The IVF clinics in Ontario are located in: Brampton, London, Markham, Mississauga, Ottawa, Scarborough and Toronto.

Geography – where people live in the province – should not keep Ontarians from getting assisted reproduction services. The relatively small number of fertility clinics across the province makes it difficult for people who live in rural, remote and northern communities to get services. Ontarians who live a long distance from a clinic may not be aware of the services, or they may not be able to take the time required away from their daily responsibilities to attend appointments or go through a procedure like IVF. Right now, many women cannot receive the daily blood tests and ultrasounds to monitor their cycle within their communities, so they have to spend up to 16 days staying near the clinic. For many, it's a question of both time away from work and family, and travel costs.

Ontario Telemedicine Network Provides One Solution

Some Ontario fertility clinics have established satellite affiliates and are using the Ontario Telemedicine Network (OTN) to make it easier for Ontarians in the rural and remote communities to get care and monitoring, without having to travel. The OTN uses cameras, monitors and tele-diagnostic instruments – such as digital stethoscopes and high resolution patient examination cameras – to connect practitioners in smaller communities with specialists at the clinics. Access to the network should be extended to all clinics, in order to reduce the barrier of distance and still provide high quality monitoring and care. In order for this to be effective, the government should ensure that the monitoring tests and technician services are available as needed outside major centres. With the OTN, patients would only have to travel to clinics for the egg retrieval, fertilization and embryo transfer, which would significantly decrease their time away from work and family as well as their travel costs.

To be eligible to the join the OTN, most organizations receive a significant portion of their operational funding from MOHLTC. This is not currently the case with the province's fertility clinics but, based on our recommendations, that should change. In the meantime, clinics can apply and their application will be reviewed on a case-by-case basis.

Many Ontarians Receiving Assisted Reproduction Services Are not Eligible for the Northern Health Travel Grant

The Northern Health Travel Grant is designed to cover some travel costs for people in Northern Ontario who have to travel to receive medically necessary care.

To be eligible for the travel grant the patient must:

- Have OHIP insurance.
- Be referred for an insured health care service under the *Health Insurance Act*.
- Reside in the districts of Algoma, Cochrane, Kenora, Manitoulin, Nipissing, Parry Sound, Rainy River, Sudbury, Timiskaming or Thunder Bay.
- Be referred by a northern physician, dentist, optometrist, chiropractor, midwife or nurse practitioner.
- Be referred to the nearest physician specialist who is at least 100 kilometres from the patient's residence.

Northern Health Travel Grant Benefits

For people living 100 kilometers (one way) from the nearest specialist/facility:

- Forty-one cents per kilometre.
- One hundred kilometre deductible per trip.
- One hundred dollar accommodation allowance per trip that does not cover expenses such as meals.
- One referral every 12 months: no limit on number of medically necessary follow-ups, but must be made within 12 months of initial referral and to the same specialist or health care facility.

The advantage of the Northern Health Travel Grant is that it reduces travel costs and helps people in the north receive more timely, appropriate care. The disadvantages are:

- It is not currently available to many people seeking assisted reproduction services because IVF is not covered by OHIP for most people (with the exception of treatment for women with blocked fallopian tubes and IUI).
- As structured, it doesn't allow people to seek out the clinic they feel will best meet their needs.

We believe that people living in Northern Ontario who are referred to a fertility clinic should be eligible for any supports that are currently provided for other medical treatments, and that Ontarians should have the option of choosing the clinic which best meets their needs.

4. Ontarians Who Could Benefit Should Have Access to Assisted Reproduction Services

4.3 The Government of Ontario should extend the **Ontario Telemedicine Network** to all fertility clinics.

4.4 The government should ensure that the **monitoring tests** required for intrauterine insemination and in vitro fertilization (e.g., sonography, lab technician services) are available as needed in designated medical centres outside Southern Ontario.

4.5 The government should extend eligibility for the **Northern Health Travel Grant** to all people in Northern Ontario who have to travel for assisted reproduction services.

4.3 People Who Need Third Party Reproduction Services Face Barriers

In **third party reproduction**, the person or couple receiving assisted reproduction services needs donor eggs and/or sperm, and/or someone to carry the embryo for them (i.e., a gestational carrier) in order to build a family.

Mark and Greg had been partners for four years when they decided to build their family. Their son, Lars, was born using donor eggs and Greg's sperm. At first, they had trouble getting referred to a fertility clinic by their primary care provider. Once referred, the IVF clinic arranged for the donor eggs and Mark and Greg found someone who was willing to be a gestational carrier for them. The egg was fertilized and implanted using IVF.

When Lars was six, Mark and Greg returned to the clinic to ask for help to have a second child. However, they learned that the laws governing third party reproduction had changed. It is no longer legal to pay for donor eggs in Canada or to compensate someone who agrees to be a gestational carrier. These new rules make family building much more difficult.

Who Uses Third Party Reproduction?

Third party reproduction services are used by:

- Heterosexual couples when the male partner has no sperm or a low sperm count (donor sperm).
- Single or lesbian women (donor sperm).
- Women who are unable to provide their own eggs because of age, a genetic disorder, premature ovarian failure or treatment for a medical condition like cancer (donor eggs).
- Fertile couples who are worried about passing along harmful genes to a child (donor sperm, donor eggs).
- Single men and gay couples (donor eggs, gestational carrier).
- Women who have an irregular or missing uterus, or for whom other assisted reproduction services have failed (gestational carrier).

IUI is often used in cases of donor sperm. IVF is used with donor eggs and gestational carriers.

Advantages of Third Party Reproduction	Disadvantages of Third Party Reproduction
Allows people to have a baby who otherwise would be unable.	Can be difficult to find donor eggs and sperm or gestational carriers. No legislation that clearly spells out the rights and responsibilities of donors and intended parents. Federal legislation – the Assisted Human Reproduction Act – makes it difficult to obtain donor sperm and eggs and to find a gestational carrier, because it makes reimbursement for these services illegal (see below for more information).

Federal Law Restricts Access to Third Party Reproduction Services

Before the AHRA, many people who needed third party reproduction services had access to many professional services. We have heard from a number of professionals that the Act will make it difficult for Ontarians to continue to use third party reproduction to build their families.

We believe that Ontario should be responsible for regulating assisted reproduction in this province. Any recommendations that we are making regarding action under the AHRA should be considered to be sub-optimal options.

The Act makes it illegal to pay for sperm, eggs or surrogacy. Intended parents – the people who will raise the baby – will be allowed to pay for some costs of the pregnancy (e.g., travel expenses, fertility medications), but not all. This law is forcing some Ontarians to use dangerous alternatives and to use services outside of Canada.

The Act also makes it illegal to act as an intermediary – a person or company who finds potential surrogates and matches them with people who need them – which means more people will have to find surrogates themselves. Before the Act, intermediaries helped people to find surrogates who would be a good match for them. Not only is it now difficult for people to find a surrogate at all, it is difficult to know if the surrogate is a good choice.

Included in the Assisted Human Reproduction Act is a clause that requires the federal government to review the law after three years. This review is overdue. **We encourage the federal government to review this law and Ontario to take an active role in the process.**

We believe that – should the AHRA be upheld – there will inevitably be a Charter challenge against the criminal provisions of the Act.

We recommend that the Province join or support any Charter challenge of this kind.

Health Canada has proposed guidelines for what would be allowed to be paid for by intended parents. Some groups, like the Canadian Bar Association, have developed a response to these guidelines, making suggestions about costs associated with donation and surrogacy that should be included. There has been little formal response from the medical community on these guidelines. We believe that it is important for providers of assisted reproduction services – through professional

organizations like the Ontario Medical Association or the College of Physicians and Surgeons – to develop a response to these guidelines.

Under the federal legislation, it will be very difficult to access any third party reproduction services. We mentioned earlier that Quebec is currently challenging the law. We believe that, should the law be upheld, Ontario must develop a system that would support Ontarians needing these services – for example, through developing provincial regulations governing third party reproduction and establishing a province-wide donor and surrogacy bank. It is our belief that this will be difficult under the strict laws of the AHRA, but every effort should be made to best facilitate access.

Our Views on the *Assisted Human Reproduction Act*

While our report addresses some of the barriers posed to those seeking assisted reproduction in Ontario by the *Assisted Human Reproduction Act*, we feel compelled to offer further commentary.

We share, as a point of principle, the belief that those engaged in activities related to third party reproduction face unique issues and circumstances and that these may require special consideration in policy, and in law.

Nevertheless, we have grave concerns about the prohibitions within the Act and their implications for Ontarians seeking, or facilitating, third party reproduction services.

As currently defined, the AHRA's criminal sanctions and prohibitions on third party reproduction serve not only to severely limit the options of Ontarians seeking to create a family, but force this segment of the community to turn to prohibitively expensive, unethical and/or dangerous alternatives.

It seems reasonable to us to accept that the legislation was forged with the intent to shield Ontarians engaged in third party reproduction activities from harm. However, in our opinion, given the supposed protections of the current law in place today, the community is exposed to far greater potential risk now than ever before.

The unintended consequences of criminalizing third party reproduction have put Ontario's women, men and babies at risk and the AHRA has fomented a thriving underground economy; created dangerous legal and social ramifications; and jeopardized the health and well being of its citizens.

Intermediaries who assist in matching a gestational carrier or gamete donor with intended parents may not charge for this service. In addition, fearing prosecution, legitimate physicians, lawyers and counsellors are reluctant to assist or have stopped assisting Ontarians in third party reproduction cases, leaving them to seek solutions with little guidance and fewer protections.

In this unsupported environment, those seeking third party assistance are turning to the Internet and other unreliable sources; many are forced to pursue treatment outside the province incurring tremendous expenses and subjecting themselves to inferior medical and ethical care; alternatively, many are seeking 'low-tech' home solutions, such as home inseminations without medical, legal or psychological protections, or traditional surrogacy in which the birth mother is also the genetic mother, a potential legal and ethical minefield.

Rightfully afraid of criminal sanction and unable to pursue legal recognition of intended parentage, these citizens (including the child) are living 'underground' in a situation not unlike that of illegal immigrants – without a legal connection between the child and at least one of the parents, there are a host of estate consequences, identity, passport and parental authority issues. Those participating in third party reproduction are vulnerable in black market or underground conditions and are exposed to levels of fraud and unparalleled risks of exploitation.

Arguably drafted to protect the reproductive rights of its citizens, the legislation has ironically made Ontarians more vulnerable; seeking treatment today with less medical, psychological and legal protection than ever before.

Our mandate as the Expert Panel on Infertility and Adoption is to make recommendations from which Ontario can become the best jurisdiction in which to build a family. Among the principals guiding these recommendations, our advice is motivated by a desire to protect the safety of Ontarians; to encourage access to assisted reproduction; to ensure that care is timely and evidence-based; to demand accountability; and, to pursue social responsibility.

It is against these principles which we have measured our recommendations; and, against these principles, the *Assisted Human Reproduction Act* fails to measure up.

Other Federal Legislation Makes Third Party Reproduction Difficult

Currently, Health Canada requires any donor sperm to be frozen and stored for six months (called quarantine). The donor must be then re-tested for any medical issues that may make him an inappropriate donor. This rule applies to any donor who is not the sexual partner of the woman being inseminated, even if she knows the donor (e.g., a good friend or a partner's family member). Under the same rules, if a woman would like to use a gay man as a sperm donor, the doctor must get special permission from Health Canada. Consequently, gay men using a gestational carrier must also abide by these rules. We've learned that these rules mean that people feel forced to lie about their relationships with donors, which puts both physicians and patients in undesirable positions.

We believe that a better method for assessing and screening donor sperm should be developed. Ontario should ensure that the guidelines on the safe insemination of women using known and anonymous donor sperm protect the safety of women and children.

Lack of Provincial Legislation Makes Third Party Reproduction Difficult

Alberta, Quebec, Newfoundland and Labrador, and Yukon have laws that deal specifically with the legal parentage of children born through AHR. Only Alberta and Quebec have provisions dealing with the legal parentage of children born to same-sex couples, and with surrogacy.

When a baby is born without the use of third party reproduction, legally establishing parentage is fairly easy. Parents complete the statement of live birth, and then a birth certificate is issued for the child with their names as parents. It is not as easy for parents who have a child through third party reproduction.

The current laws on how to establish parentage are outdated. Most were created before assisted

reproduction was common practice. A time-consuming, sometimes costly court procedure is often necessary to be named the legal parent of a child. While the courts have been very helpful in making this process easier for intended parents, this approach means that people using third party reproduction are sometimes unnecessarily treated differently than other parents. We believe that, wherever possible, people using assisted reproduction should be treated similarly to other parents.

We believe that an intention-based approach to parentage – for everyone using third party reproduction, even surrogacy – should be used in establishing parentage in Ontario.

The Joint CCSO (Coordinating Committee of Senior Officials)-Family Law – ULCC (Uniform Law Conference of Canada) working group has drafted recommendations on establishing parentage that attempts to:

- Accommodate both natural conception and assisted human reproduction.
- Balance three potential indicators of parentage:
  - To recognize the birth mother link.
  - To equalize natural and assisted conception models so that the two processes are treated the same as much as possible.
  - To look at an intention-based approach (those who intend to parent, regardless of genetic link, are recognized as parents).

Intended Parents and Donors Need Protection

Additionally, there is no law in Ontario that protects donors, surrogates and the intended parents. Donors and surrogates need protection so that it is clear that they do not have any parental responsibilities for the child that they helped to create. Parents need protection so that it is clear that a donor or surrogate cannot claim parental rights over the child. Currently, intended parents and donors face expensive legal costs to draft contracts that will protect the rights and responsibilities of everyone involved. Other jurisdictions have developed legislation that protects intended parents and donors that limits the need for individual contracts. We believe that similar legislation is needed in Ontario.

Ontario Needs Comprehensive Legislation

Ontario needs legislation that reflects the many ways that Ontarians build their families. We believe that an intention-based approach should be taken to establishing parentage, regardless of the genetic link, and that provincial legislation should protect the rights and responsibilities of those using third party reproduction services. The Uniform Law Conference of Canada has developed recommendations on these issues (see Appendix D for the full list of recommendations). We endorse their current approach and – assuming that they do not change significantly – we believe that Ontario should review and implement their recommendations once they are finalized.

4. Ontarians Who Could Benefit Should Have Access to Assisted Reproduction Services

4.6 When the overdue review of the *Assisted Human Reproduction Act* is undertaken by the federal government, Ontario should **participate actively in this review**.

4.7 The Province should **join or support any Charter challenge** pertaining to the *Assisted Human Reproduction Act*.

4.8 A **provincial regulatory framework** for clinics and assisted reproduction services, including third party reproduction, should be developed under the equivalency provisions of the *Assisted Human Reproduction Act*.

4.9 An altruistic, province-wide **donor sperm, egg and embryo bank and surrogate database** should be established, operated at the clinic level and regulated by and accountable to the government.

4.10 Ontario should ensure that the **guidelines on the safe insemination of women** using known and anonymous donor sperm protect the safety of women and children.

4.11 The government should review the process for **establishing parentage** to accommodate assisted reproduction services wherever possible, and to ensure that no intended parents are discriminated against on the basis of sexual orientation or reproductive needs.

4.12 Once they are finalized, the government should review and implement the **Uniform Law Conference of Canada's recommendations** on declaration of parentage.

Should the federal *Assisted Human Reproduction Act* be struck down, we recommend that Ontario establish a provincial regulatory framework for third party reproduction that facilitates access to services rather than prohibiting them while protecting Ontarians from exploitation.

4.4 Using Adoption and Assisted Reproduction Services Concurrently

Currently families are told they must "finish" infertility treatments prior to beginning the adoption process, grieve their losses and prepare themselves for their potential lives as adoptive parents. We understand how important it is for families to be physically and emotionally ready for adoption – particularly after unsuccessful assisted reproduction treatment. However, the current unwritten policy is not based on sound evidence or current social realities.

The current parental training and homestudy processes can help Ontarians identify what is right for them as a family and what might help them be the best parents for children. We believe that with proper support, families can make good decisions about their ability to explore assisted reproduction and adoption at the same time, and that people should not be forced to investigate only one option at a time. See page 78 for our recommendations on this issue.

4.5 How Do Stigma and Discrimination Affect Access?

People in Same-Sex Relationships Face Stigma and Social Barriers to Services

When Ruth and Emily wanted to start a family, they approached a fertility clinic. The first clinic they went to was not welcoming. All the forms and questions were designed for heterosexual couples. The clinic insisted that Emily go through a full fertility investigation, even though there were no signs that she would have a problem getting pregnant.

For the couple, the main expenses were the cost of purchasing sperm from the United States and the sperm washing. The IUI procedure was covered by OHIP. To help ease the cost, the two women thought about asking a friend to provide sperm. Their first child, Eliza, is now three and Emily is expecting their second child.

In 2006, almost one-quarter of all people in same-sex relationships were 34 years of age or younger.[132] People in same-sex relationships who would like to have families through assisted reproduction services are not necessarily struggling with infertility. They need access to egg and sperm donation and do not necessarily need invasive procedures.

People from the Lesbian, Gay, Bisexual, Transgendered and Queer (LBGTQ) communities say that their needs are often not recognized or met. We've heard that some providers do not use gender neutral language during assessments, clinic forms assume male/female relationships and non-traditional families are not depicted in the clinic brochures or posters.[133] It is even more difficult for LGBTQ clients to find health care providers sensitive to their needs outside of Toronto.[134]

Clinics and providers should strive to be aware of and sensitive to the reproductive needs of all Ontarians. This includes using gender neutral language, providing cues that the clinic is a positive space and allowing women to make choices about procedures that reflect the fact that they're not infertile.[135]

We recognize that there are specific barriers to assisted reproduction services experienced by the LGBTQ communities and encourage the government to continue to work with LGBTQ communities and advocacy groups to develop policies that will reduce discriminatory practices and social barriers to assisted reproduction services.

Single People Face Barriers to Services

Like same sex couples, single women and men who would like to build a family through assisted reproduction services face barriers. Single women need access to donor sperm and single men need donor eggs and a gestational carrier. In addition to these barriers, single people may also experience stigma because they are not in a relationship. We heard from some single people that primary care givers did not talk to them about their fertility or family building options because of their marital status.

We believe that all Ontarians who could benefit from assisted reproduction services should have access to these services – regardless of marital status. Ontario should develop policies that will reduce social barriers to assisted reproduction services.

The Shame and Stigma of Infertility Means that Some People Never Seek Services

There is shame and stigma associated with infertility that means some people never seek assisted reproduction services. Many people are embarrassed or ashamed to admit that they are struggling with infertility. They may not be aware of how many other people are struggling with infertility right now: one in six couples has struggled with infertility at some point in their lives.

> *"We never talked about it, but once you start to talk about it, others do as well. It is a taboo topic."*
>
> *– Interviewee*

> *"You feel like there is something wrong with you, that there is a sticker on your forehead that says you're infertile. You don't want to be with people because you are depressed."*
>
> *– Interviewee*

There is also a stigma associated with infertility. This stigma makes it difficult for some people to seek treatment or feel supported. We believe that the first step in breaking this stigma is to acknowledge infertility as a medical condition and treat assisted reproduction that is used to treat infertility like other medical treatments. Ontarians should be aware of how many people are struggling with infertility and that infertility is not a choice.

4. Ontarians Who Could Benefit Should Have Access to Assisted Reproduction Services

4.13 The government should ensure that social barriers to assisted reproduction are removed and legal barriers minimized for services to members of **the Lesbian, Gay, Bisexual, Transgendered and Queer communities**.

4.14 The government should ensure that social barriers to assisted reproduction are removed from services for **single Ontarians**.

4.15 A public awareness campaign on infertility and assisted reproduction should focus on **reducing the shame and stigma** attached to infertility.

4.6 What Barriers Do People Who Need Fertility Preservation Face?

Ontarians who must have treatment for a medical condition that could affect their fertility – like cancer or an autoimmune disease – need timely access to a fertility specialist who can arrange to have their eggs, sperm and/or embryos frozen and stored.[136] However, many Ontarians are not being offered these services.

Maria was diagnosed with cancer when she was 26. Because her cancer treatments could affect her fertility, her oncologist referred her immediately to a fertility clinic. She had a small window of opportunity before her treatments began to have some of her eggs harvested and frozen so she could use them when she recovered from the cancer. Even though everyone did the right thing, the process and the choices were not easy for Maria. OHIP does not cover the cost of retrieving, freezing and storing eggs – nor would it cover the cost of IVF for Maria once her cancer treatments were over. Faced with the prospect of a long illness, Maria wasn't sure she could afford these services, but her parents offered to pay.

Maria also struggled with some serious ethical issues. Frozen embryos store better than eggs, but Maria wasn't in a committed relationship. Should she ask her current partner to donate sperm or should she take a chance on freezing unfertilized eggs? What would she do with her frozen eggs if her cancer treatment wasn't successful? The situation caused her a great deal of emotional stress at a time when she was also faced with a life-threatening illness. She was grateful that there were services in Ontario to help preserve her fertility, but she wished there weren't so many barriers.

Many Ontarians Need Fertility Preservation

Demand for fertility preservation is growing. According to Fertile Future, a group which advocates for the fertility preservation needs of cancer survivors, in 2005, 10,000 individuals between the ages of 20 and 44 were diagnosed with cancer in Canada, and about 80% survived. Thousands of people who survive their battle with cancer will go on to lead full and healthy lives and would benefit greatly from fertility preservation services.

For Some, Timing is Key

The freezing of eggs, sperm and/or embryos must happen before cancer treatment begins. For most people, that means a small window of opportunity. Some cancer treatments begin immediately, but others may have a couple of weeks before starting treatment or surgery, or between the initial surgery and treatment. If referred to a fertility specialist, this time could be used to discuss fertility preservation options and – if the person would like to do so – collect the sperm or eggs before treatment begins. While egg freezing is still somewhat experimental, sperm and embryo freezing are proven to be successful and safe.

Knowledge is Key

According to the American Society of Clinical Oncologists, many oncologists either do not discuss the possibility of treatment-related infertility with their patients or they do not do it well.[137] Many have had little education on the methods of preserving fertility or the physical and psychological effects.[138] Other providers may be unaware of the impacts of a medical condition on fertility or that there are fertility preservation options for their patients.[139] It is important for health care providers to be aware of these services: the likelihood of someone using fertility preservation services is highly dependent on a referral from their specialist.

4. Ontarians Who Could Benefit Should Have Access to Assisted Reproduction Services

4.16 All specialists caring for people with a medical condition or providing treatment for a medical condition that can affect fertility should be aware of the availability of services to help **preserve fertility** and make timely referrals to these services.

4.17 The Government of Ontario should **fund the freezing and storage of eggs, sperm and embryos** for fertility preservation.

4.18 Clinical practice **guidelines** should be developed on how long sperm, eggs and embryos can be stored at public cost.

4.7 People Living with HIV Have Different Assisted Reproduction Needs

Within the last decade, antiviral therapy has changed the natural history of human immunodeficiency virus (HIV) infection significantly. People affected with HIV are now living longer and experiencing better quality of life. It is estimated that 25% of the people in Canada living with HIV are women and many are in their reproductive years. Studies of HIV-positive women suggest that the desire and the intent to parent children are strong.

Europeans have been assisting HIV-positive couples to reproduce since the 1980s, and at least five European countries have national programs helping people living with HIV with pregnancy planning. In Canada, Southern Ontario Fertility Technologies (SOFT) in London was the first fertility clinic to offer services to HIV-positive individuals such as sperm washing, which results in a product that can be injected into a woman, reducing the chance of horizontal transmission. A few years after SOFT had established a precedent, the ISIS Regional Fertility Centre in Mississauga and the Mount Sinai Reproductive Biology Unit in Toronto began offering assistive reproductive techniques to HIV-positive individuals and couples.

There are three main issues that need to be considered for HIV-infected people and their partners when it comes to pregnancy planning and counselling.

1. The reduction of vertical transmission between the mother and the infant, which has been significantly reduced due to combination antiretroviral therapy.
2. The reduction of horizontal transmission between partners during intercourse, which requires different prevention and treatment strategies, depending on the status and needs of the couple or persons involved.
3. The management of infertility issues and HIV.

Advances in antiviral therapy have made it safer for these women to conceive – with assistance – and have a healthy baby. These therapies have almost eliminated the risk of a mother passing along HIV to her baby and there are procedures available that reduce the risk of HIV being passed between partners during conception.

Despite the fact that many HIV-positive individuals and couples wish to have children, there is a scarcity of HIV-friendly fertility clinics outside of southern Ontario. People with HIV need advice on the management of HIV during pregnancy planning and services such as sperm washing, (used to remove the HIV viral particles from the sperm), intrauterine insemination and in vitro fertilization.

We believe that Ontario needs a comprehensive approach regarding the reproductive needs of HIV-infected individuals.

4. Ontarians Who Could Benefit Should Have Access to Assisted Reproduction Services

4.19 The Government of Ontario should develop a comprehensive approach to **reducing barriers to assisted reproduction services for HIV-infected people**.

4.20 Development of resources (including education programs) should be supported to allow **safe access** to these services in Ontario.

CONCLUSION

Ontarians build their families in different ways and many have to choose assisted reproduction out of necessity. Infertility is a medical condition. The medical treatment of infertility should be paid for publicly. Ontarians who need assisted reproduction, either because of infertility, because they are single or in a same-sex relationship, or because of a medical condition, should have access to safe, effective medical treatments and not be denied access based on income, geography, marital status or sexual orientation.

We know that the Ontario we are living in is a very different place than it was 50 years ago. We have made a lot of progress – but some of this progress has come at a price. Ontarians are delaying childbearing to pursue education, careers and personal goals. With little information about fertility available to them, many are struggling to make informed choices about family building.

The reality is that while Ontario has changed over the past fifty years, so have the technologies available to us. Assisted reproduction services have improved substantially – even over the past decade. There are many options available now to Ontarians who are struggling to build their families.

The way Ontario's assisted reproduction system is currently operating is not acceptable. The cost of services means that treatments are out of reach for many people. Social and legal barriers limit access and, in some cases, force people to use less than ideal alternatives. Ontario's multiple birth rates resulting from assisted reproduction services are too high. We know that – to provide the best opportunity for Ontario's children to reach their full potential – we must reduce these rates and ensure that the health of each and every child born through assisted reproduction is protected.

Ontario has the opportunity to become a leader in assisted reproduction in Canada and join a group of "family-friendly" countries that are setting the standards for the world.

To be the best jurisdiction to build a family, we believe Ontario should:

- **Provide information on fertility, infertility and assisted reproduction** to Ontarians so that they can make family building decisions that are best for them.
- **Respect choices** made by families – regardless of the family building option they choose.
- **Invest in high quality assisted reproduction services** that protect the health and well-being of children, women and men.
- **Eliminate existing barriers** – legal and social – to assisted reproduction.
- Provide assisted reproduction services that are **continually improving**.

We imagine an Ontario where people are given information on fertility and assisted reproduction, those who need assisted reproduction are not limited by what they can afford to pay, and where the services they receive are safe and effective. We are grateful to the government for providing us with the opportunity and resources to thoughtfully consider how to improve assisted reproduction services in this province. We anxiously await the government's next steps on making our vision a reality.

