

**Changing Developmental Trajectories:
Evidence Based Policy to Deal with
Pregnancy of Girls in Long-Term Care**

by

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B.A. (Political Science), Simon Fraser University, 2007

PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF PUBLIC POLICY

in the
Public Policy Program
Faculty of Arts and Social Sciences

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SIMON FRASER UNIVERSITY

Fall 2011

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Abstract

This study addresses the problem of high pregnancy rates among children and youth in BC government care compared to those in the general population. Key research questions addressed are: a) What is the BC structural and legislative context for girls in care and what role does this play in contributing to their higher than average pregnancy rates; and b) What can BC learn from the policies, guidelines, and program implementations of other jurisdictions that have attempted to deal with this problem in their own at-risk populations?

Research findings show that BC children and youth in care lack access to targeted, coordinated and holistic health services. A policy requiring the development of standardized guidelines, as well as set of indicators of psychosocial development to be documented within an integrated monitoring system in order to track the health and well being of children in care, is recommended. This is imperative to bolstering the well-being of children and youth in care and in turn reduce pregnancy rates. An additional recommendation, to pilot a health care coordinator program in one BC health region, is made.

Keywords: children and youth in care; foster care; early pregnancy; risk and protective factors; health and preventative care.

Executive Summary

A report on the health and well-being of children in care in British Columbia (BC) found that girls in long-term foster care become pregnant at a rate four times greater than girls in the general population (PHO & RCY, 2006). This study seeks to address the above problem as higher pregnancy rates of girls in care relates to greater health and social spending as well as, and more importantly, several negative implications for both young mothers in care and their children. These include lower educational and health outcomes as well as economic disadvantage (James et al., 2009; Dahinten et al., 2007; Coley & Chace, 1998; Dubrow et al., 1990).

The research questions, which directed this study, are as follows:

- 1) What is the BC structural and legislative context for girls in care and what role does this play in contributing to their higher than average pregnancy rates?
- 2) What can BC learn from the policies guidelines, program implementations and interventions of other jurisdictions that have attempted to deal with the issue of high pregnancy rates for girls in their own at-risk populations?

Research Findings & Study Conclusions

Research found that there is a lack of systematic health care monitoring as well as limited preventative service provision for children and youth in care in BC. Other findings show little integrated care between health and social services, for children in care, as well as lack of formal guidelines on the minimum health delivery standards for this demographic.

The study concludes that:

- Early pregnancy must be seen and addressed within the context of more general risk factors in a child or youth's environment
- Children and youth in care are more vulnerable to risk factors and are further marginalized and disadvantaged

- There is a need for more proactive service delivery in order to neutralize risk factors and adjust for any divergence from healthy developmental trajectories

Policy Options and Recommendations

Policy options identified in the study are as follows:

- 1) *Creating standardized guidelines for integrated health service delivery*, which addresses the lack of, targeted integrated health and social services to children and youth in care.
- 2) *Adopting the Multidimensional Treatment Foster Care (MTFC) model* in high need foster homes as an intervention to address girls at high risk of pregnancy.
- 3) *Adding a sexual health education module in the foster parent education program* to enhance foster parent ability to support children and youth in their care on matters of sexual health and relationships.
- 4) *Implementing Health Care Coordinators for every child and youth in long-term care* in order to enhance all health service management and delivery (with special focus on preventative care).

To assess the suitability of the options listed above, each policy option was evaluated according to a set of criteria that included: the policy options' effectiveness, its political feasibility, its implementation and administrative complexity, its cost and the level to which the policy enhances well-being of the population. The following recommendations were made:

- A set of indicators of psychosocial development must be established and documented for each child in care, as well as an integrated monitoring system developed to track the health and well-being of children in care,
- More research must be undertaken to study the cultural implications relating to early pregnancy and Aboriginal children and youth in care as well as potential policy strategies to deal with this issue
- Standardized Guidelines for Integrated Health Service Delivery should be created to form a basic strategy on poor health outcomes including early pregnancy.
- Finally, implementation of Health Care Coordinators for children in long-term care in order to facilitate health and social service integration and access to comprehensive, holistic and consistent health services.

To the two loves of my life, Tony and Matteo. God is truly good...

Acknowledgements

I could not be more appreciative of the immense support received from my supervisor, Judith Sixmith, my internal examiner Maureen Maloney and the School of Public Policy Director, Nancy Olewiler. The kindness and understanding that you extended to me during this stressful and exciting time in my life will not be forgotten.

Thank you to my wonderful family and friends for patiently listening when I needed an ear, advising when I needed direction and, most importantly, encouraging when I felt it too tough to persevere. I could not have done it without you.

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1: Introduction & Policy Problem

As of 2005 there were 9,080 children in care in BC (PHO & RCY, 2006). Of this number, 60% are in continuing care (Ibid). This means that approximately 5,448 children are in care as a result of a continuing custody order that makes the Director of Child Welfare the sole guardian of the child (see Appendix C for info on custody under the CFCSA). It is necessary to highlight that while Aboriginals make up only 7% of BC's total population, 49% of children in care are status Indian (Ibid). In addition to this, Aboriginal children in care tend to have low educational and health outcomes when compared to the general children and youth in care population (Ibid). With this stated, Aboriginal children and youth in care operate within different organizational and governance structures, as well as different cultural norms, than non-aboriginal children and youth in care. There is also a great deal of jurisdictional complexity associated with Aboriginal children in care as funding for health and social services lie within the Federal government's scope of power, while the planning, implementation and delivery of services are with Provincial ministries and regional authorities. Due to these complexities and the above stated factors, I have chosen to focus more generally on the children and youth in long term care population. Aboriginal children and youth are most definitely represented in this population and therefore common risk factors with children and youth in the general population will be addressed through the following research. The general population of children and youth in long term care in BC are therefore the focus of my research since their longer-term presence within the child welfare system allows for new policies and practices to play a positive role in their lives.

Recent studies in child welfare research have been increasingly underscoring the gaping health and educational outcome disparities between children in long-term government care and those in the general population. In BC, one of the disparities that is increasingly troubling is that

of high pregnancy rates of girls in long term care. A report produced by the Office of the Provincial Health Officer and the BC Child and Youth Officer in 2006, used Medical Services Plan (MSP) billing data to determine that females in continuing care, between the ages of twelve to nineteen, become pregnant at a rate four times that of females, within the same age range, in the general population. This poses a significant problem as several studies in child welfare suggest that early pregnancy can contribute to significant negative consequences for both mother and baby (James et al., 2009; Dahinten et al., 2007; Coley & Chace, 1998; Dubrow et al., 1990). Girls who become pregnant in care are known to experience greater educational, health, social and economic difficulties (James et al., 2009; Coley & Chace, 1998). Children of girls in care are also more likely to suffer from low educational (Furstenberg et al. 1987, as in Dahinten et al., 2007) and health outcomes (PHO & RCY, 2006) as well as elevated levels of maltreatment, engagement in risky sexual behaviour (De Paul & Domenech; Jafee et al., 2001 as in James et al., 2009) and criminal activity (Furstenberg et al, 1987; Jafee et al., 2001 as in Dahinten et al., 2007) at an early age.

Accordingly, the policy problem to be addressed in this study is as follows:

Girls in care become pregnant at a rate four times greater than girls in the general population.

This is a problem as children and youth in care are generally at greater risk of poor socio-economic outcomes and marginalization and should therefore not be further disadvantaged by preventable health outcomes (Bilchick et al., Dahinten et al., 2007, James et al., 2009).

It is imperative that the above problem be viewed from a public policy lens in order to begin to fully explore and address the various structural elements present within British Columbia's child welfare, health and social services systems that contribute to its existence. Girls in care must not be seen as independent actors who are acting out solely because of history of trauma or ill socialization, rather that they are acting within a larger system that provides the structure and avenues within which they make the right or wrong decisions. When that structure

fails to adequately provide healthy environments, through consciously placed insulating protective factors, where children and youth feel nurtured and valued, negative developmental consequences, such as early pregnancy and its related impacts become a reality. Developmental trajectories of children in care, and their general resilience and well-being, are thereby greatly affected by the structures put in place by public policies and initiatives (Interview with Wright, 2011). In addition to the role of the public health and child welfare systems, this problem is associated with significant public expenditures. Such expenditures are associated with a variety of health and social services ranging from pre and post-natal health service utilization, labor and delivery, lab and imaging, neo-natal, community outreach or public health outreach and additional child welfare services (should the infant also be admitted into government care).

2: Context of Pregnancy in the Foster Care Population

By far the greatest disparity in health outcomes between the general population and children in care in BC, is that of teen pregnancy (RCY & PHO, 2006). Girls in continuing care, who become pregnant have a higher likelihood of having pre and post natal complications because of existing health problems, including mental health and substance abuse (Ibid). It is important, however, to properly contextualize these assertions, as they can be quite misleading. Such claims can be interpreted to assume a causal relationship between children placed in foster care and heightened pregnancy rates. The discussion surrounding such a serious issue is not necessarily that the foster care system creates generations of teen mothers with mental health problems, but rather that girls that live in such a reality may be at higher risk of such problems because of previous family history and psychosocial development which led to their placement in foster care. When dealing with the subject of children in care, one must be aware that this is an unrepresentative sample of the general population and that children placed in care are there specifically for reasons relating to their neglect, abuse, family instability, parental substance addictions, poverty or trauma. These factors combined with what children become exposed to in the foster care environment may put them at greater risk for engaging in health risking activities (James et al., 2009). One can thus safely assume that the disparity in their health outcomes is both a function of the aforementioned pre-existing risk factors and a lack of developmental protective factors and the exposure to developmental risk factors in the child welfare system. Both the presence of developmental risk factors and lack of protective factors in a child's life facilitate a variety of future undesirable outcomes, and a skewed developmental trajectory that may be characterized by engagement in criminal activity, substance abuse, lack of school completion and teen pregnancy (Interview with Wright, 2011).

3: Determinants of Early Pregnancy: A Discussion of Protective & Risk Factors

This section extends from the previous to unpack a variety of risk factors, that may be present within a child or youth's foster care environment or in previous family history, which are often associated with early pregnancy. While risk factors presented are applicable to the general population, children and youth in care, and their environments, often exhibit them in clusters, where several risk factors accumulate to increase vulnerability to negative developmental outcomes. In addition to this, while it may be true that some risk factors have more weight in terms of their effect on developmental trajectories, there are no studies that compare them and attribute greater impacts to one more than another. It is generally accepted, however, that risk factors have an increasingly greater impact as they accumulate (Luster & Small, 1995). This is specifically true when referring to engagement in early sexual activity and early pregnancy (Ibid). A discussion of risk factors provides insight into the possible protective factors that can be incorporated when attempting to make policy and practice changes that are effective adjusting a child or youth's developmental trajectory and thereby reducing chances of early pregnancy.

One of the main roles of social workers is in child protection; where a child or youth is removed from his or her original familial setting because his or her neglect or abuse: to ensure their safety. When girls in care become pregnant and their social worker is aware of the mother's potential substance abuse problems, or that she struggles with a mental health disorder, the perceived risk to the unborn child is very high. In addition to this, social workers, usually overwhelmed with large caseloads, who are managing cases with pregnant girls are most often aware of the fact that the girls are engaging in risky sexual activity prior to their pregnancy but are unsuccessful in taking effective preventative action; the same is true of foster parents. This

may largely be due to the fact that children and youth in care who are engaging in risky sexual behaviour are doing so as a result of a great deal of underlying, and un-dealt with, developmental factors (Interview with Wright, 2011). With the above said, early pregnancy prevention is often unsuccessful when tackled on its own as an isolated outcome. It must be seen within a context of several developmental risk factors that contribute to its existence.

3.1 Relationship Continuity & Sexual Health Literacy

A New York Times article titled, “Teen Pregnancy: An Epidemic in Foster Care” highlights statistics found by a study from the University of Chicago that are very similar to those collected by the BC joint report on children in care and high pregnancy rates. The ongoing longitudinal study titled “Midwest Study of the Adult Functioning of Former Foster Youth” found that nearly half of girls who had spent time in the foster-care system had been pregnant at least once by the time they were 19 years old (Sullivan, 2009). The article points to two interrelated factors that lead to girls in care becoming pregnant. Firstly, a lack of relationship continuity and family-like intimacy or stability; secondly, it points to a lack of sex education and literacy on safe sex practices. Children enter the social welfare system with psychological and emotional fragility as well as possible existing health problems and are moved from home to home, making and breaking relationships as they go (Chase et al., 2006). Each parent that assumes the role of primary caregiver is not aware of what has been covered in terms of safe sex education with the foster child or youth and assumes that the previous foster parent covered it. Sometimes foster parents avoid the topic altogether, due to lack of confidence, religious beliefs or presence of embarrassment surrounding the subject (Ibid). Generally there is a lack of clarity in terms of whose role it is to speak to children in foster care about sex and contraception (Ibid). This sort of situation results in children falling through the cracks of a disjointed and inconsistent system where developing healthy relationships or feelings of belonging is difficult and in turn may never receive the consistent and continuous ‘parenting’ or support on issues of sexual

development during years of puberty and adolescence (Sullivan, 2009, Chase, 2006, Becker & Barth, 2000). In addition to the lack of foster parent support on the issue of sexual health education, children and youth in care may not receive, or miss, sexual health education through schools due to the transient nature of foster care placements (Becker & Barth, 2000). A study on foster kid's access to sexual health education in California found that those who had accessed it at schools found "its themes and messages irrelevant to their living and social situations and more suited to youths who were residing in stable, single-family homes, with clearly identifiable and accessible parent figures with whom they could discuss the material" (Ibid, 272-273).

An article published in *The Canadian Journal of Human Sexuality* discusses the findings of the 2008 *BC Adolescent Health Survey* (BC AHS), which included several questions regarding protective factors that have been associated with healthy sexual development. This article also supports the aforementioned protective factors; it states that family connectedness plays a vital role in determining the odds of early sexual intercourse and early pregnancy (Saewyc et al., 2008). BC adolescents with the lowest family connectedness were found to have much greater instances of early sexual intercourse and pregnancy than those of the same age with high family connectedness (Ibid). The cause of this may be related to findings from the Chase et al. study which points to children in care having experienced several risk factors, associated with their placement in care, of rejection and abandonment that create a strong need "to form strong attachments and to 'be loved'" (Ibid, 447; Becker & Barth, 2000). The study was based on extensive interviewing of young men and women who had been previously in the foster care system and had impregnated a girl or become pregnant. They note that there was a great frequency, within the interviews, of girls speaking about "their need to love and care for someone as reasons for wanting to continue with the pregnancy" (Ibid, 447).

Following from the above, instability of residence and transient relationships with adults and peers, and a general lack of connectedness result in unintended pregnancies where girls in care

believe "...having a child is a way to create a family that they don't have, or to fill an emotional void" (Sullivan, 2009, 1) that having their own child will bring them a sense of belonging (Chase et al., 2006, Becker & Barth, 2000). This said, emotional influences seem to play a common role in the determination of whether a girl in care becomes pregnant and chooses to keep her child (Ibid).

3.2 School Attachment, Self-Esteem & Future Aspirations

There is also prolific literature that suggests lack of school attachment as a risk factor for early pregnancy (Chase et al, 2006, Kerr et al, 2009, Saewyc et al, 2006, Dahinten et al, 2007, Becker and Bath, 2000). Many adolescents involved in the Chase et al., study "described highly disrupted experiences of education, characterized by frequent changing of schools, regular truancy, exclusion and consequently poor educational aspirations" (Ibid, 441). Poor educational outcomes and, often, aspirations in turn add to children and youth in care having a grim outlook on their future, where they "...have trouble seeing themselves as making something of their lives, going to school and getting a good job, so there's no real reason to postponing pregnancy", especially if they feel that this may give them more attention or will convince their boyfriend to stay with them (Stoeltje, 2009, 1). Generally, many studies link lack of school connectedness, extracurricular involvement and self-esteem with earlier sexual intercourse and teen pregnancy rates (Saewyc et al, 2006, Dahinten et al, 2007, Becker and Bath, 2000). This provides grounds for policy and practice interventions that are characterized by a strong focus on self-esteem building, empowerment and educational supports for children and youth in care as a means of preventing early pregnancy.

3.3 History of Sexual Abuse & Trauma

History of sexual abuse has also been linked to early first voluntary intercourse as well as lower rates of contraception use and as a result teen pregnancy (Saewyc et al, 2006, Dahinten et

al, 2007, Becker and Bath, 2000). Since the child welfare system is set up in a way that makes its primary concern the safety of the child, many child protection cases that result in the placing of children in care, are due to reasons of sexual abuse and trauma. One can thus infer that the population of children in care is overly represented with children who have this sort of history. This puts those girls in care, with a history of sexual abuse, at a higher risk of early pregnancy because of their lack of self-esteem, proven difficulty in negotiating contraception use and increased risky sexual behaviour (Ibid).

3.4 Cultural Factors

The presence of differing cultural histories and norms may also contribute to early pregnancy rates. This is especially true of Aboriginal children and youth in care, as many suggest that several First Nations traditions do not discourage or negatively associate with early pregnancy (Montgomery-Anderson, 2003). Such an example may be largely attributed to the history, and current reality, of social, cultural and economic deprivation in many Aboriginal communities, specifically those on reserve (Maticka-Tyndale et al., 2001). Aboriginal children and youth in care therefore tend to be exposed to additional risk factors that are largely of little concern to the general population of children and youth in care. These are associated with a child or youth's family and community including: widespread poverty, history of sexual abuse, lack of education and substance abuse. These risk factors are prevalent within many Aboriginal communities due to a long history of colonialism and Canadian assimilationist policy (Vermette, 2008). Residential schools, enfranchisement laws and other policies, facilitated through the Indian Act, assisted in the development of social and economic disparities between the general population and Aboriginal communities as well as generated the aforementioned risk factors (ibid). This may explain their higher than average pregnancy rates as cultural risk factors would compound with other risk factors, exhibited by the those in the general population of children and

youth in care, to place those of Aboriginal descent at greater risk of early pregnancy and other negative developmental outcomes.

The aforementioned risk factors associated with negative developmental outcomes, in the general population of children in care, provide grounds for informed and holistic preventative policies and mechanism. These would aim to support children and youth in care through adjusting their developmental trajectories by promoting feelings of self worth, belonging, connectedness and empowerment, thereby greatly reducing negative outcomes including early pregnancy. Since there is evidence to show that the cumulative effect of risk factors is much greater than the presence of one or two of these, a policy approach that seeks to neutralize several risk factors would prove the most effective in reducing the likelihood of early pregnancy (Luster & Small, 1995).

4: Negative Impacts on Mothers

The problem of disproportionately high pregnancy rates for children and youth in care, resonates clearly when assessing its affects on the health and well being of young mothers and their infants. Early pregnancy, particularly for girls in care, has been proven to disadvantage mothers and their offspring in the realms of educational attainment, socio-economic mobility and health. A discussion on the various suboptimal effects of early pregnancy is central to establishing high pregnancy rates of foster care youth as a problem warranting public policy and practice change.

Although it may be true that teenage girls, in general, who become pregnant and decide to continue with their pregnancy, experience problems with poor health and educational outcomes as well as economic ones, those in care are more seriously affected as they usually lack strong support networks and stability in terms of familial attachment and permanency. Girls in care are also more likely than others to have pre-existing problems with education and health (Knight, et al, 2006), which puts them at higher risk of being caught in a spiraling cycle of social and economic disadvantage and deprivation (Bilchik et al., 2010). The following section will seek to establish the current context for children and youth in care in BC, with regards to their educational and health outcomes. This is done with the intention of underscoring the realities that put girls in continuing care at greater risk of social and economic disadvantage as a result of early pregnancy.

