Closing the Gap: Primary Prevention Approaches to Child Protection in British Columbia

by

Julia Mazurchuk

Bachelor of Science, University of Toronto, 2006

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Approval

Name:	**Julia Mazurchuk**
Degree:	**Master of Public Policy**
Title:	**Closing the Gap: Primary Prevention Approaches to Child Protection in British Columbia**
Examining Committee:	**Chair:** Doug McArthur Professor, School of Public Policy, SFU

Jonathan Rhys Kesselman
Senior Supervisor
Professor

John Richard
Supervisor
Professor

Maureen Maloney
Internal Examiner
Visiting Professor

Date Defended/Approved: April 7, 2017

Ethics Statement

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Abstract

The child welfare system in British Columbia requires a re-orientation towards prevention. Structural factors drive substantiated maltreatment rates, which are predominantly for neglect and exposure to intimate partner violence. Many at-risk families receive no support services until crisis. The BC Ministry of Child and Family Development (MCFD) serves high-risk families where maltreatment has occurred, filtering out at-risk families to navigate a fragmented net of community services. This research study examines British Columbia's continuum of services for at-risk families to identify service gaps. A literature review informs the rationale of primary prevention programs and community development. Interviews with frontline professionals show the need for "user-informed" services. Three policy options are analyzed: increased provision of services for at-risk families through MCFD's Support Services stream, primary prevention through Nurse Family Partnerships, and population-level primary prevention through Family Connects. Family Connects is recommended to achieve a population-level effect in reducing maltreatment.

Keywords: Child welfare; Policy Analysis; Primary Prevention; Public Health; Community Services; Community Development

Dedication

To my family; mom, Roman, Kat, Arvind. Thank you for your unwavering love, support and encouragement throughout this journey, as with so many others - and many more.

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List of Acronyms

CAMP	Community Asset Mapping Project
FDR	Family Development Response
FRC	Family Resource Centre
FSS	Family Support Services
IPV	Intimate Partner Violence
MCFD	Ministry of Children and Family Development (BC)
NFP	Nurse Family Practitioner

Glossary

At-Risk Families	An umbrella term referring to the spectrum of risk
Child Maltreatment	Child maltreatment is defined as child abuse (physical, emotional and sexual) and neglect.
Intersectionality-Based Policy Analysis	Method of analysis utilized to understand implications of multiple and intersecting social identities for the purposes of promoting equity and social justice based policy (Hankivsky, et al., 2012).
Front-line Professionals	Individuals privately or publicly employed in the social services sector working directly with individuals or families
Ministry of Children & Family Development	The Ministry of Children and Family Development, Child Protection Division is responsible for child welfare programs and services. Workers in 429 offices, in five regions, provide child protection services with support from the provincial office of the Child Protection Division.
Strength-Based Practice	An evidence-based method of working with and empowering families that focuses on highlighting strengths instead of deficits
Risk	Risk is used synonymously for vulnerability or unaddressed needs
User-informed Services	Services which are founded from the user-perspective, taking into account preferred service models and pathways and barriers to service access/adherence. Barriers are informed with an intersectionality perspective through lived realities.

Executive Summary

Despite significant investment in child protection, caseloads and rates of family breakdown have remained high. The majority (68%) of substantiated maltreatment in Canada is for neglect and intimate partner violence (IPV), which are driven largely by structural factors. Nonetheless, once family needs have spiralled to high risk and led to maltreatment, rarely are there positive outcomes; both maltreatment and out-of-home placement result in significantly negative developmental outcomes for children. As British Columbia's Ministry of Children and Family Development (MCFD) is largely a tertiary system, intervening to provide services only once maltreatment has occurred, issues of equity also arise. The majority of child placements involve low-income women as primary caregivers (91%) and the disproportionate representation of Aboriginal children (61%). Complicating matters, current maltreatment caseloads are unsustainable given the context of MCFD's capacity crisis. Furthermore, BC spends $268 million a year on adverse outcomes from youth leaving care. The child protection system must re-orient towards primary prevention if child outcomes are to be improved and downstream effects of inequity reduced.

Too many at-risk families are not receiving support until crisis. A gap exists in the continuum of family support services that leads at-risk families to be underserved. The MCFD interacts with families only after maltreatment has occurred. This filters out many at-risk families who must then navigate a fragmented, complex net of community services that vary by neighbourhood in allocation and user-appropriateness. Community service gaps result due to mechanisms such as neighbourhood identity politics, lack of provincial social policy strategy, and a provincial grant system that favors groups and communities better able to mobilize. Legislation and law does not specify the degree of support that must be offered, making it questionable whether

placement is truly used as a “last resort”. There may not be enough preferred services for at-risk families. A systems perspective helps inform the problem.

A literature review explores the structural and individual risk factors associated with maltreatment in BC and provides two definitions of “at-risk” families – one broad, and one targeted. The rationale for primary prevention and barriers to access for marginalized families are outlined. Key barriers include passive outreach, stigma, and the dual role of practitioners. The literature review and stakeholder interviews inform on best practices (strength-based approach, trust, limiting dual role), fill in the gaps in the current context in British Columbia, and provide insights into feasibility of options.

Based on a literature review and stakeholder interviews, preliminary evidence suggests that active outreach and integrated services reduce barriers to access for marginalized groups. The evidence also finds that health-care practitioners, such as nurses, are particularly trusted in delivering services for at-risk families such as low-income young mothers. Since 91% of substantiated maltreatment involves the mother as the primary caregiver, particular attention to how this group accesses and navigates services should inform service delivery using an intersectionality analysis.

Three policy options were identified for British Columbia. The first is expanding the current Family Support Services (FSS) response at MCFD. The other two are evidence-based primary prevention approaches with nurse-home visitations that have demonstrated significant ROI in the United States and present an untapped opportunity for British Columbia - the Nurse Family Practitioner (NFP) program and Family Connects (FC).

Policy evaluations of FC, NFP, and FSS were supplemented with interviews from practitioners working directly within each model.

Using a systems approach, a preventative strategy will necessitate two components: (1) an evidence-based primary prevention approach to serve at-risk families and therefore address the risks to prevent maltreatment from occurring; and (2) an improvement in community services through identification and remediation of service gaps and increased attention to user-informed services. High-quality, accessible community services are necessary because all interventions (both primary and tertiary) rely on a service continuum to address the multiple needs of families.

In summary, for maximal effectiveness, the proposed solution must have two components:

1. Implement an evidence-based, primary preventative program.
2. Improve the existing net of community services to ensure an adequate service continuum.

The following policy options are assessed:

1) Enhanced Family Support Services Response
2) Nurse Family Practitioner (Metro Vancouver)
3) Family Connects (Metro Vancouver)

The recommended option is Family Connects, as it retains the primary prevention benefits of NFP but achieves a population-level effect by covering the spectrum of risk of all families in need. It further comprehensively addresses the service gaps in local community services by centralizing service oversight and allowing families to better inform services intended for them.

Introduction

Child maltreatment is defined as child abuse (physical, emotional, sexual) and neglect. British Columbia spends $500 million a year on child protection services. Besides the inestimable cost in human suffering, the national costs of maltreatment to society total over $100 billion per year (Fang et al., 2012). BC alone spends $268 million on adverse outcomes from youth leaving care (Shaffer, Anderson, & Nelson, 2016).

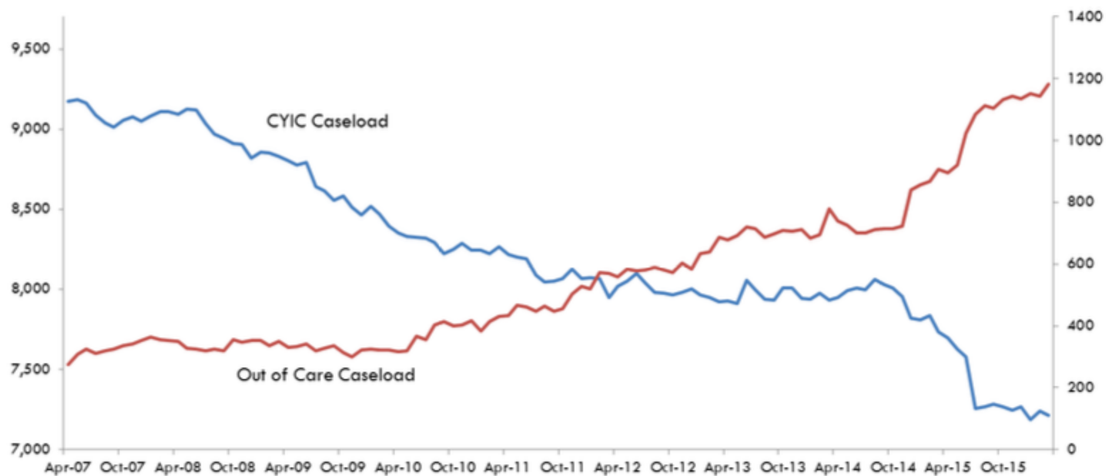
British Columbia's Ministry of Children and Family Development (MCFD) caseloads and rates of family breakdown have stayed too high. There are over 900,000 children living in BC, with approximately 18% of children and youth and their families received some form of service from MCFD (MCFD Performance Management Report, 2015). Annually, MCFD receives 39,000 protection reports (MCFD, 2016), approximately 150-200 FDR cases per month (24,000 per year) and another 1,872 family cases. After provincial intake became centralized, 300,000 reports were recorded in one month in BC. Additionally, too many cases cycle back with 21% of cases re-investigated by the MFCD. In Canada, 67% of current child investigations involve previous child welfare contact. In some regions such as the Northwest Territories, up to 76% of cases have been previously investigated (Blackstock, 2010).

Family breakdown has similarly not decreased over the past decade. In BC, while out-of-home placement has dropped from 11,000 to 7,000 over the past 10 years (RCY, 2016) from a rate of 11% to 9%, family breakdown has remained high. Out-of-Home placement (children and youth in care, i.e. CYIC) has been replaced by Out-of- Care (OCCs) placement in many cases [**Figure 1**].

This means that while youth are not in government care, they are living outside of the parental home. In 2016, there were still 10,619 children living out of home - 7,216 of these children are in government care while the other 3,403 were in out-of-home care (MCFD Corporate Data Warehouse, as of March 31, 2016).

Figure 1 : Out-of-Home Care and Youth In Care (government custody) rates[1]

Children and Youth in Care (CYIC), Out-of-Care Caseloads, April 2007 to March 2016[1]



Source: Courtesy of MCFD Performance Management Report (2016)

Significant equity issues arise. Aboriginal children make up 61% of CYIC placements (RCY, 2016) and only 9% of the population of BC. Three times as many First Nations children are currently placed in out-of-home care than were in residential schools at the height of that period (Blackstock, 2003). Low income single mothers make up 2% of the population, yet are the primary caregiver in 91% of CYIC cases.

[1] "Since April 2007 the number of Children and Youth in Care has steadily declined by approximately 2,000 (over 21%). The main reason for this decline is greater emphasis on family preservation, such as Out-of-Care residential services." (MCFD Performance Management Report, 2016). The left scale refers to the Out of Care caseload, and the right to CYIC caseloads.

Further complicating matters is the MCFD capacity crisis, making current report rates unsustainable. Capacity issues mean that only 50% of Family Service cases are completed, and 90% of Family Plans are not completed (RCY Audit, 2016). BC has fewer social workers now than in 2002. When FDR was rolled out in 2002, no additional government funding was provided. The Ministry's budget is $1.4 billion, a reduction of $100 million in real dollars since 2009 (RCY, 2016).

These statistics are likely the tip of the iceberg and an underestimation of true family needs as some families will never come under the purview of formal services, and a significant portion of maltreatment reports go separately through the police department. In short, too many at-risk families are not receiving adequate support services prior to crisis, leading to significant downstream effects including: child protection investigations and inequities, poor child developmental outcomes, and significant strain on system capacity.

A growing consensus has been emerging within the child welfare field that policies need to shift towards prevention and addressing root causes (Ed John Report, 2016). This Capstone explores the options for such a shift.

Chapter 1 summarizes the background considerations and context in British Columbia. Chapter 2 comprises a review of the scientific literature to inform on best practices. Chapter 3 outlines the objectives and methodology of this study. Chapter 4 contains the results of my thematic analyses, with interview data from frontline professionals, academics and policy professionals. Chapter 5 describes the objectives and evaluative criteria. Chapter 6 describes a set of policy options. Chapter 7 contains my analysis of three policy options. Chapter 9 specifies recommended policy action, considerations for implementation and implications for future research.

Chapter 1. Background

1.1. Demand for Family Support Services

There is a high demand for family support services. 300,000 calls were placed to BC's centralized MCFD intake team in one month, over 2,000 calls annually to the BC Family Advocates Office, and 500,000 families across Canada access support and resources through Family Resource Centres every year. Family Resource programs in BC received 1 million visits in 2015, with 80,000 unique adults and children (FRP-BC, 2016). Nonetheless, too many at-risk families do not receive adequate support services until crisis. 162,000 families in BC accessed some services from MCFD in 2015 – this is the tip of the iceberg.

1.2. The Family Support Services Gap

BC offers support to at-risk families through formal services at MCFD and the through the informal community sector via MCFD-contracted agencies and non-profits. MCFD (2016) priorities state family preservation as a goal; "Evidence shows that, where appropriately safe, keeping families together rather than placing a child into care results in better outcomes overall for these children."

At-risk families are missed because MCFD, due to legislative and funding constraints, focuses on high-risk families. Maltreatment is the criteria for services. Critics have pointed out that child protection risk assessments generally give insufficient attention to the majority of cases (96%) that do not involve serious physical harm requiring medical attention (Trocmé et al., 2005). A Child and Youth Representative Report likewise states the Ministry is focused on "putting out fires", i.e. critical cases (RCY, 2016).

The Ministry has three types of responses: Investigation, Family Development Response (FDR), and Support Service Referrals. The Support Services function is quite limited and entails quick letter or phone referrals to community services for families who fall outside of the maltreatment criteria. Community services are fragmented and families must navigate them on their own. Therefore, a large portion of at-risk families are not adequately supported until crisis stage when services are accessed, at higher cost and less efficacy, through the MCFD.

1.2.1. Ministry of Child and Family Development

MCFD (2015) states: "Evidence shows that, where appropriately safe, keeping families together rather than placing a child into care results in better outcomes overall for these children. Consequently, MCFD's practice emphasises family preservation, when appropriately safe, keeping Aboriginal children and youth from coming into care." Nonetheless, MCFD is a tertiary system. In order to qualify for services, maltreatment must have occurred. Therefore, it is arguable that there is a *significant missed opportunity* in keeping families together safely, by not acting preventatively. Three reasons drive the reactive, high-risk focus: the CFSA legislation focus on the child, the non-interventionist model, and the high volume of at-risk cases in a context of MCFD underfunding/staffing.

The primary formal pathway for at-risk families to access services is the Family Development stream in the MCFD[2]. FDR is a model based on "differential response" which has been adopted across the United States, Australia, and most Canadian provinces. The purpose is to work more collaboratively with families

[2] Although other BC initiatives allow service coordination for families, such as the Poverty Reduction Strategy's Family Consultants, Early Years Offices, and the Advocacy function of the Child and Youth Representative, these are all limited in scope or eligibility/accessibility.

without the stigma and disruption of formal Investigation. FDR has led to many improvements in family outcomes and is embraced by social workers.

The FDR stream, although focused on lower risk, is not voluntary. A maltreatment finding is needed and, if services are not accepted, it will be moved to an Investigation. It is a "choice between two modes,"[3] with FDR being a more collaborative approach. The only voluntary response for self-referred families is the Support Services stream, which, as mentioned, is a phone or letter referral to community services. Therefore, most at-risk families must rely on a fragmented web of community services with high regional variation.