RAISING AWARENESS: FAMILY BUILDING IN ONTARIO

GOAL: TO PROVIDE INFORMATION AND RAISE AWARENESS ABOUT ADOPTION, FERTILITY AND ASSISTED REPRODUCTION SERVICES AND MAKE IT EASIER FOR ONTARIANS TO ACCESS THESE SERVICES

Ontarians need information on adoption, fertility, and assisted reproduction services to make informed choices about how to build their families. In our online survey and interviews, we heard that there is a need for more education. Ontarians told us that:

- It's difficult to get information about the different types of adoption – public, private domestic and intercountry.
- The adoption process – how long it takes, the need to complete parental training and a homestudy assessment, the costs and how decisions are made – is not clearly explained or well understood.
- Many people do not know about the factors that affect their fertility.
- There is still a sense of shame and stigma about infertility that keeps many people silent and in pain.
- There is a need for sensitivity to the family building needs of non-traditional families.
- People do not know where to go for safe care.

A successful public awareness campaign would:

- Make Ontarians aware of family building options.
- Empower Ontarians to make informed family building choices that are right for them.

Ontarians need information to help them make informed decisions about their fertility and about family building choices that are right for them.

A Public Awareness Campaign Can Impact Knowledge and Attitudes

Ontario has an opportunity to show its leadership by developing a public awareness campaign that will provide accurate, up-to-date, relevant information on fertility and family building supports.

Currently, there is no public awareness campaign designed to make men and women better aware of the factors affecting their fertility, and the existing information available on adoption, infertility and assisted reproductive services is incomplete and disjointed. Some information is outdated, deficient and may not be Ontario-specific. An effective public awareness campaign would help ensure that all Ontarians – heterosexual couples, single and same-sex people, with or without a primary care practitioner, in all parts of the province – have accurate, Ontario-specific information.

An effective public awareness campaign will achieve the following objectives:

1. **Create a supportive environment** among the general population for discussing issues relating to adoption, fertility, infertility and assisted reproduction services.
2. **Raise awareness** of adoption and assisted reproductive opportunities.
3. **Help people find services** in the areas of adoption, infertility and assisted reproduction services.
4. **Destigmatize/normalize** alternative methods for building families, including adoption and assisted reproduction services.

A Multi-tiered Approach Is More Effective

A multi-tiered approach – targeted messages delivered to multiple audiences through various channels – would be effective in reaching Ontarians. These messages would need to be coordinated and Ontarians must have easily accessible places to go to for information on adoption, fertility and assisted reproduction.

Multiple Targeted Messages

While there may be some crossover between the objectives of the public awareness campaign, each may have its own distinctive messaging, intended audiences and optimal methods to deliver messages.

1. *Create support – Key messages for the general public:*
   - All children need a permanent home.
   - All family building choices are valued and respected.
   - Supporting family building in the workplace creates employee loyalty.
   - Infertility affects one in six couples in Ontario during their lifetime and is a medical condition.
   - Single and same-sex people require assistance to build their families.

We recommend focused messaging that:

- Informs the public of resources and options for creating or expanding their families.
- Highlights best practices in the workplace that support families who adopt or use assisted reproduction.

2. *Raise awareness – Key messages for targeted audiences:*
   - There are many children in Ontario waiting for permanent homes.
   - Prospective adoptive families from all backgrounds and family structures are an important resource.
   - Adoption gives many Ontarians the opportunity to parent.
   - Age is a key factor in fertility, as are other risk factors such as obesity, smoking, and sexually transmitted infections.

3. *Help people find services – Key messages for those seeking services:*
   - Those seeking to build or add to their families through adoption have three options available to them: public, private domestic and intercountry.
   - Ontarians who are exploring adoption must complete parental training and homestudy processes.
   - Adoption tax credits exist at the federal and provincial level.
   - There are 14 IVF clinics and several fertility centres in Ontario that provide a range of assisted reproduction services.

4. *Destigmatize and normalize – Overarching key messages:*
    - There's no shame in struggling to build a family.
    - Adoption is not a second choice.
    - One in eight couples is struggling right now to build their family.
    - Same-sex and single people should have an opportunity to parent.
    - Families come in all shapes and sizes.

Multiple Audiences

The public awareness campaign should target many audiences with specific, tailored messages.

Targeting messages will not only serve to raise awareness, but will also provide valuable information about specific services and options available to meet the relevant needs of specific groups. There are multiple audiences and they can be segmented in a number of ways, including by gender or age, fertility, infertility, adoption, provider and industry/employer.

Other messages may be suitable for the general population. These messages can seek to establish a more supportive environment for individuals pursuing adoption and assisted reproduction services. For example, they can serve to encourage employers to offer flexible workplaces and benefits that help Ontarians who are pursuing adoption or assisted reproduction services.

While the public awareness campaign should have a provincial framework, it should also be pursued locally. This approach mobilizes the community and ensures the information is appropriate, relevant and meets the needs of citizens in a local community. Local stakeholders including organizations, agencies, clinics, educators and providers across the province are important partners and effective vehicles for sharing community-specific information.

Multiple Channels

In our view, the release of this report with its accompanying recommendations to government is an essential first step in a public awareness campaign. There are a number of various stakeholders eager to help and anxious to broaden the case for support.

This captivated and engaged group can be leveraged to help facilitate early communication goals. Outreach through this audience can utilize a variety of communication touch points, a strategy to pursue throughout the entire public awareness campaign.

We believe that communication campaigns are more persuasive when people see and hear the messages in a variety of contexts and in media. Particularly when it comes to complex issues, people need the messages to resonate from several different sources to have impact.

Ontario should consider developing a five-year sustained, multifaceted communications strategy which may include public relations tactics such as a social media strategy, mass and direct marketing approaches, sponsorships, testimonials and endorsements.

The Dave Thomas Foundation uses a mix of brochures, public service ads, posters, videos and toolkits to promote adoption. Their messages – Children are Our Future, A Child is Waiting and Every Child is Adoptable – tap into deep-rooted social values. They also find community champions – opinion leaders – to speak about the importance of adoption.

Initiatives should include:

- Promoting the public awareness campaign with official kick-offs and promotional events that involve high-profile public officials or media personalities.
- Developing a robust interactive website with social media capabilities (such as Facebook and Twitter), which provide essential information about adoption, fertility issues and assisted reproduction services.
- The use of print, radio, television and Internet for the general population.
- Pursuing local or interest-targeted media with messages for specific, narrower audiences.
- Producing a series of public service announcements for radio and television.
- Establishing a curriculum (or class-room materials) for Ontario's high school students on family building.

Partnerships Can Increase Impact

We believe that given the numbers of Ontarians pursuing adoption or assisted reproduction or impacted by infertility, and the demographics of these individuals, the private sector and/or non-government organizations should be engaged to participate in the public awareness campaign. Their partnership and support of a public communications program could make available additional expertise and resources, and improve the effectiveness and efficacy of the campaign.

Examples of existing awareness programs driven by the private sector in the adoption and infertility communities exist.

For example, the Wendy's Wonderful Kids program, funded by the Dave Thomas Foundation for Adoption, illustrates the benefits of having private sector participation. Wendy's restaurants, their customers and other partners raise funds for the Foundation. The Foundation awards grants to local adoption organizations to hire adoption professionals to recruit adoptive families for Crown wards with special needs. The program raises awareness about the importance of adoption among the restaurants' customers and also raises funds.

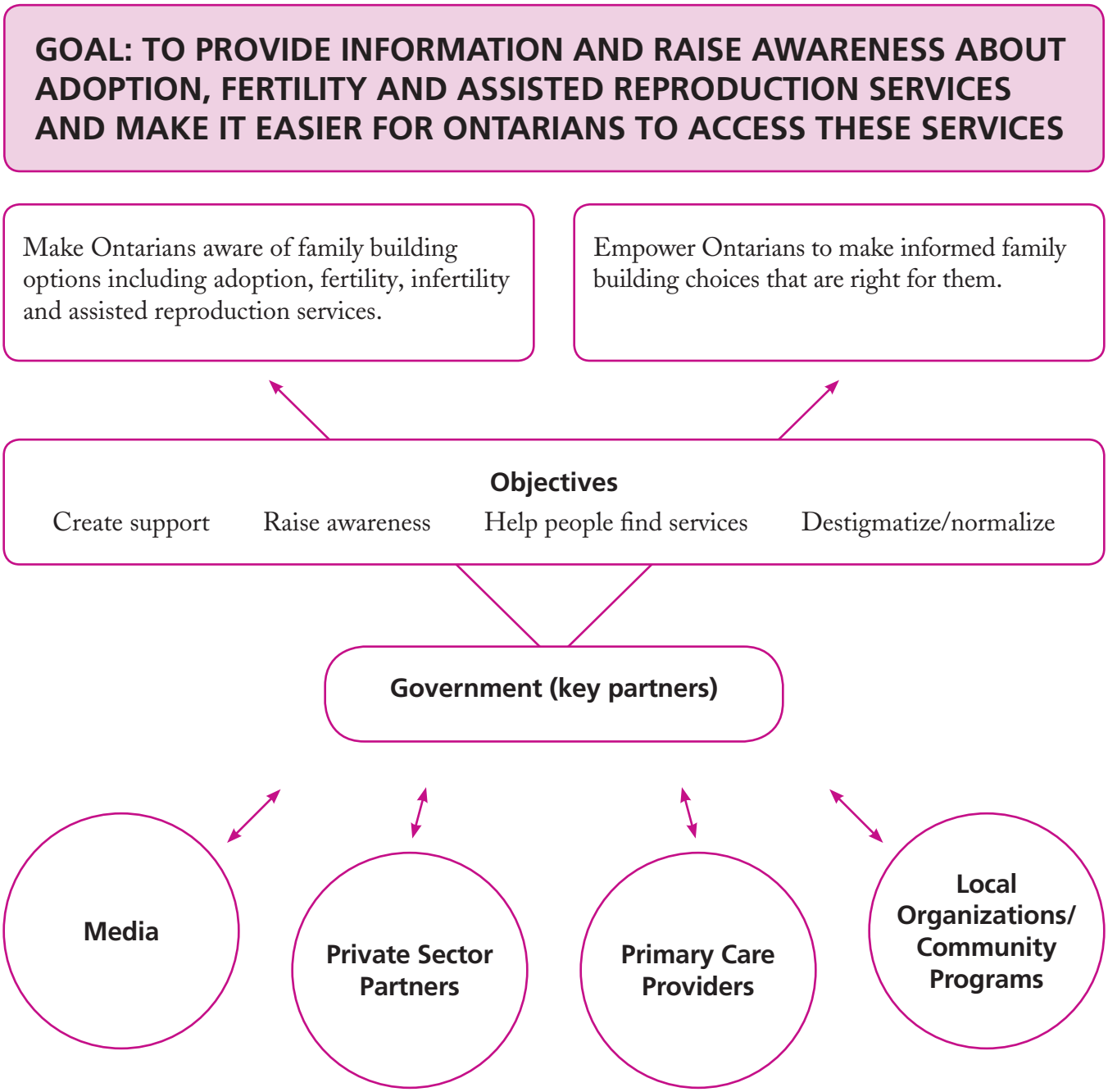
There are a number of examples of fertility awareness campaigns which include private sector involvement. These include the American Society of Reproductive Medicine's fertility campaign and a campaign on fertility with involvement from private industry. These campaigns are aimed at educating the public about their fertility and helping them to understand the causes and prevalence of infertility.

Based on informal discussions we have had, we believe that there would be some interest among organizations outside government to partner with the Province on this type of initiative. We encourage the government to pursue discussions with potential partners.

An Effective Campaign Requires Adequate Resources

A public awareness campaign must be adequately resourced to effectively deliver key messages to both general and targeted audiences. We believe that a total of $5 million of government funding should be invested annually in the campaign over the initial five-year period. We also believe that non-government partners should match government investment in this area.

Overview of Public Awareness Campaign



Adapted from: ParticipACTION model

Ongoing Evaluation and Measurement Will Strengthen the Campaign

The public awareness campaign is key to Ontario achieving its family building goals and its effectiveness must be measured. The lessons learned can help refine the campaign and ensure it has the desired impact. The evaluation can reveal any gaps in information, whether the right audiences are being targeted and which media tools have been most effective. A model for measuring the program's success must be established early in the process and a formal five-year evaluation should take place.

Based on the established objectives, an evaluation should ask the following questions:

1. Has the campaign resulted in successfully creating greater support among the general public in the areas of adoption, fertility, infertility and assisted reproduction?
   - Is there a more supportive environment for individuals pursuing adoption and assisted reproduction services?
   - What services and supports have been implemented to make Ontario the best jurisdiction to build a family?
   - Are Ontarians aware of the social and economic benefits of public funding for assisted reproduction and adoption services?
   - Is there an understanding that infertility is a medical condition?

2. Has the campaign raised awareness for people who may not know they may be eligible to adopt or who may not know they could have trouble conceiving? Has the campaign been effective in raising awareness that employers can play an important role in supporting family building?
   - Do potential adoptive parents feel valued?
   - Do Ontarians know that many children are available for adoption?
   - Are primary care service providers discussing fertility with their clients/patients?
   - Are people aware of the factors that impact fertility?

3. Has the campaign been effective in helping people find services?
   - Do Ontarians have the information they require to make informed decisions about family building – adoption and assisted reproductive services?
   - Has access to information made it easier for Ontarians to find the services they need?

4. Has the campaign had an overall impact on destigmatizing alternative methods for building families?
   - Is adoption viewed as a valued and positive choice for those seeking to build their families?
   - Do individuals seeking to adopt or pursuing assisted reproduction services feel supported?

5. Is the information on family building coordinated and easily accessible?
   - Can people easily access information on adoption, fertility, infertility and assisted reproduction services?
   - Are relevant information sites appropriately linked?

WHAT STEPS SHOULD ONTARIO TAKE TO IMPLEMENT A PUBLIC AWARENESS CAMPAIGN?

Ontarians need accurate, credible information about family building through a public awareness campaign and we recommend:

1. Raising Awareness About Family Building Options in Ontario

1.1 The Government of Ontario should develop a **coordinated public education and social awareness campaign** on family building to educate Ontarians about fertility, infertility, assisted reproduction and adoption, and about the resources and options for building or expanding their families.

1.2 The campaign should use a **multi-tiered approach** that is based on a provincial framework and implemented locally.

1.3 The multi-media campaign should utilize **partnerships with organizations outside of government.**

1.4 The government should develop **evaluation tools** to measure the success of the campaign and to shape the subsequent phases.

IN CONCLUSION

Families are the heart and soul of our society. They provide social support and add joy and meaning to life. They help to build strong children, strong communities and a prosperous economy.

Families need support to help children reach their full potential. Our province has many programs and services that we can be proud of – from early learning to child care to Ontario's new child benefit – that work together to support families and children.

But for thousands of Ontarians, family supports without the ability to start or expand a family have little meaning. Instead, these people need programs and services to help them build their families.

For these Ontarians, those who came before and those who will come after, we are committed to a vision in which Ontario is the best jurisdiction in the world to build a family. But as we've described in our report, we've got some significant impediments to building strong healthy families through assisted reproduction and adoption.

Our Recommendations Are Ambitious

We were tasked with recommending how to address these barriers and we've set out an ambitious agenda for change. We thought long and hard about our recommendations and considered many options. We determined that merely working within the status quo wouldn't allow us to achieve the vision. We concluded that bold change is needed.

We Must Act Now, Yet Think Long-term

We have to resist the urge to limit our actions to quick fixes, and start thinking long-term.

As we've demonstrated throughout our report, we're paying the financial, health and social costs every day of having short-sighted policies when it comes to family building.

The status quo keeps children in care when they could have "forever families." It leads to multiple births and increased risk for both mothers and children. It fails to give people the information they need to make family building choices that are right for them.

We're convinced that Ontario cannot afford **not** to move forward with our recommendations **now**.

The Raising Awareness Campaign

We believe a key first step is to launch the public awareness campaign on family building that we discussed in the preceding section. Knowledge **is** power. For a relatively low cost, we can raise awareness of fertility, infertility, assisted reproduction and adoption – and empower Ontarians. With this knowledge, Ontarians can make informed choices and exercise their options in making the best family building decisions for them.

We see the public release of our report as the launch of the awareness campaign. To maintain momentum, the government must move now to put the other components of the campaign in place and roll it out province-wide.

Fertility Monitoring

Given the relatively low upfront costs of fertility monitoring, we believe that the government should proceed to work with key partners to implement the fertility monitoring recommendations described in the assisted reproduction section immediately. It will be critical to track use of screening tests and impacts of the fertility monitoring program from the outset.

Funding for In Vitro Fertilization

We believe that publicly funding in vitro fertilization (IVF) in Ontario under certain conditions, described in the section on assisted reproduction, will go a long way to supporting the health and well-being of mothers and children. It's now time for Ontario to catch up with other jurisdictions who have reaped the benefits of publicly funding IVF. We urge the government to fully implement this recommendation within 18 months.

New Provincial Adoption Agency

We know it will take some time to build the new adoption agency we recommend in the adoption section and to complete the transition of public adoption responsibilities from children's aid societies to the new agency. In the short-term, we encourage the government to proceed with the creation of the agency, the appointment of a board of directors and the hiring of a chief executive officer. As we've said, we believe that there will be a transition period in which both the current adoption system and the recommended new system will have to run simultaneously, but we do believe the new agency could be fully functional in two to three years.

Post-adoption Subsidies and Supports

As we've explained in the adoption section, we believe that implementing equitable post-adoption subsidies province-wide will go a long way to supporting adoption. And because it costs a lot to keep a child in care, we think the government should move right away to address the inequities in its adoption subsidy system. The cost benefit is clear.

A Five-year Review

Throughout our report, we've set some important benchmarks that we believe can be reasonably achieved within five years. These include:

- A decrease in the current rate of multiple births of about 28% to a level no greater than 15%.
- Accreditation of all clinics and fertility centres.
- A doubling of the annual number of public adoptions in Ontario from its current rate of about 800 to over 1,600 per year.
- Increased public awareness about adoption, fertility and assisted reproduction.

Given these milestones, we believe the government should undertake a formal review of progress achieved on all of our recommendations in five years. We recommend that the best way to do so is to set up a new arm's-length, time-limited expert panel to measure and report on progress and recommend any necessary changes in course.

In Closing, We Want to Thank the Government

We'd like to commend the courage and foresight that the Premier and his Government have shown in setting up this Expert Panel on Infertility and Adoption. In so doing, they have placed Ontario among a privileged group of jurisdictions that are seriously considering these important issues and taking concrete action.

We are honoured to have been asked to assist in this process. We have every confidence that the government will make the wise decisions necessary to make Ontario the best jurisdiction in the world in which to build a family.

[1] Mary Eschelbach Hansen, "The Value of Adoption," *Adoption Quarterly* 10, 2 (2008): 65-87
[2] *Ibid.*
[3] Adapted from information provided by the Ministry of Children and Youth Services (Adoptions and Crown Wards Information System).
[4] Adapted from information found in the Child Welfare Review (October 2008).
[5] Adapted from information provided by the Ministry of Children and Youth Services from fiscal year 2007-08. This figure does not include CASs' infrastructure spending that supports adoption services.
[6] Adapted from information provided by the Ministry of Children and Youth Services from fiscal year 2007-2008.
[7] *Ibid.*
[8] Adoption Council of Ontario, 2009.
[9] *Ibid.*
[10] Lois Wright and Cynthia C. Flynn, "Adolescent Adoption: success despite challenges," *Children and Youth Services Review* 28 (2006): 487-510.
[11] Alyssa Burrell Cowan, "New Strategies to Promote the Adoption of Older Children Out of Foster Care," *Children and Youth Services Review* 26 (2004): 1007-1020.
[12] Adoption Register for England and Wales Annual Report, 2007
[13] Adapted from information found in the Child Welfare Review (October 2008).
[14] *Ibid.*
[15] Adapted from information provided by the Ministry of Children and Youth Services from fiscal year 2007-08.
[16] Rae R. Newton, Alan J. Litrownik and John A. Landsverk, "Children and Youth in Foster Care: disentangling the Relationship between Problem Behaviors and Number of Placements" *Child Abuse and Neglect* 24 910): 1363-1374.
[17] Jeffrey J. Haugaard, Julie C. Wojslawowicz and Megan Palmer, "Outcomes in Adolescent and Older-Children Adoptions" *Adoption Quarterly* 3, 1 (1999): 61-69.
[18] Kerry J. Daly and Michael P. Sobol, "Public and Private Adoption: A Comparison of Service and Accessibility" *Family Relations*, 43, 1, (1994): 86-93.
[19] Michael P. Sobol and Kerry J. Daly, "The adoption alternative for pregnant adolescents: Decision making, consequences, and policy implications" *Journal of Social Issues*, 48 (1992): 143-161.
[20] Child Welfare Transformation 2005: A strategic plan for a flexible, sustainable and outcome oriented service delivery model, Ministry of Children and Youth Services.
[21] Adapted from information provided by the Ministry of Children and Youth Services from fiscal year 2007-08.
[22] Mary Eschelbach Hansen and Bradley A. Hansen, "The Economics of Adoption of Children from Foster Care", *Child Welfare*, 85, 3 (2006): 559-583.
[23] Hansen, 2008.
[24] Jeff Katz, Julie Wilson and Rob Geen, "Listening to Parents: overcoming barriers to the adoption of children from foster care." The Evan B. Donaldson Adoption Institute, 2005.
[25] Devon Brooks, Joan Allen, and Richard P. Barth, "Adoption Services Use, Helpfulness, and Need: A Comparison of Public and Private Agency and Independent Adoptive Families," *Children and Youth Services Review* 24, 4 (2002).
[26] *Ibid.*
[27] Haugaard et al., 1999.
[28] Pamela Gough and Nitza Perlman, "Attachment disorder," Centre of Excellence for Child Welfare, (2006).
[29] John Triseliotis, "Long-term Foster Care or Adoption? The evidence examined" *Child and Family Social Work* 7 (2002): 23-33.
[30] Richard P. Barth, M. Berry, R. Yoshikami, R.K. Goodfield and M.L. Carson, "Predicting adoption disruption" *Social Work*, 33 (1988): 227-233.
[31] Lorrie L. Lutz, "Achieving Permanence for Children In the Child Welfare System: Pioneering Possibilities Amidst Daunting Challenges," 2003.
[32] Amy D'Andrade, Laura Frame and Jill Duerr Berrick, "Concurrent planning in public child welfare agencies: Oxymoron or work in progress?" *Children and Youth Serivces Review*, 28 (2006): 78-95.
[33] Triseliotis, 2002.
[34] Hansen, 2008.
[35] Adapted from information found in the Child Welfare Review (October 2008).
[36] Linda Katz, "Concurrent planning: Benefits and pitfalls." *Child Welfare*, 78, 1 (1999): 71-87.
[37] D'Andrade et al. (2006).,
[38] Child Welfare League of America Research to Practice Initiative, "Concurrent Planning Review of Recent Research Literature." (2003).
[39] Cowan, 2004.

[40] Adapted from information provided by the Ministry of Children and Youth Services (Adoptions and Crown Wards Information System).
[41] Lutz, 2003.
[42] Rosemany J. Avery, J.S. Butler, Ellie B. Gradsher Schmidt, Barbara A. Holtan, "AdoptUSKids national photolisting service: Characteristics of listed children and length of time to placement," *Children and Youth Services Review* 31 (2009): 140-154.
[43] Alberta Children's Services, "Adoption Web Site Initiative 3 Month Review," (2003).
[44] Charlene E. Miall and Karen March, "Open Adoption as a Family Form: Community Assessments and Social Support," *Journal of Family Issues* 26, 3 (April 2005).
[45] Jerica M. Berge, Tai J. Mendenhall, Gretchen M. Wrobel, Harold D. Grotevant and Ruth G. McRoy, "Adolescents' Feelings About Openness in Adoption: Implications for Adoption Agencies," *Child Welfare* 85, 6 (Nov/Dec 2006).
[46] *Ibid*.
[47] Miall and March, 2005.
[48] Berge et al., 2006.
[49] *Ibid*.
[50] Hansen, 2008.
[51] Richard Barth, Chung Kwon Lee, Judith Wildfire and Shenyang Guo, "A Comparison of the Governmental Costs of Long-Term Foster Care and Adoption," *Social Services Review* (March 2006): 127-158.
[52] Devon Brooks, Joan Allen and Richard P. Barth, "Adoption Services Use, Helpfulness, and Need: A Comparison of Public and Private Agency and Independent Adoptive Families" *Children and Youth Services Review* 24, 4 (2002): 213-238.
[53] Barbara Dalberth, Deborah Gibbs and Nancy Berkman, "Understanding Adoption Subsidies: An Analysis of AFCARS Data." Prepared for the U.S. Department of Health and Human Services (January 2005).
[54] Daly and Sobol, (1994).
[55] Richard P. Barth and Julie M. Miller, "Building Effective Post-Adoption Services: What is the Empirical Foundation?" *Family Relations*, 49 (2000): 447-455.
[56] Brooks et al., 2002.
[57] Mandeep K. Dhami, David R. Mandel, Katy Sothmann, "An Evaluation of Post-Adoption Services," *Children and Youth Services Review* 29 (2007): 162-179.
[58] Diane L. Zosky, Jeanne A. Howard, Susan Livingston Smith, Anne M. Howard and Kristal H. Shelvin, "Investing in Adoptive Families: what adoptive families tell us regarding the benefits of adoption preservation services," *Adoption Quarterly* 8, 3 (2005): 1-23.
[59] Adapted from information found in the Child Welfare Review (October 2008).
[60] *Ibid*.
[61] Community Paediatrics Committee, Canadian Paediatric Society, "Transracial adoption," *Paediatric Child Health*, 11 (7), (2006): 443-447.
[62] Alan Rushton and Helen Minnis, "Annoation: Transracial Family Placements," *Journal of Child Psychiatry* 38, 2 (1997): 147-159.
[63] Patrick Leung, Stephen Erich and Heather Kanenberg, "A Comparison of Family Functioning in Gay/Lesbian, Heterosexual, and Special Needs Adoptions," *Children and Youth Services Review* 27 (2005): 1031-1044.
[64] Jeffrey J. Haugaard, Karen Dorman and Amy Schustack, "Lesbian-Headed Households," *Adoption Quarterly* 1, 4 (1998): 93-101.
[65] Jeffrey J. Haugaard, Megan Palmer and Julie C. Wojslawowicz, "Single-Parent Adoptions," *Adoption Quarterly* 2, 4 (1999): 65-74.
[66] United States Government Accountability Office, "Better Data and Evaluations Could Improve Processes and Programs for Adopting Children with Special Needs," (2005).
[67] U.S. Department of Health and Human Services, Administration for Children & Families "The Adoption and Foster Care Reporting and Analysis System (AFCARS)" Accessed 09 June 2009 http://www.acf.hhs.gov/programs/cb/stats_research/index.htm.
[68] Dalberth et al., 2005.
[69] Mary Eschelbach Hansen, "Using Subsidies to Promote the Adoption of Children from Foster Care," *Journal of Family Economic Issues* 28 (2007): 377-393.
[70] Center for Disease Control and Prevention, 2006 Assisted Reproductive Technology Success Rates: National Summary and Fertility Clinic Reports (Atlanta: U.S. Department of Health and Human Services, 2008): 31.
[71] Reproductive Ageing: Guidelines for First Line Physicians for Investigation of Infertility Problems (Canadian Fertility and Andrology Society, 2004). & Karin Fleming, "Inconceivable? Figuring out Your Fertility Options," Women's Health Matters 07 May. 2007, Accessed on 19 Nov. 2008 <http://www.womenshealthmatters.ca/resources/show_res.cfm?ID=42131 >.