4.1 Education

A second report written by the BC Provincial Health Office and Representative of Children and Youth, in 2007, on the educational outcomes of children in care shows that children

in the general population are three and a half times more likely to graduate from high school than kids in care (PHO & RCY, 2006). Also, only twenty six percent of girls in care graduate high school compared to eighty two percent of girls in the general population (Ibid). Low educational achievement, within this demographic, may be due to several factors that are associated with the environment of foster care in addition to pre-existing behavioural and learning disorders. This may include lack of support or healthy relationships, engagement and monitoring from foster parents or frequent change in foster home placements (Chase et al., 2006). With the above in mind, it is not difficult to see why pregnancy for girls in care may create additional roadblocks to their completion of high school certificates and higher educational attainment.

4.2 Health

The first report written by the BC Provincial Health Office and The Representative of Children and Youth clearly evidenced that children in care are facing greater health concerns compared to the general population. Technologically assisted tracking and assessment of health care utilization, from MSP billings and Pharmanet dispensation, has facilitated detailed quantitative knowledge of this immense disparity. The joint report found that “In general, with the exception of neoplasms (cancer), children in continuing care were 1.2 to 4.1 times as likely to be diagnosed with a medical condition than were children who had never been in care” (Joint Report, 2007, 18). Of these conditions, respiratory, injury, perinatal, mental health conditions and pregnancy were most striking in their figures. Since mental health illnesses are intimately linked with new motherhood and particularly adolescent pregnancy (Tonnelly, 2005), I have chosen to further explore this particular health outcome to demonstrate additional negative health consequences of early pregnancy for girls in care.

4.2.1 Mental Health

Statistics show that children in continuing care have disproportionately greater mental health problems than children who have never been in care. This can have significant impact on a young mother's postnatal psychiatric health. Mental health, as defined by the American Heritage Dictionary is "a state of emotional and psychological well-being in which an individual is able to use his or her cognitive and emotional capabilities, function in society, and meet the ordinary demands of everyday life"¹. About sixty five percent of children in continuing care in BC were diagnosed at least once with a mental disorder by a physician, compared to seventeen percent of children in the general population (RCY & PHO, 2006). Also, data collected from Pharmanet, a BC-wide electronic record system that collects data on dispensed prescription drugs, shows that children in foster care were prescribed anxiolytic and psychotherapeutic medication (medication meant to treat psychosis and anxiety disorders) at rates significantly higher than those of children in the general population. Pharmanet data shows extremely high rates of dispensation for Ritalin-type drugs, a rate eight and a half to twelve times more than children in the general population (Ibid). It also shows anti-depressants, tranquilizers and anti-psychotics are dispensed at a rate five and a half to eight times higher than the rates dispensed to children and youth in the general population (ibid). The above figures suggest that girls in care who become pregnant are highly likely to be, or have been, medicated for pre-existing mental health conditions. History of previous mental illness, specifically depression, greatly increases the chances of an early mother experiencing such psychiatric illnesses as post partum depression (Roberston et al., 2004; Hay 2009). In addition to this, having a pre-existing mental health condition could significantly affect the mother's ability to care for her child should she maintain custody of the child (Sit D., et al., 2006, as cited in Hay 2009). Post partum depression's affect on early maternal interaction will be further discussed in the subsequent chapter titled "Impacts on Offspring."

¹ <http://dictionary.reference.com/browse/mental+illness>

The issue of mental illness and its prevalence among children in care also links with a high correlation or co-occurrence with substance abuse problems (Burrow et al., 2007). This adds another layer of concern with high pregnancy rates among girls in care. If having a mental illness in fact increases one's chances of having substance abuse problems, or vice versa, then girls in care are at higher risk of further negative impacts on their health and ability to care for their child.

Due to the fact that early pregnancy impacts the socio-economic well-being and health of girls in care, the benefits of implementing policy and practice that seeks to mitigate high pregnancy rates is imperative to fulfilling government's obligation as sole guardian of children and youth in this already at-risk population.

5: Negative Impacts of Young Maternal Age & Foster Care Placement on Offspring

In an American study conducted on risk factors for alcohol and marijuana use in foster care youth, research findings showed that in a sample of 320 adolescents in foster care, 40% used alcohol, 35% had previously used marijuana and 25% admitted to using both in the six months prior to the study (Thompson & Auslander, 2007). With that stated, the foster child population is at significantly higher risk for engagement in seriously health compromising behaviour (Burrows et al., 2007, James et al., 2009, Kerr et al, 2009), many girls in care who become pregnant, may not be aware of the negative effects of such behaviour on their unborn child. Girls with substance abuse problems often have children who are born addicts or have seriously compromised physical and cognitive functioning and need special and specific care. In addition to this, babies born to a mother suffering from depression or drug addiction are also at higher risk for neglect, abuse, and depression or, at the minimum, “lower than optimal cognitive development and academic progress” (Falke & Johnson, 2007, 198). One reason for this may be because mothers may not know how to cope with their newfound responsibility, given their mental health or substance problems, and lack the strong family support structures that may be able to assist them in child rearing.

Many children born to teen mothers are taken into care themselves at an early age. According to a policy brief by the American National Campaign to Prevent Teen and Unplanned Pregnancy, they are approximately 2.2 times more likely to end up in the foster care system (2008). One would imagine that girls who become pregnant in care represent a high degree of such cases since they are faced with a greater amount of risk factors, as discussed previously, than teens in the general population. This has become a significant problem as it further perpetuates

the vicious cycle (Rutman et al., 2002) where a child admitted to care loses family connectedness, has little or no permanency or continuity of care as well as relational intimacy and becomes himself or herself more likely to develop the same way that his or her mother did up to the point of her pregnancy.

Children of girls in care, once school aged, encounter several problems as they lack the same social supports that their mothers lack in the welfare system. Several studies show that children of women with low maternal age have great difficulty in the education system (Coley & Chase, 11, Dahinten et al., 2007, Kerr et al., 2009). Most of them have mothers who have very low levels of education themselves who may not place great emphasis on education or are unable to support the child in maintaining school attachment. Low maternal age and education (under 12 years) have also been linked to poor behavioural adjustment of offspring and greater chances of delinquency in adolescent years (Kerr et al., 2009; Furstenberg et al., 1987 as cited in Kerr et al., 2009; Wadsworth et al., 1984 as cited in Kerr et al., 2009). Maternal poverty, depression and low-maternal self-esteem were also linked to a presence of child behavioural problems and, as mentioned previously, lower than average cognitive development (Ibid; Falke & Johnson, 2007). Studies carried out to question how young maternal age affects children's development and education shows that the most significant impact on offspring appears during adolescent years of children (Dahinten et al., 2007). This is evident in "...higher rates of grade failure, delinquency, incarceration, and early sexual activity" (Ibid).

Children born to mothers with little education and pre-existing health conditions are shown, through a variety of studies, (Kerr et al., 2009; Furstenberg et al., 1987; Wadsworth et al., 1984; Falke & Johnson, 2007; Dahinten et al., 2007) to have significant negative health, educational and behavioural outcomes. Premised on this, the development of policy and practice that address early pregnancy rates of girls in long term care will aid in diminishing the rates of children born subject to such compounding risk factors.

6: Pregnancy Related Health Service Utilization & Associated Costs

A report issued in 2006 by the Canadian Institute for Health Information (CIHI) titled “Giving Birth in Canada: The Costs” provides the only data available on costs associated with pregnancy, pre and post-natal, neonatal care as well as labor and delivery in Canada. To date, there are no published reports from the Ministry of Health Services, or any other sources, on pregnancy related health service utilization and cost in BC. This chapter summarizes some of the data found in the CIHI report in order to shed light on approximate spending on pregnancy related health services and the possible benefits of implementing policy aimed at reducing pregnancy rates of children and youth in care who have a greater pregnancy rate than those in the general population. The figures presented below, and in Table 1, represent a conservative approximation of spending on pregnancy and delivery related health services. Since figures have been extracted from the CIHI report, which largely focuses on national data, I was unable to determine specific costs such as dollars spent by BC health authorities on inpatient pregnancy and childbirth services. Only figures on BC fee-for-service physician claims, which represent a fraction of health care expenditures per pregnancy and delivery, could be ascertained.

6.1 Prenatal Health Services

Statistics Canada data from 2000 and 2001, shows that 88% of women with children aged 0 to 11 months received prenatal care from physicians who mostly comprise of general practitioners (CIHI, 2006). It was also reported by the BC Ministry of Health Services in 2004-2005, that follow-up prenatal visits ranked among the ministry’s top 50 expenditure items for fee-for-service billing claims (ibid). Spending on prenatal follow-up visits reached a total of \$10

million that year with an average payment of \$29 per visit (ibid). According to BC vital statistics, the number of live births in 2004 was approximately 40,318². These figures do not include routine ultra sounds that are usually done and at least once, for every pregnancy at approximately 20 weeks gestation. They also don't include routine screenings for birth defects, such as Maternal Serum Screening, which the BC Medical Services Plan currently covers.

6.2 Labor & Delivery Services

Canadian hospitals spent an estimated \$821 million on inpatient pregnancy and childbirth services in the same year (ibid). This accounts for approximately 6% of total hospital inpatient spending. Inpatient pregnancy and childbirth services include, at a very general level, provision of hospital beds, any medication administered in hospital, imaging or lab testing completed in the hospital and care provided by nurses and other salaried staff. In addition to inpatient hospital costs, payment for fee-for-service physicians providing obstetrical services, excluding therapeutic abortions, totaled approximately \$154 million from 2002 to 2003 (ibid). This amounts to approximately \$470 per live birth in Canada (ibid).

Figures on BC fee-for-service physician claims for both pre-natal follow-ups and obstetrical services total \$719 per pregnancy and delivery. Again, this does not include hospital costs, variation in mothers' length of hospital stay, imaging, screening, genetic counseling services, neonatal care, medication or services administered by community based public health nurses or any other services that would be accessed outside of seeing a physician. In short, the numbers listed are a small fraction of how much is spent on pre, post and labor and delivery services in BC.

Due to the lack of publicly accessible information on the number of live births or pregnancies among girls in foster care, it is exceedingly difficult to cost the early pregnancies of

² <http://www.vs.gov.bc.ca/stats/annual/2004/index.html>

this specific demographic. With that said, the joint report on health and well-being of children in care, written by the BC Representative of Children and Youth Office and the Provincial Health Officer, shows that girls in care become pregnant at a rate 4 times greater than girls in the general population. This statistic transfers to this specific demographic utilizing pregnancy related health services at a much greater rate than would normally be the case if they were at the same developmental, academic and socioeconomic level as the average child or youth in the general population. Accordingly, there are considerable cost savings, in health care expenditures, in adjusting policy and practice to create environments where girls in care are insulated from pregnancy predisposing developmental risk factors.

Summary Table 1: Costs Associated with Early Pregnancy and Children in Care

Item Description		Cost
Health Care Costs		
Prenatal Services (general population)	Total fee-for-service physician billing costs for follow up prenatal visits by BC women (2004/05)*	\$10 million
	BC average fee-for service cost per follow up visit	\$29.00
Labor & Delivery Services (general population)	Spending on inpatient pregnancy and childbirth services by Canadian Hospitals (2002/03)	\$821 million
	Total fee-for-service payment to Canadian physicians providing obstetrical services	\$154 million
	Total fee-for-service payment to physicians per live birth in Canada	\$470
Prenatal follow-ups & Labor and Delivery Services	BC fee-for-service physician claims	\$719
National figures on total dollars spend on labor and delivery services* *	Hospital inpatient spending and fee-for-service physician claims for obstetrical services	\$975 million

*Do not include routine screening and imaging costs

** Does not include prenatal follow-up with family physician, routine screening, imaging and lab testing, community pre & post-natal services etc.

7: Why Boys Matter

Although there has been a great emphasis on attempting to understand the risks and consequences of early pregnancy for girls in care, it is extremely important that boys are not left out of the equation. Boys must be seen as contributing actors to the current problem and exploring determinants of boys impregnating girls can possibly help in contributing to the mitigation of high pregnancy rates in that specific population. Many of the risk factors associated with girls' pregnancy, as mentioned above, are relevant to boys as well. For example, the BC AHS found that boys who had a history of sexual abuse also had a higher likelihood of earlier sexual intercourse and are half as likely to use contraceptives as boys who have no history of sexual abuse (Saewyc et al., 2006). In addition to this, adolescent males who had higher family and school connectedness were a great deal less likely to have engaged in early sexual activity and have caused a pregnancy (Ibid).

Although boys share many of the same risk and protective factors with girls, as mentioned above, the BC AHS survey found that boys' involvement in supervised extracurricular activities had no relation to different sexual health behaviour. This is important in showing the slight differences in affect that some protective and risk factors have on boys verses girls and that they don't always apply generally to both genders.

8: Theoretical Grounding

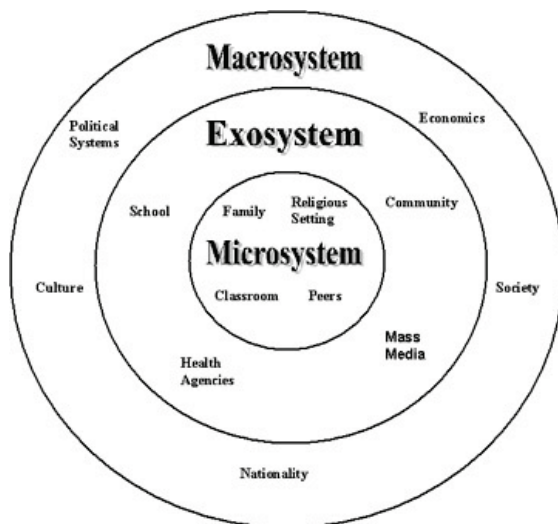
Two psychological developmental models largely inform this research by providing complementary narratives of a child's developmental trajectory and how it is affected by his or her experiences, relationships and surrounding institutions. The ecological and the psychosocial models for human development not only help in establishing a broad context within which to frame high pregnancy rates for girls in care but also establish a coherent and comprehensive framework for responsive policy change.

8.1 Ecological Model of Human Development

Renowned psychologist and author Urie Bronfenbrenner pioneered the ecological development model as a holistic description of human development. It is grounded in the idea that an interconnected network of 'systems' or spheres shapes child development. Bronfenbrenner describes this ecological environment "as a set of nested structures, each inside the next, like a set of Russian dolls" (Bronfenbrenner, 1979, 3). The innermost structure is the Microsystem. This is constituted by the developing individual and his or her immediate setting, including his or her family, classroom, peers and other persons or groups that he or she is directly linked to (Ibid). The next system is the Mesosystem, which is made up of the interactions between different settings within the Microsystem, for example between the classroom and family at parent-teacher interviews. This system underscores the great impact, on a child's development, of two or more settings coalescing (ibid). Outside of this second layer is the Exosystem, which Bronfenbrenner describes as settings where a developing individual "may never enter but in which events occur that affect what happens in the person's immediate environment" (Ibid, 7). An example of settings in such a system would be that of school boards or government ministries or institutions

that could directly or indirectly influence a child's immediate setting (school, family, etc.) through the implementation and administration of policies and protocols. Direct influences are exemplified in school boards and the policy they develop on educational philosophy or budget allocations for special needs services, extracurricular activities or educational resources. Indirect influences can be from a child's parent's workplace or work status. The family setting and its dynamics may be radically different depending on whether a child's parents are employed or have a relaxed or stressful workplace. Essentially the Exosystem is comprised of the settings that can alter or change the status or dynamics within a child's Microsystem. It is in the Exosystem that the role of public policy becomes relevant in how it can affect an individual's development and its trajectory. The Macrosystem encompasses the larger systems that together constitute the greater societal context. These include, economic, political, legal systems as well as social values and norms. The ecological model provides a lens through which policy makers see how their policy choices affect child development and allows for the generation of a holistic framework through which to address policy problems associated with such a topic.

Ecological Model of Human Behaviour



Contextualizing the policy problem within the ecological model of development not only allows for a holistic view and assessment of the problem, but it also unveils other nodes from

which to implement policy interventions to deal with the problem of high pregnancy rates among teens in care. Traditional models that have been previously utilized by governmental and non-governmental agencies in an attempt to reduce pregnancy rates have been more one-dimensional in their interventions and seek to address related factors that are obviously or more traditionally connected to pregnancy such as access to contraceptives and sexual health education. The family planning model of the 1970s and 80s is one of those models, as its main focus is sexual education and literacy on available contraceptives and their use (Brindis et al., 2005). Such a model provides a limited amount of nodes from which to implement interventions that largely target a limited set of developmental risk factors. Such nodes of contact with the child would be the classroom or clinic setting. Today, “pregnancy prevention programs are shifting from a singular focus on knowledge, attitudes, and belief-based interventions and/or interventions focused on access, to services that emphasize multifactorial, multilevel approaches to teen pregnancy” (Ibid, 24). The ecological development model provides several other nodes of contact with a developing individual since it identifies that the different settings in which an individual operates are interrelated and when they interact, with the intention of benefiting the child, they can have a significant impact on the his or her development (Bronfenbrenner, 1979). These nodes can be at the school, clinic, community center, and foster home level. This has serious implications for the development of policy and means that sexual education must be seen as one protective factor and intervention strategy among many others that assists in the mitigation of high pregnancy rates.

8.2 Psychosocial Model of Human Development

The theory of psychosocial development contributed by psychologist Erik Erikson fits well with the ecological development model as it maintains that one of the greatest determinants of a child’s healthy development trajectory is based on the social experiences and interactions, that occur within an individual’s microsystem and macrosystem (Boeree, 2006). According to Erikson’s theory, psychosocial development occurs in eight distinct stages, as illustrated in table

1.1. Each stage is characterized by a different psychosocial crisis that the individual must overcome in order to maintain a healthy development trajectory that provides foundation for the next stage (Ibid).

Table 1.1 Erikson's Eight Stages of Psychosocial Development (Boeree, 2006)

Stage	Age Category	Psychosocial crisis	Significant relations	Maladaptations & malignancies
1	0-1 Infant	Trust vs. mistrust	Mother	Sensory distortion -- withdrawal
2	2-3 Toddler	Autonomy vs. shame and doubt	Parents	Impulsivity -- compulsion
3	3-6 Preschooler	Initiative vs. guilt	Family	Ruthlessness -- inhibition
4	7-12 or so School-age child	Industry vs. inferiority	Neighbourhood and school	Narrow virtuosity -- inertia
5	12-18 or so Adolescence	Ego-identity vs. role-confusion	Peer groups, role models	Fanaticism -- repudiation
6	The 20's Young adult	Intimacy vs. isolation	Partners, friends	Promiscuity -- exclusivity
7	Late 20's to 50's middle adult	Generativity vs. self-absorption	Household, workmates	Overextension -- rejectivity
8	50's and beyond old adult	Integrity vs. despair	Mankind or "my kind"	Presumption -- despair

**Stages relevant to my research are the first six as they encompass years that a child would be in government custody, from infancy to young adulthood (or more specifically 19 years of age)*

Erikson attributes each stage with its significant actors who influence the developing individual's developmental success or failure during that phase (Boeree, 2006). Significant actors such as parents, family, school, community and peers all play a substantial role in a child's healthy growth and transition from one stage to the next, thereby establishing the need for an ecological and relational approach to interventions and strategies that seek to adjust or mend poor developmental trajectories. Brindis et al. identify the merits of the psychosocial model when counteracting high teen pregnancy rates due to its "multiple-level approach" to behaviour (Ibid,

45). They identify five levels of influence that are associated with health-related behaviour that must be taken into account when planning a health intervention:

- 1) Intrapersonal/individual factors, which include young person's knowledge base of sexual health practices and contraceptive use;
- 2) Interpersonal factors, such as communication skills between young people, their partners, peers and family;
- 3) Institutional/organizational factors, like the availability of academic support services, tutoring, peer mentorship opportunities, summer job placement support, and sexual health supports offered through community clinics and outreach workers;
- 4) Community factors, such as established values and norms within a community or media campaigns targeting youth for support in life options;
- 5) Public policy factors, which include government- financed programs aimed at supporting youth and providing specific services to adolescents (ibid, 45-46).

The above levels play a primary role in how my policy options have been developed, as they take into account the different nodes at which individual children and youth in care intersect with other individuals and environments. These intersections can be used together, as primary intervention sites, to adjust for multiple risk factors that lead to early pregnancy.