1.2.2. Community Services

The MCFD contracts with 5,400 community agencies. In addition, there are numerous non-profits and private agencies, which vary by community. Community agencies are developed based on provincial grant applications, which may be problematic as it depends on the neighbourhood's ability to mobilize and fill out grant applications. Such fragmentation is partly driven by BC's lack of a Social Policy Strategy (BoardVoice, 2014) and is further reflected by cases like *FN Caring Society v. Canada*, where the Supreme Court of Canada found 22% less funding for First Nations services on reserve. Successful FDR also relies on the presence of quality community services, as families are typically referred to ancillary services with local agencies.

The 2002 Community Asset Mapping Project (CAMP) by the University of BC assessed the developmental vulnerabilities of Vancouver children and the resources available to them and their families. Some notable findings were:

1. Although there was a wide range of family literacy, parenting, and support

[3] Personal C/O [Participant 7]

programs in Vancouver, they tended to be small, financially unstable, and transient – making access to these programs limited. Spending on child development for ages 0-5 years was less than one-fifth that of education starting at age 6.

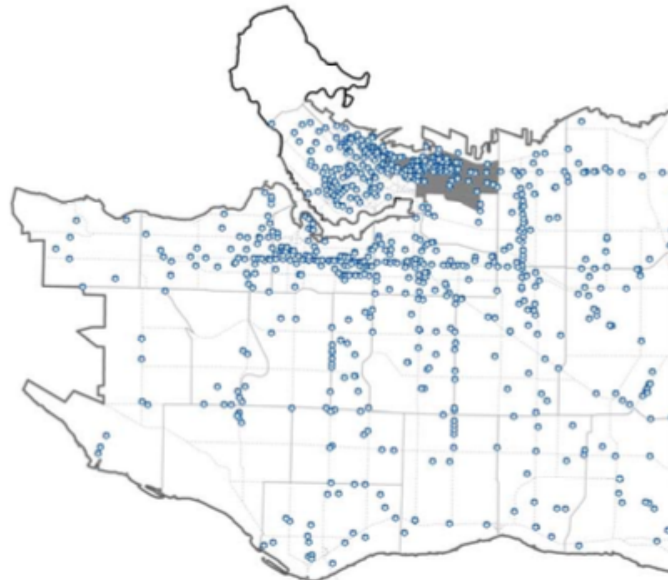
2. Child care and family strengthening/support programs were least accessible in neighborhoods where they would have the greatest developmental benefits. There is a 10-fold difference in neighbourhood child care accessibility rates across Vancouver (from 0.89 slots per child to 0.09 slots per child). The least-served areas and those with less access to centre-based care are found mostly in the working class areas of the city's east side.

The Early Development Index shows vulnerability varies between 6% to 38% across Vancouver neighbourhoods. The highest proportion of children with lowest scores on physical health, EDI, and hospital admissions lived in Downtown Eastside and Midtown, where low income lone-parent families are also concentrated. Yet the average spending on medical services on children in first year of life is the second lowest in these neighbourhoods and waitlists for infant development programs is highest. Additionally, the CAMP (2008) maps also show clustering of social programs in the Vancouver City Central but not more eastward neighbourhoods which still have high risk – suggesting some areas may not be adequately covered.

Access to universal health services such as prenatal care also varies regionally (RCY,2011), although all women in B.C. are eligible. There is currently no provincial prenatal public health program with performance standards and accountabilities delivered consistently across B.C (Ministry of Healthy Living and Sport, 2010). Women are largely responsible for finding these services. The Representative for Child and Youth (2011) states "this is not a good method of reducing risks to vulnerable infants". As research reveals active health outreach strategies are most effective for marginalized populations, the "lack of Public

Health Nursing programming in the prenatal period is a pressing issue in Canada as well as B.C." (Interior Health Authority, 2005).

Figure 2: Metro Vancouver Community and Social Services



Source: Adapted by author from BC211 Redbook Directory 2007/08.[4]

1.2.3. Legislative and Legal Context

British Columbia's MCFD is governed by the 1996 B.C. Child, Family and Community Services Act (CFCSA). Its central guiding principle states; "the safety and well-being of children are the paramount considerations." The Gove Inquiry report, following the tragic death of a child, pushed BC's child welfare system

[4] Not all services plotted

away from a “family supports” model toward “child-centered” protection. This resulted in a dramatic increase in the number of children in care in the province from 6,000 in 1994 to almost 10,000 by 1999 (Pivot Legal Society, 2008). Across the world. child protection systems can be broadly classified as “protecting children” or “supporting families” (Gilbert, 2012). The legislation in BC, as in most English speaking countries, prioritizes child safety and contrasts with “family-centered models” in countries such as Norway. As a result, family needs are addressed only to the extent they impact parenting function and pose a danger to the child. In this sense, BC child protection is constrained in terms of how much it can address the needs of parents. The Ministry can only keep the file open to offer services if there is maltreatment and insofar as the services directly relate to parenting function.

Service delivery is guided by the following principles in section 3 of the ACT:

(a) *families and children should be informed of the services available to them and encouraged to participate in decisions that affect them;*

(b) *aboriginal people should be involved in the planning and delivery of services to aboriginal families and their children;*

(c) *services should be planned and provided in ways that are sensitive to the needs and the cultural, racial and religious heritage of those receiving the services;*

(d) *services should be integrated, wherever possible and appropriate, with services provided by government ministries, community agencies and Community Living British Columbia established under the Community Living Authority Act;*

(e) *the community should be involved, wherever possible and appropriate, in the planning and delivery of services, including preventive and support services to families and children.*

The CFCSA states as a Guiding Principle that “if, with available support services, a family can provide a safe and nurturing environment for a child, support services should be provided.” As Grant et al. (2016) point out, “[A]vailable support services presumably vary widely depending on location in the province. While courts are clear that the state obligation to provide supports is not unlimited, the extent of the state obligation remains unclear.”

1.3. Defining the “At Risk” Family

1.3.1. Risk Factors for Child Abuse and Neglect

Research has established that no single factor can explain child maltreatment (Li et al. 2011), but consistently linked structural and individual factors include poverty, inequality, social isolation, drug and mental health issues.

1.3.2. Structural Risk Factors: Poverty and Inequality

Broad factors shaping maltreatment rates are poverty and inequality. Socioeconomic status (SES) is one of the strongest and most consistent predictors of child maltreatment (National Research Council, 1993), as confirmed by large-scale, cross-sectional studies of the general population including the National Incidence Studies (NIS) (Sedlak et al., 2010) and the National Family Violence Surveys (Berger, 2004). Poverty indicators are predictive at both the individual and state levels (Cacian et. al, 2010). Low SES families were five times more likely to experience child maltreatment than higher SES (Sedlak et al., 2010) and are more likely to have children placed in out-of-home care (Berger 2004). A direct causal link has been demonstrated between poverty and rates of maltreatment (Grossman, 2000). Cancian, Shook & Yang (2010, 2013) found that mothers who received an additional cash support were 10% less likely to

have a child maltreatment report. Other studies show that when social welfare supports are cut back or not offset by other income sources, out-of-home care rates and child protection reports increase (Paxson & Waldfogel, 2002;Slack at al. 2007). Income inequality also plays a key role. A study on 3,142 U.S. counties from 2005 to 2009 linked higher risk of child maltreatment to localities with greater income inequality, controlling for demographic factors (Eckenrode, 2014). This effect was stronger for counties with moderate to high levels of child poverty. Eckenrode remarks; “reducing poverty and inequality would be the single most effective way to prevent maltreatment of children”.

This is relevant for assessing the climate of risk in British Columbia. Over the last fifteen years, BC has consistently had the highest child poverty rates in the Canada (20.7% in 2013) and ranked either last or near last among Canadian provinces on low-income rates. Income inequality in BC was higher than Canada as a whole in 2011. In Vancouver, income polarization was high, with the nation’s top 10% concentrated in west-side neighbourhoods (City of Vancouver, 2015). As mentioned, income inequality is felt more strongly with countries that have moderate to high levels of child poverty (Eckenrode, 2014). CAMP (2002) maps confirm that the concentration of disadvantage (e.g. low-income, single-parent, low-education, etc.) in the north-central and eastern areas of Vancouver is paralleled by developmental vulnerabilities in children.

In conclusion, poverty and inequality in BC contributed to an elevated climate of risk of child maltreatment compared to other provinces. This is exacerbated by the historic underfunding of prevention services in child welfare and early childhood services.

1.3.3. Individual Risk Factors

The Representative for Child and Youth (RCY, 2009) report states; “Research shows that poverty and other risk factors can impact the family in a

manner that increases the probability of future involvement with the criminal justice or child welfare system. These risk factors include: young, single-parent mother, poor nutrition, especially during pregnancy, having limited extended family and community support, alcohol or drug abuse, inappropriate parenting skills, not completing high school, limited employability, unstable or conflicted partner relationships, reliance on income assistance, living in socially supported housing in neighbourhoods with high crime and little sense of community." The most common risks identified by the Canadian Incidence Study of Reported Child Abuse and Neglect–2008 (CIS-2008), a nation-wide study based on data from child welfare authorities, were intimate partner violence (IPV) and lack of social support across both populations, and alcohol abuse for First Nations.

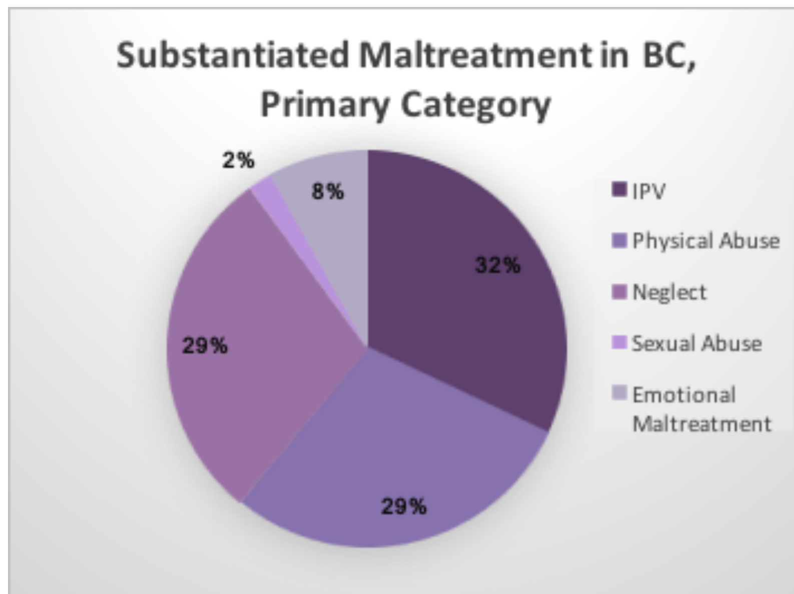
1.3.4. Intersectionality and Substantiated Maltreatment

The majority of substantiated maltreatment in Canada and BC is not for physical abuse – 68% is for neglect and exposure to IPV. The CIS-2008 reveals that from 235,842 maltreatment investigations conducted across Canada in 2008[5], neglect and IPV were 34% each. This trend is mirrored in the 2008 British Columbia Incidence Study (BCIS-2008) where IPV and neglect made up 61% of substantiations.[6] [**Figure 3**].

[5] 36% substantiated

[6] 56% of which were substantiated

Figure 3 Substantiated Maltreatment in BC by Primary Category



Source: Adapted by author from BCIS-2008 (McLaurin et al., 2011)

Over 70% of placements in BC were for Neglect, of which 42% were cases where the parent was "*unable* or unwilling to care for the child and has not made adequate provision for the child's care" [**Table 1**] (MCFD, 2016). Neglect is the maltreatment subtype most strongly related to poverty (Jonson-Reid, Drake, & Zhou, 2013). 78% of all families who reported to child protection during the 2003 cycle of the Canadian Incidence Study on Reported Child Abuse and Neglect had incomes below $40,000 (Blackstock, 2010).

Table 1: Reasons for Placement by Court Order Indicated by CYIC

Reasons for CYIC by Court Order for Protection	All
Neglect	**69%**
Parent unable/unwilling to care	42%
Neglect by parent with physical harm	25.3%
Child abandoned inadequate provision	2%
Deprived of necessary health care	0.5%
Physical harm by parent	**9.3%**
Emotional harm by parent	**5.1%**
Sexual abuse by parent	**0.8%**

Other concerns	**3.7%**

Source: MCFD, 2016

Intersectionality-based analysis informs structural and gender-factors that underlie rates of neglect and IPV. Single low income mothers comprise the overwhelming majority of child protection cases and are the primary caregiver in 91% of substantiated cases.

Table 2: Overrepresentation of Groups in Out of Home Placement

Demographic	BC Rate	CYIC Rate
Aboriginal	9%	61%
Low-income, single mothers	2%	91%

Source: Adapted from BC Child Poverty Report Card (2015); MCFD (2016)

With respect to IPV, failure to prevent a child witnessing violence against the mother is the most common subcategory. Research suggests that IPV is also a housing issue, and without adequate provision of housing it is unrealistic to expect women to leave an abusive partner on whom they are financially dependent. In examining 85 CCOs in BC, Grant et al. (2016) found the legal system treats this as a "lifestyle choice" within the context of placement decisions. Providing safe housing is not a requirement for social workers placing conditions for women to leave abusive situations, suggesting a disconnect between lived realities and mandated conditions.

Single mothers have the highest poverty rates, are most likely to be on social assistance, and in core housing need, and over 90% of children living in single parent families live with their mothers. Their employment options are

limited by childcare responsibilities. In 2011, 29% of the 149,010 female-led single-parent families in BC were living in poverty (~43,200). If mothers are not working due to expensive childcare, the poverty rate is 96.2%, in contrast to 35% among those working – the annual income of $14,300 (poverty line: $24,319). Social assistance is a key program for single mothers as they comprise approximately 1/3 of the recipients. Major social assistance cutbacks occurred in 2002 (from $1371 to $1268) and rates have not increased since 2007 even as the cost of housing and basic necessities rose. Across Canada, B.C. had the second highest proportion of children from single-parent family households in core housing need *(*BC Child Poverty Report Card, 2015*)*. In 2015, approximately 81,970 children in single-parent family households who were living in poverty (BC Child Poverty Report Card, 2015).

When low socioeconomic status and gender intersect with Aboriginal identity, the disadvantage becomes even more pronounced. First Nations families are significantly overrepresented in the child welfare system in Canada. The disproportionate representation of minority children in child welfare systems has been documented in many areas around the world, including Australia, US and Europe (Nadan, Spilsbury, Kobin, 2015). Twice the proportion of Aboriginal children (46%) live with a single parent (mainly the mother) as non-Aboriginal children. First Nations families investigated are more likely to have a neglect finding than non-Aboriginal families (46% vs. 29%) which corresponds with the findings of the two previous cycles of the CIS (Trocmé et al., 2016). Distal factors of colonialism also work through institutional barriers such as lack of prevention services. For example, the Supreme Court of Canada in *FN Caring Society v. Canada* found there was 22% less family support program funding for on-reserve First Nations. In Manitoba, with the country’s highest Aboriginal population, non-financial barriers to access manifested as Aboriginal children making up 70% of the child population but benefiting from only 30% of the family support budget (Blackstock & Trocmé, 2004). Additionally, the Aboriginal population in Canada is

the fastest-growing segment of the Canadian population (INAC, 2010), growing at a rate of 20% compared to 5% for non-Aboriginal between 2006-2011 (National Household Survey, 2011), making disproportionate representation a more pressing issue for Canadian society.