[72] National Institute for Clinical Excellence (NICE), "Fertility: Assessment and Treatment for People with Fertility Problems," Clinical Guideline 11 Developed by the National Collaborating Centre for Women's and Children's Health (February 2004): 7-9.
[73] Adapted from information provided by the Ministry of Health and Long-Term Care from fiscal year 2006-07.
[74] D.J. Cahill and P.G. Wardle, "Management of Infertility," British Medical Journal 325 (2002): 28.
[75] Arthur Leader, "Pregnancy and Motherhood: The Biological Clock," Sexuality, Reproduction, & Menopause 4 (2006): 3- 4.
[76] The ESHRE Capri Workshop Group, "Fertility and Ageing" Human Reproduction Update 11(2005): 263.
[77] Reproductive Ageing: Guidelines for First Line Physicians for Investigation of Infertility Problems (Canadian Fertility and Andrology Society, 2004).
[78] Joan Raymond "Modern Maternity" Newsweek.com September 15, 2008 http://www.newsweek.com/id/158410 (Accessed December 12. 2008).
[79] *Ibid*.
[80] Leader, 4.
[81] *Ibid*.
[82] Elise de La Rochebrochard and Patrick Thonneau, "Paternal age and Maternal Age are Risk Factors for Miscarriage; Results of a Multicentre European study, Human Reproduction 17 (2002): 1649. & Leader, 4.
[83] Leader, 4.
[84] Henri Leridon, "Can Assisted Reproduction Technology Compensate for the Natural Decline in Fertility with Age? A Model Assessment" Human Reproduction 19 (2004): 1552-1553 & Leader, 3.
[85] Leader, 3.
[86] ESHRE Capri Workshop Group, Fertility and Ageing 262 & Leader, 5.
[87] One clinic is an Independent Health Facility and receives a facility fee from the Ministry of Health and Long-Term Care to fund services provided to support any insured IVF cycles.
[88] Stephanie J Lee, Leslie R Schover, Ann H Partridge, Pasquale Patrizio, W. Hamish Wallace, Karen Hagerty, Lindsay n Beck, Lawrence V. Brennan, and Kutluk Oktay, "American Society of Clinical Oncology Recommendations on Fertility Preservation in Cancer Patients," Journal of Clinical Oncology 24 (2006): 2924.
[89] Canadian Fertility and Andrology Society – 2006 Ontario Data.
[90] Ann Thurin, Jon Hausken, Torbjön Hillensjö, Barbara Jablonowska, Anja Pinborg, Annika Strandell, & Christina Bergh Elective Single-Embryo Transfer versus Double-Embryo Transfer in Vitro Fertilization *New England Journal of Medicine* (2004): 2392-2401.
[91] Karl Nygren, " A Follow-up on IVF Children," Creating Families 4 (2009): 39.
[92] *Ibid*.
[93] ESHRE Capri Workshop Group, Fertility and Ageing 273.
[94] *Ibid*.
[95] *Ibid*.
[96] Ontario Health Technology Advisory Committee, In Vitro Fertilization and Multiple Pregnancies: Health Technology Policy Assessment (Toronto: Ministry of Health and Long-term Care, 2006): 7 & 21.
[97] Canadian Fertility and Andrology Society - 2005 Canadian Assisted Reproductive Technologies Register.
[98] Canadian Institute for Health Information, Too Early, Too Small: A Profile of Small Babies across Canada (Ottawa, 2009): 30. However the trend towards delayed child bearing in more recent years also contributed to increasing multiple birth rates as older maternal age (35 or older) is associated with multiples. (30).
[99] Ontario Health Technology Advisory Committee, 15.
[100] Jason K Min, Paul Claman, & Ed Hughes, "Joint SOGC-CFAS Guideline: Guidelines for the Number of Embryos to Transfer Following In Vitro Fertilization," Journal of Obstetrics and Gynaecology 182 (2006): 801.
[101] *Ibid*, 775.
[102] Canadian Institute for Health Information, "Giving Birth in Canada: The Costs" (2006): 29.
[103] The ESHRE Capri Workshop Group, "Multiple Gestation Pregnancy," Human Reproduction 15 (2000):1858.
[104] Willem Ombelet, Petra De Sutter, Josiane Van der Elst and Guy Martens, "Multiple Gestation and Infertility Treatment: Registration, Reflection and Reaction – The Belgian Project." Human Reproduction Update 11 (2005): 5.
[105] *Ibid*., 4-5.
[106] Canadian Institute for Health Information, Too Early, Too Small: A Profile of Small Babies Across Canada (Ottawa, 2009): 56.
[107] Christel Hydén-Granskog & Aila Tiitinen, "Single Embryo Transfer in Clinical Practice," Human Fertility 7 (2004): 176.
[108] *Ibid*.
[109] Peter Braude "One Child at a Time: Reducing Multiple Births after IVF," Report of the Expert Group on Multiple Births after IVF, October 2006: 18.

[110] Nygren, 39 & Braude, 19.
[111] Braude , 18.
[112] Yueping A Wang, Elizabeth A Sullivan, David L Healy and Deborah A Black, "Perinatal Outcomes after Assisted Reproductive Technology Treatment in Australia and New Zealand: Single Versus Double Embryo Transfer" Medical Journal of Australia 190 (2009): 234-237.
[113] Canadian Institute for Health Information, Too Early, Too Small: A Profile of Small Babies Across Canada (Ottawa, 2009): 56.
[114] *Ibid*., 67.
[115] Ombelet et al., 6.
[116] *Ibid*, 7.
[117] The Ottawa Coalition for the Prevention of Low Birth Weight Babies "Effects on the Community". http://www.successby6ottawa.ca/lbwfpn/english/community_effects.html (Accessed June 15. 2009)
[118] Note: Federal government employees in Ontario will soon be entitled to the same level of care as Quebeckers, while other Ontarians will remain ineligible for public funding of IVF.
[119] The methodology used in our analysis was adapted from the analysis done by Lindy Forte, Health Economist, for the Infertility Awareness Association of Canada. Our thanks go to Ms. Forte and IAAC.
[120] This funding also included funding for two screening programs aimed at ensuring the best care for cases of pre-term labour and premature eye disease.
[121] ESHRE Capri Workshop Group, Fertility and Ageing 262 & Leader, 5.
[122] *Ibid*.
[123] Canadian Fertility and Andrology Society – 2006 Ontario Data.
[124] Leader, 3.
[125] Y.A. Wang D. Healy, D Black and E.A. Sullivan, "Age Specific Success Rate for Women Undertaking their First Assisted Reproduction Technology Treatment Using Their Own Oocytes in Australia, 2002-2005" Human Reproduction 23 (2008): 1633-1638 & Leader, 5.
[126] Canadian Fertility and Andrology Society's 2006 Canadian Assisted Reproductive Technology Register.
[127] IVF.CA "Applying Probabilities to Birth Rate Stats" IVF.CA Accessed on 20 Mar 2009 http://www.ivf.ca/numbers.php.
[128] *Ibid*.
[129] *Ibid*.
[130] Canadian Life and Health Insurance Association – Presentation by Irene Klatt on 3 Feb. 2009.
[131] Gina Cella, "National Survey Finds Employers Covering Infertility Treatment Experience No Significant Increase in Cost," The Human Resources Portal 20 Jul 2006: 2.
[132] Statistics Canada, 2006 Census.
[133] Lori E. Ross, Leah S. Steele, & Rachel Epstein, "Lesbian and Bisexual Women's Recommendations for Improving the Provision of Assisted Reproductive Technology Services," Fertility and Sterility 86 (2006): 737.
[134] *Ibid*.
[135] *Ibid*.
[136] Liz Ellwood, Fertility Monitoring and Assisted Reproduction Working Group Discussion, 6 Jan. 2009.
[137] Lee, et al., 2917.
[138] *Ibid*.
[139] *Ibid*.

APPENDIX A

ADOPTION ACRONYMS

ACO	Adoption Council of Ontario
ARE	Adoption Resource Exchange
CAS	Children's Aid Society
CFSA	*Child and Family Services Act*
ESA	*Employment Standards Act*
FASD	Fetal Alcohol Spectrum Disorder
IAA	*Intercountry Adoption Act*
MCYS	Ministry of Children and Youth Services
NACAC	North American Council on Adoptable Children
OACAS	Ontario Association of Children's Aid Societies
PRIDE	Parent Resources for Information, Development and Education
SAFE	Structured Analysis Family Evaluation
WWK	Wendy's Wonderful Kids

ADOPTION GLOSSARY

Adoption	The process by which a child becomes the child of adoptive parent(s), for all purposes of law.
Central Authority	Under the Hague Convention (see below), the body designated to perform duties related to intercountry adoption. The Ministry of Children and Youth Services (MCYS) is the central authority in Ontario.
Child	Generally refers to children and youth under the age of 18.
Children's Aid Society (CAS)	In Ontario, children's aid societies are designated by the Minister of Children and Youth Services to provide child welfare services, including placing children for adoption. Each CAS is an independent, non-profit corporation governed by a locally elected volunteer board of directors. There are 53 CASs in Ontario.
Child and Family Services Act	Sets out the law concerning the provision of child welfare services in Ontario including provisions related to adoptions finalized in Ontario courts.
Concurrent Permanency Planning	Making plans to reunify a child with the birth family, while at the same time making an alternative plan for permanency in the event that the child is not reunified with the birth family.
Court-ordered Access to Crown Wards	The right to have communication or contact with a Crown ward. Orders may be made for birth family members, or any other person, where the relationship is meaningful and beneficial to the child and does not impair any future opportunities for adoption. Under Ontario legislation, Crown wards with court-ordered access may not be adopted.
Crown Ward	A child who is subject to a court order making them a ward of the Province of Ontario.
Crown Wardship Order	A court order whereby a child becomes a permanent ward of the Province of Ontario until either another court order is made (e.g., legal custody, adoption), or the child turns 18, or marries.
Custom Adoption	Form of adoption specific to Aboriginal peoples within the Aboriginal community that recognizes traditional Aboriginal custom, also called "customary adoption."
Disruption	The breakdown of an adoption placement (e.g., prior to finalization).
Dissolution	The breakdown of an adoption after finalization.
Employment Standards Act	Ontario's legislation providing the minimum standards for working in the province. It sets out the rights and responsibilities of employees and employers, including standards pertaining to pregnancy and parental leave.

Family	Refers to heterosexual couples, same-sex couples and single adults, with or without children.
Fetal Alcohol Spectrum Disorder	A disability resulting from prenatal exposure to alcohol.
Finalization	The final legal step in the adoption process: the court makes an order, whereby the child becomes the child of the adoptive parent(s).
Hague Convention	The *Hague Convention on Protection of Children and Co-operation in Respect of Intercountry Adoption* (Hague Convention) is an international agreement designed to ensure that intercountry adoptions take place in the best interests of the child, to establish a system of cooperation among contracting states and to prevent the trafficking of children. The convention provides a framework for Ontario's regulation of intercountry adoption.
Hard to Place	Some children are considered to be harder to place for adoption for reasons such as special needs, age, race or whether they are part of a sibling group.
Homestudy	See SAFE below.
Intercountry Adoption	The adoption by Ontario families of children who are residents of other countries. This process is facilitated by private intercountry adoption agencies or individuals licensed by the Ontario government and regulated under legislation.
Intercountry Adoption Act	Sets out the requirements that must be met within Ontario for adoptions that will be finalized in other countries.
Kinship Care	Refers to a child who is in the care of a CAS and placed with a relative, community member or other adult with whom there is a relationship significant to the child or youth. Kinship care homes must be assessed and approved under the regulatory provisions governing foster homes.
Legal Custody	Refers to an order by the court placing a Crown ward in the care and custody of a person (i.e., not a CAS) who then has the right to make decisions for the child.
Licensee	An individual or agency to whom the provincial government has issued a licence to facilitate private domestic and/or intercountry adoptions.
Openness	Arrangements whereby an adopted child and/or the adoptive family maintains some form of communication or contact with significant individual(s) from the adopted child's past, such as birth parents, siblings, relatives, foster parents or, in the case of native or Indian children, a member of the child's band or native community.
Parental Leave	In Ontario, a new parent, including an adoptive parent, is entitled to parental leave whether he or she is a full-time, part-time, permanent or contract employee, provided that the employee was employed for at least 13 weeks before commencing the parental leave and works for an employer that is covered by the ESA.

Parental Training	See PRIDE below.
Private Adoption Practitioner	A professional, usually a social worker, whom the government has approved to conduct homestudies and supervise placements in prospective adoptive homes.
Private Domestic Adoption	The adoption of a child whose birth parent(s) have voluntarily decided to make an adoption plan for the child. Private domestic adoptions are facilitated by a private adoption licensee.
Public Adoption	The adoption of a child who is a Crown ward or whose birth parents have consented to the child's adoption through a CAS.
PRIDE	A competency-based parental training model for the training and support of adoptive families.
Probationary Period	The time between the placement of a child with a prospective family and finalization (see above).
Relative Adoption	The adoption of a child by a birth relative.
Relinquishment	A process in which the birth parent(s) surrender the legal right to parent a child.
SAFE	A homestudy methodology designed to evaluate prospective adoptive homes.
Youth	Generally refers to children between the ages of 12 and 18.

ASSISTED REPRODUCTION ACRONYMS

AFC	Antral Follicle Count
AHRA	*Assisted Human Reproduction Act*
AMH	Anti-Mullerian Hormone
ART	Assisted Reproductive Technology
CARTR	Canadian Assisted Reproductive Technologies Register
CFAS	Canadian Fertility and Andrology Society
CIHI	Canadian Institute for Health Information
CPSO	College of Physicians and Surgeons of Ontario
COS	Controlled Ovarian Stimulation
ESHRE	European Society for Human Reproduction and Embryology
FET	Frozen Embryo Transfer
FSH	Follicle Stimulating Hormone
HIV	Human Immunodeficiency Virus
IAAC	Infertility Awareness Association of Canada
ICSI	Intracytoplasmic Sperm Injection
IUI	Intrauterine Insemination
IVF	In Vitro Fertilization
LGBTQ	Lesbian, Gay, Bisexual, Transgendered and Queer
MOHLTC	Ministry of Health and Long-Term Care (Ontario)
OHIP	Ontario Health Insurance Plan
OMA	Ontario Medical Association
OTN	Ontario Telemedicine Network
SET	Single Embryo Transfer
SOGC	Society of Obstetricians and Gynecologists of Canada
TCM	Traditional Chinese Medicine

ASSISTED REPRODUCTION GLOSSARY

Andrology	A specialty focusing on the male infertility side of assisted reproduction.
Antral Follicle Count (AFC)	A test using an ultrasound camera inserted into a woman's vagina to measure the actual number of follicles growing at that moment in her ovary or ovaries.
Anti-Mullerian Hormone (AMH) Test	A test measuring the level of a hormone in a woman's blood that is produced by her existing egg supply.
Artificial Insemination	A procedure in which sperm is placed directly into a woman's uterus (also known as intrauterine insemination) or into her cervix for the purpose of conception.
Assisted Human Reproduction Act	A federal Act which regulates assisted reproduction in Canada.
Assisted Reproduction Services	All treatments or procedures that involve the laboratory (in vitro) handling of both human eggs and sperm or embryos to establish a pregnancy.
Blastocyst	An embryo that is approximately five days old.
Blocked Fallopian Tubes	A condition involving the obstruction of one or both organs that transfer the egg from the ovary to the uterus and bring sperm from the uterus to the egg.
Caesarean Section	A surgical procedure to deliver a baby by making an incision in a woman's abdomen and uterus.
College of Physicians and Surgeons of Ontario (CPSO)	The body that regulates the practice of medicine in Ontario.
Cryopreservation	A procedure used to preserve and store eggs, sperm or embryos by freezing them at a very low temperature – 180°C.
Donor	A man or woman who donates their sperm or eggs to another man or woman to be used in an assisted reproduction procedure.
Egg	The female reproductive cell produced by the ovaries that, when fertilized with a male's sperm, produces an embryo. Also referred to as an oocyte or ovum.
Egg Retrieval	A procedure in which a needle is used to retrieve ripened eggs from an ovary so they can be used in an in vitro fertilization procedure.
Embryo	A term used to describe the early stages of fetal development from fertilization to the eighth week of pregnancy.
Embryo Transfer	A term used to describe the placement of an embryo or embryos into the uterus as part of the IVF procedure.

Embryologists	Laboratory personnel who are specially trained in the various aspects of handling sperm and eggs, as well as embryo formation and development.
Estrogen	The female sex hormones produced by the ovaries which are responsible for the development of female sex characteristics. Estrogens are largely responsible for stimulating the uterine lining to thicken during the first half of the menstrual cycle in preparation for ovulation and possible pregnancy.
Fallopian Tubes	Two tube-like organs extending from the ovary to each side of the uterus, where sperm and egg meet in normal fertilization.
Fertilization	A process during which a sperm penetrates an egg, fusion of genetic material occurs and an embryo develops.
Follicle	A fluid-filled sac located just beneath the surface of the ovary, containing an egg and cells that produce hormones. The sac increases in size and volume during the first half of the menstrual cycle. At ovulation the follicle matures and ruptures, releasing the egg. As the follicle matures, it can be seen with ultrasound.
Follicle Stimulating Hormone (FSH)	A hormone that stimulates the ovary to ripen a follicle.
Follicle Stimulating Hormone (FSH) Test	A test that measures the level of a protein that stimulates the follicles (egg sacs) in women's blood to produce and release eggs.
Gamete	The male or female reproductive cell – the sperm or egg.
Gestational Carrier	A woman who carries a pregnancy produced by an embryo that is not genetically related to her. Parental rights are then transferred to the intended parent(s) after birth.
Idiopathic Infertility	A term used to describe unexplained infertility.
Implantation	A process in which an embryo embeds in the uterine lining to obtain nutrition and oxygen.
Infertility	Commonly defined as the inability either to conceive a child after 12 months of unprotected intercourse, or to carry a pregnancy to delivery.
Infertility Awareness Association of Canada (IAAC)	A Canadian organization committed to providing educational material, support and assistance to individuals and couples who are experiencing infertility.
Intrauterine Insemination (IUI)	A process whereby washed sperm are injected directly into the uterus to place the sperm closer to the egg.
Intracytoplasmic Sperm Injection (ICSI)	A technique used in conjunction with IVF (see below) that involves injecting a sperm directly into an egg to facilitate fertilization.

In Vitro Fertilization (IVF)	A method of assisted reproduction that combines an egg with sperm in a laboratory dish. If the egg fertilizes and begins cell division, the resulting embryo is transferred into the woman's uterus.
Male Factor Infertility	A low sperm count or problems with sperm function that cause difficulty for a sperm to fertilize an egg under normal conditions.
Menopause	Natural cessation of ovarian function and menstruation. Menopause can occur between the ages of 42 and 56, but usually occurs around the age of 51 when the ovaries stop producing eggs and estrogen levels decline.
Miscarriage	The naturally-occurring expulsion of a nonviable fetus and placenta from the uterus, also known as spontaneous abortion or pregnancy loss.
Natural In Vitro Fertilization	An in vitro fertilization procedure without the use of ovulation-inducing drug therapy.
Ontario Medical Association (OMA)	A voluntary association representing the political, clinical and economic interests of the province's medical profession.
Ovarian Reserve	The eggs a woman has remaining in her ovaries. Some never mature, while others mature and are released during menstrual cycles.
Ovaries	The two female sex glands in the pelvis that produce eggs, estrogen and progesterone, as well as other hormones.
Ovulation	The release of a ripened egg from its follicle. This usually occurs approximately 14 days before the next menstrual period (the 14th day of a 28-day cycle).
Ovulation Induction/Stimulation	The administration of fertility drug therapy that causes the ovary to produce one or more eggs.
Premature Ovarian Failure	Also called early menopause, this can result from exposure to certain chemicals, chemotherapy and radiation for cancer treatment. Other causes are certain genetic disorders and conditions that affect the cycle-regulating hormones or damage the ovaries so they no longer produce eggs.
Progesterone	A hormone secreted after ovulation, it prepares the uterine lining for implantation of a fertilized egg and helps sustain pregnancy.
Reproductive Age	Refers to the period in which women are most fertile and most likely to conceive and carry a child to delivery.
Reproductive Endocrinologist	A gynecologist who has received certification in gynecologic reproductive endocrinology and infertility, following fellowship training in the causes, evaluation and treatment of infertility.
Semen Analysis	The microscopic examination of semen (the male ejaculate) to determine its volume, the number of sperm (sperm count), their shapes (morphology) and their ability to move (motility), in addition to other parameters.

Single Embryo Transfer (SET)	A process where a single embryo is transferred into a woman's uterus following the fertilization of an egg and sperm in a laboratory as part of the in vitro fertilization process.
Sperm	The male reproductive cell produced by the testes which, when it fertilizes a woman's egg, produces an embryo.
Sperm Morphology	The size and shape (form) of an individual sperm.
Sperm Motility	The ability of sperm to move and swim in a forward direction.
Sperm Wash	A technique that separates the sperm from the seminal fluid.
Testes	The two male reproductive glands located in the scrotum that are responsible for producing sperm and the male hormone, testosterone.
Tubal Factor Infertility	A cause of infertility related to structural or functional damage to one or both fallopian tubes.
Uterus	The hollow, muscular female organ in the pelvis where the embryo implants and develops during pregnancy.
Unexplained Infertility	Infertility for which no cause has been determined despite a comprehensive evaluation.

APPENDIX B

OVERVIEW OF SURVEYS AND INTERVIEWS

A number of information sources were used to help inform the recommendations of the Expert Panel on Infertility and Adoption. Some of these information sources included an online survey, interviews, a survey of children's aid societies (CASs) and a youth focus group.

We would like to thank all the people who took the time to participate in the surveys, interviews and focus group. Their experiences and perspectives helped us understand the service systems and assisted us in making our recommendations.

It should be noted that the opinions/information provided through the surveys, interviews and focus group are those of respondents/participants who do not necessarily represent the population as a whole, nor the position/experience of all agencies.

Online Survey

- Between November 14, 2008 and January 12, 2009, an online survey was available on the expert panel's webpage, inviting people who had experience with infertility, assisted reproduction and/or adoption services in Ontario to share their experiences.
- As part of this survey, providers of adoption and assisted reproduction services, people who were adopted, people who were donor conceived and members of the public were also invited to share their views.
- An external consultant developed and managed the online survey.

Interviews

- 106 interviews were conducted from January 5 to February 11, 2009 to gather more in-depth information about the experiences of Ontarians with the province's infertility and adoption systems.
- An external consultant was engaged to conduct this series of face-to-face and telephone interviews.

Survey of Children's Aid Societies

- A questionnaire on public adoption was distributed on March 17, 2009 to all of the member agencies of the Ontario Association of Children's Aid Societies (OACAS – 51 of the 53 CASs).
- The OACAS distributed the questionnaire on behalf of the Expert Panel.

Youth Focus Group

- In April 2009, 15 Crown wards and former Crown wards took part in a facilitated discussion on the topic of adoption.
- The discussion was moderated by an external consultant.

ONLINE SURVEY

ONLINE SURVEYS

KEY FINDINGS FROM OUR ONLINE CONSUMER SURVEYS[1]

WHO PARTICIPATED IN THE SURVEY?

- 1,918 people participated in the infertility survey.
- 833 people participated in the adoption survey.

Most were part of a heterosexual couple (married or common law), had at least a college or university degree and reported English as their first language.

- 90% were female.
- About 5% were single (106) and 2% (56) were separated, divorced or widowed.
- About 3% (71) were part of a same-sex couple.
- Most (84%) were born in Canada.
- Most (85%) had annual family incomes of at least $65,000.

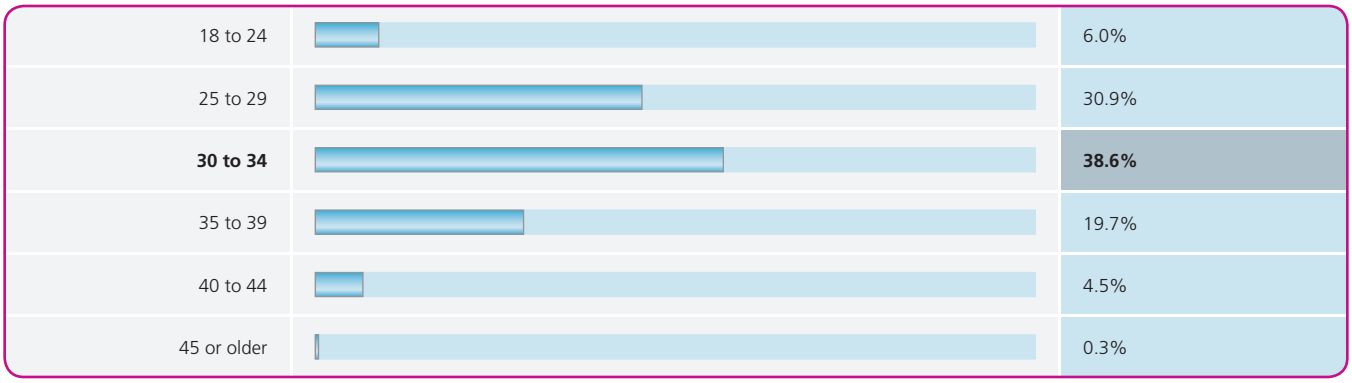
WHAT RESPONDENTS TOLD US ABOUT INFERTILITY AND ASSISTED REPRODUCTION

Most participants reported that their family doctors did not discuss fertility with them before they had problems conceiving.

- When the early discussion did occur, it was usually because the patient had a health issue that might affect fertility.
- Some doctors did discuss fertility. When they did and were supportive, patients were very appreciative – and the discussion made a difference.

Almost all Ontarians who completed the infertility survey (97%) sought help for infertility.

- Most (75%) sought help within two years of trying to conceive.
- Most were under age 35 when they sought help but about one in five were between the ages of 35 and 39.



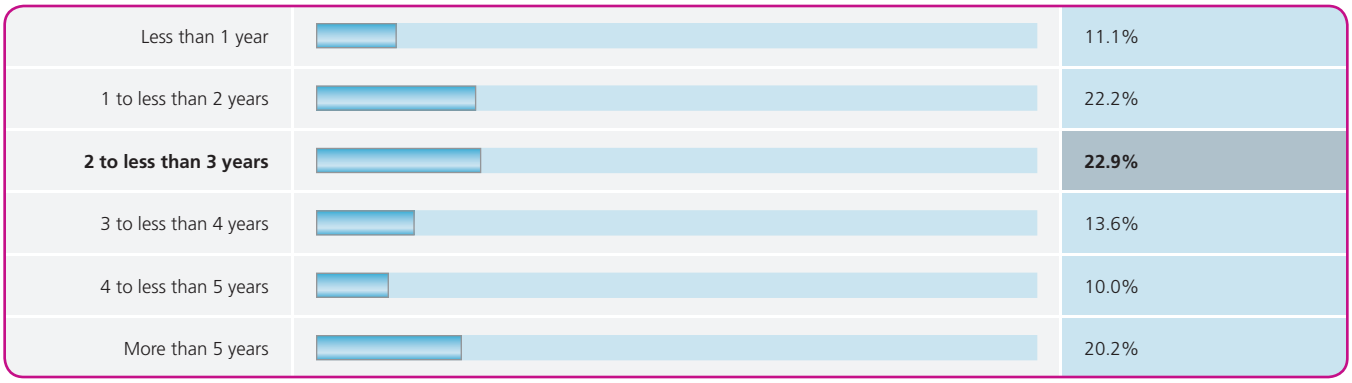
[1] It should be noted that the opinions/information provided through the surveys are those of respondents/participants who do not necessarily represent the population as a whole.