The psychosocial and ecological development models further ground my research in contributing to policy development that targets the various significant relations and interactions, which need reinforcement or supplementation in order to support girls in government care through their developmental growth. Such policies would seek to avoid the malignancies, or detrimental outcomes, of poor developmental trajectories such as school incompleteness, substance abuse, involvement in criminal activity, and engagement in risky sexual behaviour, which most often lead to unwanted early pregnancy.

9: Methodology & Research Questions

Given the literature review and theoretical grounding presented earlier the key questions this research seeks to explore are as follows:

- 1) What is the BC structural and legislative context for girls in care and what role does this play in contributing to their higher than average pregnancy rates?
- 2) What can BC learn from the policies guidelines, program implementations and interventions of other jurisdictions that have attempted to deal with the issue of high pregnancy rates for girls in their own at-risk populations?

Both questions are informed by the previous section's theories, Ecological and Psychosocial models, which relate strong environmental impacts on individuals' developmental trajectories. It is for this reason that the research questions seek to uncover the structural and legislative contexts, apparent through legislation, policy and program implementation, of various jurisdictions. Such policies have direct affect on services delivered and the environment in which children and youth in care are brought up.

The research questions listed above guide the primary research phase with the aim of delivering consistent data with which to buttress evidence based policy development and evaluation for future steps forward.

9.1 Primary Research Phase: BC Study

A mixed method approach was taken to address the first research question on BC structural and legislative context for girls in care and its role in contributing to their high pregnancy rates. Both document and interview analysis methods were used to ascertain the above. Prior to commencing a document analysis, five informal preliminary interviews and correspondences were undertaken to gauge the relevance of the policy problem and the need for

further research and policy development on this topic. These were conducted with representatives from the Ministries of Health, Healthy Living and Sport as well as Children and Family Development. All those interviewed were senior public servants at the Director level or higher. A document analysis was subsequently conducted using publicly available literature retrieved online. Such literature was mainly found through the MCFD website and outlined policy, processes, guidelines and initiatives attributed to the ministry. In addition, two, one-hour, semi-structured phone interviews were conducted with participation from Senior Policy Analyst, now CIO at MCFD, Mr. Martin Wright and the BC Deputy Representative of Children and Youth, Mr. Jeremy Berland. The purpose of such interviews was to capture any nuances or insights that were not explicit in publicly available documents on the child welfare system and flesh out the modes of service delivery to children and youth in care (See Appendix B for interview schedules). The role of interviews within case study research is very important since it can often "...initiate access to corroboratory or contrary sources of evidence" (Yin, 2009, 107).

9.2 Secondary Phase: Case Studies

In order to address the second research question, which seeks to find value in looking beyond BC's experience with girls in care to other jurisdictions that have recognized the same problem in their own areas of control, two case studies were carried out. The first addresses legislative and policy change taken by England and the United States, while the second looks into particular practice interventions adopted locally by Oregon, California and New York States. The case study methodology was specifically selected for its merits in empirically investigating "...phenomenon in depth and within its real-life context" as well as its ability to manage "...the technically distinctive situation in which there will be many more variables of interest than data points, and as one result" (Yin, 2009, 18). In the case of pregnancy rates for girls in care, these methodological attributes are very desirable since a thorough review of existing literature on

pregnancy rates of at-risk girls describes the problem as a very convoluted and multi-faceted issue (James et al., 2009; Rutman et al., 2002; Chase et al., 2006).

Jurisdictions were chosen for inclusion in the case study following a thorough review of the various jurisdictions that have a) an identified problem with high pregnancy rates of girls in government care, and b) produced initiatives, programs and policy responses to addressing the identified problem. Selection of cases was also dependant on relative similarity of government structure and the social realities of children in care primarily based on the risks factors to which this particular population is exposed.

Starting with my base case, BC, I establish each jurisdiction's current context including their population and legislative profile, as well as their model of social and health service delivery for children and youth in long-term care. England and the US State of Virginia have been profiled for their extensive legislative and policy work regarding service delivery to children and youth in care. Oregon, California and New York are three US states that have, alternatively, been selected because of their well-documented and evaluated interventions targeting pregnancy rate reduction for youth in foster care. These two case study groups provide insight into micro and macro strategies that can be replicated in order to combat high pregnancy rates in at-risk populations.

There are a variety of sources from which to obtain evidence for case study analysis including: documentation, archival records, interviews, direct observation, participant observation and physical artifacts (Yin, 2009). This research utilizes two sources as different ways to identify and collect evidence for analysis: documentation and interviews. Documentation outlining legislation, agency policies, guidelines and or process manuals on service delivery to children in care, was either accessed electronically on government websites or requested and received through a public agency contact. All documents used are published materials (ie. progress reports, formal studies, guidance manuals etc) that are relevant to the aforementioned research questions.

One, hour-long, semi-structured phone interview was conducted with key informant and Senior Manager at the US, National Campaign to Prevent Teen and Unplanned Pregnancy, Itege Bailey.. In addition to this, three informal interviews and correspondence were conducted via phone and email. These interviews were with various individuals involved in program and service delivery. This included the Executive Director of *Options For Sexual Health BC*, a facilitator of the foster parent education program at Hollyburn Community Centre and a consultant from *TFC Consultants Inc.* in Oregon. These interviews were to collect more information regarding the American and Canadian legislative, policy and program contexts. More tacit and current knowledge than was accessed through documentation was attained through these interviews as well as costing details (See Appendix B for interview schedule).

Using the case study methodology uniquely provides for the ability to study how certain policies and programs are received or supported by various stakeholders, as well as determining the success of such interventions in mitigating undesirable events or behaviour prior to adopting them within one's own jurisdiction. With that said, such a methodology has provided my research with evidence based policy direction for recommendations, to be made in latter sections, on BC's pregnancy prevention strategy for girls in long-term care.

9.3 Tertiary Research Phase: Elite Stakeholder Interviews

In addition to the previously mentioned case studies methods, an additional 3 semi-structured stakeholder phone interviews (Gubrium et al., 200) have been conducted subsequent to policy formation in order to gain expert advice and insight into the coherency, feasibility and overall evaluation of policy options. Stakeholders have been selected according to their holding of senior positions in major ministries and other agencies involved in providing oversight on child welfare as well as those responsible, through their mandate, in facilitating policy, program formation and delivery to children in care. Elite Stakeholders include representatives from:

- The BC Ministry of Children and Family Development
- BC Representative of Children and Youth Office,
- The Office of the BC Provincial Health Officer.

The three stakeholder interviews were semi-structured in order to allow for stakeholder's expertise and insights to be fully explored. The semi-structured interview allows for a more thorough exploration of complex issues thereby allowing for unanticipated themes, topics and problems to emerge (Varvasovsky & Brugha, 2000). This methodological quality is especially important in the current context since individuals interviewed are experts in their field and have a great amount of untapped tacit knowledge relevant to organizational and structural barriers to policy implementation. The second research question, which focuses on what BC can learn from other jurisdictions and integrate into its own policies, was the underlying subject being explored in the elite stakeholder interviews. Further policy questions investigated were:

- a) Whether provided policy options had been previously assessed by the represented ministry or agency and how?
- b) Whether these options are viable in BC due to organizational or structural difficulties, what barriers and facilitators exist, and what steps can be taken to enable them to become more viable for implementation?
- c) How policy options can be modified to become more consistent with relevant ministries' mandates while also staying true to their objectives?
- d) Whether any other viable policy alternatives deserve exploration and inclusion into the policy assessment.
- e) Rank policy options according to a set of given criteria (i.e. effectiveness, political feasibility, complexity, cost and cost effectiveness)

Participants in the secondary research phase were given policy options to review prior to their interview in order to ensure appropriate time was given to read and reflect upon initial options developed. All stakeholders participating in interview processes were given a consent form to read and sign preceding his or her interview. Consent forms informed the participants of their right to: 1) remain anonymous and/or choose how they wish to be identified, 2) end the

interview prematurely with no consequences, 3) request that certain parts of the interview be omitted. For more information on stakeholder consent forms refer to Appendix [A].

9.4 Overview of Data Analysis Methods

Thematic Analysis

Thematic analysis is used as the primary technique for analyzing data collected for the case study exploration. It will be used to capture insights that are relevant to the aforementioned research questions and represent a particular “patterned response or meaning” in the data (Braun & Clarke, 2006). For my purposes, themes have been pre-identified with the intention of providing a nuanced description of the similarities and differences across chosen jurisdictions, which is particularly helpful in answering the two elements of the second research question:

- What can BC learn from other jurisdictions that have attempted to deal the issue of high pregnancy rates for girls in their own at-risk populations?
- What policies and programs have proven to deal effectively with reducing pregnancy rates for girls in care?

This method of thematic analysis is specifically termed ‘theoretical’ thematic analysis since it has a precise analytical interest and top-down way of coding where themes do not emerge from inductive exploration of the data (Braun & Clarke, 2006). This was valuable for the purposes of systematically analyzing the data in a way that produced clear contributions to future policy development.

Table 1.2 Overview of Methodology

RESEARCH QUESTION #1			
1st PHASE	BC Study		
		Data Collection	Data Analysis
	Method 1	Informal and Formal Semi-Structured Interviews	Thematic Analysis
	Method 2	Document	Document Analysis
RESEARCH QUESTION #2			
2nd PHASE	Case Study 1: Legislative and Policy Cases (England & United States)		
	Method 1	Document	Document Analysis
	Method 2	Informal and Formal Semi Structured Interview	Thematic Analysis
	Case Study 2: Practice Intervention Cases (Oregon, California & New York)		
	Method	Document	Document Analysis
3rd PHASE	Policy Option Analysis		
	Method	Semi-Structured Elite Stakeholder Interviews	Thematic Analysis

10: Research Findings

The following section will tackle the main research questions put forward in the preceding chapter:

- 1) What is the BC structural and legislative context for girls in care and what role does this play in contributing to their higher than average pregnancy rates?
- 2) What can BC learn from the policies guidelines, program implementations and interventions of other jurisdictions that have attempted to deal with the issue of high pregnancy rates for girls in their own at-risk populations?

10.1 BC Study

Population Profile

A description of the BC population of children in care has been outlined earlier when introducing the policy problem (refer to Ch.1). In BC, as previously mentioned, females in continuing care, from age 13 to 19, saw a physician for a pregnancy or birth related condition more than 4 times as often as a female within the same age category in the general population (PHO & RCY, 2006). In addition to this, females in continuing care were admitted to hospital for a pregnancy or childbirth–related condition about nine times more than females who had never been in care (Ibid).

Legislative Context

The Child, Family and Community Services Act (CFCSA) is the primary piece of legislation which outlines the rights of children and families in BC. It also provides insight into what the Provincial government’s obligations are to children, families and communities. This

section is a brief overview of the principles enshrined in this legislative act as well as the relevant sections to children in care.

Firstly, the Act must be interpreted and implemented in a way that remains true to its guiding principle: safety and well-being of children is paramount. Secondly, interpretation of the act must be compatible with the service delivery principles which include the principle of community involvement, where the "...community should be involved, wherever possible and appropriate, in the planning and delivery of services including preventative and support services to families and children" (Section 1.3, (e)). Thirdly, interpretation of the act must also abide by the principles of best interests of the child. This is where all applicable factors must be considered in resolving what is in the child's best interest. For example: the child's physical, and emotional needs as well as level of development; the child's safety; the importance of continuity in the child's care and the quality of relationship the child has with a parent or other person and effect of maintaining that relationship (Section 1.4).

The portion of the Act that specifically pertains to children in care is section four, which outlines their rights and out-of-home requirements. Rights relevant to the topic of this report are as follows: "(a) to be fed, clothed and nurtured according to community standards and to be given the same quality of care as other children in the placement"; "and "(g) to receive medical and dental care when required" (Section 4.1(a)(g)).] It is important to note that it was determined through interviews with employees of MCFD and the Office of the Representative of Children and Youth, that the CFCSA is a very broad and overarching piece of legislation. It does not contain any statutory requirements outlining a mandated amount of visits to a family physician per year or a requirement for a child or youth in care to see the same family physician for their health assessments and needs. Jeremy Berland, BC Deputy Representative of Children and Youth, stated, *"the challenge is that the legislation says that children have a right to medical and dental care, so they get it. They certainly get care.... but whether or not it is consistent, I would*

be very surprised if its possible to make it consistent” (Interview with Jeremy Berland). Such gaps in the legislation may at times be filled by policies or protocols which attempt to further extend the principles of the act, for example a policy recently adopted has been to require admission and discharge medical reports, requiring a full physical evaluation of a child entering and leaving care. This report is largely form based and limited in scope in terms of requiring specific follow ups or assessing for more underlying causes of health issues (Interview with Wright, 2011). There is little else that BC has, in terms of policy or guidance manuals, that is publicly available to show that consistency and continuity of health care provision and sexual health education to children and youth in care is maintained or practiced in the duration of child’s stay in care.

Service Delivery

In BC, the main Ministries responsible for the management of health and social services are the Ministries of Health, Education and Children and Family Services. Service delivery is implemented at a variety of non-ministry levels. As ascertained through several interviews and literature reviews, health services in particular are not specialized or targeted towards the population of children in care. Although they may have full entitlements to access health services, as outline in the CFCSA, children and youth in care have such access through mainstream service providers, those who may not necessarily be aware of that specific population’s special needs and risk profiles. In addition, health services, as discussed in the next section, have been identified through stakeholder interviews and document analysis to be disjointed in their ability to provide integrated and specialized preventative care. In contrast, there is more publicly available documentation to show that social services and education are being better integrated in an attempt to cater to the foster child, youth and family population and their specific needs.

Health

A recent report by the Canadian Pediatric Society (CPS) highlighted the problems in health service delivery to children and youth in care. The report states that there are “no practice guidelines for meeting the healthcare needs of children in care” and made several recommendations to physicians and ministries responsible for child welfare to improve health care services (CPS Report, 2008). In a stakeholder interview with senior policy analyst, Mr. Martin Wright stated that MCFD has responded to the report issued by the CPS by implementing some of the recommended changes. Such implementations included requirements for the aforementioned admission and discharge physical examinations to be given to every child or youth entering or leaving care. Other recommendations that more generally pertain to medical professionals include more frequent monitoring of children and youth in foster care than the general population, physician partnership with social workers to help maintain thorough medical records, as well as physician awareness of community resources available to assist foster care givers in the care for special needs children and youth. There have been steps taken to facilitate the above through joint efforts by MCFD, the Ministry of Health and the BC Medical Association (BCMA) in providing primary care physicians with the incentive to participate in case planning conferences between social workers, foster parents and other involved parties through the establishment of a specific billing code for case conferencing. Efforts were successful in attributing a specific MSP billing code that allows physicians to bill for up to four hours of case conferencing per child, per annum (Interview with Wright, 2011). Such a feat demonstrates initiative and acknowledgement of the need for more integrated services to populations who are at high risk of poor, and often, interrelated health and social outcomes

With the above stated, Children and youth in care are still experiencing a “*stop and go relationship with physicians*” (Interview with Berland, 2011). While children are now required to

have an admission and discharge medical and there are greater incentives set up for physicians to become better involved with case planning, there is no MCFD policy or guidance manual that lays out a commitment to more consistent integrated health monitoring and service delivery throughout foster care placement. *“It may be that in the course of doing that [admission] physical some issues related to general health promotion or prevention may come up, but that would be entirely dependant on the proclivity of the physician and the interest of the worker of getting the physician to do that”* stated Jeremy Berland of RCY in a stakeholder interview. In addition to this, physicians may be more weary of taking on the consistent delivery of health services to children and youth in care as they may need to become involved in legal processes, such as testifying in court. Mr. Berland states that this a particular challenge as *“there is always a risk, of course, if you are physician seeing a child who is entering care that you are going to have to report on the bruises you saw or the child’s condition”* (Interview with Berland, 2011)

It is thus safe to conclude that specialized health care prevention and promotion for children and youth in care is not systematically present and is largely left to the initiative of individual physicians and social workers, both of whom are experiencing overwhelming caseloads in the province. A result of this lack of consistent preventative care is that children and youth in care tend to utilize acute health services, at a greater degree than children in the general population as their initially preventable and manageable health issues escalate and become more serious (PHO & RCY 2006). This is demonstrated in a variety of figures that include, hospital admissions, medication dispensation, abortions, prenatal and delivery services (Ibid).

Social Services & Education

Around 70-75% of MCFD’s budget goes to contracting service agencies to deliver training and support services to parents, care givers and children in care (Interview with Wright, 2011). Private agencies are contracted with the responsibility of delivering specialized services to the desired population that MCFD wishes to target. There is an elaborate system set up for foster

parent training and support that is administered by different provincial regional authorities. For example, Hollyburn Family Services Centre is one of several that deliver the Foster Support and Education program³ in the Vancouver Coastal Region. This region has just implemented a framework that aims at integrating four agencies in its jurisdiction, including Hollyburn, in order to provide comprehensive and seamless service delivery, which is sensitive to foster family as well as children, and youth needs.⁴ The system for social service delivery is currently based in regional authorities and is largely dependant on their initiative when integrating services with the intention of making them more accessible and effective for clients.

MCFD's "Strong, Safe, and Supported: A Commitment to BC's Children and Youth" initiative, has done a great deal of research on how to provide an environment for children and youth in care that situates them amongst the appropriate protective factors which can enhance their psychosocial experiences and in turn positively influence their developmental trajectories. A large focus of this initiative has been to recognize the importance of cross-ministry coordination as a means through which to establish the above. The result has been an effort to enhance cross-ministry work with the Ministry of Education and has resulted in the "Joint Educational Planning and Support for Children and Youth in Care: Cross-Ministry Guidelines" document. This document, released in 2008, aims to provide social workers, care providers, educators and teachers with support on how to help nurture children and youth in foster care towards educational achievement through significant periods of change or stress in their lives (Joint Educational Planning and Support, 2008). The guidelines also improve information sharing and collaborative planning (see Appendix D) for when a child or youth in care changes schools or housing. Such information sharing and collaboration would be between educators, case workers, parents or family members and care givers in order to create an integrated education plan that is

³ MCFD requires at least one foster parent in a foster home to complete The Foster Support and Education program; interestingly the 14-module curriculum does not include a module that addressed sexual health.

⁴ <http://www.hollyburn.ca/D23.cfm>

supported at the child or youth's school as well as their home and community (Ibid). These processes include implementing various interventions at the home or school level that "help the child or youth develop personal resiliency by putting in place appropriate protective factors that will position him or her for greater success at school" (Ibid, 2) (See Appendix D for sample interventions). Such an initiative is an excellent example of a joint ministry initiative that grounds itself in ecological and psychosocial developmental theory and aims at providing children and youth in care with the specialized and holistic care they need to succeed. The presence of this kind of cross ministry initiative provides a complementary framework, to that developed later in my research, that actively seeks to deal with some of the protective factors are associated with decreasing rates of early pregnancy (i.e. school and community attachment).

Perhaps one of the barriers to creating a similarly consistent and integrated system for health care delivery is that of service provider multiplicity. The BC medical system is extremely complex with a variety of different authorities, care providers and fee-schedules. Bodies and actors that deliver health services to children in care include individuals employed by various health authorities including counselors, public health nurses, and outreach workers, those employed by the provincial health services to deliver highly specialized and tertiary care, as well as largely self-employed primary care physicians.

Much of the health prevention and awareness planning for children and youth in care is left to the "case work planning" approach which allows for each child or youth to be assessed on a case-by-case basis and the development of a 'care plan' (Appendix F) to be produced by a collaboration between the child or youth, his or her case worker, and where possible, biological parents, close family members, outreach workers, health workers and foster parents (Interview with Wright, 2011). This has unique implications on those children who are in long-term care since the progression of their health issues, whether they be risky sexual behaviour or a common colds, are not being monitored in a systematic or harmonized way (Interview with Berland). This

becomes problematic in the sense that the basic level of health monitoring and planning for children and youth in care is not established and is ambiguous. This no doubt results in lack of consistent assessment of children and youth in care's health needs and many do not receive the appropriate or cost-effective proactive health services that would promote their general well being.