Dale (2004) conducted a study of the experiences of parents and child protection intervention. 66% of the participants felt very frustrated, as they had asked for help prior to the child protection investigation but either had not received help or the help offered was viewed by the parent as inadequate. Many also disagreed with the conclusion or assessment reached by the child protection worker.

It is recognized that “most cases are due to neglect driven by poverty, substance abuse, social isolation and domestic violence which impedes ability to meet child’s basic needs” (Premiers Review, 2015). Nevertheless, the most common services offered were substance abuse and parent education. While it is not possible to address all the structural barriers, recognizing how they affect service need and access should guide service matching and delivery of primary prevention services.

1.3.5. Two Definitions

At-risk families can be defined narrowly or broadly. The narrow definition that is often used by targeted programs (i.e. NFP) is a young, low SES, single mother. While no maltreatment has occurred, these are the highest risk of the “at risk”. When defined broadly, “at risk” families are those which have one or more risk factors associated with maltreatment, such as social isolation, mental health, substance abuse, etc. (RCY, 2015); this definition is used widely by prevention services. Risk is used here synonymous for “vulnerability” to show unaddressed needs of caregivers.

1.4. Summary

A systems perspective demonstrates how structural factors such as poverty and childcare policies establish a climate of risk in BC. Many families' needs are not addressed until they reach crisis and can access formal services through the MCFD. Until then, families navigate a fragmented web of community services that vary by region and are not necessarily designed from the user (family) perspective. Recognition of lived reality is necessary to ensure that services are responsive to lived experience, such as constraints on leaving situations of IPV (i.e. housing issues) and neglect driven by poverty.

Additionally, there is disconnect between the best available research, and the policy governing the large child-serving systems because of lack of data and tracking (Johnson-Reid, 2011). As a result, the system conflates contact with actual service provision. Available data often lacks the fine-grained resolution to see regional service variation (Johnson-Reid, 2011). Even the Canadian Incidence Study "did not capture information on the availability, quality or appropriateness of the services provided to families, or the extent to which the families participated in such services" (Tonmyr et al., 2011). Successful outcomes are dependent on service collaboration because child welfare contact typically results in referrals to other ancillary services such as mental health and parenting programs. Current tracking systems do not document follow-through on these referrals (Jonson-Reid, 2004).

In conclusion, though child placement should be a last resort (MCFD, 2016) and the CSCA guiding principles say that services should be fully and sensitively provided, there is a lack of data and oversight. A continuum of quality local services is a necessary component for any successful child maltreatment intervention.

Chapter 2.

Literature Review

2.1. Public Health Model

The Public Health Model aims to "prevent problems occurring in the first place by targeting policies and interventions at the known risk indicators for the problem, quickly identifying and responding to problems if they do occur, and minimizing the long-term effects of the problems" (World Health Organization, 2006). In the context of child protection, the public health model spans the service continuum from *primary* intervention services that are universally targeted to *tertiary* intervention services where abuse or neglect has already occurred. The latter are regarded as "reactive" (Stagner & Lansing, 2009) and, in this sense, MCFD has been criticized as a "reactive" system focusing on "putting out fires" (RCY, 2016). Primary interventions are gaining increasing attention as governments are recognizing that early, evidence-based interventions can reduce maltreatment and involvement with child protection systems, both of which have significant adverse impacts on vulnerable children and families (Higgins & Katz, 2008).

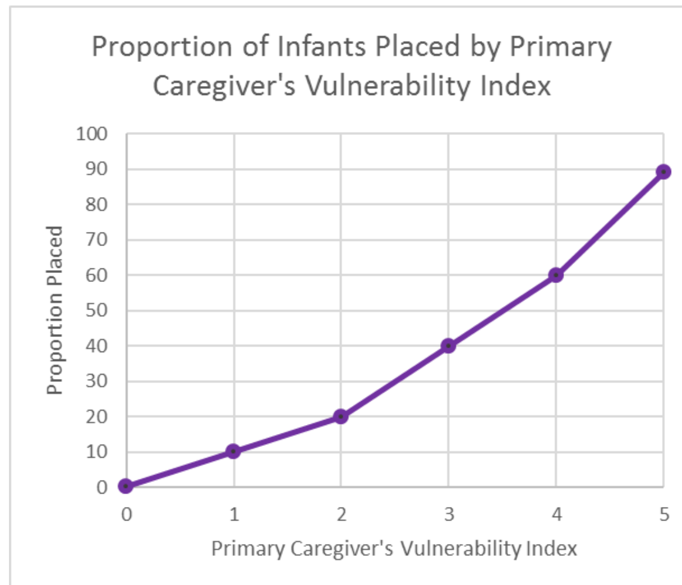
A well-balanced system has primary prevention as the largest component because this prevents progression along the service continuum (Australian Government, 2014). Risk progression means cases that are increasingly complex and thus costly and difficult to remediate.

2.1.1. The Problem with Targeting High-Risk

Research suggests tertiary services to reform parental behaviour once maltreatment has occurred are largely unsuccessful as the parenting style may have become fixed (Geeraert et al., 2004). Moreover, systematic reviews find that high risk complex cases are difficult to remediate (Layzer et al., 2001; Ello, 1998) or that behavioural changes are unsustainable over time (Goodson, Bernstein & Price, 2001).

Additionally, a study examining placement for infants by child welfare agencies across Canada found that placement probability increased by 164% per vulnerability of the primary caregiver (Tonmyr et al. 2011) [**Figure 4**]. Therefore, while IPV or substance abuse alone was unlikely to result in placement, given that risk factors tend to accumulate, placement became increasingly likely for marginalized families. Identifying vulnerabilities early before other issues arise is thus crucial. The authors conclude that a re-orientation from child-based to family-based interventions which address caregiver vulnerabilities are needed – not only for caregiver well-being but “considering their involvement with future children through additional births or reunification”.

Figure 4 Proportion of Infants Placed by Caregiver's Vulnerability[7]



Source: Adapted by author from Tonmyr et al. (2011)

2.1.2. The ROI of Early Intervention (0-2 Years Old)

The early years of childhood, particularly between 0-3 years, have been identified by experts as the most important developmental stage throughout the lifespan. This period is critical to the development of neural pathways that lead to linguistic, cognitive and socio-emotional capacities and sets the trajectory for adult outcomes in health, educational, and social functioning (CCSDH, 2015). Scientific consensus shows a high return on investment for early interventions (Heckman, 2010), with $1 spent early in life saving $17 by the time a child reaches mid-life (Blakester, 2006).

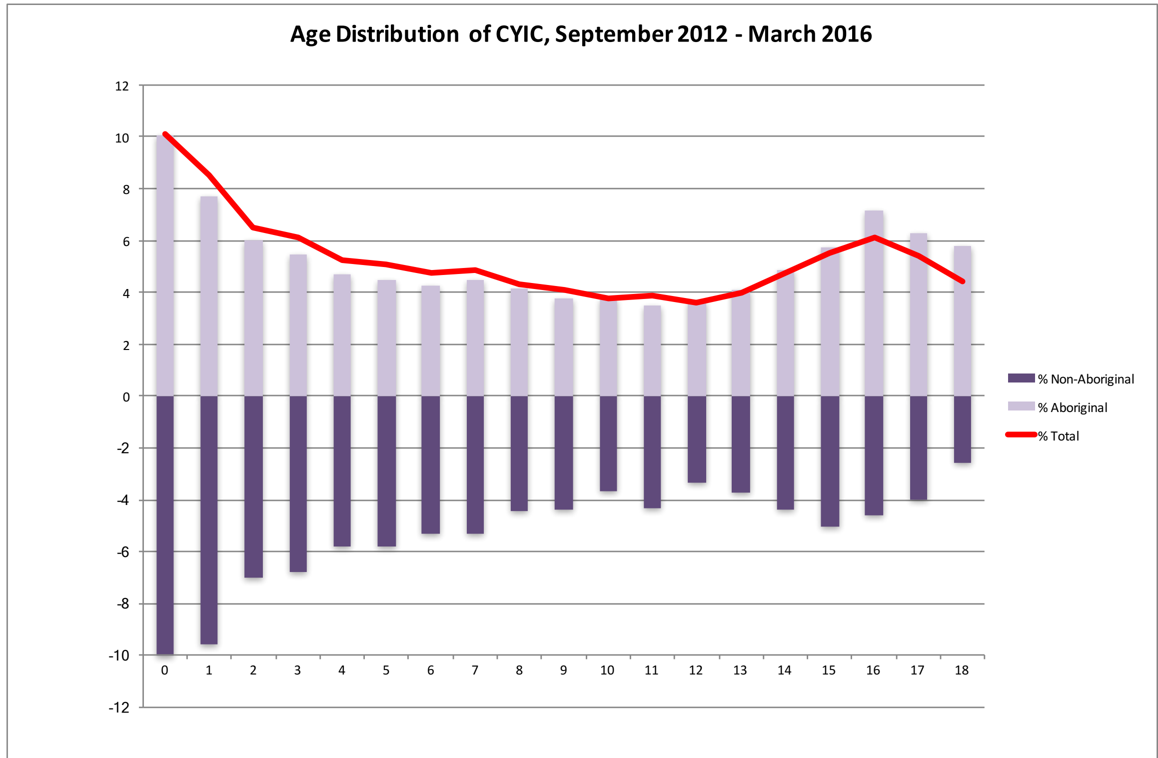
Children who have been maltreated are over 25% more likely to display problem behaviours during adolescence, including serious violent behaviour, substance abuse, teen pregnancy, low academic achievement, mental health

[7] Composite index of five binary-coded caregiver's risk factors or vulnerabilities: substance abuse, criminal activity, mental and physical health issues, and few social supports.

problems and a youth justice record (RCY, 2009). Nonetheless, out-of-home placement is also associated with negative outcomes, leading some critics to comment that the system does not offer children anything better (Blackstock, 2003; 2010). Placement has been associated with high instability, sexual abuse, and poor outcomes for youth leaving care – including increased likelihood of being unemployed, receiving social assistance, experiencing homelessness, mental health issues and criminal involvement (RCY, 2016). Research over the past decade has revealed the longer a child remains in foster care and the more placements they have, the worse the outcomes (Report to Congress, 2012). Youth who come into care are more likely to be in youth custody (36%), and once in youth custody, the chances of graduating high school drop to 13% (RCY, 2009). Aboriginal youth are five times more likely to be incarcerated than youth in the general study population (RCY, 2009). Since it costs approximately $215,000 per year for each incarcerated youth (RCY, 2016), if even 10% of 7,000 youth currently in care end up in youth custody, the costs will be $150 million per year. In fact, $268 million per year is estimated for the negative outcomes associated with every 1,000 youth who age out of care every year (Shaffer, Anderson & Nelson, 2016). Therefore, there are significant cost savings for society from early interventions.

Additionally, in BC, children are most likely to be placed between the ages 0-1 years old **[Figure 5]**, thus signifying the greatest potential for lowering placement through early, even pre-natal, intervention.

Figure 5 Age Distribution of Out of Home Placement



Source: Adapted from MCFD, 2016, Performance Management Report

Investigations involving infants are considered high-risk because of the infants' overall vulnerability and higher risk of morbidity associated with physical abuse and/or neglect (Tonmyr et al., 2011; MCFD, 2016).

As the largest developmental impacts occur between ages 0-3 years (CCSDH, 2015), and a significant number of children are removed between ages 0-1 years in BC, a primary prevention approach targeted at ages 0-2 years could achieve high developmental benefits and prevent a large portion of out-of-home placements. Additionally, such programs would provide holistic family support, i.e. support to parents, to decrease incidence of multiple vulnerabilities which exponentially increase placement likelihood.

2.2. Community Health & Social Services

Community health and individual health have increasingly become seen as intertwined. According to the Canadian Institute for Health Information (2007), neighbourhoods characterized by persistent and significant social inequalities increase infant mortality and chronic disease. Nonetheless, until recently, policy makers and practitioners working to prevent child maltreatment have perceived such structural forces as being beyond the scope of intervention (Merrit, 2009). However, since structural factors operate through community-level processes, such as stressors and lack of resources, (Coulton et al., 2007), some of the effects can be attenuated with responsive community social services. This makes community service interventions promising levers for policy impact.

2.2.1. Neighbourhood-level Effects

Ecological theory (Bronfenbrenner, 1979) locates individual health within families, communities, and the larger socio-cultural environment. Since the 1970s, researchers began recognizing that structural forces can "overwhelm even well-intentioned parents" (Daro & Dodge, 2009). Risk for child maltreatment arises from factors at multiple levels, from individual infant characteristics to community factors such as lack of accessible resources (Dodge & Goodman, 2012). Social disorganization theory (Shaw & McKay, 1942) suggests that the same forces that cause crime in distressed neighbourhoods also cause child maltreatment (Maguire-Jack, 2014). Kim (2004) found that the violent crime rate was associated with higher rates of maltreatment reports, which is also reflected in Vancouver community mapping (CAMP, 2002). Neighbourhood poverty, beyond the effects of individual income (Maguire-Jack, 2014), is the only consistent risk factor associated with higher levels of maltreatment (Kim, 2004; Merritt, 2009). Nevertheless, for neighbourhoods with equivalent socioeconomic profiles, social capital was the key factor explaining differing maltreatment rates (Garbarino & Kostelny, 1992).

2.2.2. The Mediating Role of Social Services

Social capital may be defined as the degree of trust in a neighbourhood, propensity for collective efficacy, and pro-social support networks. Additionally, some researchers point out that among the primary benefits of social capital may be access to concrete resources, such as access to childcare, mental health support, reduction in social isolation, and monetary support to alleviate the burden of poverty. In neighbourhoods facing significant disadvantage in terms of poverty and transience, access to such informal resources may be difficult. Social services may thus be particularly important in filling the void. Researchers state the two most promising components of population-based interventions are social capital development and community coordination of individualized services (Daro & Dodge, 2009). This paper argues that these objectives are interlinked.

Social capital, particularly for disadvantaged neighbourhoods, may be significantly linked to social services. In Quebec, 49% of the variation of placement between jurisdictions was explained by “availability of resources in the community and the socioeconomic status of the families” (Esposito, 2012).

This Quebec case is notable because this province has the most socially progressive and family-friendly policies in North America. It has made significant progress in addressing the broad structural factors that lead to maltreatment through a range of poverty reduction and family support services which include universal free healthcare, subsidized public child care and early learning services, affordable tuition fees, higher parental leave benefits, and a very progressive income tax redistribution system (Esposito, 2012). Among the provinces in Canada, Quebec has the second lowest rate of relative poverty among both children and single-parent female-headed families (Statistics Canada, 2015a).

Controlling for individual-level risk factors and differences in service delivery, Esposito et al. (2016) find that neighbourhood poverty health and social services spending account for 57% of the variation in regional placement for younger children less than 5 years of age. One explanation is that generous social services are enough to buffer relatively poor families from the stress of living in economically disadvantaged environments, but not for areas with a high concentration of absolute poverty. The authors urge policy-makers and child welfare professionals to pay closer attention to region-specific spending strategies, ensure community family support services are proactive in addressing family difficulties and prioritize improving access for regions with the highest rates of poverty.

In communities with high rates of maltreatment, it is particularly important to strengthen the community's service infrastructure by expanding capacity, improving coordination, and streamlining service delivery (Daro & Dodge, 2009).

2.3. Barriers to Accessing Social Services

My literature review also revealed barriers to access that result from services not being responsive to the user experience. As Northbridge et al. (2003) notes, structural inequalities influence individual health and well-being outcomes through differential access to power, information and resources. These outcomes, in turn, influence intermediate factors such as the built environment and the social context. The built environment is especially amenable to policy planning (Northbridge et al. 2003). Therefore, it is through such community development component that we can begin to address structural factors.