Almost half the people who completed the survey were currently involved in assisted reproduction treatments.

Of the 1,613 people who answered the question about whether they had been successful in having a child through assisted reproduction:

- One in four respondents reported success in having a child.
- One in four was unsuccessful.
- Almost half said "not yet."

One in five respondents had been involved in treatment for more than five years.

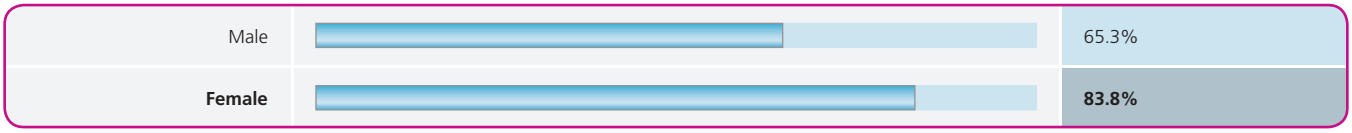


Assisted reproduction services are often associated with multiple births. Of the 452 people who answered the question about multiple births:

- About one in six had had twins.
- Just over one in 100 had had triplets.

Note: The 18% of respondents who reported having a multiple birth is lower than the approximately 30% multiple birth rate reported in studies of Canadian reproductive services.

Just over half (52%) of respondents reported that the cause of their infertility had been diagnosed. Of those, 65% reported male infertility and 84% reported female infertility.



- People found the process of being diagnosed long, costly and frustrating.
- Many reported that it took at least six to eight months to get a referral to a specialist.
- Many were frustrated because the cause of their fertility problems was undiagnosed.

Almost all sought treatment – even if the cause of infertility was undiagnosed.

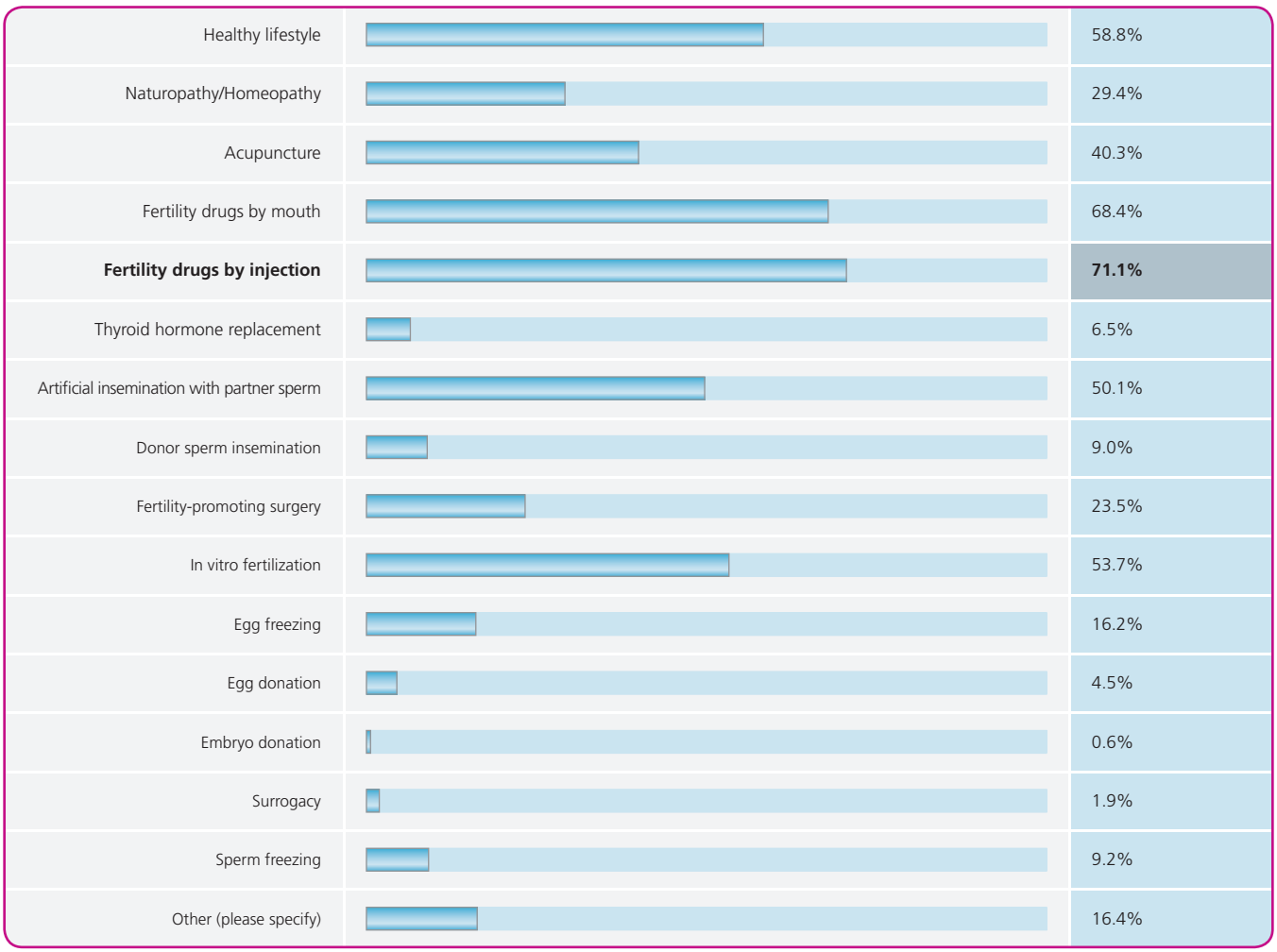
- The main reasons for not seeking treatment were the cost or the lack of a clear diagnosis.

Of those who sought treatment, one in 10 pursued options outside Ontario.

The main reasons were:

- Costs were cheaper in other countries (e.g., India, Greece, France).
- Respondents could get access to services not offered here (e.g., donor eggs more available in the United States).
- Success rates were higher elsewhere (e.g., Montreal, Alberta, Spain, United States).

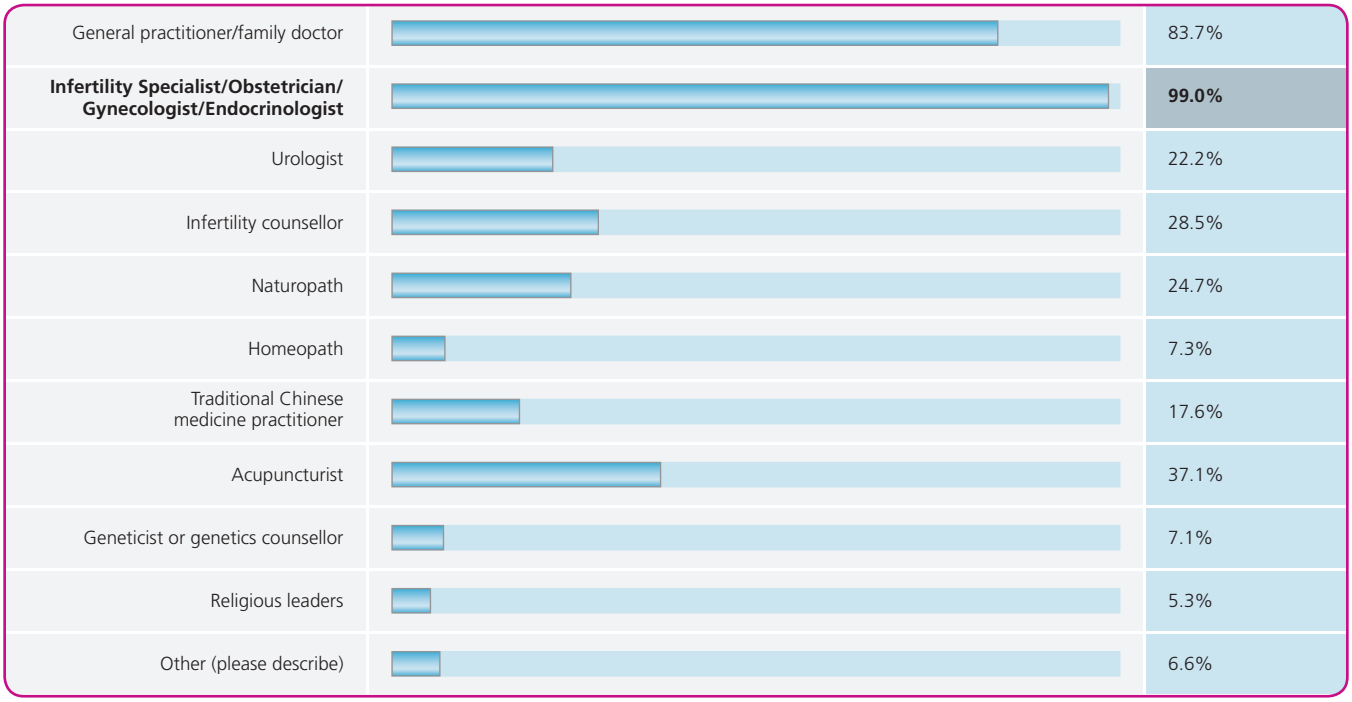
The most common treatments used in Ontario were fertility drugs by injection, fertility drugs by mouth, healthy lifestyle and in vitro fertilization (IVF).



Almost all respondents consulted a fertility specialist/reproductive endocrinologist or obstetrician/gynecologist.

- Most consulted their general practitioner or family doctor.
- The next most frequently consulted providers were acupuncturists (37%), who were more likely to be used than infertility counsellors or urologists.
- About one in four consulted a naturopath.

The "other" category included: traditional Chinese medicine practitioner, homeopath, genetics counsellor, social worker/psychologist/counsellor, massage therapist/Reiki practitioner, nurse practitioner and nutritionist.

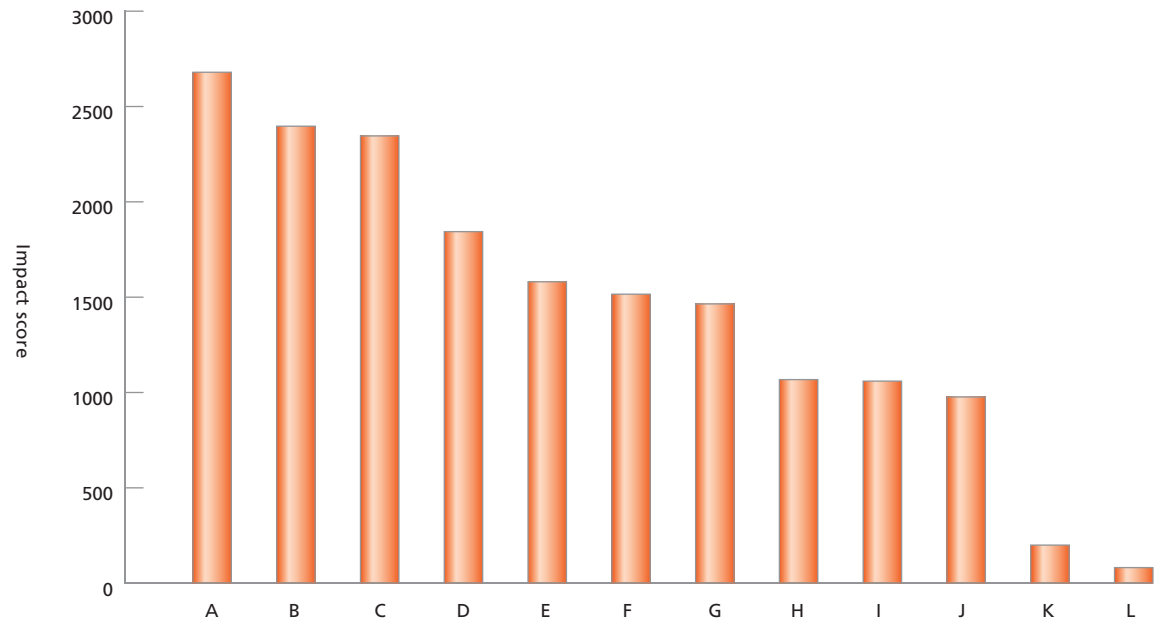


Respondents said the most helpful services/supports were infertility and other specialists and Internet information.

Respondents said the main challenges they faced were the cost of assisted reproduction services, emotional hardship, the cost of fertility drugs and problems taking time off work.

Note: In the chart below, for the purposes of simple comparison, a response of "Great Impact" was given a weight of two, a response of "Some Impact" was given a weight of one.

		Great Impact	Some Impact	Total "Score"
A	The cost of assisted reproduction services	1239	201	2679
B	Emotional hardship caused by treatments	1021	354	2396
C	The cost of fertility drugs	1025	295	2345
D	Problems taking time off work for tests and treatments	624	595	1843
E	Physical hardship caused by treatments	507	566	1580
F	Wait time to see a specialist	496	523	1515
G	Lack of emotional support	475	514	1464
H	Lack of information about assisted reproduction options	283	501	1067
I	Problems being referred to a specialist who could help	327	405	1059
J	Distance to a specialist who could help	320	336	976
K	Cultural reasons	59	81	199
L	Lack of information/resources in appropriate language	24	33	81



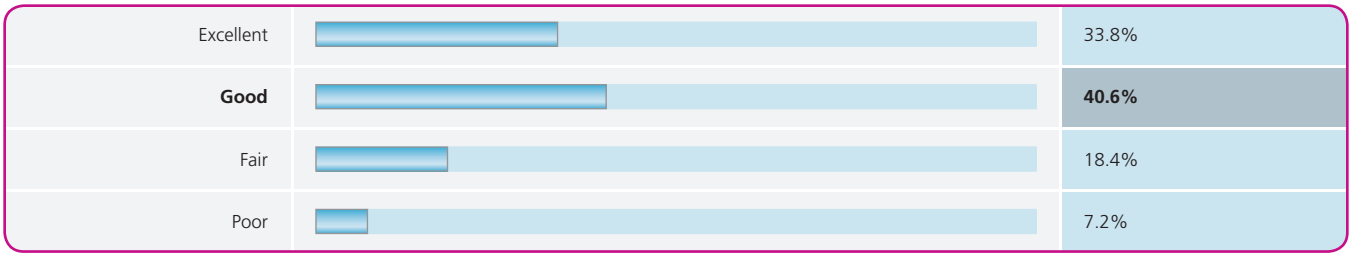
In terms of the comments, the challenges or negative aspects mentioned most frequently were:

- Cost (72 specific mentions out of 459 comments).
- Poor or impersonal communication with doctors, clinicians and social service workers, lack of support (54).
- Emotional pain (51).
- Procedural mistakes or perceived concerns about the competence of the physician (37).
- Time-related issues (e.g., wait times, time to drive to treatment) (29).
- Physical pain (21).
- Other issues mentioned at least five times were "dealing with family/colleagues," "unfairness of subsidy system" and "unavailability of service."
- Treatments either unavailable or inferior in Ontario (9).

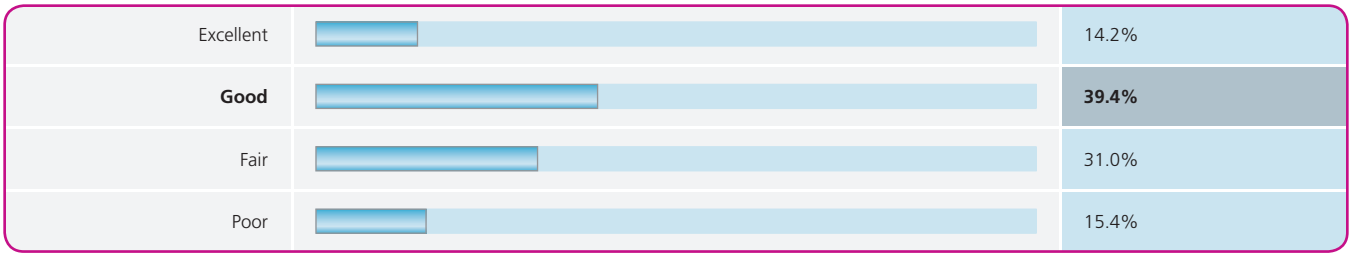
The quality of assisted reproduction services is rated, on average, as "good", and the overall experiences with assisted reproduction as between "fair" and "good."

- About 5% of respondents conceived quickly and were very positive about their experience.
- About 10% were completely positive even though they took a very long time to conceive or had not yet conceived.
- Quality of care was seen as inconsistent. It is not easy for patients to find information on clinic success rates or other quality indicators.
- Ontarians would like to see more consistency and more accountability in clinics.

Quality of Assisted Reproduction Services:

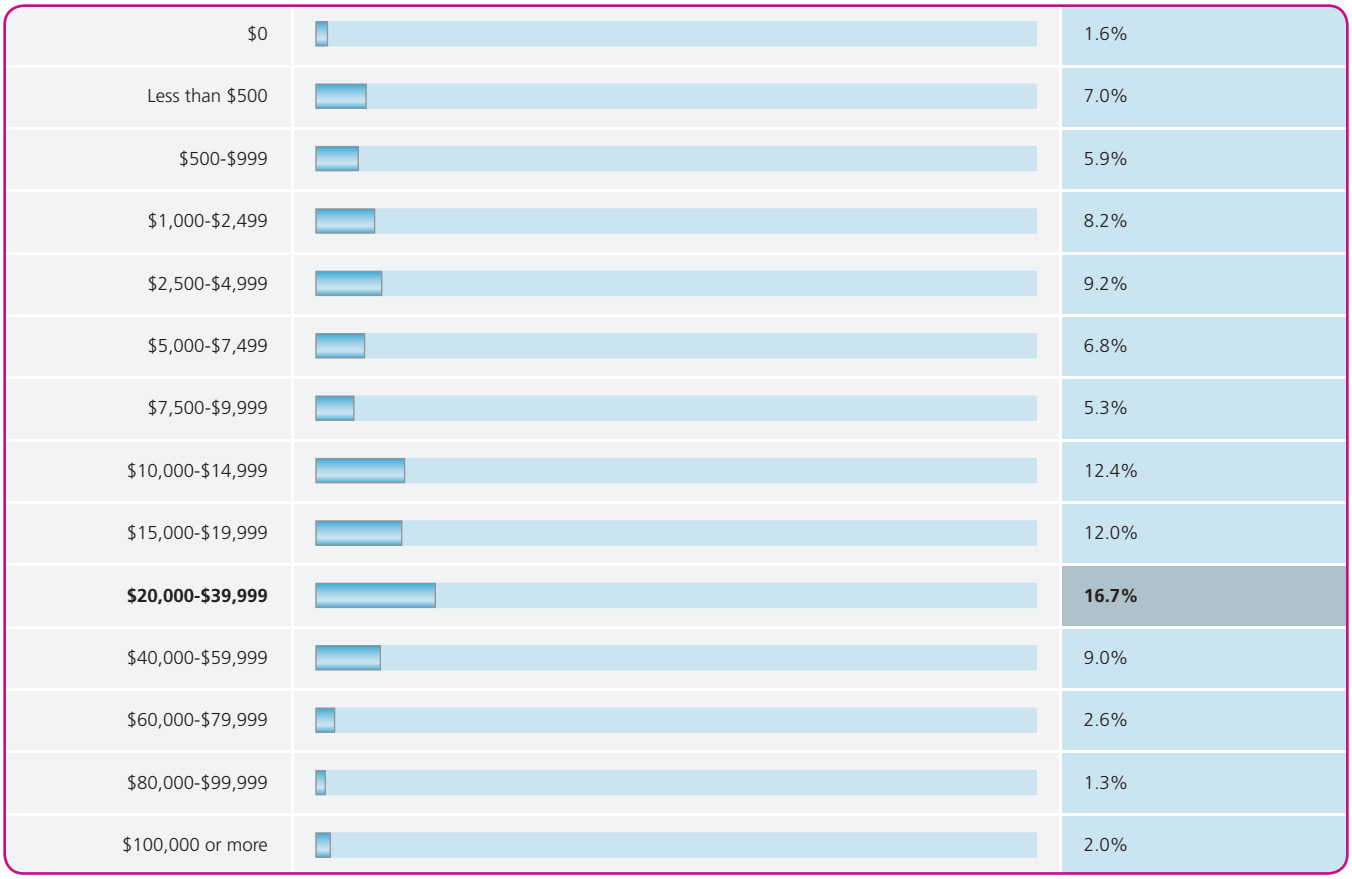


Overall Experience:



Respondents told us cost is a barrier. It puts extreme stress on individuals and relationships.

Of the 1,594 people who answered this question, more than half spent more than $10,000 on treatments and about 15% spent more than $40,000.



- Respondents want more funding for assisted reproduction services and for "alternate" procedures (e.g., acupuncture, naturopathy, massage, etc.) as well as mainstream procedures.
- About 90% of the comments (i.e., more than 800 comments) mentioned that OHIP should cover some or all costs of assisted reproduction.
- Many respondents felt that funding rules/policies are inequitable.
- Respondents reported that drug costs are higher in Canada than in other countries.

The process is emotionally devastating and there is little access to emotional support.

Most respondents commented about how emotionally difficult and often stigmatizing the experience was, and how difficult it was to find emotional support.

The attitude of providers is crucial.

- Respondents said that when providers are supportive and respectful, it makes a significant difference for people using assisted reproduction services.

Same-sex respondents felt their options were limited, and their concerns unrecognized.

About 3% (54/1,890) of people who completed the infertility survey identified themselves as being in a same-sex relationship (married or common-law). Of those 91% were female and almost one in four was between the ages of 35 and 39.

About 22% of same-sex respondents reported having fertility problems (e.g., low sperm motility, blocked fallopian tubes). Respondents told us that when same-sex couples do have fertility problems, it may take time for the problem to be diagnosed because neither they nor their providers expect them to have fertility issues.

The proportion of same-sex couples (45%) who reported using in vitro fertilization was relatively high.

In terms of the challenges they faced trying to use assisted reproduction services to conceive, responses were similar between same-sex couples and other respondents. The main barriers were cost and emotional hardship. In addition, respondents identified the heterosexual nature of the clinics and the focus on "infertility" rather than the need for "assisted reproduction" – which can mean that services are not sensitive to the needs of same-sex couples.

In terms of resources that were helpful, same-sex respondents said it was useful to have information and services explicitly tailored for same-sex couples. Despite feeling that their concerns were not recognized, same-sex couples were slightly more satisfied with the quality of assisted reproduction services compared with the overall survey respondents.

Few respondents had access to supportive workplace policies, such as time off to attend appointments, and most respondents did not have drug plans that covered fertility drugs.

- The stigma associated with infertility and concerns about job security can prevent people from asking for or using company benefits.
- The most helpful benefits were extended health benefits, flexible work hours, the company's drug benefits and time off to attend appointments.
- Individual managers were often supportive and helpful – even in the absence of formal company policies.

According to respondents, the public sector was generally more supportive than the private sector, but still does not cover everything.

Travel and travel costs were issues for a number of respondents who do not live near clinics.

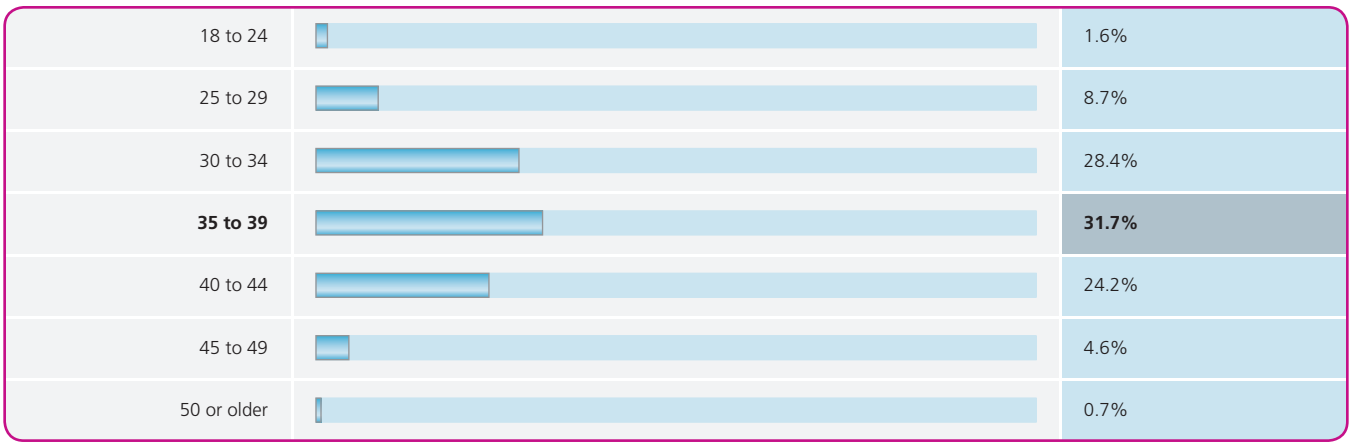
Respondents thought more education and information are needed.

- The public should be more aware of the factors that contribute to infertility and the emotional and financial issues that infertile couples face.
- There should be more information provided for people using assisted reproduction services.

WHAT RESPONDENTS TOLD US ABOUT ADOPTION SERVICES

Over half of the respondents who completed the full questionnaire had successfully adopted at least one child.

- Most were between the ages of 30 and 39 when they adopted their first child.



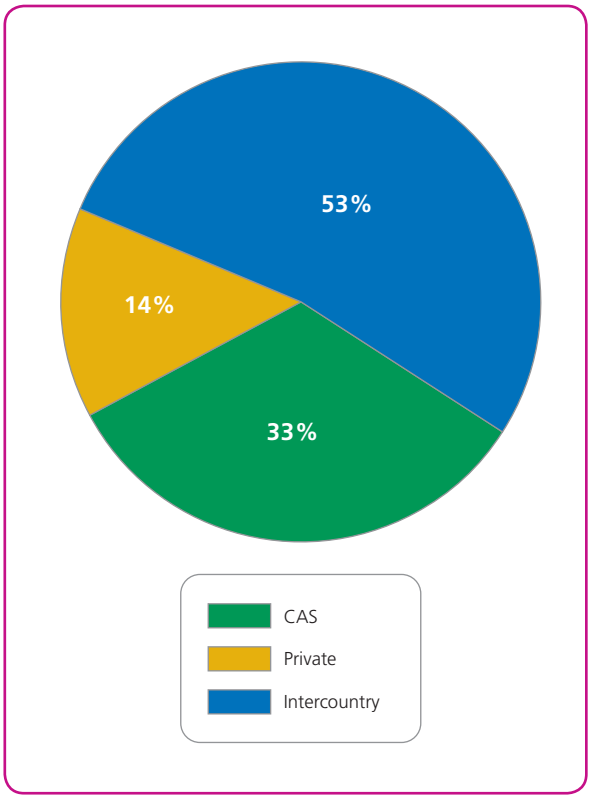
- Most were heterosexual couples.
- One in 10 was single, divorced or widowed.
- One in 20 was a same-sex couple.

Most children (84%) adopted by respondents were under three, and 71% were under one year of age.