The BC child and welfare system has shown to be moving in the right direction, given their initiatives with the Ministry of Education, and various school boards, in attempting to insulate children in care from the various negative developmental risk factors that can impact their educational outcomes. With that said, there is little to show for similar initiatives that deal with risk factors that influence poor health outcomes. A more holistic approach towards ensuring greater well-being for children and youth in care should seek to neutralize all developmental risk factors by bringing together the sphere of health service delivery and other spheres (i.e. education and social service delivery).

10.2 Case Study 1: Legislative and Policy Cases

England, UK

England has been selected as one of two jurisdictions, the other being the United States, who have implemented responsive policy and made legislative change in order to address the issue of high pregnancy rates in the foster care population.

Population Profile

With a population of 49, 866,000 in 2002, there were 59, 700 children in care in England. Children in care are called "Looked After," a term introduced in the 1989 Children Act (Hayden, 2003). The term encompasses those children and youth placed in care by court orders as well as those accommodated by voluntary placement (Ibid). In 2002, approximately 44% of children and

youth in care were girls. As of March 2008, 63% of Children in care were over the age of 10. Figures also show that children or youth who have been in care are approximately 2.5 times more likely to become teen parents than those in the general population (ibid). Accordingly, teen pregnancy in the UK is much greater than in Canada

Legislative Context

There are two main pieces of legislation that frame the context for services delivered to children and youth in care in England: The Children Act of (1989) & The Children Leaving Care Act (2000). Both acts consider the strong influence of consistent health surveillance and delivery on pregnancy rates. There is also a more recent White Paper⁵ released in 2003 by the UK government titled “Every Child Matters” which specifically focuses on developing a framework that improves health and educational outcomes of children and youth in government care. This white paper has laid down the path for development of statutory guidances whose purpose has been the enhancement of children and youth in care’s health and well-being.

Children Act 1989 (C.41)

This act constitutes the basis of government’s responsibility for social service delivery as well as the general statutory framework for children and youth in care (Ibid). It includes provisions that require the delivery of sex and relationship education (SRE) on top of what is given in schools (SCIE, 2005). This is based on research that has proven that children and youth in care are less available to attend school-based education including SRE (Ibid).

The act’s guidance states, “the experience of being cared for should also include the sexual education of the young person” including information on contraception, and “the need to treat sexual partners with consideration and not as objects to be used as well as emotional aspects and implications of early sexual activity and becoming a parent (Hayden, 2003, 12). The act also

⁵ A White Paper is an informal name for a parliamentary document that outlines government policy, or proposed action on an issue of concern.

calls for the general observation of children and youth in care's health and developmental progress (Ibid).

Children Leaving Care Act 2000

The Children Leaving Care Act governs plans for youth leaving government custody. It underscores social service providers' obligation to assist in planning and preparation prior to leaving care (Hayden, 2003). The Act's main objective is to increase the chances of a youth leaving care in having a healthy and successful life. It does so by focusing on education, training, employment and access to health care (ibid) all of which are important protective factors that lower the likelihood of a youth becoming a young parent (Chase et al., 2006). An integral part of extending this legislation is every youth's requirement to prepare a Pathway Plan that takes over from the youth's Care Plan until they leave care (21). This represents an agreement between the youth in care and the local authority that establishes the youth's needs and how they will be supported in meeting them by the local authority (Ibid). Each Pathway Plan should be comprehensive in including all elements required to ensure a healthy lifestyle when living independently like health and development related assistance including sexual health (Ibid). Examples of some responsibilities of the local authority, which are pertinent to the research topic, are as follows:

- Giving support for education and vocational training including assistance with costs associated with them. This may include contributing to living expenses or guidance on applying for supportive bursaries or grants (ibid).
- Providing a "personal adviser" who will aid the youth to be soon leaving care in receiving support and advice in drawing up their Pathway Plan, ensuring that it evolves to meet the youth's changing needs (regular 6 month review & updating) and implementing and maintaining contact with the youth until they leave care (ibid).

In addition the above, Pathway Plans should:

- be based on holistic and frequent health evaluations as well as detailed health records of the youth soon leaving care in order to ensure optimal access and use of primary health services (Ibid);
- facilitate accessible information about sexual and mental health (ibid).

Every Child Matters White Paper 2003

The Every Child Matters White Paper 2003, which followed the original Green Paper⁶, was written in light of inquiries into several deaths of children under government care and failure to protect and maximize well-being of such children (Every Child Matters, 2003). It proposes a framework for maximizing the wellbeing of children and youth in care. This framework was put forward to the public and was subject to a consultation process that eventually shaped how it was to be translated into legislation in the Children Act of 2004.

The Every Child Matters Green Paper, and subsequent White Paper, set out a framework for social services delivered to all children and young people living in England from birth to 19 years of age. Its main objective is to improve child and youth outcomes, with a particular focus on reducing educational failure, criminal and anti-social behaviour, poor health and pregnancy rates (Every Child Matters, 2003). This framework underscores the need to protect children and youth who are particularly at risk of such negative outcomes by paying particular attention to the services provided to them (ibid).

The proposals made in the white paper focus on four main areas:

1. “Supporting parents and carers;⁷
2. Early prevention and effective protection;
3. Accountability and integration – locally, regionally and nationally;
4. Workforce reform” (Every Child Matters, 2003, 7)

⁶ A Green Paper is a government report of a proposal on a matter of public concern that doesn't place any commitment to action. It is often the first step in making legislative change.

⁷ In 2003, the UK government announced the creation of a £27 million Parenting Fund over the subsequent 3 years to back the first area of focus (Every Child Matters, 2004).

While all four areas of focus, and their proposals, provide significant steps towards betterment of children and youth's well being and educational outcomes in the UK, the second area on "early prevention and effective protection" is most relevant to the structure and delivery of social and health services. It proposes greater information sharing between agencies through amendments to legislative barriers, and harmonization of data collection and storage. It also focuses on the need for data to be electronically available across all service sectors that deal with children including education, youth offending and corrections, health and social services (ibid). In addition to the above proposals, the identification of a lead professional that is responsible for the coordination of a coherent package of services" for children who are known to more than one agency is also mentioned (Ibid, 9). The last proposal included under this section is regarding the development of integrated "on the spot service delivery" where professionals would be working together in multi-disciplinary teams that are based in and around areas where children regularly congregate (i.e. schools, community centers etc.). These teams would provide on the spot support for those professionals who work on the front lines of service delivery such as teachers, social workers and others (Ibid).

The Children Act 2004

After a year of large-scale consultation over the Every Child Matters White paper, The Children Act of 2004 received royal ascent. It now forms the legislative backbone for the larger initiative that aims at improving the well-being and educational outcomes of children and youth in the UK in the context of their local circumstances (Every Child Matters: Next Steps, 2004). Consultations showed large support for the white paper proposals, with extra stress on the importance of some over others. For example, the consultees felt that having harmonized outcomes across services that work with children was of extreme importance. The Children Act of 2004 therefore enshrines the outcomes which children and youth were consulted upon: "physical and mental health; protection from harm and neglect; education and training; their

contribution to society; and their social and economic well-being” (Ibid, 14). In addition to the above, the consultees underscored their support for the white paper proposals to create “broad local partnerships” where local authorities closely work with public, private, voluntary and community sectors to enhance the quality and comprehensiveness of children’s services (Ibid, 14). The Children Act of 2004 incorporated such interests into its provisions by requiring local authorities to make partnership arrangements with key public and private partners as well as other interest groups (ibid).

It is important to note that consultees wanted to ensure that the legislation was not rigid and top-down in nature in order to allow for local needs to be dealt with differently and generally more diversity in its implementation. To reflect this, the Children Act of 2004 is not prescriptive and is written in a way that provides local authorities with flexibility in the way they carry out its provisions⁸.

Service Delivery

In light of the above legislative context and extending ministry guidances, to be discussed in this section, social and health services in England are specifically targeted towards children and youth in care. There seems to be a conscious effort in integrating services in order to improve this at-risk population’s health and educational outcomes. Two main guidance’s have been developed in the past decade in efforts to integrate social, educational and health services: “Statutory Guidance on Promoting the Health and Well-being of Looked After Children” (2009) and “Guidance on the Education of Children and Young People in Public Care” (2000). The later will not be discussed since BC has a very similar initiative, as seen in the “Joint Educational Planning and Support for Children and Youth in Care: Cross-Ministry Guidelines” document. It is my intention to focus on initiatives that are lacking in BC in order to find opportunities for

⁸ <http://www.dcsf.gov.uk/childrenactreport/#a2004>

knowledge transfer and awareness of alternatives to our own system. Therefore I will focus on a guidance adopted in the UK that seeks to promote the health of children in care.

“Statutory Guidance on Promoting the Health and Well-being of Looked After Children” (2009)

With an awareness of children and youth in care’s special needs as an at-risk population, the UK Department of Health adopted this guidance with the intention of better integrating their health and social services. The guidance’s scope extends to the local authorities (those designated in a care order to be responsible for a child or youth), Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs)(DCSF & DH, 2009). The guidance’s goals are on providing specialized consistent and continuous care, especially preventative, to children and youth in government care in order to address disparities between them and the general population (Ibid). It states that the aim of the document is to “make sure that all looked after children and young people are physically, mentally, emotionally and sexually healthy, that they will not take illegal drugs and that they will enjoy healthy lifestyles” (Ibid, 5).

The main requirements under the guidance are:

- Joint working between local authorities, Primary Care Trusts (PCTs), and Strategic Health Authorities (SHAs). This is on matters of change of a child or youth’s change of residence, and assessing and coordinating health service delivery (Ibid);
- Creation, implementation and evaluation of a child or youth’s health plan and its effectiveness. This is the responsibility of the local authority and the designated child or youth’s social worker in addition to the aforementioned care and pathway plans. Social workers have the responsibility of ensuring that the health plan is implemented by facilitating access to health care services through imparting knowledge and advice to foster parents as well as children and youth in custody (Ibid);
- PCTs and SHAs must satisfy requests from local authorities to help give support and services to children and youth in need. This is primarily ensured through PCT and SHA directors evaluating their services to ensure that they meet the specific needs of children

and youth in care. This is to the level of individual practitioner’s ability to provide coordinated care to this population (Ibid).

After assessing England’s base legislation and government initiatives regarding child welfare services, it is apparent that the English government has established a legislative framework that aids in specialized service delivery for children in care. Such a system allows for services that are tailored specifically to the needs of children in care in order to alleviate certain risk factors that contribute to early pregnancy and greater well-being.

United States

Legislative Context

The Fostering Connections to Success and Increasing Adoptions Act was federally enacted in 2008 as an all-encompassing child welfare reform law to better support foster parents and other caregivers as well as bolster a nurturing and stable environment for children and youth in care (Round Table Brief, 2008). While seeking to improve both education and healthcare, it provides specific provisions that can be extended to guide states in implementing a holistic pregnancy prevention strategy. Such provisions can be found in section 205 titled the “Health Oversight and Coordination Plan” (See Appendix G) which guides state and local programs in:

- “Improv[ing] child welfare policies and practices by expanding support for sexual health education;
- Ensur[ing] that children receive health information to remain healthy and increase protective factors;
- Prepar[ing] parents and juvenile workers to adequately address unhealthy relationships and pregnancy prevention” (ibid)

Such a legislative amendment allowed for concurrent policies and practices to be developed, for the delivery of services, in order to address issues of uncoordinated health services and high pregnancy rates. The States of Virginia and New York have both subsequently

implemented strategies to increase health coordination for children and youth in care with a special focus on pregnancy prevention.

Virginia, US

Population Profile

Children and youth in care in Virginia are 2.5 times, as in the UK, more likely to become teen parents than children and youth in the general population. The Virginia Round Table on Teen Pregnancy attributed 27 million dollars in 2004 to child welfare costs associated with children born to teen mothers (Round Table Brief, 2008). The Virginia Department of Health set a pregnancy rate goal for all teenage girls between the ages of 15 to 19, of 47.5 or fewer per 1,000 by the year 2015 (Ibid).

Service Delivery

Unlike BC, the Virginia Department of Social Service's foster care manual contains several sections on the provision of consistent and comprehensive health services that will be further elaborated below.

Section 6.8.3 on "Early Periodic Screening, Diagnosis, and Treatment (EPSDT)"

A preventative and comprehensive health program for children and youth in foster care. The program is a required component of the Medicaid program whose main goals are to keep children and youth as healthy as possible by:

- Guaranteeing that health and developmental issues are diagnosed as soon as possible
- Guaranteeing that treatment is given before health issues escalate and become acute (DSS FC Manual, 2010)

The EPSDT program accomplishes the above through providing early and regular assessment of children and youth's health care needs through periodic screenings performed by

physicians or nurse practitioners. Also, any caregiver, educator or other professional can request an unscheduled check-up or a specific “problem-focused” evaluation at anytime due to illness or change in a child or youth’s state (ibid).

Section 6.8.3.1 on “Periodicity schedule for screenings”

Under the EPSDT program, a child or youth in care must have a medical examination no later than 60 days after admission into care. Additionally, the child or youth must attend screening that occurs at consistent intervals as determined by the EPSDT Periodicity Table (See Appendix G).

Section 9.14.1.4. on “Medical Care and treatment to be provided to a child in foster care”

Section 9 deals with the provision of foster care services including medical care and treatment. It maintains that routine medical and dental screenings should be completed at least once a year (Ibid).

Through an analysis of the most recent legislative amendments and subsequently developed policy, Virginia provides an example of a social services and child welfare system that has made attempts at targeting health services as one of many mechanisms to deal with high pregnancy rates. The Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program provides a clear example of how a fairly general public health initiative can be used, as a measure to lower early pregnancy rates through better monitoring of health needs and proactive health support and service delivery.

Table 2: Legislative & Policy Cases

	BC	UK	US
Legislation	<ul style="list-style-type: none"> • Child, Family and Community Services Act (CFCSA) 	<ul style="list-style-type: none"> • Children Act 1989 • Children Leaving Care Act 2000 • Children Act 2004 	<ul style="list-style-type: none"> • Fostering Connections to Success and Increasing Adoptions Act 2008
Policy	<ul style="list-style-type: none"> • “Joint Educational Planning and Support for Children and Youth in Care: Cross-Ministry Guidelines” 	<ul style="list-style-type: none"> • “Guidance on the Education of Children and Young People in Public Care” (2000) • “Statutory Guidance on Promoting the Health and Well-being of Looked After Children” (2009) 	<ul style="list-style-type: none"> • Early Periodic Screening, Diagnosis and Treatment (EPSDT)

10.3 Case Study 2: Practice Intervention Cases

The following cases have been selected as examples of successful intervention strategies that the states of Oregon, California and New York have taken to reduce pregnancy rates among at risk populations. All of the interventions increase access to specialized social, educational, preventative and non-preventative health services with the intention of bolstering children and youth’s environments with protective factors that ultimately positively affect their developmental trajectories and reduce chances of early pregnancy.

Oregon, U.S.: *Multidimensional Treatment Foster Care (MTFC)*

Oregon State University partnered with the Oregon Social Learning Centre to conduct two randomized controlled trials (RCTs) of a behavioural intervention framework called Multidimensional Treatment Foster Care (MTFC) for juvenile justice girls mandated to out-of-home care (Kerr et al., 2009). This was initiated as an attempt to mitigate the higher than average pregnancy rates in that population and test research claims of a direct link between adverse childhood experiences, academic failure, delinquency and early pregnancy (Ibid). Prior to this

study MTCF was shown to reduce girls' delinquency at 12-24 month follow-ups (ibid). The study's hypothesis was grounded on the following: "since delinquency shares common underpinnings with risky sexual behavior and other problem behaviors (e.g. impulsivity, poor parental monitoring, deviant peer relationships) it is likely that interventions that target outcomes in one domain (delinquency) will influence outcomes in related domains (pregnancy)" (Ibid, 2). It is interesting to note that both trials exhibited the same results in terms of lower pregnancy rates in participants who received MTFC, even though one of them included a specific sexual health literacy component as part of the intervention, while the other did not (ibid). This shows that insulating girls with a variety of protective factors such as educational support, adult monitoring and counseling services could prove to be better ways of preventing early pregnancy than a more targeted approach that seeks to address risk factors traditionally associated with early pregnancy (i.e.lack of sexual health and contraceptive literacy).

Study Details

There were 166 girls who participated in the trials conducted from 1997-2006. All of the girls had been mandated to community based out-of-home care because of problems which chronic delinquency. Girls were 13-17 years old and had a history of at least one criminal referral in the past 12 months, exhibited risky sexual behavior and in many cases had been previously pregnant (ibid). The average length of stay in MTCF programs is from 6 to 9 months and varies from \$2,600 to \$3,000 per child or youth depending on qualifications of staff and number of FTEs (MTFC Staff correspondence, 2010). There is an additional approximate \$46,500 that is required for the first year of implementation, consultation and training services for program set-up as well as an annual \$10,000 for model adherence monitoring and replacement staff training⁹ (NREPP Review, 2009; MTFC Staff correspondence, 2011).

The MTFC interventions required:

⁹ Figures only reflect costs for a 10 bed program.

- Girls to be independently placed in highly trained and supervised foster homes with state certified foster parents
- Experienced program supervisors to be assigned small caseloads (10 MTFC families) and maintain daily contact, via phone or internet, with MTFC foster families to provide support, provide crisis intervention services and coordinate all aspects of the child or youth's placement.
- Weekly group support meetings for foster parents
- Daily “point-and-level program” for each participant including individual therapy
- Family therapy focusing on parent management strategies
- Close monitoring of school attendance, performance and homework completion
- 24 on call staff support for foster and biological parents
- Psychiatric consultation as needed (Kerr et al., 2009).

Evaluation & Results

Evaluation of the studies showed that girls who were involved in the MTFC interventions had fewer pregnancies after 12 and 24 month follow ups than girls placed in the control group (group home settings rather than MTFC homes). Girls placed in the group homes were 2.5 times more likely to become pregnant than those who had been placed in the MTFC homes (ibid). The study's discussion section attributes less restrictive environments, where girls were still enrolled in public schools and were able to have meaningful social interactions with peers, while having greater monitoring of their educational and social performance, to the reduction of delinquency and thereby pregnancy rates.

California, U.S.: *Power Through Choices Sexual Education Curriculum*

The *Power Through Choices Curriculum* developed by The Family Welfare Research Group, a research division of the School of Social Welfare at the University of California at Berkeley, is the first adolescent pregnancy/HIV/STI prevention program developed specifically

for adolescents in foster care (Becker & Barth, 2000). The Family Welfare Research group developed the 10-session program in a 3-year process that included:

- Extensive focus groups with youth in care;
- Interviews with staff working with youth in care;
- Site visits;
- Full pilot testing and evaluation;
- Final revisions (ibid).

Based on several pilot tests, the program was revised six times prior to being finalized (Ibid).

Goals

The curriculum's objectives include providing youth in care with the skill sets and information to aid in avoiding risky sexual behaviour thereby reducing the chances of early pregnancy and other negative consequences of unsafe sex (Ibid). The curriculum aims to support participants in: 1) recognizing and making safe choices related to sexual behaviour; 2) gaining knowledge of contraceptives and their proper use; 3) developing and practicing effective communication skills; 4) learning of and navigating local resources available to them (Becker & Barth, 2000). The curriculum also addressed the effects of past sexual abuse in the foster youth's history and how to become self-empowered through skills-building activities (Becker & Barth, 2000). Another theme enforced through skill building activities is that of the adolescents making their own choices and assessing the impact of such choices on their futures (ibid).

Results

The results of pilot evaluation, through pre and post tests, satisfaction surveys and focus group discussions, showed that a majority of teens that participated would "enhance their commitment and ability to practice safer sex" (Ibid, 279). Results also showed that youths felt "an

increased control over their lives and were significantly less likely to engage in unprotected sex than at pretest” (Ibid). In addition to this satisfaction survey results identified 94% of youths thinking that it would be easier to practice safer sex after having been put through the program (Ibid). Since the finalization of the *Power Through Choices Curriculum*, several other U.S. States have implemented the curriculum in their own jurisdictions, for example the State of Colorado’s Montrose and Mesa County have both done so as part of their own attempts to reduce pregnancy rates in foster care populations.