2.3.1. User-Informed Services

Intersectionality theory is an approach that helps to inform an individual's particular identity location, and therefore their power relations to institutions and others in society (Hankivsky et al., 2012). Particularly, it can inform patterns, barriers and directions in service utilization. Intersectionality is a powerful approach for intervention design and implementation.

As mentioned, the child protection system disproportionally serves marginalized single mothers. Elucidating their unique perspective and patterns of navigating and engaging with the system can inform how power relations affect their service use. For example, various disadvantage may lead them to be underrepresented in community advisory boards and other formal structures that could have shaped community and child welfare services to match their needs.

Gender and stigma barriers. The identity of "motherhood" for women served by child protection agencies may be incompatible with the institutional design for access which requires the admission of guilt and acceptance of stigmatizing label (Sykes, 2011). In order to protect and maintain their self-concept as a "good parent,' mothers will often resist caseworkers and services (Sykes, 2011). Engaging the mother is critical to any child protection effort, and more attention should be paid to identity needs (Waldfogel, 1998). Additionally, unlike private services (e.g. specialist, nanny) for wealthier parents, the most marginalized families must make an admission of guilt with respect to their parenting (i.e. admit the child is "at risk") in order to obtain publicly funded services (Pivot Legal Society, 2011). Interviews with women involved with child protection services further revealed there was a common fear of asking MCFD for help because it could lead to apprehension. One participant stated, "There are women who are afraid to accept food from the food bank because they believe that it is an indicator that identifies you as an at-risk family" (Pivot Legal Society, 2008).

Power relations. Power differentials exist between frontline workers and families. Beyond the institutional authority of social workers, commonly cited power imbalances include education and colonialism. According to intersectionality, the nexus of identities such as “Aboriginal” or “women” and “poor” provides a more nuanced explanation of the extent of barriers and power differentials. Furthermore, when families were not involved in crafting their service plans, they tended to see them as arbitrary (Sykes, 2011). Aboriginal communities expressed the futility of completing plans that are subject to continual alteration at social workers’ discretion (Grand Chief Report, 2016).

Preferred pathways to access. Literature suggests that informal, voluntary community services are popular with parents. For example, BC’s Family Resource Centres (FRCs) offer a range of voluntary programs and services for families, with over 90% satisfaction ratings in E-Valuations (FRP-BC, 2016). 500,000 families access these programs every year. Since access is universal, there is no stigma attached. Even typically “hard to reach” populations such as new immigrants and Aboriginal families access FRCs, the former making up 33% of those attending though they are only 10% of population, and the latter comprising 8-9% of attendees and 5% of the population [Participant 1]. Word of mouth referrals from trusted sources (i.e. family or friends) is the primary pathway to access. Some practitioners suggest there are no “hard to reach” families, but rather typical formal service models don’t recognize their preferred ways of access. The drop-in program at Marpole Family Place in Vancouver is described as a “gateway” to services [Participant 2] because it engages families through enjoyable events and meetings prior to recommending services. Such gateways to more formal support services by community agencies show a good understanding of the population they serve and recognition of the central role of trusting relationships and family-led services.

Non-financial barriers. Evidence from Vancouver Mapping Project of non-financial barriers to service access is instructive. Universal access services,

such as medical care, may still have non-financial barriers for parents. Downtown Eastside had the least amount of MSP money spent on infants in first year of life in Vancouver, despite being the highest risk area. Waiting lists for Infant Development Programs have lower ratios in privileged neighbourhoods in Vancouver. Non-financial barriers also affected accessing passively delivered developmental services, such as speech, language, dental hearing and vision services for children. For low-income neighbourhoods, referrals to these services mainly came through schools/childcare centre professionals instead of parents, whereas parents in higher-income neighbourhoods self-referred. Active outreach programs, like the Healthiest Babies Possible program, targeted at lowest-income woman significantly improved outcomes for babies' birth weights. This is also evidenced in other Canadian provinces, such as Manitoba, where Aboriginal families accounted for 70% of the child population but benefited from only 30% of family support services (Blackstock & Trocmé, 2004).

Chapter 3. Methodology

The methodology utilized in this study includes a literature review and stakeholder interviews with public sector officials, frontline health and social workers, and community service providers (see **Appendix E**). As the sample size is limited, the following is not representative of all stakeholders. The primary focus of the interviews is to identify the opportunities and challenges of providing effective support services to at-risk families. Information derived from the interviews will assist in understanding the current context of MCFD and community services in BC, their integration and synergies, as well as filling in gaps in the literature and public mandates. Stakeholders provide valuable insights to inform on best practices and barriers while working with families. Feasibility of potential policy recommendations was also discussed. A thematic analysis summarizes commonalities and divergences in stakeholder perspectives.

Chapter 4. Stakeholder Interview Results

The following is a thematic analysis derived from seven interviews with key stakeholders. The interviews were used to understand the current context of BC child welfare practice and community services.

4.1. Assessing Risk of Child Maltreatment

The Nature of Risk. The difficulty of assessing risk was noted across interview participants. Posing the question "What is risk? Is it social isolation?", Participant 1 drew attention to the fact that needs/risk factors exist on a continuum. This was discussed by Participant 7, who talked of RCT in the US which revealed the vast majority of new parents had some vulnerabilities in terms of education/service needs. Additionally, risk was described as dynamic, not necessarily cumulative, and can shift and spike suddenly with life events such as divorce or job loss. Participant 1 characterized the benefits of preventative programs which work with low to medium risk families as ensuring families do not become high risk; "*These are families that, without support, could have crises".*

Identifying and Assessing Risk. The process of identifying risk was noted to be fluid and difficult. There were also practical constraints. For example, the MCFD intake process initially identifies risk through phone assessments, which places constraints on accurately identifying the extent of risks and may lead to under-coding some cases as "FDR" instead of "Investigations." In contrast, another participant discussed the dangers of over-reporting resulting from the duty to report that binds practitioners. Particularly, unsubstantiated or malicious investigations could themselves "manufacture risk" for families and communities.

While 32% of investigations are unfounded, the longitudinal impact of these and their potential for serving as a risk factor has not been assessed. Participants generally agreed that risk may become revealed over time or as a function of the deepened trusting relationship with the service provider. Assumptions and the need of reflexivity were also noted as playing a role in the process of identifying risk. For example, Participant 4 notes that for a long time, poverty was considered high risk. While that has changed, other things such as prostitution and gendered assumptions may still influence risk assessments. Practitioners noted the importance of being reflexive, recognizing the different lived realities of families and the limitations on their ability to do so (i.e. “We can hear stories but will never understand the full lived experience”).

4.2. Community Services

Role of Community Services. Frontline professionals acknowledged the important role of community services in the continuum of care. For example, FRCs were said to be successful insofar as they connected people to the larger community, both services and neighbours – ensuring they were extremely aware of the existing resources in a neighbourhood. NFP also works intensively to connect families to community services particularly to ensure ongoing support when a family is ready to “graduate” from the 2 year program.

Community Service Landscape*.* Fragmentation was said to occur for a variety of political and bureaucratic reasons. For example, competition between non-profits for grant applications and the differing abilities of social group to mobilize (write grants and communicate effectively) can impact service creation. Community identity could also act as a barrier. For instance, one participant discussed how West Vancouver did not want to admit they had a poverty problem and therefore did not want food banks in their neighbourhood. Government conflicts, such as the funding dispute between municipal and

provincial government, led to the failure to establish a Burnaby homeless shelter. In the event of a service gap, most agencies did not have a direct role in creating community services. Non-profits generally seemed to have more flexibility in creating new programs in response to community needs, including both independent initiatives (e.g., community gardens) and innovative partnerships which leveraged community resources to create new synergies. For example, FRC works with Vancouver Public Library comes in to do story-time and grocery stores to donate bread (Participant 2). Child protection agencies were not involved in creating community services as they were said to work at the individual-family level. Nevertheless, some individual SDAs developed effective partnerships for integrated services. The North Vancouver SDA created a partnership with a Domestic Violence service provider and police officers to improve service strategies and coordination. Participant 6 also drew attention to service capacity, noting that long waitlists for existing services was a more common issue than missing services.

Access points*.* There were multiple access points to services with most agencies, community and MCFD SDAs keeping their own internal referral lists. Families were said to primarily find community services through word of mouth. Programs such as NFP may get referrals from Local Health Authorities. It is unclear how regularly these types of information are updated, how services are identified, and if any are stored electronically. No comprehensive electronic database was identified.

Barriers. The barriers related to appropriate community service referrals for families included eligibility criteria and lack of transparency/tracking to improve access. For example, providers may fail to refer because they cannot recall complex eligibility criteria. Additionally, since health services require outreach for marginalized communities, some seemingly visible pathways may in actuality be underutilized. As noted by one participant, the same screening and options described as Family Connects should “theoretically” kick in when parents are

accessing or referred to Public Health Units; "There are many parallels to what we actually do to BC at present. What happens is someone comes to the attention of Public Health Unit or the family doctor or another primary care provider, and they may get referred to the Public Health Services in their region. The same set of options should kick in, theoretically." Nonetheless, it is unclear if families are accessing this option and, if not, the reasons behind this.

Service continuum*.* At-risk is a broad category, and as mentioned, there is a spectrum of risk. It was noted that no single type of service will benefit all at-risk families. The type of service that is best will depend on the needs of the family. For example, for women who work, the most important service will be local childcare. For women who are at home/on social assistance, the Family Resource Centres may be the best option.

Integrated Service (One Stop Shops). Participants were generally very favorable to one-stop shop models but expressed some concerns. Some noted past government experiments with these models and current similar models in Victoria and Calgary. The identified issues with one-stop shops were privacy and safety. For example, one concern was that people with high-risk needs (e.g. substance abuse) would then be seen by their neighbours who were accessing for low-risk needs (e.g., parenting classes). Additionally, a negative experience with one provider could lead to the perception they would gossip with other co-located providers and act as a disincentive for someone accessing any services at that centre. Centralized service could also mean longer travel distance. Another participant noted safety concerns if the physical layout allowed potentially aggressive confrontations to take place near other individuals.

4.3. Bureaucratic Constraints: Funding, Capacity, Eligibility Criteria

Training and Capacity. While adequate training was seen as key for successful social work provision, it was noted that training for FDR had been reduced from months to days. Additionally, employee retention through continuing education opportunities could be improved. There is also no training for working with community providers.

Addressing Structural Issues. Social workers used several strategies to address structural issues. If poverty was identified as the issue, the social worker would connect families to income services. Another way to address structural issues was to partner with community organizations. One SDA created an innovative partnership with a Board for Domestic Violence which worked with a variety of stakeholder – social workers, police officers, and nonprofits – to coordinate an approach to addressing family needs. Nonetheless some limitations were apparent. FDR allows 90 days, making it difficult to address complex issues. MCFD files can be initiated only for maltreatment risk and cannot be kept open just for family support or to address poverty.

Other Constraints. Another noted constraint was that social workers are not supposed to inform families about every resource they are eligible for. Paperwork and the ICM system took up time and it was difficult to establish long-term relationships. Participant 4 noted she had “much more freedom, creativity and time working with families” after transitioning from government to non-profit social work.

4.4. Relationships of Practitioners and Families

Strength-Based Practice. Frontline practitioners (government social workers

and community service providers) all noted the importance of strength-based practice when working with families. This term refers to working collaboratively with families in a way that focuses on family strengths instead of deficits. This was important even across modes. Participant 7 notes; “It’s about authoritarian versus strength based. Most complaints from communities are about authoritarian social workers. I can do an Investigation and work fabulously with families because of the strength-based approach.”

Dual Roles. Participants mentioned the dual role (duty to report) of providers working with families as a barrier to services. Participant 4 noted this broad duty may inhibit families asking for help if they feel they are at risk and there is no “truly safe supportive environment”. For social workers in particular, the majority of participants said it was difficult to overcome that dual role: “When someone says I want to help but can also take your children away in a moment, hard to be open” [Participant 4]. A difference of opinion emerged, with some participants saying it was the skills and training of the practitioner that made the biggest difference, particularly using strength-based practice and collaborative models to engage families, while others stated that any services arising from agencies with a significant dual role will still be viewed as intimidating by families. This is supported by research such as Davies (2011) which found that child protection involvement was “frightening and stressful” to families regardless of the social worker’s efforts to form a positive relationship.

Individual Skills and Training. A common theme was the individual skill and training of the social worker, nurse and community service provider in establishing a rapport with a family. Strength-based practice, collaborative approaches, and long-term relationship with the families were listed as factors for success. Training and continuing education opportunities, access to senior staff for advice and supervision, and even clinical help for themselves (in the case of social workers) were seen as important.

Power Relations. Power relations could play out in unexpected ways. As Participant 7 noted, contrary to more resistance to social workers by marginalized groups, sometimes there was less resistance because marginalized people have gotten so used to social workers in their life. This demonstrated the importance of using empowering approaches. Participant 4 noted that there are cases of social workers trying to be helpful but causing lots of unintended damage to families. This is largely a result of not understanding the full-lived experience; Aboriginal, refugee, and immigrant clients may be particularly fearful or distrustful due to the power relations and history of colonialism.

Long Term Services. Another theme among providers was that building trust took time. Participant 5 noted that the relationship with the family is “critical” and should be a “warm, close rapport and trust of that family”. In terms of NFP, nurses visit over the course of 2 years; “So that’s where, if NFP works well, it’s the ability of that nurse, if she or he goes back into the home wherever that person’s living, and has that one-to-one relationship. A lot of people think that may be one of the major ingredients for success.” For FRCs, long-term excellent staff was noted as crucial, as it takes time to establish relationships, particularly with marginalized families. Other participants noted that due to the nature of funding, many community services were short-term, though it would be beneficial for families to be able to access long-term services.

4.5. User-Informed Services

Intersectionality. In discussing work chronically homeless populations, participant 8 said “Whatever the problems for men, they are even deeper for

women – men have an average of 6 ACEs[8], women 8". Intersectionality also informs lived experiences.

User Perspective. As stated by Participant 8, "The problem is we don't think from the user perspective". FRCs were particularly responsive to neighbourhood demographics and needs. It was noted that over the course of 40 years of Marpole Oakridge Family Centre's existence, it has served diverse populations from immigrant Chinese mothers to a wave of Phillipino nannies, customizing service for each and fostering networking to reduce parental isolation and stress. Languages were adapted as were programs.

Healthcare Profession and Service Delivery. The healthcare profession for service delivery for at-risk parents may also be particularly effective, as they do not have to overcome the dual role of social protection workers. Participant 5, an NFP professional, remarks:

"I think there is a lot of trust in the health profession. I think that is one part of it. I think for many of these families, social workers are identified with child protection and identified with taking your kids away. So there would be a lot of work to overcome that. Nurses are also seen as just having a whole lot of expertise on things like child development, you know, everything from nutrition through to how do you discipline a child. So they're seen as a really trustworthy resource."

Additionally, US data show other paraprofessionals did not obtain the same positive results for children and families as nurses (Jack et al, 2016; Olds,

[8] Adverse Childhood Experiences (ACEs) are potentially traumatic childhood experiences ranging from physical, emotional, or sexual abuse to parental divorce or the incarceration of a parent or guardian. Research has shown a direct link between childhood trauma and adult onset of chronic disease, as well as depression, suicide, being violent and a victim of violence. Risk increases exponentially with 4+ ACEs (CDC, 2016).

Sadler, Kitzman, 2007). The reasons for this positive effect are not entirely clear, but may relate to perceived medical expertise.