- Almost no respondents had adopted a child over age seven.

Most respondents adopted through intercountry services (313 children).

- Through children's aid societies: 196 children.
- Through private domestic: 82 children.
- Almost all adoptions were finalized within three or four years of first contacting an adoption service; the average wait time was one to two years.



The adoption system that respondents chose depended on perception and philosophy.

Perceptions/reasons for choosing intercountry adoption:

- Faster.
- More certain.
- More likely to adopt a healthy infant.
- More likely to be able to adopt.

Perceptions/reasons for choosing private domestic adoption:

- More likely to be able to adopt a newborn.
- Lower costs than an intercountry adoption.
- Frustration with the public system.

Perceptions/reasons for choosing public adoption:

- Prohibitive costs of private and intercountry adoptions.
- More personal matching system.
- Believed in mandate of CAS to help children who need families here.
- Overseas adoption not an option for same-sex couples.

The relationship with the adoption social worker/practitioner affected the adoption experience in all three systems.

- Generally, respondents who used private domestic or intercountry systems found their adoption practitioners more helpful than those who adopted through CAS.
- Both single individuals and same-sex couples noted their relationship with their social worker was particularly important, with some suggesting their worker was particularly supportive and respectful to their lifestyle choice, and others indicating that they felt bias during the process.

Respondents who adopted through CASs would like more post-adoption supports.

- They are more satisfied with subsidies for special needs children than supports.
- They would like more ongoing support for families and more support addressing mental health needs.

All types of adoption services are viewed as time-consuming.

Respondents told us the two greatest challenges in adopting through a CAS were the time it took to adopt and the emotional hardship. Respondents who adopted through the private system said emotional hardship was the greatest challenge, followed closely by the time it took to adopt. For those who used intercountry adoption, both "time" and "complex process" were significant challenges.

Same-sex and single adoptive parents can face unique barriers.

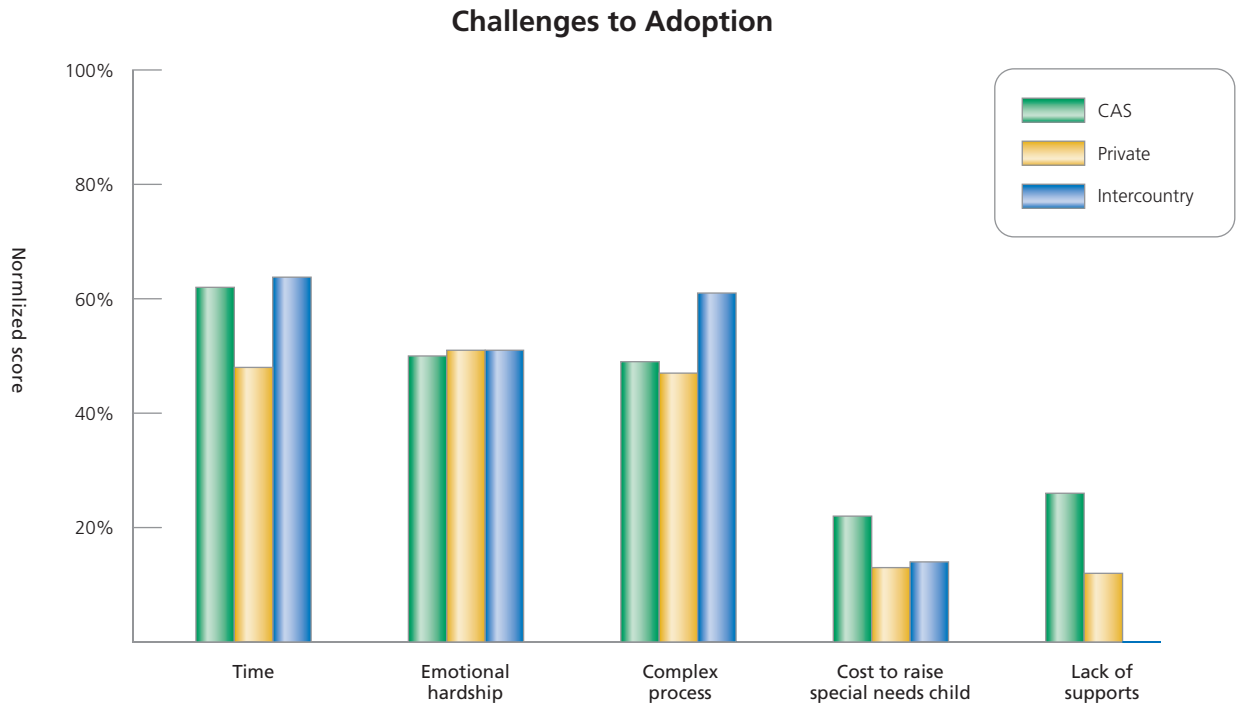
While same-sex or single individuals generally had experiences similar to heterosexual couples, some systemic barriers were noted, in particular about intercountry adoption. In these cases, respondents noted that the rules in other countries meant that they had fewer adoption choices. Similarly, some same-sex or single respondents noted that perceived bias by some workers in the public system meant the process either took far longer than it should have, or they simply were not chosen as a potential match.

Note: In the chart below, for the purposes of simple comparison, a response of "Great Impact" was given a weight of two, a response of "Some Impact" was given a weight of one.

CAS (293 respondents)	**Great Impact**	**Some Impact**	**Total Score**	**Average Score**
Time it took to adopt	147	67	361	62%
Emotional hardship	104	83	291	50%
Complex process	104	81	289	49%
Cost to raise a special needs child	48	33	129	22%
Lack of information/services/support in raising a child with special needs	59	34	152	26%

Private Domestic System (166 respondents)	**Great Impact**	**Some Impact**	**Total Score**	**Average Score**
Time it took to adopt	61	38	160	48%
Emotional hardship	67	34	168	51%
Complex process	55	45	155	47%
Cost to raise a special needs child	16	12	44	13%
Lack of information/services/ support in raising a child with special needs	13	13	39	12%

Intercountry Adoptions (381 respondents)	**Great Impact**	**Some Impact**	**Total Score**	**Average Score**
Time it took to adopt	218	93	529	69%
Emotional hardship	134	120	388	51%
Complex process	175	115	465	61%
Cost to raise a special needs child	39	25	103	14%
Lack of information/services/ support in raising a child with special needs	N/A	N/A	N/A	N/A



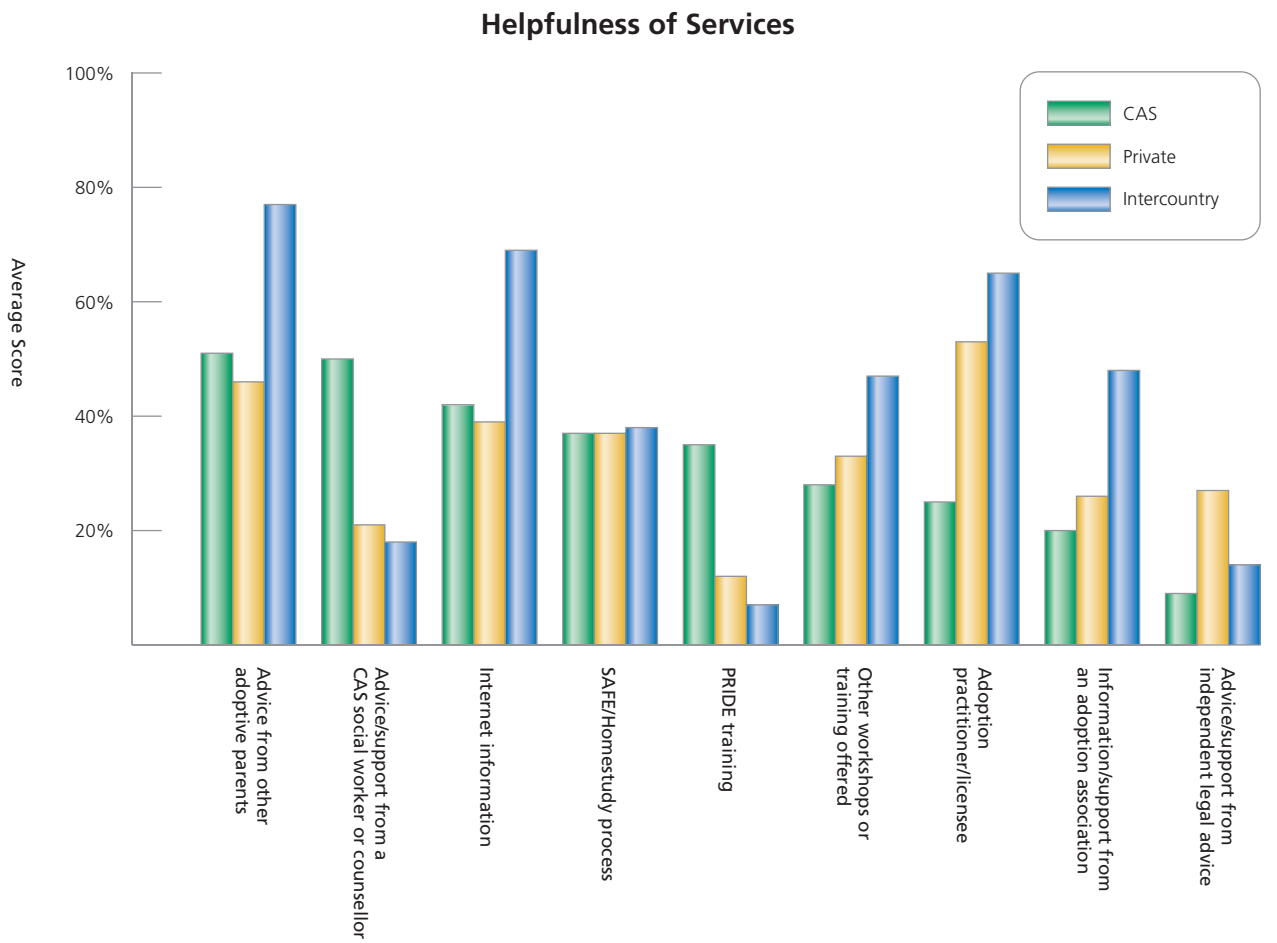
Support is helpful when adopting.

Respondents – particularly those who adopted through an intercountry adoption service – found advice from other adoptive parents very helpful. The people who completed the survey also told us that advice and support from social workers and adoption practitioners were important. People who used intercountry adoption services found the Internet helpful, while people who adopted through CASs found the PRIDE training more helpful than those who adopted through non-CAS adoption services.

CAS (260 respondents)	**Great Impact**	**Some Impact**	**Total Score**	**Average Score**
Advice from other adoptive parents	92	79	263	51%
Advice/support from a CAS social worker or counsellor	99	61	259	50%
Internet information	53	110	216	42%
SAFE/Homestudy process	59	72	190	37%
PRIDE training	60	62	182	35%
Other workshops or training offered	51	43	145	28%
Adoption practitioner/licensee	53	22	128	25%
Information/support from an adoption association	33	36	102	20%
Advice/support from independent legal advice	13	19	45	9%

Private Domestic System (130)	**Great Impact**	**Some Impact**	**Total Score**	**Average Score**
Advice from other adoptive parents	46	28	120	46%
Advice/support from a CAS social worker or counsellor	24	7	55	21%
Internet information	31	40	102	39%
SAFE/Homestudy process	34	27	95	37%
PRIDE training	12	8	32	12%
Other workshops or training offered	35	15	85	33%
Adoption practitioner/licensee	60	18	138	53%
Information/support from an adoption association	20	28	68	26%
Advice/support from independent legal advice	28	13	69	27%

Intercountry Adoptions (343)	**Great Impact**	**Some Impact**	**Total Score**	**Average Score**
Advice from other adoptive parents	232	63	527	77%
Advice/support from a CAS social worker or counsellor	48	26	122	18%
Internet information	181	109	471	69%
SAFE/Homestudy process	80	99	259	38%
PRIDE training	17	12	46	7%
Other workshops or training offered	115	95	325	47%
Adoption practitioner/licensee	179	88	446	65%
Information/support from an adoption association	125	80	330	48%
Advice/support from independent legal advice	34	28	96	14%



Most adoptions were completed within two years.

Most respondents who were successful in adopting were able to complete their adoption in two years or less. Although many people who chose an intercountry adoption did so because they thought it would be faster, the data show that adoptions through a CAS were often as fast or – in some cases – faster to complete for respondents.

Years to Adopt	CAS	Private Domestic	Private Intercountry
Less than 1	32%	50%	16%
1 - 2	49%	46%	69%
3+	19%	4%	15%
TOTAL	100%	100%	100%

According to respondents, there was a significant difference in cost between the different adoption services.

The average costs of adoption reported in this survey were as follows:

	CAS	Private Domestic	Private Intercountry
Home Study + PRIDE	$301	$1,852	$1,775
All other costs	$350	$12,140	$23,474
TOTAL	$651	$13,992	$25,249

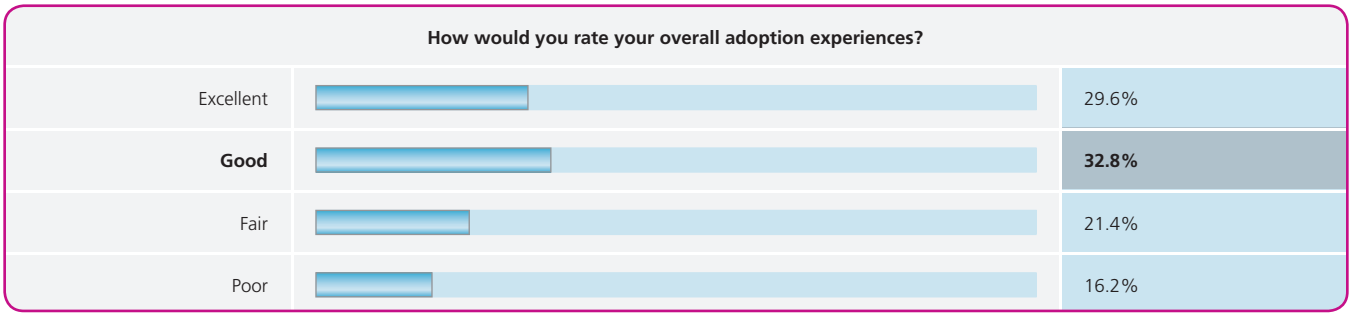
About one-third of respondents had some workplace supports, such as flexible work hours and paid adoption leave.

In general, respondents either didn't have access to supportive workplace policies or they did not find the supports available very helpful.

- Just over 40 respondents who adopted through a children's aid society reported receiving some subsidies or supports.
- Respondents who did receive subsidies found them helpful – although many noted that they were hard to get and did not adequately cover the costs associated with a special needs child.
- Respondents tended to be less satisfied with the support services available for children, mainly because of wait times or lack of services.

About two of every three respondents rated their overall adoption experience as good or excellent.

Although most respondents commented about how difficult and frustrating the adoption process was, almost two-thirds said the experience was good or excellent.



ONLINE SURVEY

KEY FINDINGS FROM THE ONLINE SURVEY OF PROVIDERS, ADOPTEES, DONOR-CONCEIVED PERSONS AND THE PUBLIC[2]

WHO PARTICIPATED IN THE SURVEY?

- 115 service providers: 34% were assisted reproduction service providers and 66% were adoption service providers (of whom 41% worked for a CAS and 59% were private practitioners).
- 63 adoptees (of whom 81% were adopted through a CAS, 14% through private adoption in Ontario or Canada and 2% through intercountry adoption (3% did not know).
- Nine donor-conceived persons.
- 102 members of the public.

THE PROVIDER PERSPECTIVE

Ontario has highly skilled, effective assisted reproduction services but barriers – such as cost, lack of awareness and inequity of access – prevent Ontarians from using these services.

According to assisted reproduction service providers, Ontario has highly skilled and knowledgeable practitioners and the technologies are improving. As a result, more people are conceiving successfully. Some felt that having legislation such as the federal *Assisted Human Reproduction Act* to regulate services was a strength, while others felt that it made it more difficult for people to access services. Several also noted that the regulations have not been developed and the Act is not yet enforced.

Although some assisted reproduction services – particularly diagnostic services – are publicly funded, the main weakness or barrier (according to providers) is the high cost of assisted reproduction treatments.

Providers also feel there isn't enough information about fertility: people don't realize that they have a small "window of opportunity" to access assisted reproduction services when they are more likely to be effective.

To improve services and access to services, providers suggested:

- Public funding of services.
- Education about fertility.
- An independent way to verify clinic success rates.
- More training/certification of counsellors.
- A stronger regulatory environment and the ability to track treatment outcomes.
- More research on the causes of infertility.

[2] It should be noted that the opinions/information provided through the surveys are those of respondents/participants who do not necessarily represent the population as a whole.

Ontario's public adoption services have skilled, dedicated workers but not enough resources to meet needs.

According to adoption service providers who work for a CAS, the strengths of public adoption services include:

- Dedicated, experienced, skilled workers.
- A strong focus on meeting the needs of the child, especially children with special needs.
- The availability of post-adoption supports for families.

A number of providers also identified the SAFE homestudy and PRIDE training processes as strengths, although some thought the programs were too long and too intrusive.

Having said that, CAS providers also told us that they don't have enough resources to do the job they want to do. To strengthen public adoption services, they would like to see:

- More post-adoption supports.
- More resources, particularly to find homes for older children and children with special needs.
- More funding for adoption services overall, and a change in the way services are funded to encourage adoption rather than keeping kids in care.
- Smaller caseloads.
- Less bureaucracy.
- Faster court processes to make children available for adoption.

With more resources, providers think they could reduce the time it takes to complete an adoption.

Some CAS providers are concerned that existing approaches lead to an adversarial attitude to both birth parents and adoptive parents, as well as discrimination against minority groups.

CAS providers also think public adoption services would benefit from more focus on providing services and less on "protecting turf", better public relations and more consistency between jurisdictions.

Ontario's private domestic and intercountry adoption services have skilled, dedicated workers, but their services are costly.

According to providers who facilitate private domestic and intercountry adoptions, the strengths of these two services include:

- Dedicated, experienced, skilled workers.
- Flexible, creative and personalized services.
- More choice for parents.
- Lack of bureaucracy.
- A focus on working in the best interests of the child.

The weaknesses identified were the costs incurred to adopt, the increasing amount of administrative work required and the lack of collaboration between public and private adoption services (e.g., lack of sharing of completed homestudies).

THE ADOPTEE PERSPECTIVE

All the adoptees who completed the survey had been adopted at age three or younger, and the majority were adopted as infants. Most were happy to have been adopted, although a few were opposed to adoption.

Most seemed to have been drawn to the survey because of their interest in the recent Ontario legislation to open records from past adoptions. The majority were in favour of disclosure and identified lack of openness as the main weakness in Ontario's adoption system, but a small group were against disclosure.

THE DONOR-CONCEIVED PERSPECTIVE

Respondents ranged in age from 20 to 38, with an average age of 28. The small number of people conceived through donor eggs or sperm who responded generally felt that the secrecy surrounding third party reproduction was a weakness. A number felt they didn't "fit" in their family and wanted to know more about the donor as part of understanding their own identity, personality and biology.

Many did not learn until they were older that they were donor-conceived, and they described finding out as a "shock." Some identified concerns about not knowing their donor's identity.

THE PUBLIC PERSPECTIVE

Members of the public were asked what Ontario could do to improve access to adoption services and assisted reproduction treatments. For both adoption and assisted reproduction, the public identified cost as the main barrier. Seventy-nine of the 102 people who responded (78%) said that OHIP should cover some or all of the cost of assisted reproduction treatments. Some suggested making adoption costs tax deductible.

To improve access to services, the public also suggested:

- More information/advertising for young women about their fertility, and for the public about fertility problems and treatment options.
- More widespread fertility clinics.
- Earlier fertility testing.
- Changes to the federal *Assisted Human Reproduction Act* to reduce barriers to third party reproduction.
- More psychological support and counselling for couples going through assisted reproduction.
- Making it easier to adopt (i.e., reducing training requirements, the number of forms, and the frequency of updating homestudies and background checks, as well as giving adoptive parents the same maternity leave as other parents).
- Allowing families to pursue fertility treatments and adoption at the same time.
- Hiring more social workers to work in adoption services.
- Establishing a database of families who want to adopt.
- Establishing one agency with information on adoption and the children available for adoption in Canada.

There was also a small number of members of the public who were opposed to assisted reproduction. None was opposed to adoption, but a very small number noted that it was important for adoptive parents to be able to understand the adopted child's perspective.

INTERVIEWS

INTERVIEWS

KEY FINDINGS OF THE INTERVIEWS[3]

One hundred and six interviews were conducted. Seventy three participants were recruited from the panel's online survey and 33 from referrals by expert panel members. A total of 83 interviews were conducted over the telephone and 23 were conducted in-person.

Of the 106 interview participants, 78 shared their experiences with the infertility system, 39 shared their experiences with the adoption systems and seven shared their experiences with foster parenting. Most interview participants (89%) were between 30 and 45 years old. Most people (90%) who answered the infertility questions were married, 7% were in common-law relationships and 3% were single. Of those who answered the adoption section, 92% were married, 5% were in common-law relationships and 3% were single. Of the 106 interviews, three were conducted with participants who were in same-sex relationships.

Fertility

When asked what triggered their decision to seek fertility services, almost all interview participants said they realized there may be an issue when they were unable to get pregnant after about eight months. The majority indicated that they had tried conceiving naturally for about one year before deciding to seek medical help. More than half became concerned about their fertility after the age of 30. One-third reported unexplained infertility, one-third reported male factor infertility, and one-third reported female factor infertility.

Participants were generally unaware of fertility issues prior to experiencing infertility. Those who indicated they were moderately aware said this was because either they or a family member worked in a health care field or they had friends or family who had experienced infertility. Almost all participants said they had not received any information on fertility at school. Few discussed fertility issues with their immediate families before seeking treatment. Very few participants said a primary health care provider had asked if they wanted to discuss fertility issues prior to their mentioning a desire to have children. Many had received counsel from their general practitioner on birth control but not on fertility issues. More than half of the interview participants said they were never concerned about fertility before attempting to have children. Most of those who said they had been concerned about fertility before attempting to have children were aware because they had existing health problems.

Participants consulted a wide range of health care professionals and used a wide range of treatments. Many used multiple treatment options and several had had surgeries. Acupuncture was a popular therapy among infertility patients, but mostly as a stress-reliever, and as an indirect way to help get pregnant through improving general physical and mental health.

Among participants who had undergone assisted reproduction services, about one in four were successful in having one or more children. About 35% said their treatments had thus far resulted in no successful pregnancies. Five women disclosed that they were currently pregnant as a result of using assisted reproductive technologies. About one-third of the women interviewed disclosed that they had miscarried after becoming pregnant with the aid of assisted reproduction services.

[3] It should be noted that the opinions/information provided through the surveys are those of respondents/participants who do not necessarily represent the population as a whole.

Many respondents said they had considered stopping the treatment process at one time. The top two reasons for making the decision to stop treatment were costs and emotional exhaustion. Many said they were "lucky to have good jobs," but the costs of testing, procedures and drugs severely impacted their lives, and disrupted long-term financial planning.

All participants felt OHIP should cover assisted reproduction services, at least in part, based on a view that infertility is a medical issue and not a lifestyle choice. Several suggested the government could cover three rounds of IVF and most felt health insurance plans should cover the cost of drugs and counselling.

Participants noted inconsistencies and significant discrepancies in costs of treatments across clinics and geographic locations. Several said that they had been counselled by the clinic to go straight to IVF treatment without having testing done first, which they believed was financially motivated on the part of the doctors, the clinic and the industry in general. Several participants said the costs have prevented them from expanding their family, as they simply could not continue the costly treatment process for financial reasons.

About 65% of interview participants indicated that they had received some kind of financial assistance (for treatments, drugs, etc.). Several participants questioned why OHIP covers three cycles of IVF treatments for women with two blocked tubes, but does not cover the treatments when the cause is male factor infertility or other female factor infertility.

Many participants cited the financial impact of time off work to undergo treatments, testing and monitoring. Participants felt the effect of the treatment process on their jobs and careers was both financial and psychological. Only about half said their employer was aware that they were pursuing assisted reproduction services, and a majority of this group said that their employer was accommodating – for example, giving them a more flexible work schedule and time off for medical appointments.

Interview participants said infertility is an extremely devastating experience and one of the most difficult they have had to endure. The ups and downs of the treatment process are very challenging. Participants consistently stated that the process is extremely stressful and affects every relationship in their life, with their partner, their family and their friends.

Participants disclosed that the financial burden of infertility treatment also causes a huge stress on a marriage or partnership, especially if one person is more determined and committed to having a biological child through assisted reproductive treatments than the other.

Most interview participants said the general lack of public education and the stigma attached to infertility are significant contributors to the feelings of isolation and sadness. Almost all participants recommended a public education campaign on infertility to educate people about the prevalence of infertility in society and to help dispel the stigma associated with infertility.

About half the respondents indicated they had sought counselling to deal with their emotional concerns, and almost all participants said having someone to talk to about their situation would be very helpful. Seeking professional counselling was not an option for a number of participants because of the costs involved. Participants found online support groups and discussion boards helpful in dealing with the emotional impact of infertility, and these were also useful resources for information on treatments, clinics and doctors.

Given that the system is inconsistent in terms of costs, testing and accessibility of treatment options, most respondents felt the industry should be regulated. People wanted standards for testing and treatments, as well as mechanisms for tracking and reporting of success rates. Some respondents wanted honest counsel on when to stop treatment, rather than having clinics give them false hope. Others raised concerns about the long-term impact of fertility treatments and drugs on women and children.

Some participants mentioned egg/sperm donation and surrogacy as options for people struggling to build their family. Participants suggested there was a lack of understanding of the legislation regarding these options, and said they would like Ontario to lift restrictions on egg/sperm donation (although this issue resides within the federal jurisdiction, the interviewees were not aware of the distinction). A few said they sought treatment in other countries which allowed access to donor eggs and sperm.

Participants felt a great deal of effort should be invested in educating doctors, providers and the general public about infertility. They pointed out the need to educate the public about infertility and its prevalence in society, and to educate employers and human resources professionals about the time and emotional demands of assisted reproduction services. To support education about fertility, they felt the government should develop a centralized place where people can get information about infertility and assisted reproduction services (such as statistics, clinics, doctors and treatments).

About half the participants indicated they had considered adoption as an alternative to assisted reproduction services, but mainly as an option if their treatments failed. Most said they chose to pursue assisted reproduction services over adoption because they believed it would be faster and easier and that they would have more control over the process. Some said they had to choose between one more cycle of IVF or starting the adoption process, as they were financially unable to do both.

Listed below is a summary of suggestions and ideas provided by interview participants to inform the recommendations of the expert panel:

- Recognize that infertility is a medical condition.
- Fund assisted reproduction services under OHIP.
- Eliminate inequities in the system.
- Regulate the providers of assisted reproductive technologies to improve accountability.
- Train more doctors and open more clinics.
- Educate to improve awareness and remove stigma.
- Provide early testing and screening.
- Fund counselling and other services to provide emotional supports.
- Set clear rules on assisted reproduction services including embryo transfers, donor eggs/sperm and surrogacy.