New York, U.S.: *Health Care Coordination Program*

Purpose

In light of the federal Fostering Connections to Success Act and Increasing Adoptions Act, the New York State Office of Children and Family Services (NYOCFS) developed a pilot project to assess the impact of greater health care coordination for children and youth in foster care in 2003. The project was also developed in recognition of the fact that this particular demographic experiences barriers to high quality and comprehensive care. The concept of health care coordination is one that places emphasis on creating “a locus of responsibility” for all health services delivered to children and youth in care (NYSOFCS, 2009). Ideally, one individual (a Care Coordinator) is tasked with the responsibility of monitoring, facilitating and managing all aspects of health care for every child and youth in foster care (Colman et al., 2007). Coordination activities complement the child’s care plan and support the creation and implementation of a treatment plan by focusing on specific health issues and needs that the individual child or youth has, and coordinating health services and access to them (Ibid). Such activities also support the assessment, and delivery of treatment, and follow- up services according to set health care standards (NYSOFCS, 2009).

Hypothesized Benefits of Care Coordination

There are a number of presumed short and long-term benefits to the implementation of health care coordinators for children and youth in foster care. The short-term benefits largely stem from a Care Coordinator's sole and primary responsibility to coordinate all of a child or youth's health related issues. This enables him or her to devote more time and effort to focusing specifically on the provision of consistent and comprehensive health care to those assigned to their caseload (Colman et al., 2007). This is much less likely to occur with a child or youth's social or caseworker, since they tend to have large case loads and an array of issues to coordinate in relation to a child's welfare leading to less time spent on monitoring and identifying specific health needs. Due to the above, the general short-term benefits of care coordination include:

- A greater chance that a child or youth will get a comprehensive amount of health related screenings at intake into foster care;
- Improved identification and documentation of health care needs;
- Increased communication and education between all related parties (i.e. social workers, biological and foster parents, and health practitioners);
- More timely access to health care services (Colman et al., 2007)

The project assumes that the long-term results of care coordination largely surround permanency. This is following from the logic that children who are accessing well-integrated care have a greater chance of having their emotional, mental and physical needs met. This results in health coordination services alleviating pressure on caregivers, which may result in a reduction of changes in foster care placement (Ibid).

Another alleged long-term effect is regarding the theory that "increased access to health education, reproductive services (e.g., family planning, gynecological care, etc), and mental health and/or substance abuse services may also help to reduce the likelihood that children in foster care will engage in risky behavior and become teenage parents" (Ibid, 4).

Project Details

In 2003, The NYOFCS initiated the project by contracting nine local service providers in the state to develop and implement “Care Coordination” programs (Colman et al., 2007). Funds for the program came from the OFCS’s administered Quality Enhancement Fund that is set up to back the development and assessment of innovative child welfare services and practices that promote child permanence in their families and teen pregnancy prevention (Ibid). Each local service provider was given the ability to develop their own program in order to better cater to the specific needs of the population of children and youth in care in their locality. In addition, each service provider agency required different contract moneys due to their unique staffing resources and operational structures (see Appendix I). Regardless of differences across pilot sites, health care coordinators were generally responsible for similar tasks. Broad responsibilities included the requirement to maintain close contact with children’s social or caseworker and take up all coordination of a child’s health care delivery including health education, appointment bookings and communication with foster families and all other necessary professionals on matters of a child or youth’s health etc. (See Appendix J). The project included 1,113 children and youth in care as participants who received care coordination services from February 2003 to March 2006 with a total of approximately 2.9 million dollars spent in contracting dollars in those 3 years.

Project Evaluation & Results

The project implemented a variety of impact evaluation activities that sought to assess how health care coordination affected the following:

1. Initial health assessments upon admission into care
2. Identification of healthcare needs
3. Receipt of health services (including pregnancy prevention education)
4. Communication between foster care agency, foster and biological parents as well as health service providers
5. Permanency in terms of fewer foster care moves

The above impact evaluations were measure in comparison to the experiences of children and youth in care who received traditional foster care services that did not include care coordination (Colman et al., 2007).

All of the above listed areas saw positive effects except for permanency where, at the 18 month post study follow-up, it was determined that those children and youth who received care coordination were just as likely as those in the control group to experience foster care moves (ibid). With that said, children and youth who received health care coordination had a greater chance of getting the state recommended initial health and dental assessments on time; had improved recognition and comprehensive detection of health concerns (including those regarding sexual health); experienced an increased likelihood of accessing needed health care services; and had their health issues better documented and communicated between all parties involved in their care (ibid).

Table 2.1: Intervention Cases

	Multidimensional Treatment Foster Care (MTFC) Program	Power Through Choices Sexual Education Program	Health Care Coordination Program
Purpose	Enhance educational performance thereby reducing delinquency, risky sexual behaviour and early pregnancy.	Providing youth in care with the skill sets and information to aid in avoiding risky sexual behaviour thereby reducing the chances of early pregnancy and other negative consequences of unsafe sex.	Better integrate health services and social services to provide children in care with specialized high quality health care with the intention of reducing health issue escalation and health care utilization.
Duration of program	6-7 months	10 (90min) sessions. Implemented within 1 month or less	Varying depending on child & youth's length of stay in government custody
Benefits			
Short Run	<ul style="list-style-type: none"> ▪ Foster parents involved in program are better equipped, supported and trained to deal with and nurture high risk children and youth. ▪ Children and youth in program receive specialized care that reinforces protective factors in their lives (i.e. better study skills, structured day schedule, greater caregiver monitoring etc.). 	<ul style="list-style-type: none"> ▪ Addresses specific sexual health needs of youth in care Participants felt: <ul style="list-style-type: none"> ▪ An enhanced ability and commitment to practice safe sex ▪ An increased control over their lives and reported that they were less likely to engage in risky sexual behaviour ▪ More capable of practicing safe sex. 	<ul style="list-style-type: none"> ▪ Improved surveillance, documentation and communication of health issues. ▪ Delivery of integrated and specialized (according to child's needs) health services. ▪ Increased access to preventative and non preventative health services (including sexual health education and support).
Long Run	<ul style="list-style-type: none"> ▪ Lower delinquency scores ▪ Higher 	<ul style="list-style-type: none"> ▪ Greater probability of practicing safe sex, thereby resulting in lower early 	<ul style="list-style-type: none"> ▪ Chronic health issues are better managed and less likely to result in

	<p>educational outcomes</p> <ul style="list-style-type: none"> ▪ Lower pregnancy rates* 	<p>pregnancy rates.</p>	<p>need for acute care services and hospital admission.</p> <ul style="list-style-type: none"> ▪ Pregnancy rates fall due to better communication on sexual health, and preventative measures such as education of child or youth and others involved in their care (projected benefit).
Approximate Costs			
Implementation	\$46,500 (first year)** 10,000 (subsequent years)***	n/a	n/a
Annual Cost/Child or Youth	\$2,600-\$3,000	n/a	\$868.5

*Girls in MTFC were 2.5 times less likely to become pregnant than girls in control groups at 12 and 24-month follow-ups

** training (for a 10 bed program) and travel expenses for MTFC staff and foster parents in Eugene, Oregon.

*** annual model adherence monitoring and replacement staff training

11: Criteria for Policy Evaluation

The following chapter lays out the framework for criteria and measures that will be used to assess policy options put forward in the subsequent chapter. They have been selected to methodically evaluate each option in order to provide clear and coherent rationalization of policy recommendations. Criteria and measures as well as the policy evaluation, presented in the chapter to follow, and in summary Table 3, have been produced in consultation with elite stakeholders, Mr. Jeremy Berland Deputy Representative of Children and Youth, Mr. Martin Wright CIO of MCFD, as well as Dr. Perry Kendall BC's Provincial Health Officer. A summary table is presented after the chapter's description of each criterion and its measure.

Effectiveness

There are both short and long term policy objectives that must be viewed together in order to determine the overall effectiveness of proposed policy routes. Generally the greater and long-term policy objective is to lower pregnancy rates of girls in care thereby lowering pregnancy related health utilization and promoting greater economic and social well-being for girls in care. This can only be achieved through the realization of several short-term policy objectives that have a far-reaching effect on the general health and well-being of children and youth in care.

The short-term objectives of the proposed policies are as follows:

- A. Establishment of a **systematic harmonized practice of comprehensive monitoring, recording and evaluation** of children and youth in care's health issues, concerns and goals.
- B. **Coordinated facilitation of access to preventative health care services** that are tailored to the specific needs of the child and youth in care population.

- C. Formation of partnerships between the Ministry of Health, local Health Authorities and the Ministry of Child and Family Development in order to establish **integrated health and social services that engage in active planning and information sharing** in order to create environments that insulate children and youth in care from developmental risk factors and reinforce protective factors and healthy lifestyles.

The achievement of the above short-term policy goals will no doubt take some time to come to fruition and bear the long term goal of lower pregnancy rates for girls in government care in BC. Nonetheless, policies that attempt to mitigate such multi-faceted and complex social phenomena must be seen as having long-run benefits that extend past their specific objective and result in wide spanning benefits to other positive developmental outcomes. It can be assumed, with great conviction, that the above short-term goals will result in a general enhancement of long run health, social and educational outcomes for BC children and youth in care.

Long term effectiveness will be measured by how well the particular policy addresses, through its application, Brindis et al.'s five levels of influence associated with health related behaviour:

- 1) Intrapersonal/individual factors, which include young person's knowledge base of sexual health practices and contraceptive use;
- 2) Interpersonal factors, such as communication skills, relationship building and connectedness enhancement between young people, their partners, peers and family;
- 3) Institutional/organizational factors, like the availability of academic support services, tutoring, peer mentorship opportunities, summer job placement support, counseling and sexual health supports offered through community clinics and outreach workers;
- 4) Community factors, such as established values and norms within a community or media campaigns targeting youth for support in life options;
- 5) Public policy factors, which include government- financed programs aimed at supporting youth and providing specific services to adolescents (Brindis et al., 2005, 45-46).

Addressing the above levels is important, and will prove effective in reducing pregnancy rates because it ensures that a multitude of risk factors are addressed at all levels of influence or spheres that effect a child or youth's psychosocial development.

It is important to note that this criterion has been weighted more heavily, where an option that is assessed to be greatly effective will receive a score of 4 rather than 3. This is due to the importance of a highly effective option offsetting its medium or poor score on cost.

Admittedly, I am placing greater emphasis on effectiveness (as well as cost-effectiveness and enhancement of well-being, to be discussed further below) than cost because the status quo would invariably score as high, if not higher, than other options given that the associated implementation costs and complexity is low.

Political Feasibility

Political viability was measured according to a discussion with elite stakeholders during consultation interviews during the third research stage. A thematic analysis was done to determine general agreement or themes arising from discussion surrounding political feasibility of each option.

Complexity

Complexity was further broken down into two parts: implementation complexity and administrative complexity. *Implementation complexity* measured the degree of difficulty related to implementing policy according to the jurisdictional levels required to coordinate its implementation. Accordingly, a policy that required greater cross-jurisdictional coordination upon implementation, received a lower score in implementation complexity. *Administrative complexity* was based on the level and difficulty of change required to the status-quo of administration services. This would include whether the policy being assessed required cross-ministry/agency coordination in the administration of new services or processes.

Cost

Like the complexity criterion, cost was further broken down into two elements: costs associated with implementation and administration/operation. *Implementation costs* are defined as additional budget allocation for implementing the policy. This includes costs for initial additional staff, training, travel expenses associated with training, additional equipment or any other capital investment. *Administrative costs* included those costs incurred by administering or continued operation of the policy option. This was measured by whether the policy option required additional budget allocation for such costs.

Cost Effectiveness

Cost effectiveness is defined based on the policy option's ability to produce cost savings in the long term that are disproportionately greater than the costs of the policy itself. Since it was impossible to determine the average costs associated with pregnancy and delivery in BC as well as the exact number of pregnancies within the foster child and youth population, I was unable to attribute specific cost-savings figures to each option. With that stated, cost effectiveness has been determined through an assessment of both the option's effectiveness and its potential to reduce health utilization of children and youth in care through delivery of, cheaper, proactive health monitoring and

support services that reduce the escalation of health issues and chances of acute service utilization.

Cost effectiveness, like the effectiveness criterion, has been weighted with a greater total score as I feel that if a change in policy or process can create long term cost reduction, then upfront costs should be considered an investment.

Enhancement of Well-being

There is an intrinsic value in enhancing the well-being of children and youth in society, particularly those who are disadvantaged. For this reason, this criterion evaluates whether a policy option addresses the enhancement of well-being of children and youth in care. Policies and/or interventions that rate high on this criterion will show evidence of successfully enhancing the general well-being of girls in long term care through access to more comprehensive and holistic health care services as well as improved health outcomes. This option has been weighed more heavily than cost and complexity as enhancement of well-being should be prioritized and is the most important underlying objective of this research.

Criteria			
	Definition	Measure	Score
1) Effectiveness			
Short term	Policy achieves the 3 short-term policy objectives.	Addresses 1 objectives Addresses 2 objectives Addresses 3 objectives	Low (1) Medium (2.5) High (4)
Long term	Policy lowers pregnancy rates for children in care by addressing Brindis et al.'s five levels of influence associated with health-related behavior: Intrapersonal factors Interpersonal factors Institutional factors Community factors Public Policy factors	Addresses 1 - 2 factors Addresses 3 factors Addresses 4-5 factors	Low (1) Medium (2.5) High (4)
2) Political Feasibility			
	Political viability as assessed by elite stakeholders.		High (3) Medium (2) Low (1)
3) Complexity			
Implementation	Level of difficulty related to policy implementation. Dependent on number of jurisdictional levels are involved and required level coordination across such levels.	1 jurisdictional level 2 jurisdictional levels 2 + jurisdictional levels	Low (3) Medium (2) High (1)
Administrative	Level and difficulty of change required to status- quo of administration of services	High amount of change Medium amount of change Low amount of change	Low (3) Medium (2) High (1)
4) Cost			
Implementation	Policy requires additional budget allocation for implementation	No or little additional budget allocation Average amount of	Low (3) Medium

		additional budget allocation	(2)
		Large amount of additional budget allocation	High (1)
Administrative	Administration of the policy requires additional budget allocation	No or little additional budget allocation	Low (3)
		Average amount of additional budget allocation	Medium (2)
		Large amount of additional budget allocation	High (1)
5) Cost Effectiveness			
	Option 's ability to produce cost savings in the long term that are disproportionately greater than the costs of the policy	Little or no cost savings	Low (1)
		Average amount of cost savings	Medium (2.5)
		High cost savings	High (4)
6) Enhancement of Well-being			
	Evaluates whether the option improves access to comprehensive and holistic health services as well as long-term health outcomes of children and youth in care.	Dichotomous:	
		Does not enhance the well-being of children and youth in care	No (1)
		Enhances the well-being of children and youth in care	Yes (4)

12: Policy Options & Analysis

The proposed policy options encompass two major categories: 1) legislative and policy-centered options; and 2) Practice Intervention based options. Policy options have been developed in light of the MCFD and Ministry of Education's integrated initiative targeting low educational outcomes. Consequently, options do not address the specific risk factor of school attachment since it is already being tackled by existing initiatives.

An evaluation of the various policy options will follow the outlining of each option. The analysis is a reflection of how each policy measured against the criteria proposed in chapter 10, as well as consultation with elite stakeholders: Mr. Jeremy Berland BC Deputy Representative of Children and Youth, BC Provincial Health Officer, Dr. Perry Kendall and Chief Information Officer of MCFD, Mr. Martin Wright. Their extensive expertise provided unique insights on the various intricacies related to feasibility, political acceptability and implementation complexity of the options. A matrix is presented following the evaluation to portray detailed results and comparisons of each policy's analysis against the other according to the established criteria.

12.1 Legislative & Policy-centered Options

Option 1: Status Quo

This option provides a benchmark for other options to be evaluated against. It includes the current version of the Child, Family and Community Services Act (CFCSA) and how it is presently carried out through policy and practice. It maintains the existing wording on health service delivery to children in care, which many argue does not adequately flesh out the details and standards of such services. It also allows for a great deal of variation across service standards and processes. It must be noted that the absence of standardized protocols or process guidelines,

which would ideally work to extend the current legislation, also add to the lack of coherent and comprehensive strategies on health service delivery to BC children and youth in care.

Evaluation

	Effectiveness	Pol. Feasibility	Complexity	Cost	Cost Effectiveness	Total Score
Score	Low (1)	Medium (2)	Low (3)	Low (3)	Low (1)	10/17

Effectiveness: The status quo option scored ‘low’ for effectiveness as the current legislative, policy and program environment does not work towards any of the short or long term policy objectives previously outlined. Also, the status quo does little to address the disparity in pregnancy rates between children and youth in the general population and those in care.

Political Feasibility: This option rates average on political feasibility, as it does not require any restructuring, assessment or change in the management of services for children in care. A policy that does not require change is therefore largely politically feasible as business can just carry on as normal. With that said, a point was detracted as there is a gaining public awareness and dissatisfaction over the gaps between health and social outcomes of children in care and the general population. This is likely to affect the feasibility of maintaining the status quo as more voices demand attention be paid and change made with regards to this problem.

Complexity: Both implementation and operational complexity rate highly on this option as they do not require additional coordination or integration across jurisdictions. Administration and operation of services are unaffected and do not require increased levels or alteration in how they are provided.

Cost: Implementation as well as operational and administrative costs for this option also rate well for this criterion, as there is no need for additional funds to be delegated to services or strategies that are remaining the same under this option.

Cost Effectiveness: This option rates low on cost effectiveness as the current rates of utilization of health care services by children in care are disproportionately greater than the utilization of health services for children and youth in the general population (RCY&PHO, 2006). Many of these services utilized by children and youth in care are largely due to preventable illnesses that could be managed more effectively through the delivery of preventative services and a more reactive health system that targets this population's special needs. The above shows that there is great room for cost savings in investing in alternative ways to support the delivery health services to children in care that the status quo is currently not capturing.

Enhancement of well-being: The status quo does not enhance the well-being of children in care. This is evident in their poor health and educational outcomes as outlined in the background and the BC study.

Overall this option scores an overall 11 points out of a maximum of 21. The quo's advantage is its score in complexity and cost, as it does not require additional planning, coordination or funds. This is offset by poor scores on effectiveness and cost effectiveness as the status quo does not sufficiently address that problems of high health care utilization and the disparity in health outcomes between children and youth in care and those in the general population.

Option 2: Creation of Standardized Guidelines for Integrated Health Service Delivery

This option draws from elements of policies generated and implemented in England and US cases on establishment of consistent monitoring and evaluation of children and youth in care's health needs in order to adopt preventative health practices rather than more costly reactive ones.

It also recognizes the BC Ministry of Children and Family Development’s ability to see value in, produce and back initiatives that promote integrated preventative services, as they have outlined in their “Strong, Safe, Supported” initiative and their subsequent “Joint Educational Planning and Support for Children and Youth in Care: Cross-Ministry Guidelines”. This option, similarly, requires flexible processes or guidance manual development for social workers, health care professionals and other caregivers on the issue of access to comprehensive integrated health services. These would be flexible guides to allow for implementation that best addresses a child or youth’s individual and unique needs, while providing a standardized system that establishes the basic standards for the monitoring and delivery of health services. The health care manual or guidance booklet should be developed in consultation with stakeholders from the medical, social worker, caregiver communities as well as the child and youth in care population to include the following:

A	Steps to guide the creation, implementation and evaluation of a “Health Plan” (would include provision of sexual health education and counseling services) for every child in care that would supplement their “Care Plan” by specifically focusing on the child and youth’s individual health needs and act as a plan to facilitate access to services that would help with such needs. An imperative component would be the development of such plans in partnership with the child or youth to promote empowerment and ownership of health status and lifestyle;
B	Guidance on the regular assessment and identification of child or youth’s health needs through the establishment of a periodicity schedule for health screenings;
C	Include guidance on collaborative planning and information sharing among and across health and social services that would delineate the roles and responsibilities of social workers, foster parents and health care professionals in facilitating child or youth’s access to health services and the passing on of knowledge, and advice to child or youth while enhancing an environment of connectedness and trust (this would include a special focus on sexual health education and planning).