Pathways to Services. Across community service providers, many users found them through word of mouth from family and friends. Additionally, MCFD workers also keep a roster of community service agencies, but these are largely internal lists developed idiosyncratically. Additionally, building trust with providers can be a gateway to other more intensive services. As noted by Participant 2, families may come in with one need but over time reveal additional needs once staff is trusted. Allowing families to ask for help, instead of pushing them into services, was noted. Participant 4 speculates that even when MFCD intended contracts with non-profits to be a “voluntary non-adversarial stream,” it may nonetheless still seem “scary” to families. Active outreach mode for health services is also effective and well received.

4.6. Summary of Interview Results

Participants expressed differing opinions on whether responses to at-risk families captured or missed too many families. While some thought the duty to report led to over-reporting and significant harms being done to families and communities as a result of unsubstantiated/malicious investigations, others thought that cases were being missed or under-coded. Risk was described as dynamic, difficult to measure, shaped by the underlying beliefs, assumptions and even time/resource constraints. This suggests tertiary intervention will face challenges in risk identification. Participants expressed support for prevention-based solutions.

The concept of risk is dynamic and exists on a continuum from one need to multiple, entangled, complex needs. This means no single service can address all family needs, and a multitude of varied services are necessary. For example,

FRCs are best suited for social isolation, but if a mother is working, then childcare may be most appropriate.

In terms of service delivery, a problem is the lack of thinking “from the user perspective” [Participant 8]. Community service representatives said users found them through word of mouth referrals, suggesting the significance of informal pathways and trusted relationships in pathways to access for marginalized populations.

Participants talked of the relationship of trust with the practitioner and parental involvement in the service plan being key to successful collaboration, as supported by research (Sykes, 2011). The dual role of practitioners arising from a duty to report suspected child maltreatment to child welfare agencies was listed as a barrier. One reason why nurses would be more well-received was that this dual role was less apparent. Given the salience of the dual role, even voluntary services through social welfare agencies may be intimidating to families.

There are many points of entry to community services, as agencies keep their own internal lists, though it was unclear whether any were comprehensive. In terms of the community service landscape, input into which community services are established in the area was limited or non-existent. Most agencies relied on already existing community services and had limited ability to create new services or increase capacity.

Chapter 5. Policy Criteria & Evaluation

The criteria considered are: safety/protection, stakeholder acceptance, effectiveness, development, budgetary cost and administrative complexity.

5.1. Safety/Protection

This criterion considers the degree to which the policy widens or improves access to primary prevention services, thus addressing the spectrum of risk by capturing the largest share of at-risk population (low to high risk, but no history of maltreatment).

Options that are universal, active outreach, home-based and limit stigma/dual role will perform better. Active outreach best increases service access for marginalized groups as research shows it overcomes SES differences in timely access to developmental programs (CAMP, 2002). Additionally, services that have a dual role or are stigmatizing (i.e. targeted) will rank lower as that will typically keep people out. Options will score higher if they are able to capture less visible populations (i.e. residents of wealthier neighbourhoods that may not have as much social worker access). Increasing voluntary self-referral not only improves service outcomes, but also achieves the greatest population-level effect. CAMP (2002) maps show that while the highest risk of vulnerability is concentrated in the poorest neighbourhoods, the largest number of children at developmental risk is spread across middle-class neighborhoods (CAMP, 2002) and the bottom 10% were not distributed clearly across neighbourhoods (City of Vancouver, 2015).

5.2. Effectiveness

Effectiveness refers to effective maltreatment prevention and child placement reduction. It comprises two components. The intervention: (1) is evidence-based primary prevention; and (2) targets the 0-2 year age group.

Evidence-based refers to the degree to which existing data/research (i.e. RCTs) support a reduction in indicators of maltreatment (e.g. reduced infant emergency room visits, better parental mental health and quality of home environment/parental care, decreases in child protection re-referral), with higher ratings for data from comparable jurisdictions.

Targeting the 0-2 age group is important because of the significant developmental effects during this period and disproportionate rates of placement between ages 0-1. Downstream effects on children from, for example, substance abuse exposure, can also be limited and reduce rates of behavioral problems which are the leading cause of family breakdown as children get older (MCFD, 2016). Many infants are placed due to positive toxicology reports, which some researcher believe partly explain the increase in children in care with special needs or behavioral problems (Tonmyr et al., 2011); 70% of children in care had educational special needs, 65% mental disorder during childhood, and of those involved with the justice system, 72% had intensive behavioral problems (RCY, 2009).

5.3. Stakeholder acceptance

All options listed are voluntary and based on self-referral. Thus, in order to differentiate among them, stakeholder acceptance refers to the *degree* to which affected parties are expected to support the option: families, Aboriginal families, and frontline workers (MCFD social workers and community providers). It measures the proportion of stakeholders that highly support the policy.

The Canadian public is not considered separately, though evidence suggests strong general support for child health and poverty initiatives. 80% of Canadians think that ending child poverty should be a goal for any federal government, 86% agree that providing quality care for children is an expression of Canadian health care values, and the majority (51%) say it would affect their voting decision (Ipsos Reid, 2014;2016).

In evaluating stakeholder acceptance, literature was used to project the acceptability to families. For frontline professional acceptance, stakeholder interviews informed the expected acceptability, subject to limitations of representativeness.

5.4. Development

Development refers to the centralization and oversight of community services to one agency or department to ensure continuity. This would begin to approximate Virginia's successful state-supervised, locally administered social services system[9] and fill in for the regional variation and lack of a Social Policy framework in BC (BoardVoice, 2014) at a local level. Community services are integral part of intervention continuum as the multi-systemic needs of families require multiple services. Ranking will be higher for options that increase visibility of existing services, work to actively identify gaps, and collaborate with families and service providers to improve services and capacity. This can in turn support social capital and therefore neighbourhood health.

Literature support for this criterion comes from region-specific risk profiles revealed by the Esposito (2012) Quebec study and the noted need for frequent

[9] In shifting towards prevention in the past decade and implementing local integrated family support teams, with universal access, Virginia decreased its rate of children in care by 27% over 3 years (2007-2010) (Peace & Woolard, 2015)

case reviews to “ensure community family support services are responding to address family functioning concerns”.

5.5. Budgetary Cost

The budgetary cost considers the implementation and ongoing costs to the federal and/or provincial government, recognizing fiscal constraints and scarcity of resources. It includes costs of staff (FTEs, part-time, contract), training, licensing, equipment, resources or infrastructure.

5.6. Administrative Complexity

This option captures whether new departments, policies, practices and job duties need to be implemented.

Chapter 6. Policy Options

In the British Columbia context, amending the CFSCA legislation to re-orient policy towards family-centered practice was not considered likely at this time due to political will and cost but should remain a key consideration for future reforms[10]. Nor are policy options addressing larger structural poverty considered. Instead, the present options are informed by the best emerging and established practices in Canada and similar jurisdictions, such as the United States and Australia. These signify currently untapped opportunities with the highest likelihood of success and immediate implementation within the existing context.

Metro Vancouver was chosen due to the potential for population-level impact in reducing MCFD caseloads, given the high concentration of target populations in this area (Figures 6-9). Vancouver has the highest concentration of provincial population in BC, and child population ages 0-2 years (**Table 3**). Specifically, 3 SDAs (Vancouver, South and North Fraser) contain 51% of the 0-2 year-old child population. The population density and relative availability of community services compared to the challenges of infrastructure and distance in northern communities makes Metro Vancouver an easier location for initial implementation of a population-based primary prevention program. Nonetheless, options may be implemented in northern communities in the future.

[10] Options for reform could include a clearer definition of the extent of services to be provided to ensure child placement is a measure of last resort, as well as a greater recognition of parental needs in a holistic family support model.

Table 3: Population & Population Proportion for Ages 0-2 By SDA, 2016

Service Delivery Area	0-2 Total Number (134,460)	Percentage
South Fraser	25,958	19.3%
Vancouver/Richmond	22,092	16.4%
North Fraser	20,749	15.4%
East Fraser	10,364	7.7%
Kootenays	4,041	3%
Okanagan	8,694	6.5%
Thompson Cariboo Shuswap	5,824	4.3%
Coast/North Shore	7,202	5.4%
South Vancouver Island	11,431	8.5%
North Vancouver Island	7,975	5.9%
Northwest	2,518	1.9%
North Central	4,535	3.4%
North East	3,077	2%

Source: MCFD Performance Management Report, 2016

6.1. Option 1: Modified Family Support Services Response

Active Outreach	Access	Location	Practitioner
No	Universal	Off-site	Social worker

The MCFD Family Support Services (FSS) response creates a highly visible, centralized voluntary referral department for families at risk levels falling outside the scope of FDR/Investigation. This option entails building further capacity through additional FTEs and resources to create a truly comprehensive response.

MCFD Support Services currently responds to self-referred families with a letter or phone call for referral. Expanding the capacity of this department means (1) creating a database and mapping of community providers; (2) mandatory follow-up with referred families to see if services "stuck" and reasons for cases in which they did not; (3) working with community service providers on how to improve services and identify capacity or service gaps; and (4) researching best practices in community service matching to support the FDR team. Family feedback and troubleshooting with community providers will ensure quality assurance. Reasons for service attrition or incompletion such as distrust or mismatch of providers can be identified and addressed. The database of community service providers will be regularly updated and can lead to GIS-based asset mapping, which can be made available for convenient, quick referrals by

social workers or online to families. With GIS, distance can be immediately calculated. Social workers and families can also automatically sort by qualifying criteria to see if families are eligible for the service. This will improve transparency in identifying service gaps within communities.

Additionally, FDR workers will have a new Community Provider training component as part of regular FDR training. This will include training on how to form partnerships with community service providers, use the new database/ mapping of services, and how to best match families with providers. Research on best practices will be supplied by FSS, which can be done in partnership with FRP-BC which currently does such knowledge translation. Some limitations are that FSS will not do comprehensive Family Plans like FDR and will still largely only refer clients over the phone, except when FSS makes specific exceptions.

6.2. Option 2: Nurse Family Practitioner Model

Active Outreach	Access	Location	Practitioner
Yes	Targeted	Home-based	Nurse (NFP)

The Nurse Family Partnership (NFP) is a nurse home-visitation program that has been identified as the best available evidence for preventing child maltreatment (Tonmyr et al., 2011). It is a highly targeted primary prevention program for disadvantaged women under 24 years of age having their first child. It has shown short- and long-term improvements on maternal and child variables (Kitzman et al. 1997; Olds et al. 2007;2014). Its limited inclusion criteria ensures that the most benefits are realized ($5.07 vs. $1.02 ROI for high vs low risk;

RAND, 2005), as effects are reduced when the program is offered to older mothers or women who are not disadvantaged.

According to Lead Researcher, Charlotte Waddell (Participant 5):

"Our research group had looked into effective interventions not only in preventing childhood mental disorders but child maltreatment, and in doing so we had repeatedly encountered the Nurse Family Partnership program in the United States as one that had really very, very strong benefits for children – preventing childhood injuries, seeming to address child neglect as well, so the child maltreatment indicators were really promising and then showing improved child development, cognitive intellectual development in particular, but later measures as well of child behavior including quite severe antisocial behavior and also some other mental health conditions like anxiety and depression."

An NFP pilot is currently underway in British Columbia, with support from the government, including leadership in the Provincial Health Office, Population and Public Health and MCFD. It has been piloted since 2008 in Ontario and adapted from the United States model by Hamilton Public Health Services and McMaster University. The long-term goal is to integrate it into the Canadian public health system (McMaster, 2016).

NFP is one of the earliest interventions for new mothers because it begins prenatally. Nurses visit families approximately 65 times over 2.5 years, providing a range of education, support and referrals. When the family is ready to "graduate" there is a significant component of connecting them to community resources to ensure that, if necessary, they continue to receive the support they need. Nurses may get assistance finding community resources through Local Health Authorities.

This option would implement NFP in select areas in British Columbia, depending on demographics, such as, Surrey and Cranbrook. For example, births to teenage mothers aged 15 to 19 years can be used as a proxy for the NFP target population. While teen pregnancy rates have also been steadily declining with Vancouver rates (8.3 per 1,000 live births) well below the provincial average (30.1 per 1,000 live births), there are regional variations (Vancouver Coastal Health, 2013). The highest rates are found in Surrey (26.6 per 1,000 live births). Cranbrook's rate of teen pregnancy is 40.8 per 1,000 based on a 2007-2009 survey, significantly higher than the rest of BC. The highest teen pregnancy rate in the province is the Northern region at 51.1 per 1,000 teenage women. Therefore, the number of potential cases will vary significantly based on region.

6.3. Option 3: Family Connects Pilot (Metro Vancouver)

Active Outreach	Access	Location	Practitioner
Yes	Universal	Home-based	Nurse

Family Connects (formerly Durham Connects) is a community-based, child neglect prevention program. It provides universal nurse-visitation program for new parents. First established in North Carolina, it is currently piloted in select US states (i.e. Iowa, Minnesota and Illinois). The core components of FC include: 1) emergency assistance; 2) home visiting family intervention (including weekly visits involving family assessments outcome-driven service plans, and individual and family counseling; 3) advocacy and service coordination with referrals; and 4) multi-family supportive and recreational activities (DePanfilis, Filene, & Brodowski, 2009). While NFP is targeted and intensive, this program provides universal reach and allows a graduated response based on a family needs

assessment. Family Connects is based on an RCT which demonstrated that, across areas of demographic risk, 94% of families in Durham had one or more needs for education and/or community resources. The guiding principle of Family Connects is that a population-level impact will be achieved only by "providing services to all families who choose to participate is the only route to community-level change".

FC directly provides services to parents/caregivers to address the following concerns: poor household conditions, financial stress, inadequate social support, parenting stress and poor parenting attitudes, unsafe caregiver/child interactions, poor family functioning, poor adult functioning (e.g., mental health problems/substance abuse) that impacts parenting, and poor family resources.

Primary physicians (the family's pediatrician or doctor) and other frontline practitioners ensure that parents know about voluntary self-enrollment to the program. A nurse visits every family shortly after birth to assess needs and provide immediate support. The nurse uses a tested screening assessment tool, Family Needs Matrix, to assess family strengths and needs in order to link families to matched local community resources and services, factoring in family wishes. The Family Support Matrix includes factors such as "Support for Health Care," "Support for Caring for Infant," "Support for Safe Home" and "Support for Parents." Each factor is rated by trained nurses as: 1 = No family needs; 2 = Needs addressed during visit; 3 = Community resources needed; 4 = Emergency intervention needed. Nurses use an Agency Finder to quickly identify services based on eligibility criteria, distance and other variables.

This universal approach does not eliminate the need for targeted services. Instead, Family Connects determines need and can recommend enrollment in targeted programs when they are eligible, such as Healthy Families America, Early Head Start, Nurse Family Partnership, and others, making it an excellent gateway to more intensive parenting services.

The Community Alignment Framework ensures a database of community service providers (Agency Finder) and ongoing collaboration with funders, providers and families to troubleshoot issues, identify service gaps and improve services. Community Alignment staff (typically 1-2 FTEs) work to continually ensure communication and feedback between providers and local stakeholders. The Agency Finder tracks community referrals and documentations. It identifies existing services for child and family needs, ranging from housing to mental health to interventions. A Community Advisory Board (CAB) of key community stakeholder, including parents, is established to inform about the local context and to support expanded program reach. Family input is a key component. In this way, Family Connects works to align local resources with family needs from a user perspective.

The CAB allows for assessment of community readiness prior to program installation as well as ongoing monitoring of community engagement during program implementation. It also fosters community buy-in and ownership of the program.

Chapter 7. Policy Assessment & Evaluation

Table 4 Evaluative Framework

For each criterion, each policy receives a score of high (3 points), medium (2 points), or low (1 point) associated for the purposes of quantifying the results. Options are ranked relative to each other. While there is no weighting for the criteria, the first two criteria (safety/protection and effectiveness) were considered most important from the policy standpoint. They are most vital to advancing the status quo through the novel user-informed way to improve health outcomes. They further have synergistic effect by increasing effectiveness and access simultaneously. Other analysts may wish to apply weights to the criteria that accord with their policy-related values.