Adoption

Most respondents who discussed their experiences with Ontario's adoption system said their desire to adopt a child was directly related to their inability to conceive naturally or through assisted reproduction services. Several said they had adopted after years of being foster parents. Some respondents, however, said they had adopted after already having had biological children. Three interviews were conducted with gay/lesbian couples with adopted children. Most respondents were between the ages of 35 and 45

when they adopted their first child. Several had spent years in the infertility system before considering adoption. Most respondents (90%) were married when they first adopted a child.

Initially, more interview participants were interested in adopting through the international system (44%), followed by the public system (33%) and the private system (23%).

- Those who expressed initial interest in international adoption did so because they felt the wait time would be shorter and there would be more structure and certainty.
- The main factor for those who initially expressed interest in the public adoption system was that the costs were minimal.
- Those whose initial preference was to adopt through the private system cited reasons, such as: they did not wish to adopt a child with special needs, they had concerns about long wait times in the public system, or they believed the private system offered the best chance of adopting an infant.

Depending on the system they used, participants' experiences with adoption varied substantially in terms of wait times for adoption, age of adopted children, needs of the children, costs and knowledge and helpfulness of the social workers. While individuals' experiences varied considerably, participants felt there is much higher certainty of getting a child through adoption compared with assisted reproduction services. About 46% of respondents used the public system, 39% used the international system and 31% used the private system.[4]

For those who used the public system, it took an average of just less than two years between the first inquiry into adoption until the finalization of the public adoption. The age of the adopted children was, on average, just under three years old. Peoples' experiences generally depended on a range of factors, including the local children's aid society (CAS) and their individual social worker, their personal situations and the expectations they brought to the public adoption process.

Some interview participants said they had very good experiences with the public system, including short wait times and great social workers. Several of these individuals, however, had hired private adoption practitioners to help them navigate the local CAS process and to act on their behalf as an advocate within the system. The majority of participants who used the public system admitted to being frustrated. Several described the public system as highly bureaucratic and lacking transparency. In their view, these factors contributed to longer wait times and greater stress on the adoptive parents.

For many respondents, a key issue with the public system was that there was no advocate working on behalf of the adoptive parents. Several noted a lack of resources for the local CAS, in terms of staff resources, making better use of modern business practices and tools, and providing Crown wards with a full range of diagnostic tests to identify underlying physical and mental health issues. Some respondents who adopted through different CASs in different cities across Ontario noted there is little consistency within and between each CAS.

For those who used the private adoption system, it took an average of two years between the first inquiry into adoption until the finalization of the private adoption, and the adopted children were about 17 to 18 months old, on average, when the adoption was finalized.

People generally had positive opinions about the private adoption system. They did not have long wait times and felt there was transparency within the system. However, they noted that their experiences depended on the professionals they hired. Also, several participants said they had experienced reversals in the private system, which they described as extremely disappointing and distressing.

[4] Six participants said that they used multiple systems.

Participants provided several comments on the time, effort and money involved in the private adoption system to develop a profile, because of its importance to the birth parent. Respondents also commented on how different agencies competed with each other, and on the lack of coordination between agencies.

Ontario's open adoption legislation was often cited as a reason why people did not pursue private adoptions. Several commented that the possibility of "sharing a child with their birth parent" was very unsettling. Others felt the private system was too focused on the rights of the birth parents, rather than on adoption solutions that would serve the best interests of the child.

Among those who used the international adoption system, it took an average of two years between the first inquiry into the adoption until the finalization of an international adoption, and the children were, on average, just over 18 months old when the adoption was finalized.

Several participants said that they were highly frustrated with international adoption. People reported that the process is expensive and slow, with too much paperwork. Many respondents commented that they did not understand the age restrictions and felt the international system should allow adoption of children older than three years of age.

Regardless of the system used, respondents agreed that adoption is a slow and expensive process, but one which, if successful, is worth the investment. Participants noted their choice of system largely depended on the family's ability to pay. For those who used the private system, adoptions had cost, on average, about $40,000. For those who used the international system, adoption had costs as high as $70,000. Several commented on the discrepancies between agencies in terms of costs, and called for "standardized" fees and processes so they could plan effectively and understand the costs associated with adoption.

Many people took umbrage with the PRIDE training, and several dismissed the program as simply a "money grab." Those who adopted internationally said the PRIDE training had very little value for them as parents of an international child. Many felt the SAFE home study was intrusive and it violated their privacy rights.

Most respondents noted that adoptive parents only have nine months of parental leave, while birth parents have 12 months. Several noted that it takes a great deal longer to bond with an adoptive child than a birth child, so the parental leave should be at least 12 months or longer, particularly if the adoptive child is older or has special physical, medical or emotional needs. Parents of internationally adopted children noted there can also be a language barrier that must be overcome, making it critical to have parental leave that is long enough for the child to be well-grounded in the home.

Many participants commented on the lack of government oversight for CASs as a whole, and they recommended that there should be increased monitoring. Several expressed frustration at not being able to complain about the lack of information, contact and follow-up because there was no complaints process in place.

Several participants said they had transitioned from assisted reproduction services to the adoption system and were still dealing with the social, emotional and physical challenges from the assisted reproduction process. Some were told they had to choose between assisted reproduction services and adoption, with social workers stating that prospective parents were "not allowed" to be involved in assisted reproduction services when considering adoption. Others found the scrutiny of the home study difficult to take after the disappointment of failed assisted reproduction services.

Adoptive parents made a number of suggestions to guide the panel's recommendations on improving access to adoption services in Ontario, which are summarized below.

- Change Ontario tax credits to cover more of the adoption costs and better publicize the credits.
- Standardize the fees for private adoption agencies.
- Open up international adoption to children older than three years of age.
- Provide distance learning options for PRIDE training.
- Appoint a body to oversee all CASs, with a complaints process and advocacy arm for adoptive parents, and add a public information role.
- Speed up the adoption process.
- Provide more parental support during the adoption process.
- Provide more notice for adoptive parents (from the time a child is available until he or she has to be picked up).
- Lobby the federal government to provide adoptive parents with 12 months of Employment Insurance (EI) parental benefits.
- Develop a PRIDE training program for parents of internationally adopted children.
- Re-examine the SAFE home study to ensure that privacy and personal sensitivities are being protected.
- Provide more CAS staff and resources, and ensure more transparency.

Fostering

All participants agreed that being a foster parent was generally a very good experience, although some said they were sometimes frustrated by the CAS. Most participants said that what motivated them to want to be foster parents was a desire to help a child in need, as well as the goal of public adoption. The decision to be a foster parent was often in response to infertility.

Some foster parents only had one foster child (because they intended to adopt). Others fostered many more. The age of the foster children ranged from newborn to 18 years old. Foster parents had children in their home for as little as one week and as long as many years.

Asked about what supports should be available for children in their care, participants commented that psychological services should be more readily accessible through the CAS, including mental health and social support groups. One noted that there are no services that diagnose or support children with fetal alcohol spectrum disorder and there is a lack of understanding of this disorder in the system.

On the financial side, a few participants commented that if adoption subsidies were uniform across the province and at the same level as what foster parents receive, there would be more foster parents adopting the children in their care. The participants indicated the reasons for not adopting the children they are caring for in foster care were mostly financial.

Foster parents made a number of suggestions to guide the panel's recommendations on improving access to adoption services in Ontario, which are summarized below.

- To provide for better continuity, children should stay with the same foster family.
- The goal of the foster system should be the adoption of the children.
- More support should be provided for foster parents who want to adopt the children in their care.

- Foster parents should be asked to provide input when determining what is best for the children with regard to adoption.
- A centralized CAS should be created to monitor other agencies so they better manage resources and address the needs of the children.
- More social workers should be recruited and trained.

SURVEY OF CHILDREN'S AID SOCIETIES

SURVEY OF CHILDREN'S AID SOCIETIES

KEY FINDINGS FROM THE SURVEY OF CHILDREN'S AID SOCIETIES[5]

The questionnaire included qualitative questions about agency practices/procedures, the barriers and obstacles that CASs face in working in adoption and suggestions for improving the province's adoption system. A number of quantitative questions were also included in the survey. CASs were asked to provide some data on children in care and adoption-related activities.

RESPONSES

Twenty-one CASs responded to the questionnaire, representing 41% of OACAS member agencies and 39% of all CASs in the province. Fifteen of the 21 respondents provided data estimates.

AGENCY PRACTICES

Recruitment Methods

Roughly half of respondents noted utilizing either the Adoption Resource Exchange or AdoptOntario as a method to recruit prospective adoptive families. Other cited methods included discussing adoption with foster families, maintaining a list of waiting families and using regional "zone" meetings.

SAFE and PRIDE Portability

Six of the 21 responding agencies stated that they accept, with minimal changes, homestudies or parental training administered by a private practitioner. By contrast, five of the respondents suggested that a thorough documentation review, homestudy update and potential PRIDE update would be required.

Similarly, nine agencies stated that they provide families with a signed homestudy upon completion, while 10 other agencies stated they do not provide families with a copy of the homestudy. One other agency stated it provided families with an unsigned copy of the homestudy, and one other did not respond.

Best Practices

The most common best practices cited by agencies included collaboration within agencies between child protection and adoption workers in order to assist with concurrent planning (five agencies), early permanency planning (five agencies) and the provision of subsidies for older or special needs children (four agencies). Other responses included the use of "zone" consultations, reviewing existing Crown ward access orders and utilizing the Adoption Resource Exchange.

Barriers

The most commonly cited barrier was delays in the court process, which was mentioned by over half of the responding agencies. Seven agencies also mentioned a lack of funding and/or resources for adoption work, as well as the fact that many prospective adoptive parents only desire to adopt young children. Finally, five agencies stated that there is a lack of direction from the ministry.

[5] It should be noted that the opinions/information provided through the surveys are those of respondents/participants who do not necessarily represent the position/experience of all agencies.

CHILDREN'S AID SOCIETY ESTIMATES

In the questionnaire we also asked agencies to provide some data on adoption-related activities. In cases where hard data were not accessible, we asked for best estimates. As mentioned above, we do recognize that this information is not statistically significant, nor is it representative of all agencies in the province. However, it does provide us with a window on adoption in the reporting agencies that we would not otherwise have had.

The Adoption Process

Most agencies stated they receive five or less inquiries about adoption per month, though two agencies stated they receive over 20 per month. Similarly, most agencies stated they had 10 or less families waiting to start their training and homestudy, although one agency said they had a waiting list of over 85 families waiting to begin the adoption process.

Most agencies said it takes six months or less to begin their training and homestudy, although two noted their wait time was more than 12 months. No agency stated that their waiting list was longer than two years.

Children in Care

To gain some directional insight into whether some of the changes under the transformation agenda were taking hold, agencies were asked to provide information on children who had become Crown wards in April 2007 or later. Responding agencies (n=15) provided data on a total of 1,494 Crown wards who had become Crown wards in or after April 2007.

In total, agencies reported that approximately half of the new Crown wards had access, and half had no access. The range across reporting agencies was quite large, however, with one agency reporting that 21% of Crown wards since April 2007 had no access, and another agency reporting that 69% of Crown wards since April 2007 had no access.

Furthermore, agencies reported that 568 of the new Crown wards had a permanency plan of adoption, corresponding to 83.5% of new Crown wards with no access and 38% of all new Crown wards in total.

Finally, 258 of the new Crown wards were reportedly in adoption probation placements and a further 194 adoptions had been finalized for new Crown wards since April 2007. In addition, agencies reported a total of seven adoption disruptions for new Crown wards.

Placement Options

Agencies were also asked about their use of openness orders, agreements and legal custody orders for Crown wards. A total of three legal custody orders, 14 openness agreements and five openness orders were reported for adoptions of new Crown wards since April 2007.

Children in Foster Care

Finally, agencies were asked to report on the number of Crown wards in foster care who had been in care for three years or more and, of those children, how many had been with the same foster family for at least the last three years. In total, an average of 45% of the children who have been in foster care for three years or more have been with the same family for at least the last three years.

YOUTH FOCUS GROUPS

YOUTH FOCUS GROUPS[6]

CONTEXT

The youth were given an opportunity to respond to the following questions:

- What is your understanding of adoption? Tell us what the term means to you.
- Can you describe what adoption into a permanent family looks like to you?
- When is adoption a good option for Crown wards?
- Would adoption be a good thing if Crown wards had ongoing access to a person close to them and could continue that access after the adoption?
- Do you think it is a good idea for foster parents to adopt their foster children? Under what circumstances would it be a good idea?
- Have you had opportunities to be adopted? Describe your experiences.
- Do Crown wards need services or supports before they can be ready for adoption? If so, please describe them.
- Do Crown wards have ways to express their needs and have their concerns heard in relation to the adoption process? If not, what mechanisms should be available?
- Are there any messages or suggestions that you would like to convey to the panel, based on your personal experience and views, which may inform their recommendations?

The discussion was very active and most participants seemed comfortable sharing their feelings and opinions with the group. Some chose to listen more than speak, but when asked if they agreed with what was being said they said yes.

This report provides a summary and analysis of the input provided by youth during the discussion group.

SUMMARY ANALYSIS

When asked for their understanding of adoption and what the term meant to them, many participants felt that adoption signified *commitment* and led to *permanency*. These two phrases (commitment and permanency) were the dominant theme of the two-hour discussion. Another theme that emerged throughout the discussion was the *sense of belonging* that accompanies commitment and permanency.

Some youth felt that the term "adoption" meant taking the responsibility for a child away from the government and placing it with the adoptive family. One person said, "*As a Crown ward, you dread certain dates but if you are adopted, those "cut off" dates aren't as worrisome because you are supported by your adoptive family.*" Another person felt that adoption was "*peace of mind because you have somewhere permanent to go home to each day.*"

With respect to adoption into a permanent family and what that looked like to the participants, many felt it was "*the best term you can hear because it means long-term and you no longer have to worry about always having to switch places.*" One participant said that adoption "*takes the worry away about where you'll be in a week or two weeks from now.*"

[6] It should be noted that the opinions/information provided through the focus group are those of respondents/participants who do not necessarily represent the population as a whole.

Many felt that *stability* was important, but others observed that it wasn't necessarily about having a stable home, but about having stable and meaningful *relationships* and an environment where someone can build *bonds* and *trust* with individuals.

Others commented that adoption into a permanent family meant being "*included as part of the family versus being in a foster situation.*" Many felt there was comfort in sharing the same last name as the adoptive family.

One person felt adoption into a permanent family meant that "*no matter how difficult things might be, adoptive parents are more likely to stick by you than foster parents who may give up on you when you mess up.*"

Others agreed that, in an adoptive situation, you are not forced to leave home at 18 when you may not yet be ready to be out on your own. That theme was important to this group. Many participants talked about the anxiety of "ageing out" of foster care at 18, and one person commented that what they wanted and needed was a permanent place to *run to* (adoption) versus *run from* (care).

When asked whether adoption was a good option for Crown wards, the group unanimously agreed that it should be dealt with on a case-by-case basis.

There was general agreement with the observation made by one participant that, if a youth has lived with a family for a long time and the youth fits well with the family, then adoption is a good option. Several commented that when adoption is a good option for Crown wards, it should be available as early as possible.

Another person felt that adoption is a good option for youth under the age of 10 who are not going back to their permanent (biological) family.

A large portion of the group felt that Crown wards should be able to be adopted even if they are in contact with their biological family. They felt that open adoption is good, and noted that communication between the biological family and foster family is key.

Several believed that adoption should be open to all ages, because children come into care at different times. One person commented that children should be provided another window of opportunity for adoption before they start high school.

Most participants agreed that the government should continue to be involved in the lives of youth in care who are adopted, by providing the benefits that the youth would have been eligible to receive if still in care. They perceived that potential loss of government benefits was a disincentive for some foster families to consider adoption, particularly families of modest means with their own biological children.

A majority of the group also felt that some foster families do not think about adoption as being an option when fostering older children. Because the adults in their lives do not talk about adoption as being an option for older children and youth, Crown wards also come to think that adoption is not something that is available to them. Most participants said they considered themselves "too old" for adoption and some had even been told this by their social workers and foster families.

One participant commented, "*Everyone wants a baby versus an older child. They think about young children and do not even consider adoption for older children.*" Another said, "*You can love a child at any time, regardless of age.*"

One person said that it is not a good idea to get adopted if the doors are going to be closed for other options, and suggested that supports such as mental health support should all still be available to Crown wards after adoption.

When the participants were asked whether it is a good idea for foster parents to adopt their foster children, they again agreed that it comes down to a case-by-case basis.

Discussion of this topic revolved around foster families needing to be "in it for the right reasons." Participants generally agreed that stability was key and that, when pursued for the right reasons, adoption by foster parents is fine. They suggested that foster families be given more information to make sure they know the commitment they are getting into with respect to adopting a child rather than fostering a child.

Only a few participants in the group said they'd had an opportunity to be adopted, including one participant who said the process had been close to being finalized before the foster parents changed their minds. However, no members of the group had ever formally been adopted, and most members had no experience in this area.

As for services and supports that Crown wards need before they can be ready for adoption, many commented that more information needed to be made available. Several commented that case workers should be focusing on and talking about *permanency* as an option, including adoption, versus preparing Crown wards to live on their own after they reach age 18.

Several participants commented that the system should look at what kind of relationship a Crown ward has with his or her extended family and siblings, and how often contact occurs with the Crown ward's extended family ("how often you speak with them"). They felt that this factor plays a role in adoption in the long run. One participant commented that if you don't have an active relationship with your family, the adoption option should be on the table sooner.

Other services identified by participants included:

- Information on the options that exist for youth, including adoption.
- A youth-friendly website as a place to get reliable information.
- Post-adoption support (i.e., a CAS worker to follow up to see how the progress is going).
- Workers should be better educated on adoption, so they can guide people down that course as an option.
- Support groups for youth in care because they are very helpful and there should be more of them.
- Mentor programs – also helpful.
- Support available during the "transitions" would be helpful, both for youth and for foster families making the transition to being an adoptive family.

The group also felt the government must do more to promote and educate people about fostering and adopting youth in Ontario. Information needs to be accessible to members of the public, so more people know there are kids at home in Ontario who need to be adopted. That way, prospective adoptive parents could pursue adoptions of Ontario children, rather than pursue international adoption.

There was considerable discussion about information that is put in a Crown ward's files. The group felt that in many cases, the information about them contained in the file gave the wrong impression to foster parents or prospective adoptive parents. They felt the government needs to make sure that this information is accurate and correct. One person said, "*Accuracy is important because it can affect you in the long run for adoption, depending on what is in the file.*" Some felt that foster parents or prospective adoptive parents should not be allowed to read the file. Another suggested that reading the file should only occur after the foster or adoptive parents had met the child in person.

Other comments about the files included:

- Get to know youth first. Don't assume they are bad because the file may say so.
- Give youth a chance to defend themselves. The file should not be the final word.
- Not everything in the file should be readily accessible to everyone.
- Foster families should keep a file of how many kids they have fostered and, if those relationships did not work out, an explanation.

When asked about the mechanisms that should be available for Crown wards to express their needs and concerns, a majority felt that focus/discussion groups were helpful. Others felt that the Expert Panel should have included a former Crown ward or adopted youth as a member to gain firsthand insights.

One participant spoke about the need for a book or information materials on "what to expect when you go into care." Participants agreed that more resources like this should be made available to ease the fears many youth have.

Someone suggested there should be an interactive section on the Ministry of Children and Youth Services' website where people can ask the Minister questions and get responses back (similar to what's on the Ministry of Transportation's website).

Many felt that agencies need to realize that youth are not "hand me downs" or "numbers." One participant noted, "*We actually need to be cared for – and in an environment that we'll thrive in.*"

Several commented that social workers need to explore more adoption and permanency options for youth in care ("think outside the box"). Many commented that they wished their workers were more resourceful, compassionate and available. "*The problems in my life don't just happen from nine to five,*" one person commented.

The following list is a summary of the messages and suggestions that the youth group said they would like conveyed to the Expert Panel:

- Every child is different. There should not be a one-size-fits-all approach.
- Find the right place for youth ("*right place for the right person*").
- "*No relationship should start with an expiry date.*"
- Youth in care are not just file numbers – "*We're individuals*" (look beyond the files).
- Promotion and awareness about adopting in Ontario is important.
- Adoption is not the only route to permanency. Permanency should be the overall goal even if it is with a permanent foster family.
- Adoption can be done at any age.
- Permanency is not just planning. Action needs to be taken.

KEY THEMES

Permanency

- For youth, permanency is an important value and highly desired outcome. Achieving permanency and stability for youth in care should be the system's central goal.
- Youth need a sense of belonging. They want a permanent home they can go to – one that they know is there for them.
- More than just a home, youth want permanency in their relationships with adult caregivers – the emotional bond that comes with stable and trusting relationships.
- Adoption is not the only route to permanency. The system should focus on finding "the right place for the right person."

Foster Care is Not Permanency

- Even when they are living within a stable and supportive foster family, youth still feel the need for belonging and permanency. Youth want social workers to continue to pursue the adoption option, even if the youth is in a stable foster care situation.
- Youth agreed the question of whether foster families should adopt the children they are fostering should be made on a case-by-case basis. There are some foster families who are good at providing foster care but do not want to adopt.
- Foster parents should be given enough information and support to make an informed decision about whether to adopt.

Awareness

- Ignorance about adoption as an option for youth is a major barrier.
- Few prospective adoptive parents and youth in care know about adoption. Furthermore, many social workers do not talk about adoption as an option.
- Youth want the government to do more to promote the fact that there are "great kids in Ontario" available for adoption, who can be adopted at any age.
- In addition, there is a need to build greater awareness among social workers and foster families about adoption as an option for older children and youth.

Ageing Out at 18

- For older youth, the system is focused on getting them ready to leave at age 18 and not on seeking permanent solutions such as adoption.
- Youth in care have significant anxiety over "ageing out" of the system at age 18, regardless of whether they are ready to move out and live on their own. They note that other youth in stable families do not face this eventuality.

Stigma

- Youth feel that too many people harbour a negative perception of youth in care. There is a stereotype that youth in care are "bad kids" who have "bounced around too much" and are "in and out of trouble."

- Youth have concerns regarding the information that is contained in their case files. Participants generally felt that most of the information in their files was "inaccurate" or "wrong" and that it created a false impression of the type of person they are.

Supports

- Youth need a range of supports, including access to reliable information about adoption and about what to expect when in care (preferably through a youth-friendly website).
- Youth want to be engaged in the issues, either in peer support groups and mentorship programs or through online forums such as an "Ask the Minister" feature on a website.
- Youth want their social workers to "think outside the box" and be more willing to explore options to find permanent solutions.
- Youth have concerns about losing access to existing supports that they receive while in care if they become adopted.

Contact with Birth Families

- Youth want flexibility in this area. They feel it is important to keep the channels of communications open with their birth family or extended families where these contacts exist, but they also feel that such contact should not preclude them from being adopted.

APPENDIX C

COSTING

Costing analyses were completed to determine the financial implications of moving forward with some of our findings and recommendations.

ADOPTION

Provincial Adoption Agency

Based on a centralized agency with a local presence and including the functions that the agency would fulfill (e.g., become a centre of excellence, match children and families), a costing analysis was conducted. We estimate that running an agency would be cost neutral and could be done with the money that is currently being used for public adoptions in Ontario. However, the information we have pertaining to the current spending on public adoption in Ontario does not include CASs' infrastructure spending that supports adoption services. Consequently, this analysis may underestimate the amount currently being spent by the Province on public adoption.

Adoption Subsidies

This cost-benefit analysis was conducted to determine the impact of providing adoption subsidies on costs for the government. The costing analysis revealed that providing subsidies in Ontario would result in cost savings. For the full analysis, including assumptions, please see page C-3.

Non-refundable Adoption Tax Credit

This analysis was conducted to determine the cost of increasing the ceiling of the current adoption tax credit to $30,000. The assumptions underlying the costing for increasing the non-refundable adoption tax credit were based on the following:

- Between 2004-2007, the average annual number of adoptions was 623 for intercountry adoptions and 148 for private domestic adoptions.
- The cost for adoptions applied to the costing calculation was $30,000 for intercountry and $20,000 for private domestic adoptions.

Based on the average number of adoptions and the cost associated with each adoption, the cost of increasing the tax credit ceiling was estimated to be less than $1 million.

ASSISTED REPRODUCTION

Fertility Monitoring

A costing analysis of the fertility monitoring recommendations was conducted. The analysis applied only to the extra costs associated with providing screening tests to women and men in Ontario. For the full analysis, including assumptions, please see page C-7.

Savings from Reducing Multiple Births and Funding for In Vitro Fertilization

A costing analysis was conducted to estimate the savings that the Province would incur by implementing our recommendations and reducing multiple births from assisted reproduction. These savings could be used to offset the costs of funding IVF. For the full analysis, please see page C-8.

Refundable Tax Credit for Fertility Medications

We found it very difficult to cost this recommendation as there is little information available on the number of people who require fertility medications in the province. Referring to other jurisdictions, we estimate that this recommendation could potentially cost the Province approximately $2 million per year.

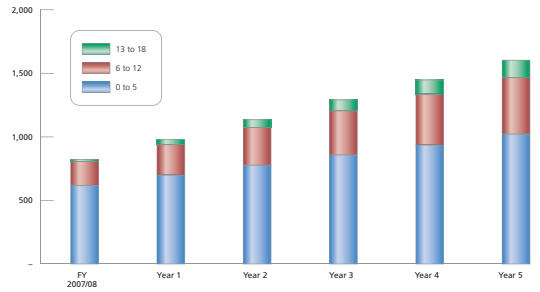
ADOPTION SUBSIDIES

INCREMENTAL ADOPTION SAVINGS FORECAST

Adoption Summary Forecast

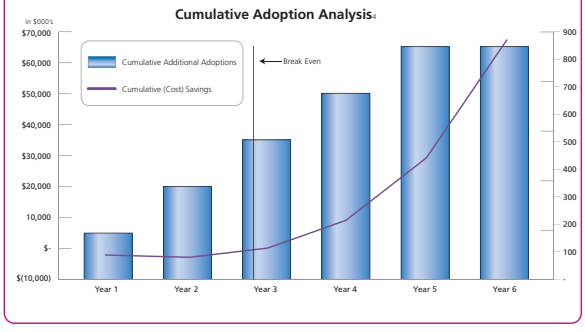
Projected Annual Adoptions [1]	Age Group 0 to 5	6 to 12	13 to 18	Total
FY 2007/08	617	189	16	822
Year 1	696	241	41	978
Year 2	776	292	65	1,133
Year 3	856	344	89	1,289
Year 4	936	396	113	1,444
Year 5	1,016	447	137	1,600
Annual Average Increase [2]	80	52	24	156

1. Based on expectation that a dedicated adoption agency and increased subsidy payments could roughly double adoptions from current rates (FY 2007/08) to 1600 total adoptions within 5 years.
2. Adoption increases for each age group calculated with figures provided to the panel by ICES on age specific placement rates. These are used to calculate the incremental cost analysis below.