Evaluation

	Effectiveness	Pol. Feasibility	Complexity	Cost	Cost Effectiveness	Total Score
Score	High (4)	High (3)	Medium (2)	Low (3)	Medium (3)	15/17

Effectiveness: This option scored ‘high’ on the effectiveness criterion as it addresses all three short term goals that work towards the systematic monitoring and coordination of health services that are targeted to the specific needs of children and youth in care as well as the integration of such services through shared ministry planning and information sharing. This option also satisfies many of the long-term goals that deal with providing protective factors at all levels of children and youth in care’s lives in order to be effective in lowering pregnancy rates of children and youth in care. The different protective factors addressed by this policy are at:

- (1) At the individual level, where a child or youth in care would be involved in his/her health planning and assessment as well as have access to educational preventative services that promote empowerment, self-confidence and aid them in making the right decisions to promote their own health and well-being;

- (2) At the interpersonal level, where the creation of distinct Health Plans for each child or youth in care would facilitate better communication, and ideally promote trust, positive adult relationships and continuity, between the child or youth in care and their social worker, community outreach worker, health service provider and foster parent regarding the specific health needs and goals of each child;
- (3) At the institutional level, where all caregivers (ie. Foster parents, outreach workers, health service providers and social workers) would be able to support child or youth in care in accessing appropriate government and community programs and services such as sexual health education and community youth clinics that administer free contraception and counseling services;
- (4) At the public policy level, where the mandated creation of Health Plan for each child would be a step in the right direction for the delivery of proactive health services that target the specific special needs of children and youth in care. This level did not receive a full score, as it does not follow through with the creation of programs that are solely designated for the service of children and youth in care such as primary care clinics that only serve children and youth in care.

Political Feasibility: This option rates ‘high’ for its political feasibility as elite stakeholders felt that there is a compelling argument in its support due to the large gaps in health outcomes between children and youth in care and the general population and the lack of process guidelines surrounding health provision. In addition to this it would show the current government’s initiative in attempting to address the current disparity in health outcomes between children and youth in care and those in the general population. This option also rates well in cost and complexity, to be further discussed subsequently, which aid in argument for its viability and political acceptability.

Complexity: This option’s implementation and operational complexity rate at ‘medium’ as they both require a great degree of consultation across ministries, service provider agencies, and individual caregivers and providers. Complexity was not rated high because the option only addresses the creation of the guidelines document not its implementation into practice. Also, if the creation of such guidelines would in fact be largely based on coordination and consultation of

all stakeholders mentioned earlier, implementation of the guidelines in practice would be much less complicated. This is because insights from front-end workers would provide for better understanding and consideration of their capabilities and preferred ways of coordinating services to achieve the policy's main objectives.

Cost: Implementation and operational costs for this policy would most likely be quite low for this option, as it would use current ministry staff to head the initiative and its coordination as well as maintain current levels of administrative staff. Perhaps the only additional costs required for this policy would be those that may be associated with the incentivization of stakeholders to engage in the process. With that said, there is a great likelihood that stakeholders would rise to the opportunity to impact the promotion of health and well-being of children and youth in care, or in the least, to have a say in a process that could potentially impact the way that they may have to practice in the future.

Cost Effectiveness: This option would be cost-effective in the sense that it would be using current levels of funding and budget to create a plan for the better coordination of health services for children and youth in care that would have positive long term effects on their utilization of health services. With that said, it is not guaranteed to have an effect on individual practice of front-end workers if does not include them and other stakeholders in the process and isn't enforced by management. For this reason this option gets an average rating on cost effectiveness.

Enhancement of well-being: This option seeks to enhance the well-being of children and youth in care by providing clear guidelines that outline how health and social services should deliver specialized and comprehensive care to this disadvantaged population. One of the first steps towards improving the health and well-being of children and youth in care is to recognize the demand for health and social services that are tailored to their different needs (Cooper et al., 2002; Towner & Dowswell, 2002) . This policy option recognizes such demand and lays out a plan for how the provision of specialized services will be carried out. Adoption of this option

would also create greater transparency on the standards by which children and youth in care are cared for and will facilitate greater government accountability for the enhancement of well-being of children and youth in care.

Overall, this option rates 19 out of a possible score of 21. One thing of note, which was raised during an elite stakeholder consultation, is the fact that the creation of guidelines and protocols does not always equate to adoption of their outlines practices and would thus have an effect on the overall effectiveness and feasibility of implementation of this proposed policy. This is important to bear in mind when, and if, this option is considered for implementation. Ideally, consultation with a variety of stakeholders, including children and youth in care themselves as well as all those involved in the delivery of their social and health services, in the creation of such guidelines would increase the likelihood of their uptake at the individual practice level. A process that only involved policy analysts and government bureaucrats in the creation of guidelines would not be as effective in achieving buy in from front-end service providers and would likely fail in achieving the purposes of holistic, integrated and proactive health service delivery.

12.2 Practice Intervention Options

Option 3: Multidimensional Treatment Foster Care (MTFC)

This option acts as a specific intervention for girls who have proven, through previous monitoring, to be at greater risk of pregnancy and delinquency. This could be determined through the review of the child or youth's records of previous pregnancy, knowledge of consistent engagement in risky sexual behaviour, educational failure, and involvement in criminal activity. MTFC programs usually enroll at risk youth for a period of six to seven months.¹⁰ Since approximately 60% of BC, children and youth in care's population are under continuing custody

• ¹⁰ For more information on the specifics of MCFD interventions and results refer to the Oregon case study (section 10.4.1) on page 50.

orders this would eliminate approximately 3,632 from admission into the program. The remaining 5,448 children under continuing custody orders would include both males and females ages 0 to 19. The MTFC program would only enroll girls in continuing care, who are identified to be at higher risk of pregnancy, between the ages of 12-19. Because of current inability to determine the number of girls that would apply under such enrollment criteria and the lack of staff that are trained to carry out this intervention on a large scale, the option would have to be implemented in several phases.

Implementation of this intervention would require consultation, planning and training services from the Oregon based, *TFC Consultants, Inc.*, which “is dedicated to the implementation of community-based programs that are cost effective and achieve positive outcomes for children, youth and families”¹¹. *TFC Consultants, Inc.*, is founded and led by the Dr. Patricia Chamberlain who developed and established the MTFC model in 1983. The costs presented in the subsequent section have been provided after brief consultation with *TFC Consultants, Inc.*, and are based on the following items:

• ¹¹ http://www.mtfc.com/about_us.html

A	A team of 4 (3 clinicians [2FTEs] and 1 foster parent recruiter/trainer/PDR caller [.75 FTE]) is required for every 10 youth enrolled
B	Planning services cost \$1,500 per team
C	Foster parent compensation should be approximately 25% above average Foster care rates
D	First year implementation costs (training, consultation, technical assistance) amounts to approximately \$46,500 plus travel expenses (5 trips to the program centre in Eugene, OR) Second-year costs are variable, about half of year 1 on average
E	\$10,000/year for ongoing model adherence monitoring, replacement staff training, etc.
F	Operation costs per youth range from \$2,600 to \$3,000

The following chart breaks down approximate total costs of running the MTFC program in BC. The first two years represent the first phase of program implementation and would accordingly require greater funds to establish program administration recruitment and training of staff. The second phase would assess demand from the previous phase and adjust enrollment numbers accordingly. Depending on whether there is higher or lower demand, additional funds may need to be contributed towards additional staffing and training. Should this option be seriously considered by the BC government, further consultation with *TFC Consultants Inc.*, is needed to ascertain exact costs through a more thorough assessment and quote process.

	PHASE 1: IMPLEMENTATION		PHASE 2: EVALUATION & ADJUSTMENT
	Costs Year 1	Costs Year 2	Costs Year 3*
Enrollment #	150 girls	150	150
Planning Services (for 15 teams)	\$22,500	22,500	22,500
Consultation & Training costs (training for 70 staff members)	\$697,500	348,750 ¹²	0
Operation Cost (for 150 youth in care)	\$450,000	\$450,000	\$450,000
Cost of annual model adherence monitoring and replacement staff training	\$150,000	\$150,000	\$150,000
Additional Foster Care Placement Costs (for 150 youth in care)	\$34,123 ¹³	\$34,123	\$34,123
Total Costs	\$1.35 million	\$1 million	\$656,623

*Possibility of cost variation due to greater or lower enrollment rates

Evaluation

	Effectiveness	Pol. Feasibility	Complexity	Cost	Cost Effectiveness	Total Score
Score	High (3)	Medium (2)	Medium (2)	Medium (2)	High (4)	13/17

Effectiveness: This option rates well in effectiveness as it achieves both long and short-term objectives of the policy. It provides integrated health and social service delivery, coordinated facilitation to such services, as well as systematic monitoring and evaluation of children and

¹² Costs decrease by half the previous year as less training is needed

¹³ Foster care rate of payment for ages 12-19 is \$909.95/month.
http://www.mcf.gov.bc.ca/foster/monthly_rates.htm

youth in care's health issues. It also satisfies the long-term effectiveness criterion by addressing several developmental risk factors at the individual, interpersonal institutional and public policy levels. Protective factors introduced at these levels include:

1. Having additional adult monitoring, follow up and support on child or youth's education including, school attendance, performance and homework completion.
2. Provision of family therapy for foster parents and children
3. Individual counseling services for children in need of such due to history of trauma, or present mental health concerns.

In addition to the criterion's definition of effectiveness, this option has been proven through controlled scientific studies and trials to reduce pregnancy rates as girls in the studies who received MTFC services were 2.5 times less likely to become pregnant than those who were placed in control groups (Kerr et al., 2009). With this said, the option did not receive a full score of 4 as it only affects those girls enrolled in the program (i.e. girls who are screened and found to at greater risk for early pregnancy due to history of previous pregnancies, engagement in risky sexual behaviour, exhibit educational failure, and/or involvement in criminal activity). Policies that received a full score of 4 in this criterion applied to the larger population of children and youth in continuing government care and are focused on early prevention rather than intervention after identification of high risk factors as outlined above.

Political Feasibility: MTFC scored average on this criterion. Some elite stakeholders perceived it as an additional model of foster care that would be difficult to sell to Treasury Board, as the province already funds different models of out-of-home care.

With that said, the current structure of out of home placement, provides an possible alternative to setting up of MTFC infrastructure (such as homes and recruitment of foster parents etc.) in the current "Specialized Family Care Home" settings that are set up to deal specifically with children or youth who exhibit moderate to extremely challenging behaviour

(HRSDC Report, 2000). There are three levels of such care homes in operation in BC with the second and third having specifically trained foster carers and often providing assessment and interventions to the child or youth in their custody (Ibid). With this said, a structure seems to already exist where such Specialized Family Care Homes can be used to implement MTFC interventions without the need for major additional capital funding or restructuring. Whether or not this strategy is politically feasible depends on whether those invested in the current Specialized Family Care Home models are open to adopting and implementing MTFC models in place of their current models.

Complexity: This option received an average score for implementation and operational complexity, as it would require a great deal of coordination across jurisdictions to implement. In addition to this, a great deal of training and support is required for staff, foster parents and other caregivers. With that said, the presence of a plurality of consulting firms that specialize in varying models of MTFC would help alleviate some of the complexities by providing training, set processes, manuals, consultation and monitoring pre and post implementation. In addition to this, the existing structure of Specialized Family Care Homes would make implementation much smoother since the recruitment and training of foster carers would not be as tedious.

Cost: This option received an average cost score in implementation and operational costs as most programs similar to this one, which are currently, implemented in BC double the total child welfare costs per child or youth per annum (Interview with Wright, 2011). Since there are currently similarly priced intervention models in existence, there is evidence to show that such an intervention model will not be written off due to its costs. In addition to this, the option of current funds directed to run and train personnel for Specialized Care Homes in BC can be used to implement the MTFC model within such settings.

The average score is also attributed to this option with the rationale that although costs are higher in the first year, they go down in the second and third (i.e. from \$1.35 million in the first year, to \$1 million in the second and approximately \$656,600 in the third year).

Cost Effectiveness: The delivery of MTFC programming rates ‘high’ in cost effectiveness as it is proven to reduce pregnancy rates of children in care thereby eliminating a variety of costs associated with pregnancy related health utilization, the child welfare and youth criminal justice systems. In addition to these cost savings, the program’s emphasis on the mitigation of educational failure and delinquency arguably results in shaping girls enrolled into more economically productive members of society in the long-run. Elite stakeholder Martin Wright of MCFD suggests that cost effectiveness of this program can be conservatively equated to that of early childhood development and support strategies that are proven, through a variety of cost-benefit studies, to show a return of \$7 on every dollar spent on a disadvantaged child in early childhood (Wickelgren, 1999; Campbell et al, 2001; Schweinhart et al, 2005). He claims “*benefits of MTFC are analogous to early childhood development programs in how they adjust developmental trajectories*” (Interview with Wright, 2011). In addition to this he maintains that MTFC may have greater benefits to early childhood development and support strategies as all dollars allocated to this program would be used to address, already identified, high risk adolescents as opposed to dollars spent on early childhood initiatives, where not all children will necessarily need the support or exhibit poor developmental outcomes and dollars may be accordingly ‘wasted’.

Enhancement of well-being: This option rates high in its ability to enhance the well-being of children and youth enrolled in a MTFC program. This is due to the ability of such programs to lower delinquency, improve educational outcomes and lower risky sexual behaviour amongst high-risk youth (Kerr et al., 2009). Children and youth in care who would be enrolled in a MTFC program would thereby have a much greater likelihood of establishing

positive social relationships, having greater self-esteem and becoming more successful in their future social and economic lives.

Overall, this option scores 17 out of a possible 21 points.

Option 4: Sexual Health Education for Foster Parents & Children and Youth in Care

As assessed in my research, there is a lack of standard access to sexual health education that is specifically targeted towards children and youth in care and their special needs. It was also determined through correspondence with BC foster parent support services personnel, that the required foster parent education curriculum does not include a module on adolescent sexual health and how to support foster children and youth on this subject. This provides a significant gap which, if filled can alleviate risk factors associated with early pregnancy (i.e. lack of parental monitoring, lack of access to accurate sexual health information, lack of connectedness or meaningful adult relationships etc.). In addition to this, the transient nature of foster care placements allows for a greater chance of lapse in school attendance and missing traditional school-based sex education (Becker & Barth, 2000, Sullivan, 2009, Chase, 2006). Many children and youth in care therefore do not benefit from school-based sexual health education and need specialized access to such services in a different environment. This option accordingly requires the implementation of two separate components:

COMPONENT 1 – Foster Parent Education

An additional 15th module be added to the current foster parent education curriculum in order to prepare and train foster parents on how to better communicate and support children and youth in care on matters of relationship and sexual health.

COMPONENT 2 – Foster Child & Youth Education

A pilot project of the Power Through Choices Curriculum in one BC Region to tests its merits and its possibility for future adoption Provincially.

Implementation of this option's first portion (foster parent education) would require:

A	A review of other foster parent modules on sexual health and selection of the most suitable one for delivery in BC by MCFD and the BC Federation of Foster Parent Associations;
B	Training of foster parent education facilitators or contracting <i>Options For Sexual Health BC</i> to deliver the additional module;
C	Additional hours added to the currently required level of hours (53hrs) completed by foster parents to be eligible for foster child placement.

Implementation of this option's second portion (foster child education) would require:

A	Determining region and location for pilot implementation;
B	Training staff (whether local agency or <i>Options For Sexual Health BC</i> facilitators) in delivery of the <i>Power Through Choices Curriculum</i> ;
C	Engaging youth in care foster parents, social workers, and community outreach workers.

Evaluation

	Effectiveness	Pol. Feasibility	Complexity	Cost	Cost Effectiveness	Total Score
Score	Medium (3)	High (3)	Medium (2)	Medium (2)	High (3)	13.5/17

Effectiveness: This option attained a fairly high score, although not a full score of 4, for effectiveness as it partially addressed two of the short-term policy objectives and adequately addressed the long term effectiveness measures. Short term objectives addressed were: (a) Facilitation of access to preventative services; and (b) establishment of integrated health and social services that engage in active planning and information sharing in order to create environments that insulate children and youth in care from development risk factors and reinforce protective factors and healthy lifestyles. This option fulfills the above by providing access to preventative sexual health education through integrating health and social service providers (i.e. public health nurses, social workers and community outreach workers). The option scored fairly high in terms of long-term effectiveness as it addresses four out of the five spheres of influence associated with health related behavior:

- (1) Intrapersonal, where children and youth benefit from empowerment and self-esteem skills building exercises as part of the PTC curriculum;
- (2) Interpersonal, where children and youth learn how to effectively communicate with adults and partners about sexual health topics, seek out help and negotiate contraceptive use;
- (3) Institutional, where children and youth gain training and support on where and how to access community resources on sexual health and contraceptive use; and
- (4) Public policy, where sexual health and education will be implemented as a standard requirement, as part of the 14 module foster parent education program, for certification. Also, that sexual health education will specifically cater to the foster care population and their different needs through its delivery outside of the

traditional school setting and amongst peers who can associate with their experiences and lived realities.

Political Feasibility: This option rated high in political feasibility as stakeholders advocated for inclusion of a policy option that specifically addressed sexual health education for both foster parents and children and youth in care. The option also rated high on political feasibility due to its first segment's fairly low complexity and cost score as adding an extra module on adolescent sexual health would be fairly straight forward. Piloting a project in one BC region would also be politically feasible as cost and complexity would be much lower than if the program was implemented province wide. There are also clear and convincing arguments in support of such an initiative due to the apparent lack of attention to this particular disparity between children and youth in care and the general population.

Complexity: This option scores average on implementation and administrative complexity as both components of the option would require differing levels of cross jurisdictional coordination and change in the administration of services. Component one would require little cross jurisdictional coordination and change in administration of services since it would only require the addition of an extra module in the currently delivered curriculum for foster parent education and the subsequent training of facilitators who would be responsible for delivering the module. Another option for this, which may reduce the need to train facilitators, is to involve sexual health education agencies such as *Options for Sexual Health BC*, in facilitating the 1 or 2-hour sessions specifically designed to place emphasis on items that are particularly relevant to the foster parent population and sexual health topics, similar to their current "Askable adults" program.

The second component, however, would require greater amounts of cross jurisdictional coordination as social service providers and health providers would need to coordinate and collaborate on various aspects of the program, from enrollment to delivery and assessment. In terms of administrative complexity for component two of this option, a high amount of change

would need to occur to the status quo as there is currently no service provided to BC children and youth in care that is specifically crafted and delivered according to their special needs, therefore no current infrastructure. Determination of location for program delivery as well as agencies and instructors who are trained and willing to delivery the program would need to be set up from scratch. This, again, could involve the contracting of *Options for Sexual Health BC* to deliver the Power Through Choices Curriculum as this specific agency has the most experience in terms of delivery of awareness and educational programming on sexual health and contraceptive use.

Cost: The average cost of delivering a sexual health program is dependant on course time. As ascertained through correspondence with Executive Director, Greg Smith, of Options For Sexual Health BC, an hour of course time is costed at \$150 (inclusive of all costs including facilitator prep and evaluation). For the first component of this option, this would equate to approximately \$450 dollars per sexual health module delivered to foster parents as part of the required education program.¹⁴ For the second component, hours per session were not identifiable, although it was ascertained that 10 sessions are required for the completion of this curriculum. Assuming that each session is 2 hours long, the approximate cost of administering this program would be \$3,000 sine this component is merely a pilot that will be limited to one region in BC, it can be assumed that its approximate costs are negligible.