	Criteria	Measures	Ranking
Safety/Protection	The policy supports all families in need by addressing a broad risk spectrum	• Increases access and likelihood of voluntary participation to all at-risk families	High = universal access, active outreach and limited dual-role/stigma Medium = some of the following accessibility factors: universal access, active outreach, limited dual role/stigma Low = targeted, passive access, and salient dual role /stigma
Effectiveness	The policy will reduce the rates of high-risk cases	• The intervention is evidence-based • The policy addresses childhood risks at the earliest opportunity (0-3 years old)	High = The intervention has strong research evidence base in comparable jurisdictions indicate the policy option will reduce risk of maltreatment, targets risks for 0-2 years old. Medium = The intervention lacks either an evidentiary base or is not

			specifically targeted at 0-2 years old. Low = evidence-informed but comparable data/research is unavailable or impact is uncertain and 0-2 years old is not specifically targeted.
Stakeholder Acceptance	Do families support the option? Do Aboriginal families support the option? Do frontline workers support the option?	• What proportion of stakeholders highly support the option?	High = All stakeholders highly support the policy option. Medium = Two out of three stakeholders highly support the policy option Low = One or zero of the groups support the policy option
Cost	Financial impact on government	• Cost to provincial government budget of implementation and ongoing costs • Personnel and non-personnel costs	High = <$10 million Medium = $2 million - $10 million Low = ≥$2 million increase
Administrative Complexity	The administrative ease of implementation	• Legislative or procedural changes • Human resource capacity changes • Technological changes i.e. database management	High = Limited number of administrative changes and minimal complexity Medium = Some administrative changes Low = Significant administrative change and increase complexity

An analysis of each policy option utilizing this evaluative framing follows. The three policy options are: (1) Modified MCFD Family Support Services Response (FSSR); (2) Nurse Family Practitioner Model; and (3) Family Connects.

7.1. Option #1 Modified FSS Response

7.1.1. Safety/Protection

The modified Family Support Services Response (FSSR) performs more poorly than the alternatives in Safety. While universal access allows access to a larger portion of at-risk families through a highly visible pathway, some families are still likely to be missed as a result of passive outreach and the dual role of the MCFD. As previously noted, active outreach in health services in Vancouver was related to overcoming SES barriers for marginalized populations (CAMP, 2002). Additionally, it is crucial that voluntary services are attractive to families. Families with negative views of MCFD or its dual role may forgo services. Given historic context, this may disproportionately affect Aboriginal families. Furthermore, some families may perceive even voluntary services through contracted MCFD agencies as "scary" [Participant 4]. As noted by Participant 5, since for many of the families, social workers were identified with child protection and removal, "there would be a lot of work to overcome that." As this option is phone-based, it would be available in remote communities, unlike the other options, and therefore be accessible to a broader base of the population. Nonetheless as most remote communities are served by Aboriginal Delegated Agencies which are already increasingly oriented towards culturally appropriate family support and prevention, this option is not expected to provide significant additional value.

7.1.2. Effectiveness

Data for effectiveness of Family Support services is not available. Nonetheless, it is comparable to FDR because it provides collaborative support services. FDR is evidence-based and proven to reduce re-investigation rates in BC. The FSS department can work with FRP-BC to implement the latter's extensive research on evidence-informed best practices for working with families. A limitation is FSS will not work with the families to create Family Plans, like

FDR, and is therefore less comprehensive. It also does not specifically target support for children aged 0-2 years.

7.1.3. Stakeholder Acceptance

This option performs well on stakeholder acceptance as only families who voluntarily self-refer will receive services. Nevertheless, family acceptance is unlikely to be high. The other options of nurse-home visitation include more comprehensive support (i.e. home-based, immediate concrete support) and healthcare practitioner delivery (less dual role). Some families may also prefer socially and community engaged services such as Family Resource Centres. The majority of families prefer establishing a long-term trusted relationship prior to discussing their needs, particularly as parenting needs may be sensitive – in this respect, all the other options perform better than FSS.

MCFD reactions may be mixed. Funding, staffing capacity, and adopting a new computer database for referral tracking may pose additional stress and complexity for already overburdened social workers, particularly considering the numerous legislative and procedural changes (e.g. ICM system) in the past decade. Still, social workers have also expressed interest in building skills and capacity to address complex problems (RCY, 2016) and prevention-based measures and some are likely to be supportive of the initiative. As many municipalities (e.g., Surrey, Delta, Vancouver), agencies (e.g., Community Living BC, Vancouver Coastal Health), and nonprofits in Greater Vancouver have already begun creating community asset maps, including GIS (i.e. Burnaby), MCFD may build off these efforts.

Community service providers and social workers are expected to be favorable to performance measures (i.e. adherence, satisfaction) as this information can be used to guide service development and delivery. Interview

participants expressed support for prevention strategies as well as ensuring *long-term* community services are available for families.

7.1.4. Development

This option allows MCFD to centralize oversight of community services that impact at-risk families. A database would establish a single source of up-to-date resources, and community mapping will increase transparency and identify service gaps. Furthermore, FSS will work with community providers and families to troubleshoot challenges to service adherence (e.g., cost, cultural appropriateness, capacity, etc.). This would ensure that "social workers at the Ministry [will] be in a position to advise policymakers in other ministries on the resources required to better keep families together" and that funds are allocated to effective alternatives to apprehension (Pivot Legal Society, 2008).

Additional Community Partnership/ Provider training for FDR will foster greater capacity for service matching and working with community providers and can promote more innovative partnerships similar to the one in Vancouver-Richmond's Domestic Violence Board.[11].

7.1.5. Budgetary Cost

This option is the least expensive, both in absolute terms and relative to the alternatives. The MCFD budget has been substantially increased with $145 million in new funding for a total of $332 million over 3 years (BC Budget 2017). Costs are largely based on hiring additional FTEs in the 13 SDAs. Since the department in Vancouver-Richmond currently has one FTE dedicated to FSS, it is assumed only 1-2 more FTEs need to be hired, depending on the size of the

[11] This innovative partnership helps foster service coordination and strategies with nonprofits and police to address domestic violence which plays a pivotal role in child investigation and placement – C/O (Participant 7)

region/population. With 20 FTEs, assuming a salary of $50,000, the total annual cost is $1 million and training costs and technology (mapping software costs, i.e. GIS) costs [for calculation: **Appendix D**)**.** Since the BC government has provided funding for 100 new social workers over the three-year period (2017 Budget), it is possible some of these new workers may be allocated to fill these new positions. Additional costs may arise for setting up a database and mapping, as well as FDR Community Partnership Training.

7.1.6. Administrative Complexity

The administrative complexity will mainly be in community asset mapping and setting up a database of service providers. This can be done through a partnership with universities (i.e. UBCM) and municipalities that have already done extensive work on establishing community asset maps. A referral tracking system for following up with clients will also be required.

Safety/ Protection	Effectiveness	Stakeholder Acceptance	Development	Budgetary Cost	Administrative Complexity
Low	Low	Low	Medium	High (inexpensive)	High (non-complex)
1	1	1	2	3	3

7.2. Option #2 Nurse Family Practitioner (Metro Vancouver)

7.2.1. Safety/Protection

NFP is a highly targeted approach, capturing only a subset of "at-risk" families (i.e. highest risk, without maltreatment history). The criterion is limited to first-time mothers under age 24 with low SES. Pregnant women who matched the demographic criteria would be told about this program by their doctor. They could choose to voluntarily enroll in the program. While Type I error is low, Type II error is relatively high compared to universal screening (i.e. FC) because while families selected for intensive services are the highest risk demographic group, other medium to high risk families will be excluded by design (e.g., over age 24 or not first pregnancy).

Due to the expense of NFP personnel, this option is more feasible to implement in denser (i.e. urban) settings than remote, rural communities as nurses can make multiple visits in one day. From a Health Authority perspective, this would make NFP personnel an underutilized, costly resource. As a result, it is unlikely this program would be implemented in rural Aboriginal communities (though teleconferencing is being investigated). Nonetheless, as over 50% of First Nations live in urban areas (INAC, 2010), the program will still be accessible to a significant portion of Aboriginal families. The dual role barrier is limited with nurses, and the home-based nature of the intervention reduces barriers to access for marginalized groups, specifically low-income mothers.

Based on 23,403 annual births and a rate of 8.3 per 1,000 attributed to teen pregnancy, the potential NFP caseload for Vancouver CMA was calculated as about 194 per year.

7.2.2. Effectiveness

NFP is considered best practices in primary prevention, with numerous positive RCT results in the United States and internationally (Waddell et al., 2016). The outcomes of the intervention are to improve: 1) pregnancy outcomes; 2) child health and development; and 3) parents' economic self-sufficiency (Jack et. al., 2015). The intervention begins prenatally and is specifically targeted for 0-2 year olds. Participant 5 notes on the benefits of NFP offering early support:

"Speaking as a child psychiatrist, it made sense to me, because many early childhood development programs in my opinion wait too late. If you wait, for example, until kids are two, three years old, they've already had the pre-natal period and then they've had a couple of years where a lot can happen, both positive and negative. So this is the earliest program that anyone's really ever attempted to implement."

This program is expected to reduce the number of emergency hospital visits. According to BC Children's Hospital, there were 43,445 emergency department visits in 2013/14, 26,142 of which were in Vancouver Coastal (PHAC, 2014).

7.2.3. Stakeholder Acceptance

Nurses may be the best practitioners to deliver services to at-risk families. The long-term relationship of 2.5 years with the family fosters trust. Additionally, studies in the US found that nurses were more effective than other paraprofessionals (Olds et al. 2007;2014). As to why nurses may be particularly trusted by families, Participant 5 remarks, "I think there is a lot of trust in the health profession" and that "Nurses are also seen as just having a whole lot of expertise on things like child development, you know, everything from nutrition through to how do you discipline a child. So they're seen as a really trustworthy resource."

Nurse-delivery may be particularly effective with marginalized women, as noted by Participant 5:

"Suppose you think about being a teenage girl who is pregnant for the first time, who herself, certainly in the case of the NFP participants, they themselves have been through many, many difficult experiences. They're living in poverty, lots of them are, if not homeless, their housing is very insecure. They may or may not have much in the way of support systems. They may have systems that are actively not supportive like abusive families or partners. So establishing trust where somebody's had a history of maltreatment themselves is really, really important."

Frontline social service workers and community providers are likely to support this option highly, as many have expressed support for prevention initiatives, and can decrease their caseloads of high-risk complex cases. For example, Interior Health Authority (2005) supports intensive public health nurse home visiting from the prenatal period into early childhood, stating that it ensures "best outcomes for vulnerable families" (Interior Health Authority, 2005). Promoting healthy behaviours prenatally (e.g. nutrition, reducing substance abuse) and fostering developmental knowledge, could limit downstream behavioral and developmental problems in children arising from exposure to substance abuse in utero and dysfunctional parent-child interaction patterns. As **Figure 5** illustrates, the next largest portion of children after infants are removed between ages 15-18 years, due to behavioral problems (MCFD, 2016).

7.2.4. Development

The NFP model works with the Local Health Authority to locate appropriate community services for families. Existing databases are used and this option does not actively develop new services in the community, increase service provider capacity, or create community asset mapping. It may identify

service gaps on a case by case basis but is limited in its impact on community development (i.e. increasing transparency, creating new services, or increasing interagency connections) as its primary focus is working directly with families.

7.2.5. Budgetary Cost

This option is relatively expensive. NFPs are highly trained and well paid. Caseloads are limited to 20 families for each full-time nurse. 25 new NFPs were assumed, the standard for a large hospital such as Vancouver Coastal Health, with costs approximately $3.3 million per year. Costs are contained because this is a “highly targeted” approach, focused on disadvantaged young mothers under 24 years – such targeting also ensures that there is a high ROI of $5.07.

The expected net return over 10-15 years is approximately $18,000 per family in avoided costs to other social services and criminal justice (RAND, 2005). Similar to Option 3, ROI data is mostly from the US, though there is more data on NFP and tracking of long-term outcomes than for FC. However, Canadian data from comparable jurisdictions is increasingly becoming available, ensuring greater comparability of NFP outcomes for Metro Vancouver. The targeted nature of NFP increases its ROI from $3 to $5 per $1 invested (RAND, 2005) and longitudinal US data as well as comparable Canadian data make NFP a more reliable investment than FC from a political standpoint. It retains the short-term benefits of lower infant emergency room visits similarly to FC. Overall, this option is less expensive than Option 3 but significantly more expensive than Option 1.

7.2.6. Administrative Complexity

Administrative complexity results from the increased personnel, new departments and capacity. As a successful Canadian pilot program was implemented in Hamilton, Ontario, and an NFP pilot has been established in BC,

there are relevant implementation precedents to provide guidelines for expanding the program. Specifically, the BC Healthy Connections Project (BCHCP) NFP pilot will include a process evaluation describing how the NFP is implemented and delivered across the five participating BC Health Authorities (HAs), including describing variances within and between sites (Jack et al., 2015). The results will be available by 2020.

Safety/ Protection	Effectiveness	Stakeholder Acceptance	Development	Budgetary Cost	Administrative Complexity
Medium	High	Medium	Low	Low (expensive)	Medium
2	3	2	1	1	2

7.3. Option #3 Family Connects (Metro Vancouver)

7.3.1. Safety/Protection

This option scores the highest on safety and protection as it captures the largest share of risk. FC is universal, active outreach and home-based, which overcomes barriers to access for marginalized populations. Similarly to NFP, pregnant women would be notified about the existence of this program by their doctor. Since access is universal, significantly more first-time mothers would be eligible. It does not have the stigma of targeted programs, which makes it more

likely that less visible populations (i.e. wealthier residents)[12] will also enrol. Therefore, this option, in providing support to all new families in a non-stigmatizing way, can enhance safety in wealthier neighbourhoods that typically have less social worker oversight. Identifying vulnerabilities for all new parents is important. For instance, post-partum depression does not discriminate between low and high income, and is a risk factor for maltreatment. Again, the largest *number* of children living in poverty and vulnerable on EDI measures are spread out across neighbourhoods in Vancouver, though certainly many are concentrated in Strathcona (City of Vancouver, 2015; Statistics Canada, 2013; CAMP, 2002). Therefore, this option captures more at-risk children than targeted neighbourhood approaches. Participant 6 further notes that the simple eligibility criterion of Family Connects can increase referrals by practitioners as doctors would not have to remember complex eligibility details.

US studies show 71% of families with newborns completed the program in 2015 (Family Connects, 2016).

This option covers the entire at-risk population. It allows *universal screening* for new parents and *a graduated response depending on risk level.* Nurses can decide whether a family needs a few sessions or scale up and refer to more intensive, targeted services. Immediate needs from developmental education to infant nutrition to post-partum depression are addressed. This option covers 23,403 families (based on births), many more than the 200-500 cases projected for NFP, for a cost of approximately $16-23 million per year (70% vs. 100% enrollment, respectively). Compared to NFP, this program has reduced likelihood of Type II error – missing women at risk of maltreatment – because the vast majority of new mothers are included. Type I error – mislabeling as elevated maltreatment risk – is reduced through a tested family

[12] Differential rates in maltreatment between low and high SES neighbourhoods are partly driven by less visibility in wealthier neighbourhoods which can hinder social workers with legal challenges – C/O Participant 7

assessment tool that allows a fine-grained assessment of needs and graduated response.