Incremental Cost Analysis [1]	Forecast Period Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Adoptive Years [2]	(Cost) / Savings
Adoption Costs	(3,758,316)	(7,516,632)	(11,274,947)	(15,033,263)	(18,791,579)			(56,374,737)
Subsidies Paid								
0 to 5	(291,353)	(874,060)	(1,748,119)	(2,913,532)	(4,370,298)	(4,370,298)	(61,912,559)	(72,109,922)
6 to 12	(441,221)	(1,323,664)	(2,647,327)	(4,412,212)	(6,618,318)	(6,618,318)	(54,049,600)	(69,492,343)
13 to 18	(281,698)	(845,095)	(1,690,189)	(2,676,133)	(3,662,077)	(2,957,832)	(5,633,965)	(14,789,158)
Total Subsidies Paid (New Adoptions)	(1,014,273)	(3,042,818)	(6,085,636)	(10,001,878)	(14,650,694)	(13,946,448)	(121,596,124)	(156,391,423)
Incremental Subsidy Payments for Original Adoptees [5]								
0 to 5	17,570	17,570	17,570	17,570	17,570	17,570	281,124	368,975
6 to 12	(822,524)	(822,524)	(822,524)	(822,524)	(822,524)	(822,524)	(13,160,391)	(17,273,013)
13 to 18	(131,076)	(131,076)	(131,076)	(131,076)	(131,076)	(131,076)	(2,097,218)	(2,752,599)
Incremental Subsidy payments for Original Adoptees	(936,030)	(936,030)	(936,030)	(936,030)	(936,030)	(936,030)	(14,976,485)	(19,656,636)
Children In Care Savings								
0 to 5	1,836,844	5,510,532	11,021,063	18,368,439	27,552,658	27,552,658	391,247,749	455,537,285
6 to 12	1,188,757	3,566,270	7,132,540	11,887,567	17,831,350	17,831,350	147,405,827	189,012,311
13 to 18	554,992	1,664,975	3,329,951	5,272,422	7,214,894	5,827,414	11,099,836	29,137,070
Total Children in Care Savings	3,580,592	10,741,777	21,483,554	35,528,428	52,598,902	51,211,423	549,753,412	673,686,666
Total Incremental (Cost) Savings [3]	**$ (2,128,026)**	**$ (753,703)**	**$3,186,940**	**$ 9,557,257**	**$18,220,599**	**$ 36,328,944**	**$ 413,180,803**	**$ 441,263,870**

1. The summary analysis only considers the additional adoptions over and above FY 2007/08. The figures were run through three separate models with specific variables which apply to each age category. Results shown are not discounted or adjusted for inflation.
2. Remaining adoptive years calculates the (costs) and savings beyond the displayed six year period. The remaining savings are dependant on the year of adoption and the age group of the child. Younger adoptive children carry a longer period of savings.
3. There is a net cost in the first 2 years, where costs of adoptions out weigh the savings of reduced children in care costs. Year three is the first year which displays a net savings. These savings will carry through the remaining adoptive years.
4. Cumulative chart analysis displays the (cost) / savings in the line graph in dollars. On the secondary axis the bar graph displays the cumulative additional adoptions provided by the program changes. Note dollars are displayed in 000's. Breakeven point is the point at which the cumulative (cost) / savings is zero.
5. Incremental subsidy payments for original adoptees is the cost for payments made for original adoptions which would have occurred regardless of an increase in subsidy. The incremental subsidy payment is the total subsidy payment less $3,707 which was the average subsidy payment made in 2007/08.

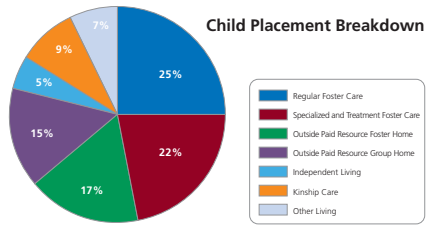


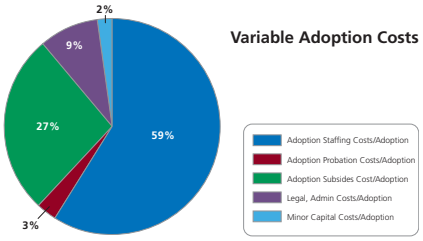
ADOPTION SUBSIDIES

Base Case Information

Children In Care Statistics	
Crown Wards[1]	9,401
Crown Wards - Available for Adoption (25%) [2]	2,350
Average age of candidate Crown Wards[3]	8.40
Boarding Days per Crown Ward (use CIC #)	352
Foster care - Regular per diem (Used for Model)[3]	$40.00
Annual cost per Ward available for adoption	$14,600
Residential Client Service Cost per CIC[1]	$3,947
Staffing Support Cost[3]	$6,257
Children Special Allowance - Federal Benefit[3]	$(1,792)
Regular Foster Care	25%
Specialized and Treatment Foster Care	22%
Outside Paid Resource Foster Home	17%
Outside Paid Resource Group Home	15%
Independent Living	5%
Kinship Care	9%
Other Living	7%

Subsidy Statistics	
Foster care - Regular per diem (Used for Model)	$37
Current Subsidy Payment	$3,707
Subsidy payments made per adoption	$2.42
Adoption Statistics	
Adoptions	822
Average for children in candidate Range	8.40
Probation days / Adoption	345
Adoption Staffing Costs / Adoption	$19,434
Adoption Probation Costs / Adoption	$1,082
Adoption Subsides Cost / Adoption	$8,980
Legal, Admin Costs / Adoption	$2,950
Minor Capital Costs / Adoption	$688





Assumptions:

1. Information sourced from MCYS costing document
2. Target Candidates for phase one conversion from foster care to adoption, are Regular Foster Care and Outside Paid Resource Foster Home
3. Information sourced from MCYS employee resource

INCREMENTAL ADOPTION ANALYSIS (CHILDREN AGED 0-5)

Incremental Cost of Increasing Subsidy

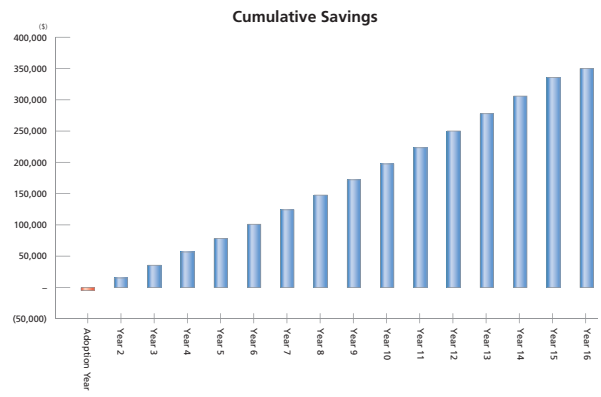
Model Input Controls[1]	
Candidate Pool as a percentage of Crown Wards available for adoption	40%
Adoption Costs (Variable Component)	100%
Percentage of new adoptions receiving subsidy	50%
Average age of Adoptee	2.50
Subsidy paid as a percentage of annual foster care costs[6]	50%
Boarding Cost per diem based on target group	$40.00
Hurdle Rate (Discount Factor)	3%
Inflation rate for subsidy payments and CIC savings	3%

1. TEXT IN BLUE CAN BE ALTERED TO ADJUST THE MODEL
2. SUMMARY OF SAVINGS WILL POPULATE BASED ON AGE CRITERIA
3. DISCOUNTED SAVINGS CALCULATED IN SUMMARY OF SAVINGS

Cost Analysis	Total Cost	Per Adoptee
Additional Adoptions[2]		80
Adoption Costs		
Adoption Staffing Costs	$1,551,305	$19,434
Adoption Probation Costs	86,343	1,082
Legal & Admin Costs	235,443	2,950
Minor Capital Costs / Adoption	54,925	688
Total Variable Adoption Costs	1,928,016	24,154
Subsidies Paid (for new adoptions)	291,353	3,650
Total Cost for Additional Adoptions	**$2,219,369**	**$27,804**
Adoption Savings		
Children removed from Crown Ward[3]		80
Boarding Cost Savings	$1,165,413	$14,600
Residential Client Service Cost	315,022	3,947
Staffing Support Cost	499,451	6,257
Children Special Allowance - Federal Benefit	(143,042)	(1,792)
Total Savings for Each Adoption	**$1,836,844**	**$23,012**
Total Savings (Cost) In Year of Adoption	(382,525)	(4,792)
Post Adoption Savings (not discounted)	22,946,744	287,471
Post Adoption Subsidy Payments	(4,515,975)	(56,575)
Total Cost Savings of Adoption Subsidy Increase	**$18,048,244**	**$226,104**

Summary of Savings Per Adoptee[4]

Summary	Adoption Costs	Subsidies Paid	Children In Care Savings		Total Savings
Adoption Yr	(24,154)	(3,650)	23,012		(4,792)
2		(3,760)	23,702		19,942
3		(3,872)	24,413		20,541
4		(3,988)	25,145		21,157
5		(4,108)	25,900		21,792
6		(4,231)	26,677		22,445
7		(4,358)	27,477		23,119
8		(4,489)	28,301		23,812
9		(4,624)	29,150		24,527
10		(4,762)	30,025		25,262
11		(4,905)	30,926		26,020
12		(5,052)	31,853		26,801
13		(5,204)	32,809		27,605
14		(5,360)	33,793	-	28,433
15		(5,521)	34,807	-	29,286
16		(2,843)	17,926		15,082
Total un-discounted Savings					**$351,032**
Discounted Savings[5]					**$267,912**



1. Original input controls based on Base Case page
2. Assumption that additional adoptions would occur in year 1
3. Assumption that all new adoptions are children removed from Crown Ward
4. Savings in summary chart use inflation assumption in input control table
5. Discounted savings use hurdle rate assumption in input control table
6. Subsidy paid as a percentage of 2007/08 foster care costs including current per diem

INCREMENTAL ADOPTION ANALYSIS (CHILDREN AGED 6-12)

Incremental Cost of Increasing Subsidy

Model Input Controls[1]	
Candidate Pool as a percentage of Crown Wards available for adoption	40%
Adoption Costs (Variable Component)	100%
Percentage of new adoptions receiving subsidy	90%
Average age of Adoptee	8.50
Subsidy paid as a percentage of annual foster care costs	65%
Boarding Cost per diem based on target group	$40.00
Hurdle Rate (Discount Factor)	3%
Inflation rate for subsidy payments and CIC savings	3%

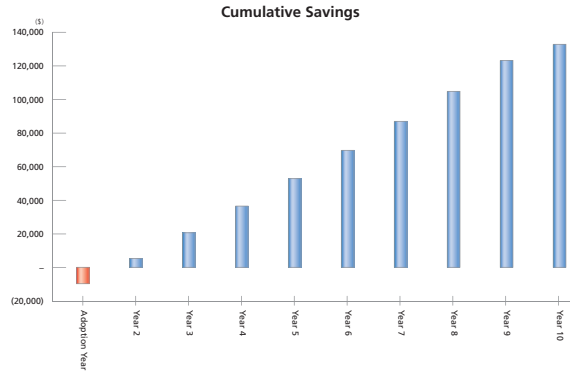
Cost Analysis	Total Cost	Per Adoptee
Additional Adoptions[2]		52
Adoption Costs		
Adoption Staffing Costs	$1,003,963	$19,434
Adoption Probation Costs	55,879	1,082
Legal & Admin Costs	152,373	2,950
Minor Capital Costs / Adoption	35,546	688
Total Variable Adoption Costs	1,247,761	24,154
Subsidies Paid (for new adoptions)	441,221	8,541
Total Cost for Additional Adoptions	**$1,688,982**	**$32,695**
Adoption Savings		
Children removed from Crown Ward[3]		52
Boarding Cost Savings	$754,224	$14,600
Residential Client Service Cost	203,874	3,947
Staffing Support Cost	323,232	6,257
Children Special Allowance - Federal Benefit	(92,573)	(1,792)
Total Savings for Each Adoption	**$1,188,757**	**$23,012**
Total Savings (Cost) In Year of Adoption	(500,225)	(9,683)
Post Adoption Savings (not discounted)	9,101,934	176,192
Post Adoption Subsidy Payments	(4,191,602)	(81,140)
Total Cost Savings of Adoption Subsidy Increase	**$4,410,107**	**$85,369**

1. Original input controls based on Base Case page
2. Assumption that additional adoptions would occur in year 1
3. Assumption that all new adoptions are children removed from Crown Ward
4. Savings in summary chart use inflation assumption in input control table
5. Discounted savings use hurdle rate assumption in input control table

1. TEXT IN BLUE CAN BE ALTERED TO ADJUST THE MODEL
2. SUMMARY OF SAVINGS WILL POPULATE BASED ON AGE CRITERIA
3. DISCOUNTED SAVINGS CALCULATED IN SUMMARY OF SAVINGS

Summary of Savings Per Adoptee[4]

Summary	Adoption Costs	Subsidies Paid	Children In Care Savings	Total Savings
Adoption Yr	(24,154)	(8,541)	23,012	(9,683)
2		(8,797)	23,702	14,905
3		(9,061)	24,413	15,352
4		(9,333)	25,145	15,812
5		(9,613)	25,900	16,287
6		(9,901)	26,677	16,775
7		(10,198)	27,477	17,279
8		(10,504)	28,301	17,797
9		(10,819)	29,150	18,331
10		(5,572)	15,012	9,440
Total un-discounted Savings				**$132,294**
Discounted Savings[5]				**$110,016**



INCREMENTAL ADOPTION ANALYSIS (CHILDREN AGED 13-18)

Incremental Cost of Increasing Subsidy

Model Input Controls[1]	
Candidate Pool as a percentage of Crown Wards available for adoption	40%
Adoption Costs (Variable Component)	100%
Percentage of new adoptions receiving subsidy	100%
Average age of Adoptee	15.50
Subsidy paid as a percentage of annual foster care costs	80%
Boarding Cost per diem based on target group	$40.00
Hurdle Rate (Discount Factor)	3%
Inflation rate for subsidy payments and CIC savings	3%

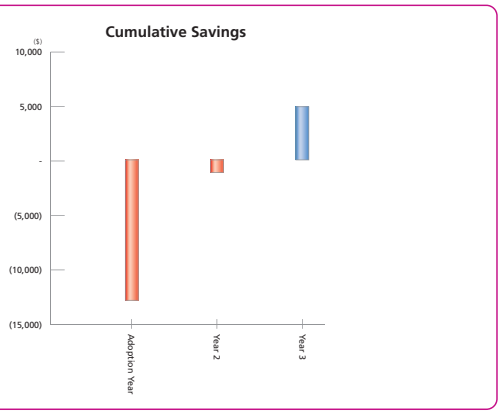
Cost Analysis	Total Cost	Per Adoptee
Additional Adoptions[2]		24
Adoption Costs		
Adoption Staffing Costs	$468,718	$19,434
Adoption Probation Costs	26,088	1,082
Legal & Admin Costs	71,138	2,950
Minor Capital Costs / Adoption	16,595	688
Total Variable Adoption Costs	582,539	24,154
Subsidies Paid (for new adoptions)	281,698	11,680
Total Cost for Additional Adoptions	**$864,237**	**$35,834**
Adoption Savings		
Children removed from Crown Ward[3]		24
Boarding Cost Savings	$352,123	$14,600
Residential Client Service Cost	95,182	3,947
Staffing Support Cost	150,906	6,257
Children Special Allowance - Federal Benefit	(43,219)	(1,792)
Total Savings for Each Adoption	**$554,992**	**$23,012**
Total Savings (Cost) In Year of Adoption	(309,245)	(12,822)
Post Adoption Savings (not discounted)	1,118,262	46,366
Post Adoption Subsidy Payments	(704,246)	(29,200)
Total Cost Savings of Adoption Subsidy Increase	**$104,771**	**$4,344**

1. TEXT IN BLUE CAN BE ALTERED TO ADJUST THE MODEL
2. SUMMARY OF SAVINGS WILL POPULATE BASED ON AGE CRITERIA
3. DISCOUNTED SAVINGS CALCULATED IN SUMMARY OF SAVINGS

Summary of Savings Per Adoptee[4]

Summary	Adoption Costs	Subsidies Paid	Children In Care Savings	Total Savings
Adoption Yr	(24,154)	(11,680)	23,012	(12,822)
2		(12,030)	23,702	11,671
3		(6,196)	12,206	6,011

Total un-discounted Savings	**$4,860**
Discounted Savings[5]	**$4,053**



1. Original input controls based on Base Case page
2. Assumption that additional adoptions would occur in year 1
3. Assumption that all new adoptions are children removed from Crown Ward
4. Savings in summary chart use inflation assumption in input control table
5. Discounted savings use hurdle rate assumption in input control table

FERTILITY MONITORING

FERTILITY MONITORING

Fertility Screening Analysis

Age Category	Canadian First Live Births	Canadian Total Births	%	Ontario Live Births	Ontario First Births
30-34	41,037	111,321	37%	46,325	17,077
35-39	14,599	52,593	28%	23,369	6,487
40-44	2,629	9,939	26%	4,570	1,209
Total	58,265	173,853	34%	74,264	**24,773**

Fertility Screening Costs

Screening Base (Ontario First Births)	24,773	
ART Pregnancies	2%	
Fertility Medication Pregnancies	2%	
% of Women Accepting Screening	50%	
% of Females whose Male partner accept screening	50%	
Fertility Screening Costs Female	$107	
Fertility Screening Costs Male	$56	
Incremental Screening Costs	**Tests**	**Cost**
Total Screens Female	11,891	1,272,093
Total Screens Male	5,945	329,974
Total Cost		**$1,602,066**

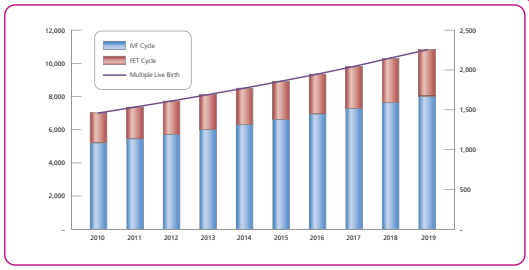
SAVINGS FROM REDUCING MULTIPLE BIRTHS AND FUNDING FOR IN VITRO FERTILIZATION

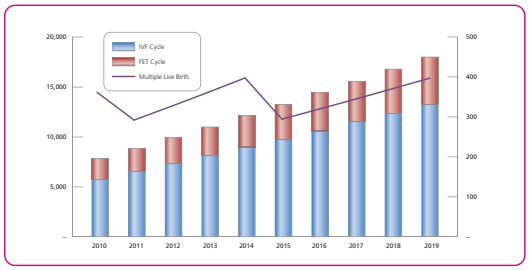
SAVINGS FROM REDUCING MULTIPLE BIRTHS AND FUNDING FOR IN VITRO FERTILIZATION

Model Input Stats	
Current funding annual demand increase	4.9%
Target IVF cycles per million	900
Live Birth differential for single embryo transfer	88.0%
FET Available 1	40.0%
FET Available 2	17.1%
Average Multiples	3.20
Caesarean Birth percentage singleton	21%
Caesarean Birth percentage twin	50%
Caesarean Birth percentage triplet / HOM	100%
Average life expectancy of LBW babies	59
Singleton Live Births resulting in LBW	5%
Twin Live Births resulting in LBW	50%
Triplet / HOM Live Births resulting in LBW	90%
Percentage of cycles for women 42 and older	7%

Success Rates	IVF	FET
Average Live Birth rate	24.1%	13.0%
Success <36	30.6%	13.0%
Success 36-38	22.8%	13.5%
Success >38	11.1%	12.4%
Average Pregnancy Rate	30.8%	19.2%
Success <36	37.8%	19.3%
Success 36-38	28.9%	21.3%
Success >38	17.5%	16.4%

Costs	
Hurdle Rate (For NPV calculation)	5.00%
Pregnancy Costs	
Average costs of pregnancy loss	$144
Average pregnancy costs singleton	$980
Average pregnancy costs twins	$2,313
Average pregnancy costs triplets+	$2,319
Delivery Costs	
Average cost vaginal delivery singleton	$3,301
Average cost vaginal delivery twins	$3,747
Average cost vaginal delivery triplets	$4,592
Average cost caesarean delivery singleton	$5,410
Average cost caesarean delivery twins	$6,469
Average cost caesarean delivery triplets	$ 7,921
Hospitalization Costs	
Singletons	
Full Term (≥37 Weeks)	$1,050
Moderate Preterm (32–33 Weeks)	$19,463
Very Preterm (28–31 Weeks)	$43,718
Extremely Preterm (<28 Weeks)	$84,235
Multiples	
Full Term (≥37 Weeks)	$1,871
Moderate Preterm (32–33 Weeks)	$21,388
Very Preterm (28–31 Weeks)	$47,318
Extremely Preterm (<28 Weeks)	$90,123
Disability Costs	
Ist year costs of disability	$63,017
Lifetime cost of disability	$885,165
Childhood Disability Costs (first 10 years)	$250,000





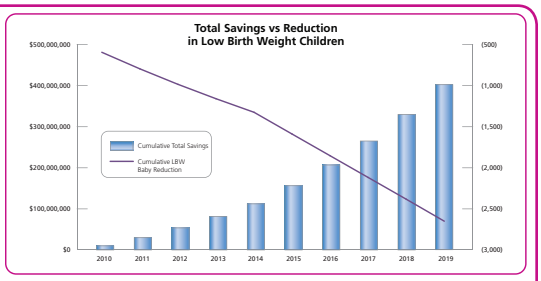
Cycle Information	Projected										
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Base Case											
IVF Cycles	**5,232**	**5,489**	**5,758**	**6,040**	**6,336**	**6,646**	**6,972**	**7,313**	**7,672**	**8,048**	**65,504**
<36	1,044	1,095	1,149	1,205	1,264	1,326	1,391	1,459	1,530	1,605	13,067
FET Cycles	**1,825**	**1,914**	**2,008**	**2,106**	**2,210**	**2,318**	**2,431**	**2,551**	**2,676**	**2,807**	**22,845**
IVF Cycles per million	395	409	424	439	455	472	489	507	526	546	4,663
Public Funding Case											
IVF Cycles	**5,739**	**6,508**	**7,294**	**8,097**	**8,916**	**9,751**	**10,604**	**11,474**	**12,359**	**13,260**	**94,002**
FET Cycles	**2,083**	**2,362**	**2,647**	**2,938**	**3,236**	**3,539**	**3,848**	**4,164**	**4,485**	**4,812**	**34,113**
IVF Cycles per million	433	485	537	589	640	692	744	796	848	900	6,664
Ontario Population	13,260,200	13,426,200	13,591,700	13,756,600	13,921,000	14,084,000	14,248,000	14,410,600	14,572,300	14,733,000	14,000,360

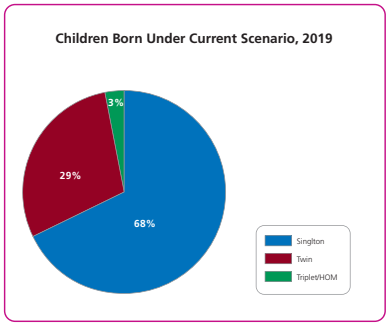
Birth Statistics	Projected										
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total
Number of Live Births											
IVF Cycles	1,261	1,323	1,388	1,456	1,527	1,602	1,680	1,763	1,849	1,939	15,786
FET Cycles	237	249	261	274	287	301	316	332	348	365	2,970
Non Funding Live Births	**1,498**	**1,572**	**1,649**	**1,729**	**1,814**	**1,903**	**1,996**	**2,094**	**2,197**	**2,304**	**18,756**
IVF Cycles	1,383	1,568	1,758	1,951	2,149	2,350	2,556	2,765	2,978	3,196	22,654
FET Cycles	271	307	344	382	421	460	500	541	583	626	4,435
Funding Live Births	**1,654**	**1,876**	**2,102**	**2,333**	**2,569**	**2,810**	**3,056**	**3,306**	**3,561**	**3,821**	**27,089**
Number of Pregnancy Losses											
Non Funding	464	486	510	535	561	589	618	648	680	713	5,805
Funding	514	582	653	725	798	873	949	1,027	1,106	1,187	8,413
Number of Singleton Live Births											
Current 69.0%	1,034	1,084	1,138	1,193	1,252	1,313	1,377	1,445	1,516	1,590	12,942
Funding	1,298	1,590	1,781	1,977	2,178	2,522	2,743	2,967	3,196	3,429	23,682
	79%	85%	85%	85%	85%	90%	90%	90%	90%	90%	
Number of Twin Live Births											
Current 28.5%	427	448	470	493	517	542	569	597	626	657	5,346
Funding	351	281	315	350	385	281	306	331	356	382	3,339
	21.25%	15.00%	15.00%	15.00%	15.00%	10.00%	10.00%	10.00%	10.00%	10.00%	
Number of Triplet / HOM Live Births											
Current 2.5%	37	39	41	43	45	48	50	52	55	58	469
Funding	4	5	5	6	6	7	8	8	9	10	68
	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	0.25%	

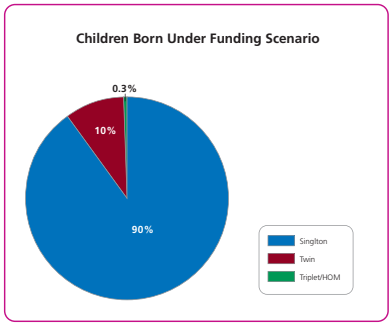
Incremental Analysis	2010	2011	2012	2013	2014	Projected 2015	2016	2017	2018	2019	Total
Pregnancy Losses	50	96	143	189	236	284	331	379	426	474	2,608
Singleton Live Births	265	505	644	784	926	1,209	1,365	1,523	1,681	1,839	10,741
Twin Live Births	(76)	(167)	(155)	(143)	(132)	(261)	(263)	(266)	(270)	(275)	(2,007)
Triplet / HOM Live Births	(33)	(35)	(36)	(37)	(39)	(41)	(42)	(44)	(46)	(48)	(401)
Reduction in Low Birth Weight Live Births											
Singleton	13	25	32	39	46	60	68	76	84	92	537
Twin	(38)	(83)	(77)	(71)	(66)	(131)	(132)	(133)	(135)	(137)	(1,003)
Triplet / HOM	(30)	(31)	(32)	(34)	(35)	(36)	(38)	(40)	(41)	(43)	(361)
Total Multiple	(68)	(114)	(110)	(105)	(101)	(167)	(170)	(173)	(176)	(181)	(1,364)
Low Birth Weight Live Births Reduced	(55)	(89)	(77)	(66)	(55)	(107)	(101)	(97)	(92)	(89)	(827)