Cost Effectiveness: This option received a high score in cost effectiveness, as it would most likely increase awareness of safe sex practices, as well as self-confidence of youth in foster care in engaging in healthy sexual relationships thereby reducing early pregnancy rates in the long run. The option did not receive a full score, of 4, however because it is too specific in its targeting of sexual health education as a protective factor rather than attempting to address other developmental risk factors that have been proven to bear a great deal of weight on pregnancy rates as well as general health and well-being. Other options deal with the issue of early

¹⁴ Based on an average of 3 hours per module delivered in the foster parent education program

pregnancy in a much more developmentally holistic way, by addressing several risk factors that aren't, at face value, related to early pregnancy, thereby incurring cost savings at greater scale than just pregnancy related health utilization.

Enhancement of well-being: This option enhances well-being of children and youth in care in a more narrow sense than the previous options by strictly focusing on their awareness and literacy of sexual health practices. This narrow focus is still important, with respect to enhancement of well-being, as it builds much needed self-esteem and empowers children and youth to make informed and healthy decisions regarding their lives. Empowering children and youth and building self-esteem in one area of their lives (ie. sexual health practices) can spillover to other areas of their lives and produce more general attitudes of empowerment and self-confidence.

Overall, this option rates 17.5 out of a possible score of 21.

Option 5: Health Care Coordination

This option provides holistic integrated health and social services while attempting to alleviate pressure on social and health care workers who may not have the time to comprehensively monitor and facilitate access to health services due to large caseloads. It is adopted from the New York Case study on their Health Coordination Pilot Program which showed effective results in facilitating better communication and information sharing across health and social service providers as well as foster parents and children in care. The program also showed better results for monitoring, and access to preventative and non-preventative health services for children and youth in care. The benefit of adopting a program that has been previously piloted, and now formally adopted, is not only its positive impacts on health and well-being of children in care but that there are implementation strategies established that can be used as guides for our own implementation in BC. Implementation was flexible in New York, where

each contracted agency was free to carry out Health Coordination in a way that suited their local populations’ needs so long as basic processes were being met.

The program would either enroll all children in continuing care of the BC Government or only girls in continuing care as this is stays inline with my research focus and requires a smaller dedicated expenditure. Regardless of route taken, this option would better ensure health issues and concerns of the particular population are monitored and addressed. This option, like the previous one, would have long reaching effects in terms of well-being. In addition to pregnancy prevention, it would promote better health outcomes for children in care who would normally not receive the appropriate health monitoring, caregiver information coordination and facilitation of access to a variety of preventative and non-preventative health services.

Requirements of Health Care Coordination implementation are as follows:

A	Allocation of funds towards the initiative. Arguably, this could involve a cost-sharing agreement between the Ministry of Health Services and the Ministry of Children and Family Development.
B	Creating an RFP ¹⁵ process to contract out regional agencies to implement Health Coordination in their local communities
C	Contracted regional agencies would carry out recruitment and training of social or case workers to solely take on the role of Health Care Coordinators for a limited number of cases (10 file caseload/caseworker).
D	Annual evaluation of regional agency performance and children and youth’s health outcomes.

Since implementation in New York involved the contracting of local agencies to deliver the program, costs varied across agency depending on number of staff required and children served as well as variations in qualifications of staff. A total of \$2.9 million was spent, in contracting dollars, over 3 years that served approximately 1,113 children. Proposed costing for implementation in BC is a reflection of the above since no further cost breakdowns were given by

¹⁵ Request for Proposals

the New York Office of Family and Children Services' pilot evaluation study. Costing details for the proposed program, to be considered for implementation in BC, are as follows:

Costing Details	For all Children & Youth in Continuing Care	For Girls in Continuing Care
Enrolment #	5,448*	2,724***
Cost /child in continuing care	\$868.5	\$868.5
Total annual cost	\$4.73 million**	\$2.37 million**

* Amount of all children and youth in continuing government care in 2006

** Further consultation is needed with the New York Office of Family and Children Services to determine cost breakdown for recruitment and training, administration, operation and evaluation.

*** Assuming a 50-50 gender split amongst children and youth in continuing care

Evaluation

	Effectiveness	Pol. Feasibility	Complexity	Cost	Cost Effectiveness	Total Score
Score	High (4)	Medium (2)	Medium (2.5)	Medium (2)	High (4)	14.5/17

Effectiveness: The Health Care Coordination option rates high for effectiveness as it addresses the objectives of integrated health and social service delivery, coordinated facilitation of such services, as well as systematic monitoring and evaluation of children and youth in care's health issues. It also satisfies the long-term effectiveness criterion by addressing risk and protective factors at the:

- (1) Individual level, where children and youth are empowered and develop a sense of self-esteem, ownership and purpose due to their regular involvement and consultation in health planning;
- (2) Interpersonal level, where there would be regular coordination between caregivers, health providers, community outreach workers and children and youth in order to

improve communication, relationship building and a sense of continuity that would foster feelings of connectedness for children and youth in care;

- (3) Institutional level, where children and youth in care would be supported in determining the best available resources available to them and facilitated (by the health coordinator) in the access of such services;
- (4) Public policy level, where there would be a designated individual mandated to coordinate and facilitate health services children and youth in care according to their specific individual needs.

Unlike the previous option (MTFC), it applies to all children and youth in continuing government care, regardless of gender or early pregnancy risk factors. Due to this, it is arguably more effective as both boys and girls in care's health and developmental needs are addressed in order to mitigate low health outcomes and early parenthood resulting from either gender's poor developmental trajectories.

Political Feasibility: This option rated average in political feasibility as stakeholders felt that it required large-scale system change with the introduction of a new designation that would solely be assigned the task of health care coordination of any item related to children and youth in care's health. With this said, Dr. Perry Kendal, in an elite stakeholder consultation on policy options, recommended the introduction of this option as a pilot that would be implemented in one or two health regions. This would provide for the opportunity to prove the program's economic and social merits locally, and in turn help garner political and social support for such a program to be implemented province-wide. Both Mr. Berland and Mr. Wright agreed that public health nurses who have training in health planning and coordination for at-risk populations could largely carry out such a position. This would however require the political will to reallocate funds from a different, perhaps less effective, public health program.

Complexity: This option rated ‘average’ in implementation and operational complexity, as it would require the designation of a particular set of health care professionals with the responsibility for delivering this program, the creation of specific standardized process guidelines and information databases to house health information. On the other hand, this would not be extremely complex to implement since there are international examples, i.e. New York, of implementation processes, process guidelines and manuals. In addition to this, once implementation was complete and processes established, operational complexity would be fairly low as one individual, most likely with similar qualifications of a public health nurse, would be tasked with the coordination of a child’s health. The caseloads would be small (approximately 10 per health coordinator), in order to maximize the time and attention paid to each child’s health needs as well as to minimize complexity as coordination across several different individuals (i.e. health professionals, caregivers, community outreach workers, teachers etc.) is required per caseload. In addition, this option’s complexity may be further reduced. due to the recently established MSP billing code available for physician billing for case conferencing and planning which provides physicians with greater incentives to participate in the regular health planning of children and youth in care.

Cost: The costs associated with this option rate fairly average when compared to the average costs of similar programs delivered by health authorities and funded by the Ministry of Health Services. Based on the New York Office of Children and Family Services’ pilot, costs of operating this program per child are approximately \$868.50 annually. A program that funded this service to all children and youth in long-term care (approximately 5,448 in 2006) would accordingly cost approximately \$4.73 million annually. Similar programs like the, American implemented, Nurse-Family Partnership program that serves at-risk first time mothers throughout their pregnancy and up till their child’s second birthday to promote

positive maternal and infant outcomes costs approximately \$5,000 a year/per female served (Interview with Dr. Kendall, 2011).

Cost Effectiveness: The cost effectiveness of this option is extremely high as the potential for long run cost savings in general health care utilization dollars. This assumption is based on the fact, as established earlier, that children in care utilize a great amount of health services. Many of which are acute care services that could be deterred through more efficient proactive management of their health issues or concerns. If correctly implemented, this option would positively affect a variety of low health outcomes, including early pregnancy. This would largely be done through health coordinators regularly monitoring health behaviour of children and youth in care and accordingly facilitating the delivery of educational and preventative services in addition to any required non-preventative services.

Enhancement of well-being: This option greatly enhances well-being in a broad sense, as it provides avenues towards empowerment and ownership for children and youth in government care. Having health care coordinators will allow for much needed protective factors like relationship continuity amongst the coordinator, child and caregivers as well as continuity in health care delivery (Saewyc et al., 2008; Becker & Barth, 2000). This option also ensures that appropriate and timely preventative services will be delivered to children and youth in care in order to proactively enhance their health and well-being.

Overall, this option rates 18.5 out of a maximum 21 points, making it the second highest scoring option.

Table 4: Policy Evaluation

Criteria	Status Quo	Legislative/Policy -Centered Option1	Program Option 3	Program Option 4	Program Option 5
1) Effectiveness					
Short term	Low (1)	High (4)	High (3)	Low (1)	High (4)
Long term	Low (1)	High (4)	High (3)	High (4)	High (4)
2) Political Feasibility					
	High (3)	High (3)	Medium (2)	High (3)	Medium (2)
3) Complexity					
Implementation	Low (3)	Medium (2)	Medium (2)	High (1)	Medium (2)
Administrative Operational	Low (3)	Medium (2)	Medium (2)	Medium (2)	Low (3)
4) Cost					
Implementation	Low (3)	Low (3)	Medium (2)	Medium (2)	Unknown
Administrative Operational	Low (3)	Low (3)	Medium (2)	Medium (2)	Medium (2)
5) Cost Effectiveness					
	Low (1)	Medium (3)	High (4)	High (3)	High (4)
6) Enhancement of well-being					
	No (1)	Yes (4)	Yes (4)	Yes (4)	Yes (4)
TOTAL SCORE	11	19	17	17.5	18.5

13: Research Limitations, Recommendations & Conclusions

13.1 Research Limitations & Associated Recommendations

Currently there is a lack of Canadian literature on the specific subject of children in care and their sexual health issues including pregnancy. In the context of BC, there have been a few qualitative research projects which have sought to capture the lived experiences of girls who become pregnant in care, as well the experiences of their social workers. Until 2006 and 2007, there had been no clear quantitative data to show disparities in health utilization, mortality and educational outcomes of BC children and youth in care in comparison to children and youth in the greater population. Although, social workers, foster parents and health care workers may be able to anecdotally provide evidence of such, currently there are not any consistent mechanisms in place by which such information or data can be jointly documented and stored in order to evaluate the health and educational outcomes of children within long-term government care. Mr. Berland of the RCY stated in a stakeholder interview *“if no one is tracking in an active manner the number of pregnancies, or abortions, or difficulty managing birth control or any unmanageable sexual behaviour, in the sense of multiple partners ...if no one is taking a look at that picture, as a health issue its very difficult to figure out what the health response might be”* (Interview with Berland, 2011). Mr. Wright of MCFD goes further in stating that there is a need for establishing a set of good *“indicators of psychosocial development”* that are less traditionally collected (i.e. self-esteem, attachment etc.). These would indicate vulnerabilities in each child’s development and help address the root causes of poor developmental trajectories, and negative outcomes, such as early pregnancy, educational failure and involvement in criminal activity. Such information is imperative to the functioning of a healthy policy system that grounds its decision-making in identifiable and reliable information. **With the above stated, it is recommended that**

a set of indicators of psychosocial development are established and documented for each child, as well as an integrated monitoring system is developed to track the health and well-being of children in care. This is necessary in order to engage in proactive policy that is able to timely mitigate future negative outcomes by adjusting children and youth's developmental trajectories upon the identification of present psychosocial risk factors.

In addition to the above, it has become clear, throughout the research process, that Aboriginal children and youth in long-term care have additional specific needs that are not addressed in my policies due to the limited time frame and size restrictions attributed to this project. These specific needs are mainly in relation to cultural factors that predispose them to early pregnancy. Since, this population represents an extremely large subset of the children and youth in care population, **it is imperative that more research is undertaken to study the cultural implications relating to early pregnancy and aboriginal children and youth in care as well as potential policy strategies to deal with this issue.**

13.2 Policy Recommendations

Policy recommendations are based on the previous chapter's evaluation of each policy according to the previously stated criteria and measures. Option 2, **“Creation of Standardized Guidelines for Integrated Health Service Delivery”**, received the highest rating among the five different options. This was largely due to its advantage in high political feasibility and low implementation and administrative costs. This option is recommended as a way to address the lack of coordinated, comprehensive health service delivery to children and youth in care as well as a way to create integrated processes for the monitoring and evaluation of children and youth in care's health needs. With that said, there is still a concern that guidelines don't necessarily translate to practice. Accordingly, I also recommend option 4, **“Health Care Coordination”**, which received the second highest rating, to be implemented as a pilot study according the BC Provincial Health Officer's suggestion. This should be done in order to better establish and

delegate responsibility for the provision of proactive, and holistic management of children and youth in care's health. Both recommendations are highly comprehensive in acknowledging and addressing the major psychosocial developmental risk factors associated with early pregnancy and would thereby be more effective in adjusting poor developmental trajectories. This would dramatically improve the general health and well-being of children in care, including lowered pregnancy rates and the added benefits of lower health utilization and related health expenditures.

13.3 Conclusions

The statistic showing that girls in long term care become pregnant at a rate 4 times greater than the general population is one that is intimately linked with the psychosocial realities of children and youth in care. Many children in care exhibit a multitude of risk factors that predispose them to poor developmental trajectories and negative health, social and educational outcomes, including early pregnancy. It is only through the promotion of a policy system that is acutely aware of such indicators and their cumulative affect on the health and well being of children and youth in care, that effective programming and supportive care can be provided. The establishment of guidelines that lay out clearer roles and responsibilities for carers, service and health providers, as well as determine basic health monitoring standards and cross-agency information sharing strategies would:

- a) Underscore the Provincial Government's awareness, concern and willingness to take action regarding the current discrepancies in health outcomes for children in care and the general population;
- b) Begin to fill the ambiguities with regard to roles and frequency in screening, monitoring and evaluation of children and youth in care's health concerns;
- c) Commit to the importance of creating strong, safe and empowering environments where children and youth in care feel valued and engaged in planning and decision-making surrounding their health and well being.

Overall, adjusting poor developmental trajectories of children and youth in care is founded on: a) the awareness of present indicators associated with negative psychosocial development; and b) corrective action taken through the development of policy and practice. Accordingly, making steps to implement the recommendations presented in this research and, perhaps considering other high scoring policy options, would complement present strategies targeting educational attachment and school connectedness. This, in turn, would have significant positive implications on the health and well being of BC children and youth in long term care as more detrimental psychosocial indicators will be addressed to correct poor developmental trajectories and increase their chances of having resilient futures as productive members of society.

Appendices

Appendix A: Consent Form for Stakeholder Interviews

Changing Developmental Trajectories: Evidence Based Policy to Deal with Pregnancy of Girls in Long-Term Care

You are invited to participate in a research study being conducted by Mary Gerges, a student in Simon Fraser University's Master of Public Policy program. This research will complete a requirement to earn a Master of Public Policy degree. The supervisor for this research is Professor Judith Sixsmith, School of Public Policy, Simon Fraser University.

Purpose of the Study

The proposed study will explore the current BC context of girls in care with the intention of establishing a benchmark for developments to enhance their health and social supports in hopes of preventing early pregnancy. The policy problem addressed is: *females in continuing care, between the ages of twelve to nineteen, become pregnant at a rate four times that of females, within the same age range, in the general population.* Early pregnancy is a problem as it leads to significant healthcare expenditures, on the part of government, as well as poses several social, economic and health risks to young mothers and their children.

Through this study I will be looking to other jurisdictions that have identified a similar problem in their own child welfare populations and are leading the way in innovative preventative solutions. After a thorough assessment of such jurisdictions, policy options that are identified to be effective in mitigating the above policy problem will be recommended. These options will be presented to senior BC Government officials in hopes of mobilizing pregnancy prevention mitigation efforts for girls in care.

What it Means to Participate in this Study

If you agree to participate, you will take part in a 30 minute interview with me, Mary Gerges, that will take place at a mutually agreed upon time and place. With your permission, the interview will be audio-recorded. Your name will not be removed from all of the documents and reports that are written about this study unless you so request.

We do not expect that there is any risk to you if you decide to participate. You may choose to terminate or cancel your participation at any time. You can also choose not to discuss specific issues without having to explain why or ask for certain parts of the interview to be omitted. You can ask for a summary of the findings from me by contacting me directly at maryg@sfu.ca

This study has been approved by the Office of Research Ethics at Simon Fraser University. If you have any concerns or complaints, please contact Hal Weinberg, Director, Office of Research Ethics at hal_weinberg@sfu.ca or (778) 782-6593.

Security of Data

All data collected for use in this study will be transferred to a USB key or hard copy. It will then be stored for a period of three (3) years in a locked, fire-safe cabinet. Three years after the completion of the study, all data will be deleted from the USB key and any hard copies will be shredded.

Questions about Participating

If you have any questions about participating in this study you can contact me, Mary Gerges at maryg@sfu.ca. If you require any further information about this study you can contact my supervisor, Judith Sixsmith by email at jsixsmit@sfu.ca.

Appendix B: Care and Custody Under the CFCSA

	Legal Status	Powers and Duties of the Director
Custody Includes care and guardianship of a child.	Interim Order: Section 35(2)(a)	To consent to health care, to make necessary decisions about the child's education and religious upbringing, and to exercise any other rights and carry out any other responsibilities of a guardian of the child's person, except the right to consent to the child's adoption: Section 47(1). *The court may order that the parent retain certain rights, in the child's best interests: Section 47(3).
	Interim custody to a person other than a parent under the director's supervision: Section 35(2) (d)	The director supervises the child in the living arrangement according to the terms of the accompanying supervision order. The person with the custody of the child is responsible for the child's care and guardianship, except for any rights retained by the parent according to the court order.
	Temporary custody to a person other than a parent under the director's supervision: Section 41 (1) (b)	The director supervises the child in the living arrangement according to the terms of the accompanying supervision order. The person with the custody of the child is responsible for the child's care and guardianship, except for any rights retained by the parent according to the court order.
	Temporary Custody Order: Section 41(1)(c)	To consent to health care, to make necessary decisions about the child's education and religious upbringing, and to exercise any other rights and carry out any other responsibilities of a guardian of the child's person, except the right to consent to the child's adoption: Section 47(1). *The court may order that the parent retain certain rights, in the child's best interests: Section 47(3).
	Continuing Custody Order: Sections 49(4) or (5); Section 41(1)(d); and <i>Family Relations Act</i> , Section 29	The director has all the rights, duties and responsibilities of a guardian of the child's person, including the right to consent to the child's adoption: Section 50.
	Section 54.1 Transfer custody of a child in the continuing care of the director to a person who is not the child's parent.	The director is involved in the planning and assessment process. Once the order is granted, the custody of the child is transferred from the director to the care provider. The director may provide financial assistance after transfer of custody.