Pregnancy outreach programs are established in B.C., but actual access data were unavailable in health records (RCY, 2011). The RCY states: "Because the regional health authorities in B.C. are not required to comply with detailed province wide standards that outline how care is to be delivered, there are many different models of postnatal care delivery across the province. […] The result is a fragmented system of unpredictable care, where the initiative for accessing services is often left with the mother." Therefore, in ensuring universal, active, standardized access, issues of fragmentation are reduced.

This option would face similar implementation challenges as NFP for remote communities.

7.3.2. Effectiveness

Family Connects is certified as an evidence-based home visiting model by the U.S. Department of Health and Human Services, showing a 28% reduction in maternal anxiety and 36% reduction in emergency hospital visits. It was developed in Durham, North Carolina, over 3 years and evaluated through 3 RCTs. Over 10,000 Durham County families have completed the program. Compared to control group families, the intervention families had more connections to community services and sources, higher quality mother parenting behavior, and safer home environments. Participants showed positive changes in protective factors (i.e., parenting attitudes, parenting competence, and social support) and reductions in risk factors (i.e., depressive symptoms, parenting stress) and improved safety and child behavior (DePanfilis &Dubowitz, 2005). The outcomes were 50% less total infant emergency medical care in the first 12 months and 37% less total infant emergency medical care by 24 months. It also

showed 78% successful community referral rate. This program specifically targets the 0-2 year age group.

7.3.3. Stakeholder Acceptance

All families are likely to be highly favourable to this option. This program is voluntary and provides active support for all new parents, through an “individualized and non-stigmatizing entry into the community system of care” (Family Connects, 2017). Families are asked what resources they need, making this program collaborative rather than prescriptive. Family involvement at every step makes this program highly user-informed. Service referrals are rapid, as nurses find local providers with Agency Finder, an online tool which allows services to be sorted by criteria such as eligibility, transportation availability and distance. Families and communities also provide feedback to service providers, and Family Connects works with the latter to improve services and build capacity. Additionally, follow-up tracks whether families were satisfied. In a 2009 RCT, 99% of participating mothers would recommend the program to another new mother. Community participation is also voluntary. According to Participant 7, community participation is voluntary and communities approach the program when ready. The success of Family Connects is “attributed to the community collaboration, collaborative funders, and stakeholder buy-in” [Participant 6].

7.3.4. Development

This program comprehensively addresses the continuum of community services by working to ensure there are no gaps in local systems of care. Families receive follow-up which ensures services “stick”. In 2015, 78% of FC referrals resulted in successful connection with a community agency. According to Participant 6, the agency gets “multi-tiered info” regarding the community to increase the efficacy of services, relying on multiple sources of information and follow up with clients. The primary barrier to community services is usually not

that a community service is missing, but rather a lack of capacity, i.e. childcare subsidies. Family Connects works with service providers and founders to inform on how to increase capacity. This program is heavily involved in collaborative problem solving with all stakeholders and has strong social media presence to enhance engagement. The Community Alignment component includes the Community Advisory Board, comprised of community leaders and families, Community Alignment Specialists, and the establishment of an Agency Finder for community referrals and documentations. Capacity is developed as Community Alignment specialists work with providers teaching them how to apply for grant funding, get a bigger space, and other issues as they arise. Nurses use the Agency Finder to provide comprehensive, centralized referrals and oversight, following up to ensure “stick”; the full spectrum of other risk factors (housing, domestic violence, parent support groups, etc.) are also addressed.

While Family Connects does not target social capital directly, the long-term outcome may nonetheless build social capital by connecting families with neighbourhood resources. As Participant 6 explains; “If you want community health you can’t have a targeted program”. The rationale for Family Connects is that to affect community-level indicators a program must work within the community with local ownership.

7.3.5. Budgetary Cost

The typical implementation time is 1 year. Start-up costs for training, dissemination, and initial audits are $70,000 and ongoing costs are estimated to be around $700-800/birth. There are also costs for yearly and 3rd year audits.

Assuming approximately 23,403 births in Vancouver at $800CAD per birth [see calculation: **Appendix D**], the ongoing costs per year will be $23 million.[13]

Staff requirements are typically 1-2 Community Alignment specialists, a Nursing Director, and nurses (the number varying based on size of the community). For the present case, 14 Community Alignment FTEs were assumed for the 14 subdivisions in Vancouver (1 staff for every subdivision with population greater than 30,000). 50 additional RNs were assumed for 23,403 births. This is more nurses than Option 2, which includes 25 new NFPs. Nonetheless, as these are RNs who do not have to be NFP trained (annual salary of approximately $68,000 vs. $130,000), there are some cost savings. Two Nursing Directors will be required to supervise and support nursing staff ($200,000).

Due to a larger number of families having access, the ROI is not as high ($3.17 vs. $5.07 for NFP). However, the return on investment for each $1.00 in program costs at $3.17 in savings by community was realized by child's age 2 as a result of savings from infant emergency medical care. When comparing $23 million in costs per year to $268 million costs BC pays every year due to negative outcomes associated with youth leaving care[14] (Shaffer et al., 2016), this investment would need to reduce just 8% of youth entering care to pay for itself. Given that the majority of youth coming into care are from urban areas, investing in Vancouver CMA is likely to achieve this reduction.

[13] In clarification, since this option entails many referrals of individuals for access to other public services, the calculation does not encompass the full associated public costs.

Additionally, the ROI of FC has been demonstrated in as little as 12 months, with a decrease in infant emergency visits.[15] Given the short time frame for community-wide benefits to arise, this option may be politically favorable.

7.3.6. Administrative Complexity

There are implementation documents and a team to assist. A Readiness document assesses whether there is a need, whether the community is ready for it and the presence of a stable funding source. Training and technical assistance is available by a team affiliated with the University of Maryland School of Social Work. Existing community groups such as FRP-BC could serve as the foundation for the Family Connects Community Advocacy Board. A key legal consideration may be the need to specify lliability issues with respect to oversight and addressing identified service gaps.

Safety/ Protection	Effectiveness	Stakeholder Acceptance	Development	Budgetary Cost	Administrative Complexity
High	High	High	High	Low (expensive)	Low (complex)
3	3	3	3	1	1

[15] ROI was demonstrated for US communities with a smaller population than Metro Vancouver so caution for reliability is warranted [See Appendix D for methodology]

Table 5 Policy Options Evaluation Summary

	Safety/ Protection	Effectiveness	Stakeholder Acceptance	Development	Budgetary Cost	Admin Comp.	Total
Modified FSS	1	1	1	2	3	3	11
NFP	2	3	2	1	1	2	11
Family Connects	3	3	3	3	1	1	14

Chapter 9. Recommendations and Implementation

Based on a multi-criteria policy analysis, I recommend that British Columbia implement a Family Connects pilot in Metro Vancouver. This option would have a similar ROI and benefits as NFP while providing support to the most families. However, in the short-term, and to enable FC in the future, BC should seek to improve service oversight through community mapping.

Three principles guide re-orienting the BC child welfare system towards prevention: (1) Early Intervention - to ensure it is easier to resolve issues and decrease the likelihood of escalation, (2) Accessibility - services should be accessible and user-friendly, and (3) Voluntariness - families should be able to participate voluntarily.

Recommendation 1 (Short Term)

In the short term, the MCFD should establish community mapping to enhance the visibility of social services and identify underserviced neighbourhoods, allowing data-driven risk assessment to enable social workers and policymakers to proactively identify priority areas for provincial grants or locations of social services. To promote evidence-based policy, it is necessary to implement “systems mapping” and “linking services to outcomes” (Johnson-Reid, 2011). Additionally, this would allow a more comprehensive list of services for matching families and tracking adherence and waitlists. To summarize, this recommendation would:

- Identify priority neighbourhoods with disadvantage and residual risk (e.g. track waitlist ratios)

- Create a centralized trusted source of up-to-date information on neighbourhood assets/social services
- Enable the establishment of an online database accessible to families on the MCFD website
- Inform the future development of social services in the area
- Enable future monitoring of service adherence to identify barriers and create user-informed services

Recommendation 2 (Medium Term)

Family Connects is recommended for middle-term implementation. This option avoids the dual role of child protection by establishing separate agencies serving different functions (Lonne, Parton, Thomson, and Harries, 2009). This facilitates voluntary access and comprehensive coverage.

This option covers the largest share of risk and still retains an ROI of $3.17. As noted, Family Connects would have to prevent only 8% of the adverse cases to pay off. Additionally, "when families get what they need, no more and no less, community agencies avoid additional costs" (Family Connects, 2016). Through a graduated response, families are able to get tailored support.

This is also the only community development approach among the policy options considered. It targets social capital in the long-term, albeit indirectly through service and neighbourhood connections and resources. This approach is also likely to be supported by traditional Aboriginal knowledge which views neighbourhood and individual health as intertwined.

A communications strategy will be required to advertise the program to social service agencies, doctors, and hospitals. The resources needed to implement the program include a trained social worker, office space, and emergency/concrete needs fund. A minimum of one hour of face-to-face contact

between the nurse and clients weekly is recommended and services are short term, ranging from 3-4 months.

Nurses provide services such as:

1. Standardized clinical assessment to identify risk and protective factors associated with child maltreatment as part of the comprehensive family assessment
2. Advocacy/service facilitation of community interventions to support families
3. Case plan evaluation/progress assessment

Additionally, nurses should receive specific training to identify IPV, given its relevance to child protection investigations.

Beyond its initial implementation, Family Connects could be expanded to northern Aboriginal communities. Currently, lack of infrastructure and services are the key priorities. While options outside of the scope of this paper may prove more feasible currently, the growth of teleconferencing may provide an innovative solution to expanding the Family Connects program.

Future research should explore novel options for supporting families in remote, rural communities where community resources and/or expertise may be lacking. In the BC context, this would include many Aboriginal people living on isolated reserves. While the most evidence-based options were presented for immediate action for the present research, other promising pilot projects (i.e. Alberta temporary live-in caregiver programs) should also be further investigated. Most crucially, further research is needed to survey vulnerable families (at-risk or involved with child welfare) to begin building knowledge on the user perspective. For instance, we need to know which programs they use and which program elements they find satisfying. This would provide a basis from which to craft user-informed family services. Lastly, analysis on how to best reform current child

protection legislation to support a shift towards a family-centered support model is recommended.

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Appendix A. Semi-Structured Interview Schedule

This section contains the schedule of questions used as guidelines in the semi-structured informational interviews with front line workers (social workers and community service managers). The semi-structured nature of the interviews meant question order varied and a number of spontaneous questions/topics that do not appear in the schedule were also discussed.

1. What are the strengths and limitations of the approach you use at your agency for working with families?

2. How do you/your agency address structural issues such as poverty when working with families? How do you address complex needs?

3. How do you identify who is at risk of child maltreatment?

4. What is your view on best practices for working with families? Are there best practices for working with families with complex needs which require multiple services?

5. How do families find your services?

6. How does your agency find other community providers (i.e. database, internal lists, other agencies such as health authorities, word of mouth, etc.)?

7. What are the most popular programs or best services for at-risk families?

8. If a service is missing in the community, how do you overcome this limitation? In your role, have you or could you work to create services when gaps were identified?

9. In your opinion, are there any best-service models (i.e. One Stop Shops)?

Appendix B. Consent Form

Participant Consent Form: **Application No.: 2016s0611**

Keeping Families Together: Best Practices for Prevention-Based Service Design

Study Application Number:

Hello,

My name is Julia Mazurchuk and I am a student in the Masters of Public Policy program at Simon Fraser University. I am reaching out to you today in order to invite you to become a participant in my research. In order to complete the requirements of my graduate degree, I am writing a capstone report investigating the child welfare services in BC. The purpose of the study, entitled "Keeping Families Together: Best Practices for Prevention-Based Service Design", is to help inform ways by which to enhance existing services in BC and reduce out of home placement of children in BC's child welfare system. In addition to this, the project hopes to be able to comment on the resources most needed to best support at-risk families, as informed by experts in the field. The data collected will be used in the production of a thesis report and *may* be shared with Ministry of Child and Family Development for their use. It may also be used for future conferences and presentations.

As an expert in this area of study, your perspective will enhance not only my understanding of the general issue area, but also my understanding of potential policy alternatives as well as their benefits and trade-offs.

If I should request organisational approvals to speak to you, please advise. Otherwise, I will not be pursuing organisational approvals. As such I want to inform you of the potential risks of participating. The data I hope to evoke will present minimal to no risk to you professionally or as part of your daily life.

If you are interested in my research and are willing to be interviewed, please let me know in your return email by indicating yes or no below and we can begin scheduling a time for the interview to take place. The interview may happen in-person at Simon Fraser University's Harbour Center campus, at your place of work, or over the telephone at your convenience. The interview will consist of one session approximately thirty to forty minutes in length.

Participation is voluntary and you have the opportunity to withdraw from the study at any point. There are no anticipated direct benefits to you from this study. If you choose to withdraw from participation after your interview has been conducted all data collected from you will be deleted immediately. Refusal to participate or withdrawal/dropout after agreeing to participate will not have an adverse effect or consequences on you, your employment, education or services. In addition to this, below you are able to indicate whether you would like to be directly referenced in the report with your name, title and organisation used when your quotes or comments are referenced in the report. If you indicated that you do not wish to be directly referenced generic terms will be used in replacement. These include but are not limited to: academic researcher, social advocate, government official.

SFU SCHOOL OF PUBLIC POLICY

Maximum efforts will be made to ensure your confidentiality throughout the entire interview and communication process. However, depending on the medium of communication, and because some of the information will be quoted directly in the final study, absolute confidentiality cannot be assured. Please be aware that conversations conducted over: the telephone, skype to telephone, and email are not considered confidential by Simon Frasier University's ethics department. Skype to skype conversations are considered confidential. You will be audio recorded during the interview. The audio recording data will be transferred from the audio recorder to a password protected laptop. The audio will be used to produce a transcript of the interview. After the transcript is created the audio file will be immediately deleted. The transcription file will be stored on a password protected laptop and the file themselves will be encrypted. The data will be held for two years due to Simon Fraser University's research auditing protocol. After this time has elapsed your data will be deleted on March 1, 2019. Consent forms will be similarly encrypted and stored on a password protected laptop and paper versions stored in a locked office. They will be destroyed March 1, 2019.

No remuneration will be provided if you consent to participate.

Do you consent to be an interview participant?

YES_____ NO______

Are you an adult 19 years or older?

YES_____ NO______

Do you consent to having your name, title and organisation reported in the body of the report?
YES______ NO______

Would you be willing to be re-contacted for follow-up questions after the initial interview?
YES______ NO______

Please print your name: ______________________

Please provide your signature: ____________________________

Date: ______________________ (YYYY/MM/DD)

Complaints or questions that may arise can be directed to:

Director Office of Research Ethics *Dr. Jeff Toward*
Simon Fraser University, Burnaby, B.C. Canada, V5A 1S6

Questions should be addressed to:
Julia Mazurchuk (Principal Investigator)

Professor Rhys Kesselman - Graduate Supervisor
Simon Fraser University

If desired you may request a copy of my report upon its completion. This can be obtained through electronic distribution. The report will also be available publically through the Simon Fraser University's library.

Thank you very much for your time. I sincerely look forward to speaking with you.