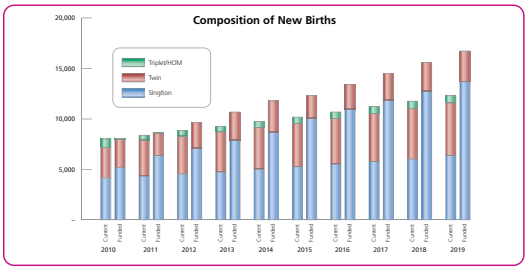
Savings Forecast	2010	2011	2012	2013	2014	Projected 2015	2016	2017	2018	2019	Total
Pregnancy Loss Costs	7,178	13,796	20,472	27,197	33,961	40,748	47,568	54,390	61,206	68,003	374,519
Pregnancy Costs											
Singleton	259,331	494,998	630,986	768,450	907,259	1,184,808	1,337,991	1,492,117	1,647,088	1,802,685	10,525,712
Twin	(174,662)	(385,295)	(357,500)	(330,509)	(304,448)	(604,504)	(609,109)	(615,665)	(624,306)	(635,203)	(4,641,201)
Triplet / HOM	(77,269)	(80,240)	(83,392)	(86,735)	(90,278)	(94,036)	(98,017)	(102,236)	(106,706)	(111,441)	(930,350)
Delivery Costs											
Singleton	990,717	1,891,029	2,410,542	2,935,694	3,465,982	4,526,296	5,111,499	5,700,305	6,292,336	6,886,761	40,211,163
Twin	(385,726)	(850,889)	(789,505)	(729,899)	(672,346)	(1,334,993)	(1,345,161)	(1,359,640)	(1,378,723)	(1,402,788)	(10,249,670)
Triplet / HOM	(263,941)	(274,092)	(284,858)	(296,276)	(308,381)	(321,217)	(334,815)	(349,227)	(364,496)	(380,670)	(3,177,974)
Hospitalization Costs											
Singleton											
Full Term	263,962	503,837	642,253	782,172	923,460	1,205,965	1,361,884	1,518,762	1,676,500	1,834,876	10,713,671
Late Preterm (34–36 Weeks)	49,889	95,226	121,387	147,833	174,536	227,930	257,399	287,050	316,863	346,796	2,024,911
Moderate Preterm (32–33 Weeks)	28,277	53,973	68,800	83,789	98,924	129,187	145,890	162,695	179,593	196,558	1,147,686
Very Preterm (28–31 Weeks)	48,882	93,303	118,935	144,846	171,010	223,326	252,200	281,251	310,462	339,791	1,984,006
Extremely Preterm (<28 Weeks)	65,303	124,648	158,892	193,507	228,461	298,352	336,926	375,737	414,761	453,943	2,650,529
Multiple											
Full Term	(76,877)	(162,308)	(151,320)	(140,673)	(130,419)	(252,081)	(254,264)	(257,256)	(261,112)	(265,901)	(1,952,210)
Late Preterm (34–36 Weeks)	(287,784)	(486,108)	(465,780)	(446,505)	(428,416)	(710,154)	(720,945)	(733,921)	(749,226)	(767,039)	(5,795,877)
Moderate Preterm (32–33 Weeks)	(228,356)	(385,726)	(369,595)	(354,300)	(339,947)	(563,505)	(572,068)	(582,365)	(594,509)	(608,644)	(4,599,015)
Very Preterm (28–31 Weeks)	(369,835)	(624,705)	(598,580)	(573,810)	(550,563)	(912,629)	(926,497)	(943,173)	(962,842)	(985,733)	(7,448,369)
Extremely Preterm (<28 Weeks)	(444,882)	(751,470)	(720,045)	(690,248)	(662,284)	(1,097,821)	(1,114,503)	(1,134,562)	(1,158,222)	(1,185,759)	(8,959,795)
Long Term Costs											
Reduction of LBW Children	(158)	(241)	(226)	(211)	(197)	(318)	(317)	(317)	(318)	(321)	(2,625)
First Year Cost	(9,972,004)	(15,185,498)	(14,237,664)	(13,321,933)	(12,442,976)	(20,019,640)	(19,964,120)	(19,977,385)	(20,064,391)	(20,231,567)	(165,417,178)
Subsequent Savings		(3,956,077)	(9,980,443)	(15,628,785)	(20,913,840)	(25,850,197)	(33,792,355)	(41,712,488)	(49,637,883)	(57,597,795)	(259,069,865)
Total Savings (including singletons)	**(10,567,953)**	**(19,871,840)**	**(23,866,639)**	**(27,516,396)**	**(30,840,504)**	**(43,924,482)**	**(50,880,815)**	**(57,895,927)**	**(65,003,927)**	**(72,243,447)**	**(402,611,930)**
Total Savings (excluding singletons)	**(13,108,117)**	**(25,051,150)**	**(31,009,337)**	**(36,810,395)**	**(42,474,306)**	**(59,434,111)**	**(69,402,118)**	**(79,633,529)**	**(90,162,685)**	**(101,027,168)**	**(548,112,915)**

Fast Stats	Amount
Cost Savings	
Cumulatative Savings over 10 year period (w/ singletons)	$402,611,930
Cumulatative Savings over 10 year period (w/out singletons)	$548,112,915
NPV of future savings beyond the 10 year period (w/singles)	$376,821,072
NPV of future savings beyond the 10 year period (w/out singles)	$459,487,226
Birth Statistics	
Cumulative incremental increase in healthy newborns	7,042
Total Reduction of LBW babies from multiple births	(3,162)
Total Reduction of low birth weight babies	(2,625)









APPENDIX D

Proceedings of Annual Meetings - 2008 Quebec City, QC

UNIFORM LAW CONFERENCE OF CANADA CIVIL LAW SECTION ASSISTED HUMAN REPRODUCTION REPORT OF THE JOINT ULCC-CCSO WORKING GROUP

Readers are cautioned that the ideas or conclusions set forth in this paper, including any proposed statutory language and any comments or recommendations, may not have not been adopted by the Uniform Law Conference of Canada. They may not necessarily reflect the views of the Conference and its Delegates. Please consult the Resolutions on this topic as adopted by the Conference at the Annual meeting.

Quebec City, QB
August 10-14, 2008

REPORT OF THE WORKING GROUP – AUGUST 2008

Background

[1] The Conference was approached in 2007 by the CCSO-Family Justice Working Group to set up a joint working group to present uniform legislation to address advances in the area of assisted human reproduction. At last year's conference, a joint project was proposed and subsequently chosen as one of the new projects to be undertaken by the ULCC. It was agreed that a joint working group would be formed consisting of members of the ULCC and members of the CCSO Family Law group.

ULCC-CCSO Joint Working Group

[2] In December 2007, the ULCC formed a joint working group with members of the CCSO Family Justice Working Group, at the request of CCSO. The ULCC-CCSO Working Group is co-chaired by Betty Ann Pottruff, Q.C. (SK-CCSO) and Elizabeth Strange (NB-ULCC). Members of the Working Group are: David Nurse (NS-ULCC), John Booth (AB-CCSO), Jill Dempster (BC-CCSO), Miranda Gass Donnelly (ON-CCSO), Lisa Hitch (CA-CCSO) and Hoori Hamboyan (CA-CCSO).

[3] Janis Cooper (NT-ULCC) had been a member of the Working Group and was responsible for drafting the English version of the legislation; however, she recently left her position in the Northwest Territories and, as a consequence, is no longer a member of the Working Group.

[4] Since the establishment of the Joint Working Group conference calls have been held on a monthly basis. These conference calls have focused on reviewing the mandate, reviewing the CCSO Family Report, discussing the policy, deciding on when and who to consult, deciding on how to proceed with drafting (i.e. whether to draft a stand alone Act or amend the existing Uniform Child Status Act) and reviewing drafts.

[5] The Working Group agreed that the preferred way to proceed would be to amend the existing Uniform Child Status Act. The main reason for this decision is that assisted human reproduction relates directly to issues dealt with in the Uniform Child Status Act and a new Act would create overlap and possibly confusion with the existing Act.

[6] To date, seven drafts of the amendments have been reviewed in English. A new English drafter and a French drafter have recently been assigned to continue the drafting process. In conjunction with the drafting, consultation is being held with both Assisted Human Reproduction Canada and Vital Statistics Registrars in order to gain their input on any issues that could affect the proposed amendments.

[7] The following report consists mainly of portions of a paper prepared by the CCSO Family Working Group that was presented to and adopted by Deputy Ministers of Justice in October 2007. It serves as the policy framework for the ULCC-CCSO Working Group.

Report of the CCSO Family Law Working Group

[8] Advances in AHR have made determining the legal parent-child relationship more complicated in certain cases. Most of the child status statutes across the country are based on a historical reality that pre-dates most AHR techniques, so they provide little guidance to a court when challenged. As a result, judges are being asked to make decisions in a policy vacuum. If this situation is not remedied there is great potential for the law to develop in an ad hoc way from individual court decisions, within jurisdictions and with no consistency between provinces and territories. From the child's perspective, inconsistency in child status rights may arguably be inherently unconstitutional, since birth registration is a foundation document from which citizenship and the right to participate in society flows.

[9] Changes to the law in this area would respond to the realities of AHR by clarifying the relationship in such cases. Like many policy issues in family law, changes to clarify the law will have to address any remaining fundamental unfairness that exists for same-sex couples and their children. Although in Canada same-sex relationships are legally recognized, children born to same-sex couples may still experience different treatment in terms of the registration of their births. While these differences often reflect the historical purposes of the birth registration process, accommodation is needed to recognize equivalent parental and child rights in these situations.

[10] Because parentage laws and birth registration are the societal markers of legal parentage, same-sex couples have commenced numerous court challenges to ensure their inclusion in this fundamental element of family formation. Many Canadian jurisdictions have already experienced Charter challenges to these two legislative frameworks, and these challenges will only continue if legislatures are slow to respond.

[11] Opposite-sex couples who use AHR have not encountered the same difficulties in registering their children's births. However, since registration is not determinative of legal parentage, in the absence of specific legislation to resolve issues such as the legal status of the intended parents and third party donors of genetic material in relation to the child, they face the same legal uncertainty regarding the legal status of the parent-child relationship as same-sex couples do.

Defining the Policy Issues

[12] There are two related policy questions which must be resolved:

who are the legal parents of a child at the moment of birth; and

who is entitled to register as the child's parents.

[13] These issues may seem to be the same, but, in the legal construct of most provincial and territorial law, they are quite different. Typically, common law provinces and territories have child status

legislation which defines who are the parents of a child and grounds legal responsibilities for support, custody and access and inheritance. In addition, they have birth registration provisions in their vital statistics legislation, which require and permit the administrative act of registration of parentage. There is substantial interplay between these two types of legislation. For example, a man who certifies the birth registration is presumed to be the father in several child status statutes, and likewise, a person who receives a declaration of parentage under child status legislation is generally permitted to amend the birth registration.

[14] The period since 2001 has seen a high level of development in the law of birth registration, mostly through successful challenges to existing registration regimes. However, the issue of child status – who are the parents of a child at birth – has been less litigated, and is less understood by the public.[1]

[15] To accommodate same-sex parentage, and on occasion in response to court challenges, some jurisdictions have changed their registration process without changing their child status regime. Proceeding in this manner allows the administrative fact of registration to drive the legal child status policy development process, and has been questioned by some members of the AHRWG for that reason. Because child status is a legal status, and registration is to a great extent a reflection of that status, it is important that the policy work on determining parentage precede work to change vital statistics legislation.

Overview of Principles Adopted

[16] Canada's obligations under the UN Convention On The Rights Of The Child must be respected, including:

protecting the child from discrimination,
recognizing the best interests of the child is a primary consideration, and
ensuring the status of the parent/child relationship is protected from birth.

[17] Commodification of children and reproductive abilities should be avoided.

[18] Equality of treatment of children regardless of the means of their conception should be promoted.

[19] The fact that women and men perform distinct roles in reproduction, which may merit distinct treatment for the woman who gives birth, should be recognized.

[20] The concept expressed in the Civil Code of Quebec and in the common law that a child has a maximum of two legal parents, but that other adults can take on parenting roles through their actions and relationship with the child or the child's parent should be accepted and maintained.[2]

The Recommended Approach

[21] The potential indicators for parentage are the act of birth, genetics and intention to parent. The current law of parentage in most common law jurisdictions is based on biological presumptions. Parentage begins with the act of birth – the birth mother is the legal parent of the child, and a man who shares a conjugal relationship with the birth mother is presumed to be the father. This approach to parentage does not always work well in the AHR context. The result is to exclude some persons who have started families using AHR from acquiring automatic parental status by operation of law on the birth of a child.

[22] The challenge in developing a scheme for determining parentage that accommodates both natural conception and AHR is to balance the three potential indicators of parentage in a way that best reflects the principles set out above. The approaches are: to recognize the birth mother link; to equalize the natural and assisted conception models so that the two processes are treated the same as much as possible; and to look at an intention-based approach, where those who intend to parent, whether or not there is a genetic link, are recognized as parents. In all instances, court and/or administrative processes remain for persons who are left out of the determination of parentage at birth but who seek to be named as parents after birth.

[23] The AHRWG recommends a scheme for determining parentage that uses the model that equalizes, as far as possible, natural and assisted conception.

Parental status at birth:

[24] The birth mother is the child's legal mother at the time of birth. This applies whether or not the child is conceived using the birth mother's egg or a donor's egg. This provides stability for the child and treats natural and assisted conception the same.

[25] Unless a statutory provision (like a presumption) provides otherwise, the genetic father and the birth mother are the parents of a child.

[26] There are two means by which the birth mother can relinquish her parental status, and another person can gain parental status: adoption and surrogacy. The surrogacy approaches are outlined below.

Presumption of the "other" parent:

[27] In all cases except surrogacy, the parental status of the other parent will be presumed from that person's conjugal relationship with the birth mother at the time of conception or birth. This presumption applies whether or not there is a genetic link between the birth mother or the other parent and the child (i.e. it applies in cases where both egg and sperm are donated by third parties). This approach provides stability for the child and equal treatment of natural and assisted conception.

[28] The birth mother and a person with whom she shares a conjugal relationship, whether of the same or opposite sex, may jointly register the child's birth with a Vital Statistics registry showing themselves to be the child's parents. They do not have to go to court to get declarations of parentage.

[29] In cases of natural conception, the current presumptions of parentage continue to be available for fathers. The presumptions can be rebutted by proving on the balance of probabilities that the presumed father is not the child's father. Currently, this is often done using DNA evidence to show that there is no genetic link between the presumed father and the child.

[30] In AHR cases (excluding surrogacy), presumptions of parentage are also available to the person in a conjugal relationship with the birth mother, whether of the same or opposite sex. However, since the child is not conceived through natural conception, proof of lack of a genetic link between the presumed parent and the child will not rebut the presumption of parentage. In order to rebut the presumption, the presumed parent will have to prove, on the balance of probabilities, that he or she did not consent, or prior to conception, withdrew consent to be the child's parent.

[31] When necessary, courts continue to be able to make declarations of parentage confirming or rebutting a presumption of parentage or in circumstances where a presumption does not operate or is challenged.

Rights of Third Parties:

[32] In all cases, third party donors of genetic material have no parental rights or responsibilities unless there is an express legislative provision otherwise. This is based on the fact that, as a general rule, third party donors do not intend to be the child's parents.

Surrogacy:

[33] Surrogacy arrangements are not enforceable.

[34] The AHRWG agrees that in all cases the surrogate will be recorded as the birth mother of the child and the surrogate's consent to relinquish her parentage will have to be obtained after the child's birth before the intended parents can be registered as the child's parents. If the surrogate consents to relinquish her parentage, no presumption would operate in favour of her spouse or conjugal partner because surrogacy is an exception to the presumptions rule

[35] Jurisdictions can choose whether or not to require intended parents in surrogacy arrangements to obtain court declarations of parentage before they are allowed to register themselves as the child's parents with a Vital Statistics registry. This decision will depend on how the jurisdiction views the role of the court and state in terms of considering the "best interests of the child" in these circumstances and whether to view these situations as similar to adoption or different.

[36] 2 options are being considered in determining the parentage of children born using surrogacy.

The first option focuses on a genetic link with at least one of the intended parents and intention to parent. In this option, parentage in surrogacy situations would be determined based on the provision of genetic material for the child's conception by at least one of the intended parents. Legislation would allow the genetic parent and that parent's spouse or conjugal partner to apply for a declaration of parentage in a surrogacy situation. If the surrogate mother consents to the application, and the consent could only be given after the birth of the child, the court could make the declaration of parentage in favour of the genetic parent and the genetic parent's spouse or conjugal partner. Where the surrogate mother consents to the declaration, no presumption would operate in favour of her spouse or conjugal partner because surrogacy is an exception to the presumptions rule. (A jurisdiction could choose to allow the transfer of parentage to occur administratively through a registration process rather than require a court application.)

In this option, where there is no genetic link between at least one of the intended parents and the child, the intended parents must apply to adopt the child.

The second option looks only at the intention to parent. It goes further than option 1 because it does not require the intended parents to apply to adopt the child where neither of them is genetically related to the child. It provides the same process in all surrogacy cases, regardless of whether or not there is a genetic link. This approach is based on distinguishing between adoption and surrogacy on the basis of when the intention to parent this particular child arises. In surrogacy situations both the intention of the intended parents to parent and the intention of the surrogate to relinquish her parentage arise before conception.

Conclusion

[37] CCSO Family recommends this scheme to common law jurisdictions as the best response to the principles adopted to guide our work. It responds to most of the issues currently before Canadian courts.

[38] This scheme does not change the law for determining the parentage of children born through natural conception. To the greatest extent possible, it treats children and parents in the same way, whether the children are born as a result of natural conception or AHR. It ensures that the legal parent/child relationship is clear from birth, so that legal rights and responsibilities can flow, and children are not discriminated against on the basis of means of their conception. Most of the same presumptions apply and so two parent status can generally be assumed or found. It recognizes AHR based on sperm donation and egg donation and treats them both in the same way.

[39] It avoids the commodification of children or reproductive abilities, for example, by not allowing surrogacy agreements to be enforced and leaving to jurisdictions the decision on the nature of review required to recognize such arrangements. The scheme includes two options for surrogacy cases. Option 1 provides an effective way of determining parentage in surrogacy arrangements where there is a genetic link between one of the intended parents and the child. This applies not only to opposite-sex couples for whom natural conception or other means of AHR are not viable but also to both male and female same-sex couples and single men and women. Option 2 provides a way to extend the scheme to determine parentage in surrogacy situations where neither intended parent is genetically related to the child, if a jurisdiction wishes to do so.

[40] The scheme protects the surrogate in two ways: as the birth mother, her consent is needed to permit parentage to be transferred to the intended parents, and since surrogacy arrangements are not enforceable, her rights are protected and balanced with the rights of the intended parents.

[41] In addition, it permits jurisdictions a choice in determining how to recognize parentage in surrogacy arrangements – either through registration at first instance or by requiring a court order before registration.

[42] The scheme also protects third party donors who do not wish to be parents by providing that they acquire no parental rights or obligations, unless legislation provides otherwise.

Next Steps

[43] It is the Working Group's expectation that drafting will continue and once the results of the consultations have been reviewed, a final report on the project and a draft Act and commentaries will be prepared for consideration at the 2009 Annual Meeting. In order to achieve these goals, the Working Group will continue to have regularly scheduled conference calls and meet as required.

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[1] The exception is Alberta, which amended its child status legislation to accommodate the use of AHR. Charter litigation in Alberta has resulted in the extension of automatic parental status to same-sex spouses and partners in some circumstances. See Fraess v. Alberta, [2005] A.J. No. 1665 (Q.B.).

[2] This policy is being reviewed in light of an Ontario Court of Appeal finding that a child can have three legally recognized parents. See A.A. v. B.B., (2007), 220 O.A.C. 115.

APPENDIX E

ACKNOWLEDGEMENTS

The Expert Panel would like to gratefully acknowledge the following individuals/organizations who provided their expertise and insights to us during the course of our work:

Ann Barnard Ball, Executive Director, Children's Aid Foundation

Dr. François Bissonnette, Medical Director, Ovo Fertilité, President, Canadian Fertility and Andrology Society

Michael Blugerman, MSW, Executive Director, Children's Resource and Consultation Centre of Ontario

Wilma Burke, Supervisor, Adoption Department, Children's Aid Society of Toronto

Wendy Conforzi, London Coalition of Adoptive Families

Pat Convery, Executive Director, Adoption Council of Ontario

Nancy Dale, Chief Operating Officer, Children's Aid Society of Toronto

Liz Ellwood, Executive Director, Fertile Future

Irwin Elman, Chief Advocate, Provincial Advocate for Children and Youth

Rachel Epstein, Coordinator, LGBTQ Parenting Network, Sherbourne Health Centre

Infertility Awareness Association of Canada

Dr. Keith Jarvi, Head of Urology, Mount Sinai Hospital

Louise Johnson, Chief Executive Officer, Infertility Treatment Authority (Victoria, Australia)

Kelly D. Jordan, Lawyer, Jordan Battista Barristers LLP

Irene Klatt, Vice-President, Health Insurance, Canadian Life and Health Insurance Association

Betty Kennedy, Executive Director, The Association of Native Child and Family Services Agencies of Ontario (ANCFSAO)

Kelvin Lam, Biostatistician, Institute for Clinical Evaluative Sciences

Sherry Levitan, Lawyer

Shirley Levitan, Lawyer

Jeanette Lewis, Executive Director, Ontario Association of Children's Aid Societies

Dr Cliff Librach, Chair, Ontario Medical Association Section on Reproductive Biology

Daniel Moore, Executive Director, Family and Children's Services of Guelph and Wellington County

David Moss-Cornett, Adoptee

Kristina Reitmeier, Chief Counsel/Director Legal Services, Children's Aid Society of Toronto

Bruce Rivers, Chief Executive Officer, Community Living, Toronto

Lori Ross, Research Scientist, Centre for Addiction and Mental Health, Assistant Professor of Psychiatry, University of Toronto

Virgina Rowden, Director of Social Policy and Mentor to the YouthCan Program, Ontario Association of Children's Aid Societies

Beth Pieterson, (former) Executive Director, Licensing, Inspections and Registry, Assisted Human Reproduction Canada

Kim Stevens, Project Manager, Community Champions Network, North American Council on Adoptable Children

We would also like to extend our sincere appreciation to all of those individuals and organizations who participated in interviews and focus groups and took the time to share their experiences and suggestions. We have made every effort to incorporate those perspectives into our work.

We would also like to acknowledge the efforts of the consultants who supported our deliberations.

Finally, the Expert Panel would like to thank the hard work and support of Government of Ontario staff from the Ministry of Children and Youth Services, the Ministry of Health and Long-Term Care and other ministries.

APPENDIX F

BIOGRAPHIES

David Johnston, Chair, is President, University of Waterloo and has degrees from the United States (Harvard, A.B.), England (Cambridge, LL.B.) and Canada (Queen's, LL.B.), and is a Companion of the Order of Canada. He has held many academic positions, including Dean of the Faculty of Law, University of Western Ontario and Principal and Vice-Chancellor, McGill University. David has served on many boards, and provincial and federal task forces and committees. He has also chaired many bodies, including the National Round Table on Environment and the Economy, the Canadian Institute for Advanced Research and Harvard University's Board of Overseers. David and his wife have five daughters and six grandchildren (two through adoption, two through IVF and two through surrogacy).

Cheryl Appell is a lawyer with the firm Dickson MacGregor Appell LLP in Toronto and has extensive experience in the area of adoption law. Over the past 28 years, she has acted as an advisor in adoption proceedings. She is also licensed to place children for adoption. Cheryl is a member of the American Academy of Adoption Attorneys and the Ontario Association of Practitioners in Private Adoption.

Robin Cardozo is an adoptive parent. Since 1999, he has been Chief Executive Officer of the Ontario Trillium Foundation, an agency of the Government of Ontario. The Foundation is a catalyst that enables Ontarians to work together to enhance the quality of life in their communities. Previously, he held progressively senior positions with United Way Toronto, culminating in his appointment as Vice-President and Chief Operating Officer. Robin is a chartered accountant and currently serves on the boards of Bridgepoint Health and Diaspora Dialogues Charitable Society.

Dr. Marjorie Dixon is an assistant professor in the Department of Obstetrics and Gynecology at the University of Toronto (U of T) and co-founder of First Steps Fertility in Toronto. She is a graduate of McGill University's School of Medicine with postgraduate training from U of T in obstetrics and gynecology, and in reproductive endocrinology and infertility from the University of Vermont. Dr. Dixon is now on staff at Sunnybrook Health Sciences Center and her current practice deals with infertility, reproductive ageing and recurrent pregnancy loss. She is actively involved in undergraduate and professional medical education in both national and international forums. Her professional affiliations include the Canadian Fertility and Andrology Society and the Society of Obstetricians and Gynecologist of Canada. She lives in Toronto with her partner and two children.

Will Falk is the Managing Partner of Accenture's Health and Life Science Practice in Canada and leads a team of professionals serving health care clients across the country; he is also a member of the firm's global leadership team for health and life sciences. Will has been a strategic consultant for more than 17 years based in New York and Toronto and has served many of North America's top academic medical centers, as well as health ministries and regional authorities across Canada. He is an adjunct professor at the Center for Health Strategy at the Rotman Business School at the University of Toronto and was a visiting research fellow at Yale University's School of Management for the 2002-03 academic year. He serves on several boards, including the Children's Aid Foundation, the Institute for Clinical and Evaluative Sciences and the Information Technology Association of Canada – Health Division. He and his wife are foster and adoptive parents licensed through the Children's Aid Society of Toronto and previously through Bucks County Children and Youth Services.

Dr. Carol Herbert is Dean of the Schulich School of Medicine & Dentistry at the University of Western Ontario and a professor in the Departments of Family Medicine and Pathology. She graduated in medicine from the University of British Columbia (UBC) and practised as a full-service family physician, including in maternity care, for nearly 30 years. She was head of the UBC Department of Family Practice (1988-98) and a founder of the UBC Institute of Health Promotion Research. She has served on many boards, task forces and committees and she co-chaired the Health Canada Advisory Committee on Inter-professional Education for Patient-Centred Collaborative Care. Carol has three children, three stepchildren, and 10 grandchildren.

Dr. Art Leader is a physician and professor of Obstetrics, Gynecology and Medicine at the University of Ottawa, and a co-founder of the Ottawa Fertility Centre. He is a member of the Royal College of Physicians and Surgeons (Canada) and the American Society for Reproductive Medicine and is a past president of the Canadian Fertility and Andrology Society (CFAS). Art has received Awards of Excellence from both the CFAS and the University of Ottawa. He has also chaired expert working groups for Health Canada and is currently chair of a Canadian Standards Association subcommittee on assisted human reproduction. He is the father of an in vitro fertilization (IVF) daughter.

Danny Roth is the founder and President of Brandon Communications, a Toronto-based public relations firm. He currently serves on the board of the Save A Child's Heart Foundation, Canada. He is also an officer and executive member of the Canadian Jewish Congress, Ontario Region and is on the Board of the Infertility Awareness Association of Canada, where he's been a committed advocate for Canadians struggling with infertility. Danny and his wife Jillian are proud adoptive parents.

Sharon Sell is a Private Adoption Practitioner in the Halton region and a social worker. She completed her undergraduate degrees in psychology and social work at York University and her masters in social work at the University of Toronto. Sharon has a private practice working with adoptive parents who are adopting internationally, privately in Ontario or through a children's aid society. She has more than 23 years' experience in child welfare, including seven years serving as a supervisor of an adoption department.

Jan Silverman co-founded the first Canadian infertility support network, Infertility Facts and Feelings. In 1992, after earning a second masters degree at the Ontario Institute for Studies in Education, she established the Infertility Support and Education Program at Women's College Hospital. In her work there, she continues to counsel on infertility and related reproductive issues, lectures and supervises nursing and medical students. She is a past chair of the Ontario Women's Health Network and created her family by adopting two children.

Mary Wong is the founder of ALIVE Holistic Health Clinic, located in downtown Toronto, specializing in women's health, gynecology, and fertility by integrating acupuncture and Chinese medicine with mainstream medicine. She completed her bachelor's degree in biological sciences at McMaster University and went on to receive her doctorate in traditional Chinese medicine in 1993 from the Canadian College of Acupuncture and Oriental Medicine in Victoria, British Columbia. She is a member of the Canadian Society of Chinese Medicine (CSCMA), the Ontario Acupuncture Examination Committee (OAEC) and is a Fertile Soul practitioner. Mary is a practitioner and educator committed to making a difference for people struggling with infertility. Having faced fertility challenges herself, she is currently looking at adoption through China.