Appendix C: Key Informant Interview Schedules

1st Key Informant Semi-Structured Interview Schedule

Purpose:

- A. To gain a good understanding of current BC context for girls in care in terms of legislations, social service and health delivery.
- B. To gain insight into initiatives and strategies aimed at reducing early pregnancy amongst girls in care

Key Themes and or Questions:

- 1) Models of Service delivery to girls in care
 - o Access to health & social services
 - o Individuals involved on the ground
 - o Specialized or general access (targeted or non-targeted services)
- 2) Legislative context
 - o Any recent changes or additions related to prevention initiatives?
- 3) Governance Structure
 - o How many ministries' & agencies' mandates are connected to issue
- 4) Description of preventative initiatives and policies
 - o Barriers and facilitators to success

2nd Key Informant Semi-Structured Interview Schedule

Purpose: Policy review and assessment by key BC stakeholders

Key Themes and Questions:

- 1) Have provided options been previously assessed by the represented ministry or agency and how?
- 2) Option viability in BC due to organizational or structural difficulties
 - What are the barriers?
 - What are the facilitators?
- 3) What steps can be taken to enable them to become more viable?
- 4) Can options be modified to become more consistent with relevant ministry mandates while also staying true to their objectives?
- 5) Any options overlooked?
 - o New policies or strategies for inclusion into the policy assessment
- 6) Ranking of policy options according to a set of given criteria

Appendix D: Collaborative Planning and Information Sharing Checklist

Checklist for Collaborative Planning and Information Sharing When a Child or youth in Care Changes Schools				
Team member(s) responsible	Required actions	Pending	Date completed	Signature
Child welfare worker	Inform the principal (or designate) and appropriate school staff at the receiving school of the incoming child/youth's circumstances and individual needs.			
	Work collaboratively with the sending school to support a successful school transition.			
Child welfare worker and caregiver(s)	Consult with the school to determine any specific supplies that are required for the child/youth's classes and provide them as soon as possible.			
	Update and maintain all of the child/youth's records: contact information of family members, caregiver(s), child welfare worker and emergency contact.			
Receiving school principal	Contact the sending school's principal to share information about the child/youth's individual needs.			
Receiving school staff	Contact the sending school and request school files (indexed to student's PEN). Note: Form 1704 and inclusions (recent report card, attendance records, IEP, transcripts) can be faxed, with originals to follow by mail, as per Ministerial Order M190/91. Complete a file review of faxed material to:			

Checklist for Collaborative Planning and Information Sharing When a Child or youth in Care Changes Schools				
Team member(s) responsible	Required actions	Pending	Date completed	Signature
	<ul style="list-style-type: none"> determine what services to coordinate for the child or youth (e.g., Student Learning Plan, Counselling, LA/Resource [special educational services]) understand the child/youth's strengths, interests and needs (i.e., identify and provide opportunities for extracurricular involvement, learn about the child/youth's personality style, etc.). 			
	Make short-term plans to ensure a smooth transition into the new school setting, such as identifying a mentor to help the child or youth settle into his or her new environment.			
	Provide additional learning resources, as needed, to help the child or youth achieve educational goals.			
Child welfare worker, caregiver(s), and school staff	Provide and sign any necessary release forms for the previous and new schools to share information to enhance planning for the child or youth.			
	Determine needs for support to stabilize the child/youth's comfort and compliance with routines: <ul style="list-style-type: none"> take time to orient and welcome the child or youth and family to the school to establish a sense of belonging familiarize the child or youth with the new school's code of conduct speak directly to classroom teacher(s) about homework and upcoming field trips familiarize themselves and the child or youth with sign-in/sign-out procedures, and attendance expectations familiarize themselves and the child or youth with 			

Checklist for Collaborative Planning and Information Sharing When a Child or youth in Care Changes Schools				
Team member(s) responsible	Required actions	Pending	Date completed	Signature
	opportunities to be included in school clubs and other extracurricular activities.			
	Immediately following registration at the new school: <ul style="list-style-type: none"> • discuss the child/youth's needs and past strategies and practices • identify and provide the individualized supports and resources the school determines necessary to ensure a successful transition (e.g., IEP or SLP, and the Child's Plan of Care).* 			
	Document ongoing communications (e.g., log of phone calls, meeting notes, checklists, letters, email, etc.)			
	Other considerations:			

Appendix E: Example of Interventions

Role of caregiver(s), child welfare worker(s), family member(s)	Role of principal/vice-principal, classroom teacher(s), school-based case manager, counsellors
<i>Protective Factor: Interest and involvement in education and community life</i>	
<ul style="list-style-type: none"> • Participate in school-based team transition meetings and parent-teacher meetings, and be involved in school life. • Foster participation in the community (Little League, Big Brothers/Sisters, etc.). 	<ul style="list-style-type: none"> • Consult with caregiver(s)/child welfare worker(s) about the educational needs and program of the child or youth (e.g., appropriate program and placement). • Encourage all parent(s) to engage in the planning process (e.g., those who may be or appear to be hesitant or upset). • Match interests and talents to opportunities within the school and community (extra-curricular activities and clubs).
<i>Protective Factor: Awareness of the child/youth's specific developmental, cultural, and individual strengths and needs</i>	
<ul style="list-style-type: none"> • Provide pertinent information that is unique to the child/youth's needs and strengths when discussing educational programming. • Provide opportunities for the child or youth to continue to be connected to his or her individual culture and community. 	<ul style="list-style-type: none"> • Liaise with the sending/receiving school (as per the Permanent School Record – Form 1704). • Establish a plan to meet the short-term needs for belonging and acceptance, and the long-term need to support educational outcomes; this may include development of an IEP and/or participation in Aboriginal language or cultural programs as appropriate. (See Appendix I for suggested interventions and strategies.)
<i>Protective Factor: Joint assessment and planning for children's/youth's needs and shared accountability among caregivers, family members and relevant support professionals</i>	
<ul style="list-style-type: none"> • Child welfare worker shares relevant aspects of the Child's Plan of Care (CPOC) to align school-based collaborative planning with the broad goals for the child/youth's future. 	<ul style="list-style-type: none"> • Establish clear timelines for review and/or revision of goals and strategies. • Focus discussion at scheduled parent/teacher interviews on aligned school-based collaborative plans, and review IEP if applicable. • Consider alternative pathways to graduation for youth when all other strategies have been attempted.

Role of caregiver(s), child welfare worker(s), family member(s)	Role of principal/vice-principal, classroom teacher(s), school-based case manager, counsellors
<i>Protective Factor: Timely records/information sharing</i>	
<ul style="list-style-type: none"> • Share information from relevant reports relating to the well-being of the child or youth. 	<ul style="list-style-type: none"> • Share report cards and concerns with caregiver(s). • Conduct appropriate school-based assessment and reporting.
<i>Protective Factor: Consistency and stability</i>	
<ul style="list-style-type: none"> • Maintain positive ongoing communication with the school-based team and the child or youth. 	<ul style="list-style-type: none"> • Appoint an adult mentor/champion to check in frequently with the child or youth and advocate for his or her needs and participation in and enjoyment of school life.
<i>Protective Factor: Development of Resiliency</i>	
<ul style="list-style-type: none"> • Model optimism and hardiness when difficulties arise, and state belief in the child/youth's future. • Ensure that the child or youth knows the adult is aware of his or her strengths and gifts, and convey to the child or youth through consistent positive feedback his or her importance in relationships. 	<ul style="list-style-type: none"> • Help the child or youth recognize and evaluate his or her automatic thoughts, help to explain the occurrence of events, "decatastrophize" circumstances, and provide opportunities for control over events (e.g., input into rules and discussion about consequences, opportunities to master skills and knowledge). • Teachers help students view themselves in a positive light by providing "quiet availability, fundamental positive regard and simple sustained kindness" (Higgins, 1994).

(Joint Education Planning and Support for Children and Youth in Care: Cross-Ministry Guidelines, 2008)

Appendix F: Assessment & Planning for Child in Care

CIC STANDARD 11: ASSESSMENTS AND PLANNING FOR A CHILD IN CARE	
STANDARD STATEMENT	<p>Immediately and within a maximum of 30 days of a child coming into care:</p> <ul style="list-style-type: none"> • complete an initial assessment of the child's needs • begin an initial plan of care for the child, and • address the child's health needs and urgent developmental needs. <p>Within six months of the child coming into care, complete a full assessment and written plan of care with the involvement of the child, the family and extended family, the Aboriginal community if the child is Aboriginal, the caregiver, and any significant person involved in the child's care or life.</p> <p>Complete assessments and develop and implement a plan of care that promotes the child's well-being and achieves the best possible outcomes in the following areas:</p> <ul style="list-style-type: none"> • health, emotional, spiritual and behavioural development • educational and intellectual development • culture and identity • family, extended family and social relationships • social and recreational involvement • social presentation and development of self-care skills related to assuming successful independent functioning, and • placement. <p>Review the child's plan of care:</p> <ul style="list-style-type: none"> • at least every 90 days while the child is in care • more frequently based on the child's developmental needs or if specified in the plan • if circumstances arise that make a review necessary • when there is a change in the overall goal, and • in preparation for the child leaving care. <p>If required, based on the review, revise the child's plan of care.</p>
INTENT	<p>The intent of this standard is to ensure that every child who comes into care has a plan of care that:</p> <ul style="list-style-type: none"> • is holistic, current and relevant to the child's unique circumstances and needs • reflects ongoing significant changes in the child's development, and • takes into account the child's family and community situation. <p>The plan of care:</p>

CIC STANDARD 11: ASSESSMENTS AND PLANNING FOR A CHILD IN CARE	
	<ul style="list-style-type: none"> • reflects and is responsive to ongoing assessments of the child’s needs • ensures that services in place for the child support the overall goal and are focused on the best outcomes for the child, and • is developed in collaboration with the child, family, extended family and cultural community. <p>The child’s plan of care is a “living document” that is reviewed regularly or as significant circumstances change. The documentation accurately reflects the current needs of and goals for the child and the services in place to support them.</p>
REFERENCES	<ul style="list-style-type: none"> • <i>Child, Family and Community Services Act (CFCSA): s.33.2(1)(b), s.35(1), s.42.1(5)</i> • <i>Adoption Act</i> • Practice Standards and Guidelines for Adoption • Council on Accreditation (COA): S5.2.05, S21.2.04, S21.2.05 • Service Delivery Agreement between MCFD and the Public Guardian and Trustee of B.C. • UN Convention on the Rights of the Child
POLICY	<p><u>Developing an initial written plan of care</u> Immediately, or within a maximum of 30 days of a child coming into care, assess the child’s needs and develop an initial plan of care that includes:</p> <ul style="list-style-type: none"> • the overall goal for the child, including establishing stable and ongoing living arrangements (e.g., return to parent or extended family) • contact with the child’s parent, siblings, family, extended family, community and others involved with the child • a description of the services required to implement the plan of care • health care needs and appointments • where the child will attend school, including, wherever possible, strategies to ensure that the child can attend the same school • maintaining the child’s involvement in social, recreational and spiritual instruction and activities. <p><u>Developing a plan of care</u> Within six months of a child coming into care, complete a thorough assessment of the child’s needs and develop and implement a written plan of care that promotes the best possible outcomes for the child within the following developmental domains:</p> <ul style="list-style-type: none"> • health, emotional, spiritual and behavioural development • educational and intellectual development • culture and identity • family, extended family and social relationships • social and recreational involvement • social presentation and development of self-care skills related to assuming successful independent functioning, and

CIC STANDARD 11: ASSESSMENTS AND PLANNING FOR A CHILD IN CARE

- placement.

When appropriate and consistent with the child's best interests, invite and support the participation of significant people in the child's life in developing a plan of care, including:

- the child
- the child's parents, family, extended family and community
- if the child is Aboriginal, a member of his or her Aboriginal community
- the child's caregiver
- an advocate for the child, and
- proposed care providers, caregivers or adoptive parents.

When developing a plan of care, ensure that the child in care:

- has health care needs met, including medical, dental, optical and hearing examinations
- is enrolled in a school, vocational or skills training program, or specialized educational program that meets the child's individual needs where he or she is of school age
- has a cultural plan, if the child is Aboriginal
- has consistent opportunities to participate in available and appropriate social and recreational activities according to individual abilities and interests
- has the appropriate autonomy, support and guidance to develop a positive identity, spiritual beliefs, and understanding of his or her cultural and ethnic heritage
- has opportunities to develop and enhance social skills and presentation,
- receives effective treatment and therapeutic support for persistent emotional and behavioural problems, and
- is cared for in a smoke free environment.

Reviewing a plan of care

At least every 90 days while a child is in care, complete a review of the child's written plan of care that includes:

- an assessment of whether the plan of care is effective in achieving the overall goal, particularly in relation to the child's need for stability and continuity of lifelong relationships
- a review of whether the services provided are effective in meeting the goals identified in the plan of care.

If required, based on the review, revise the child's plan of care.

Comprehensive review of a plan of care

Complete a comprehensive review of a child's plan of care every six months, or more frequently based on the child's developmental needs or if specified in the plan.

CIC STANDARD 11: ASSESSMENTS AND PLANNING FOR A CHILD IN CARE	
	<p>Complete a comprehensive review of a plan of care by:</p> <ul style="list-style-type: none"> • involving the child, and wherever possible the child's family and other significant people in the child's life, in the review of the plan • reviewing the outcomes for the child within the developmental domains • ensuring the services in place for the child address the child's needs as identified in those domains • determining whether the services in place for the child address the child's overall goal, including the child's need for stability and continuity of lifelong relationships. <p>After the comprehensive review of the child's plan of care, if the overall goal for the child has changed, or if the services needed to address the goal have changed, document these changes on the child's written plan of care.</p>
ADMINISTRATIVE PROCEDURES	<p>The current assessment and planning tools for a child in care include:</p> <ul style="list-style-type: none"> • the Looking After Children Assessment and Action Record and Comprehensive Plan of Care (LAC), used when a child is in: <ul style="list-style-type: none"> – continuing custody of a designated director – care under s.29 of the Family Relations Act, and – long-term care under the Adoption Act • the Comprehensive Plan of Care Assessment and Planning Guide for Children in Care (CPOC), used when a child is in care by agreement, interim order or temporary order. <p>Consistent with his or her best interests, keep copies of the child's assessments and plans of care in his or her file.</p> <p>Give copies or parts of the plan of care to:</p> <ul style="list-style-type: none"> • the child • the caregiver • the parent • members of the family who are involved in the child's care • the representative from the Aboriginal organization involved in the child's care or plan, and • any other person who plays a role in the child's care.
ADDITIONAL INFORMATION	<p>Health Supports for Children in Care and Youth Agreements: http://www.mcf.gov.bc.ca/foster/pdf/health_supports_cic.pdf</p> <p>Dental Benefits for Children in Care and Youth Agreements: http://www.mcf.gov.bc.ca/foster/pdf/cic_dental_guide.pdf</p> <p>Orthodontic Benefits for Children in Continuing Custody Consent Forms for Aboriginal Children for Non-Insured Health Benefits</p>
KEY DEFINITIONS	

**Appendix G:
Section 205. Health Oversight and Coordination Plan Of *The Fostering Connections to Success and Increasing Adoptions Act* (2008).**

Section 422(b)(15) of the Social Security Act (42 U.S.C. 622(b)(15)) is amended to read as follows:

‘(15)(A) provides that the State will develop, in coordination and collaboration with the State agency referred to in paragraph (1) and the State agency responsible for administering the State plan approved under title XIX, and in consultation with pediatricians, other experts in health care, and experts in and recipients of child welfare services, a plan for the ongoing oversight and coordination of health care services for any child in a foster care placement, which shall ensure a coordinated strategy to identify and respond to the health care needs of children in foster care placements, including mental health and dental health needs, and shall include an outline of--

‘(i) a schedule for initial and follow-up health screenings that meet reasonable standards of medical practice;

‘(ii) how health needs identified through screenings will be monitored and treated;

‘(iii) how medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record;

‘(iv) steps to ensure continuity of health care services, which may include the establishment of a medical home for every child in care;

‘(v) the oversight of prescription medicines; and

‘(vi) how the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children; and

‘(B) subparagraph (A) shall not be construed to reduce or limit the responsibility of the State agency responsible for administering the State plan approved under title XIX to administer and provide care and services for children with respect to whom services are provided under the State plan developed pursuant to this subpart;’.

Appendix H: Virginia Periodicity Table for EPSDT Program

Virginia EPSDT Periodicity Chart																					
Age	Birth *	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	24 months	3 years	4 years	5 years	6 years	8 years	10 years	12 years	14 years	16 years	18 years	20 years
History, Measurements, Physical Exam Lab Tests and Anticipatory Guidance, etc.	Follow the AAP Recommendations for Preventive Pediatric Health Care																				
Mandatory Blood Lead Test							12 & 24 month Blood Lead Test			Lead Test if no prior history											
Immunizations	Immunizations follow American Committee on Immunization Practices (ACIP)																				
Vision Screen	Follow the AAP Recommendations for Preventive Pediatric Health Care																				
Hearing Screen	Follow the AAP Recommendations for Preventive Pediatric Health Care																				
Developmental/ Behavioral Assessment	Follow the AAP Recommendations for Preventive Pediatric Health Care																				
Developmental Testing							Administered at the 9, 18, and 24 month visit														
Dental Services							12 m				Refer for dental services. Dental exams provided every 6 months.										
							If medically necessary refer to Dentist														
Age	Birth *	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	24 months	3 years	4 years	5 years	6 years	8 years	10 years	12 years	14 years	16 years	18 years	20 years

*Newborn care visits should occur according to the most current American Academy of Pediatrics guidelines. DMAS allows additional visits following hospital discharge in addition to both the newborn and one month visits.

Appendix I: Agencies Participating in NYS OCFS Care Coordination Pilot Project

Agencies Participating in the NYS OCFS Care Coordination Pilot Project

AGENCY	ANNUAL CONTRACT AMOUNT*	REGION SERVED	LEVEL OF CARE	STAFF
Abbott House	\$196,000	NYC	Foster Boarding Home Hard To Place	3 BA @ FTE 1 LPN @ FTE 1 RN @ .5 FTE
Catholic Guardian Society	\$130,000	NYC	Foster Boarding Home Mother/Baby Group Home	2 MSW @ .6 FTE 1 RN @ FTE 1 RN @ .5 FTE
Children & Adolescent Treatment Services	\$150,000	Erie County	Foster Boarding Home	2 BA @FTE 1 MA @ FTE 1 Support Staff @ .8FTE
Episcopal Social Services	\$100,000	NYC	Foster Boarding Home	2 MPH @ FTE

AGENCY	ANNUAL CONTRACT AMOUNT*	REGION SERVED	LEVEL OF CARE	STAFF
Green Chimneys	\$85,000	NYC, Lower Hudson Valley	Institution	1 BA @ FTE
House of the Good Shephard	\$125,000	Oneida County and surrounding area	Therapeutic Foster Boarding Home, Institution	1 MA @FTE 1 MSW @ FTE
Jewish Board of Family and Children's Services	\$155,000	NYC	Institution	-
Kinship Family and Children Services	\$82,000	Southern Tier	Therapeutic Foster Boarding Home	1 RN @ FTE 1 MS @ FTE
St. Vincent's Services, Inc	\$150,000	NYC	Foster Boarding Home	1 BA @FTE 1 RN @ FTE 1 Support Staff @ FTE

*With the exception of JBFCs, amounts listed reflect funding levels for the 2003-2004 appropriation year. JBFCs no longer has an active contract; amount listed reflects funding given in the 2002-2003 State Fiscal Year, the last year of that program's operation.

Appendix J: List of Care Coordinator Responsibilities

- ◆ Collecting information on a child/family's health history from primary caregivers;
- ◆ Establishing and maintaining a comprehensive and up-to-date medical file;
- ◆ Obtaining written consent from biological parents for routine medical treatment as well as specialty care;
- ◆ Scheduling and overseeing the completion of medical, dental, developmental, mental health, and substance abuse assessments at foster care intake and obtaining any necessary and appropriate follow-up evaluations;
- ◆ Establishing service relationships and coordinating and monitoring on-going therapeutic services;
- ◆ Communicating the results of initial assessments and on-going health care treatment with the child's primary care provider, case manager, and other relevant service professionals;
- ◆ Educating the child, biological parents/caregivers, and foster family about a child's health needs and issues;
- ◆ Coordinating treatment planning meetings with child, parents/caregivers, family members, and all potential service providers;
- ◆ Facilitating the development and incorporation of health-related goals in the child's treatment plan;
- ◆ Arranging for and/or providing age appropriate pregnancy prevention educational classes;
- ◆ Compiling health, mental health, developmental, and substance abuse information for use by agency personnel in routine court hearings;
- ◆ Communicating with schools regarding the health and developmental needs of children; and
- ◆ Establishing a medical home for children preparing to exit foster care.

** Taken from Colman et al. "The New York State Care Coordination Pilot Project: Process & Impact Evaluation Study Findings" New York State Office of Children and Family Services"*

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