Julia Mazurchuk
Candidate for Masters in Public Policy
Simon Fraser University

Version 2 December 5, 2016

Appendix C. Figures

Figure 6: Female Population Ages 15-24 concentrated in Metro Vancouver

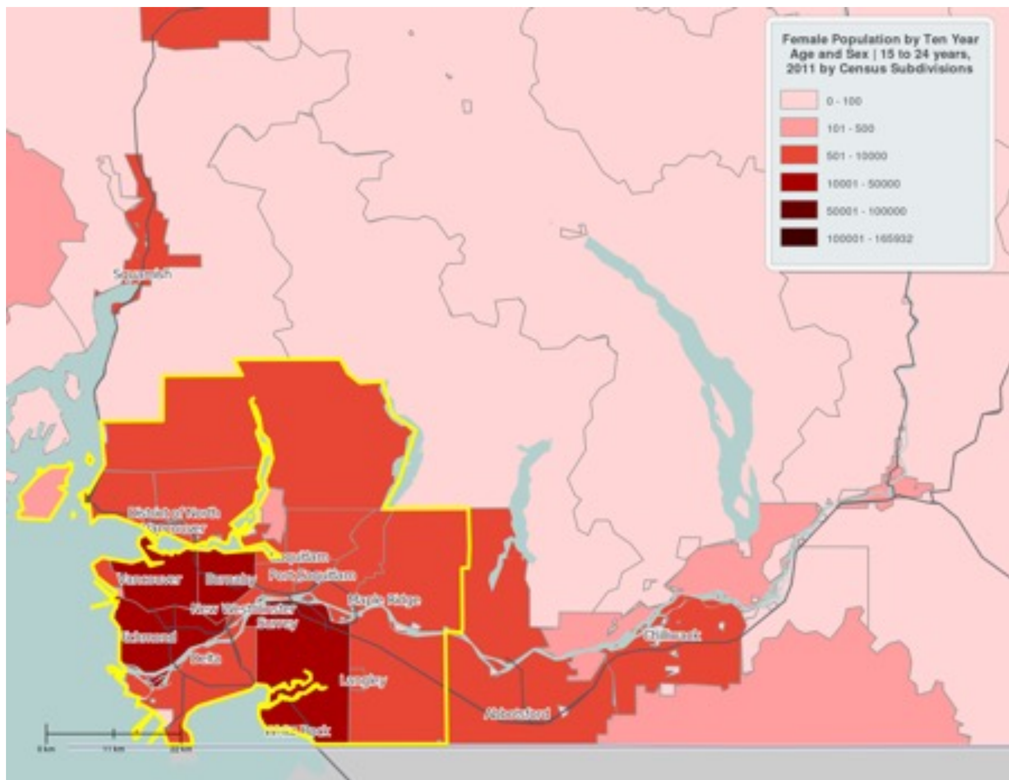


Figure 7: Female Lone Parent Households

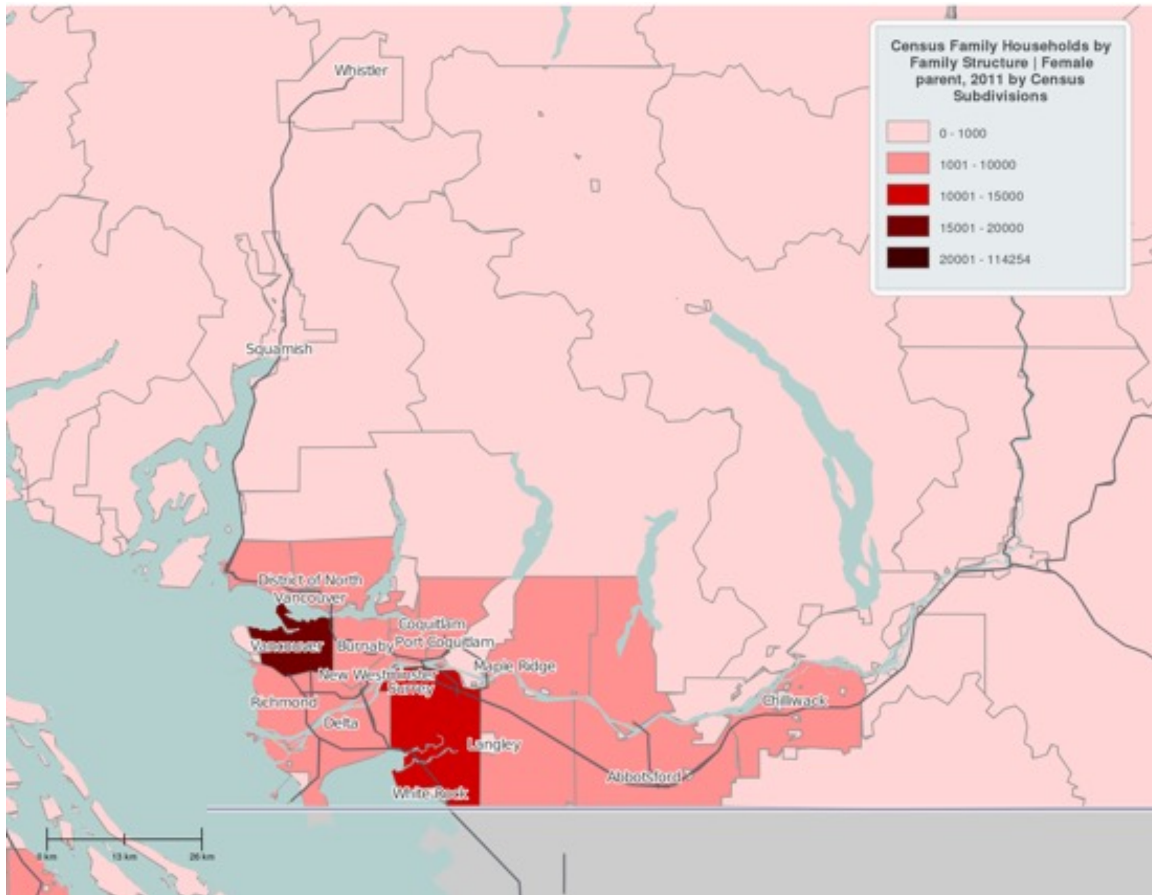


Figure 8 Number of children aged 0-4, concentrated in Vancouver and Surrey

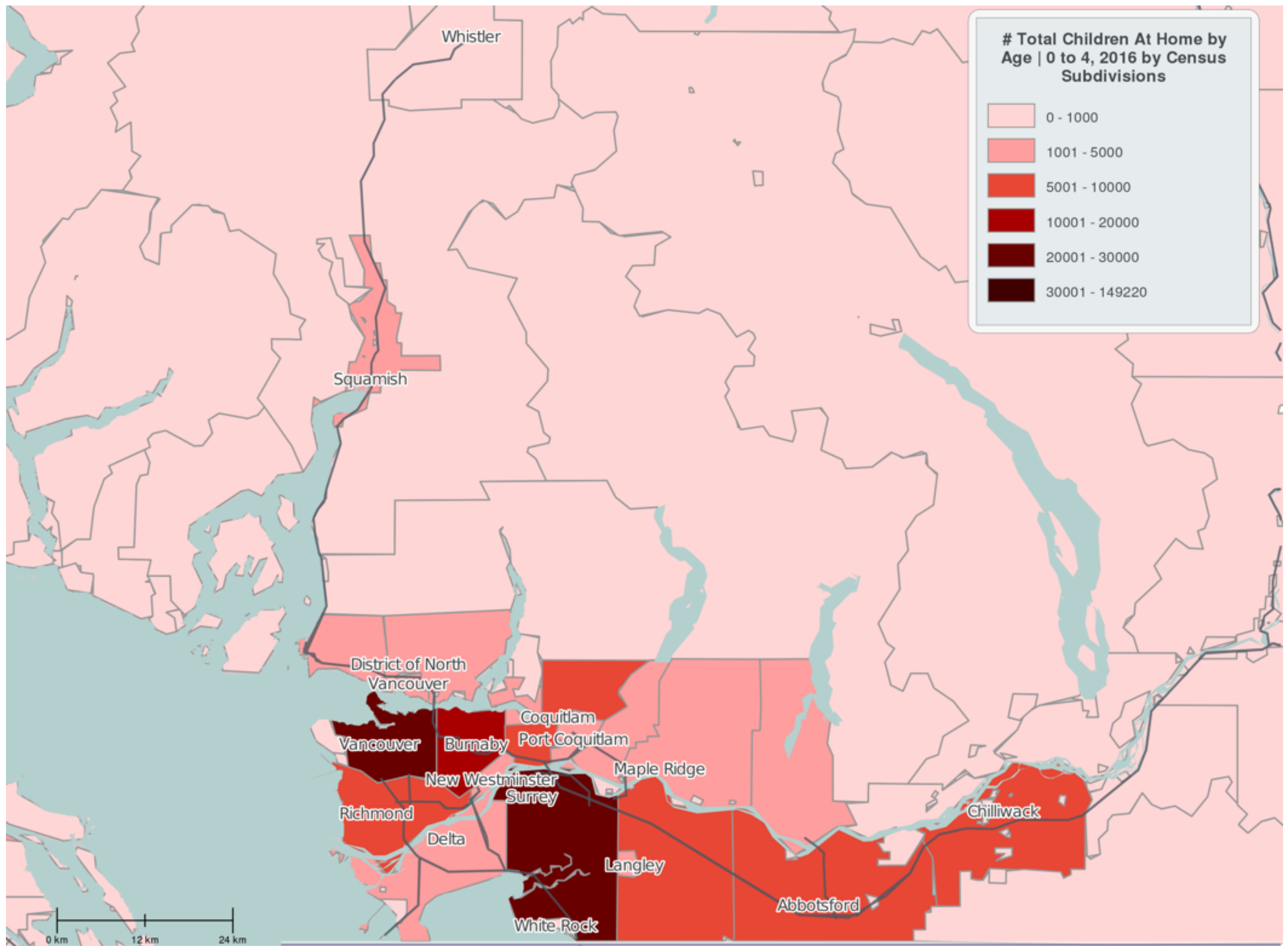
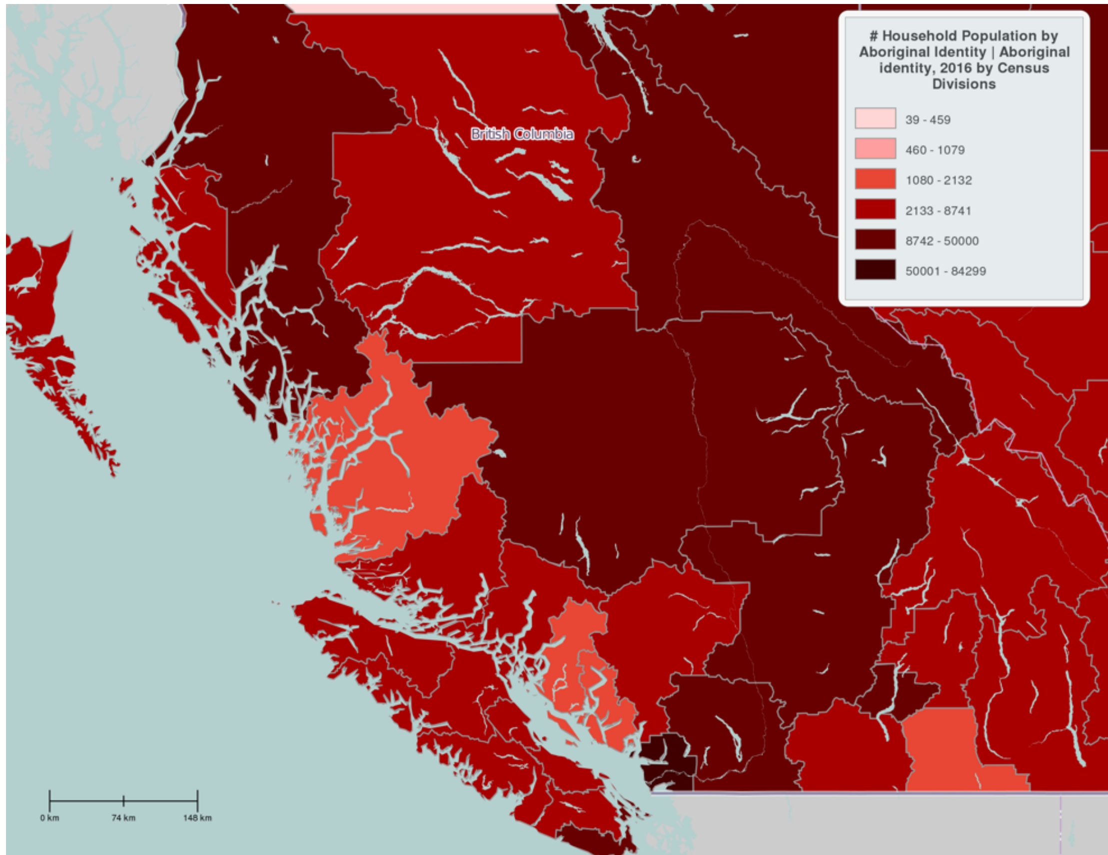


Figure 9 Aboriginal people, concentrated in Metro Vancouver



Appendix D. Budgetary Cost Calculations for Policy Options

Option 1: Family Support Service Response

Assuming 1-2 new social workers per 13 SDAs.

Type	Cost	Total
Personnel		
Social Workers	$50,000/year	$650,000 - $1,300,000
Non-Personnel		
Training	---	--
Technology (mapping)	---	---
TOTAL		**~$975,000** (average) + training+ technology costs

Option 2: Nurse Family Partnership

<u>New Staff:</u>

Assuming 25 additional Nurse Family Practitioners (NFPs) for Metro Vancouver (capacity = ~ 500 cases).

NFP Cost Projections by Hospital Size

Table 6 Ontario NFP Cost Estimates.

	Large Hospital	**Medium Hospital**	**Small Hospital**
Total Unit Wage Cost (Annual Wage+24%*)	$133,920	$133,920	$133,920
Total Cost of hiring NPs [varying number of FTEs, depending on size of hospital]	25 FTE NPs $3,348,000	15 FTE NPs $2,008,800	5 FTE NPs $669,600
% Total Hospital Budget	Budget: $400 million 0.84 %	Budget: $120 million 1.67 %	Budget: $43 million 1.56 %

*Source: Registered Nurses' Association of Ontario. http://nptoolkit.rnao.ca/why-nps-make-sense/economic-analysis/cost
Additional 24% of the base salary is added for employment costs (includes benefits, recruitment, training, support staff.

ROI studies:

Washington State Institute for Public Policy (2008): USD$18,000 per family (over 10-15 years)
The Rand Corporation (2005): $5.07 per $1 investment

Option 3: Family Connects (Metro Vancouver)

Implementation costs and additional FTEs.

Assuming 23,403 births and high-end cost of $800/birth = $**18,722,077**

New Staff:

14 subdivisions each need 1 Community Alignment FTEs, and a total of 50 new nurses (RNs) and 2 Nursing Directors.

Type	Cost	Total
Personnel		
Nurse Director (x2)	$100,000/year	$200,000
Nurses - RNs (x50)	$68,000/year	$3,400,000
Community Alignment FTEs (x14)	$45,000/year	$630,000
Non-Personnel		
Implementation (training, dissemination, and oversight costs for 16 months, estimating training <4 nurses) and initial audits*	USD $50,000 (~$66,878 CAD)	$66,878
Cost per birth (x23,403)	$800CAD	$18,722,077
TOTAL[16]		**$23,018,955**

[16] Family Connects costs per individual family have been found to vary from $428 to $17,372. For detailed costing of 5 sites implementing FC, see review by Filene, Brodowsky & Bell (2014). Additionally, this costing does not include referrals for access to other public services and thus does not encompass full associated public costs.

TOTAL (if 70% enrollment)[17]		$16,113,268.50
ROI (expected)[18]		$3.17 per $1 invested (within 24 months)

ROI:

Dodge et al. (2013): $3.17 per $1 invested (within 24 months).

ROI estimates were for Durham, NC, with an average of 3,187 resident births per year, a local average of $423 per emergency visit and $3,722 per hospital night. The FC intervention cost was $700 per birth. Thus an investment of $2,230,900 for FC yielded a community-wide emergency health care cost savings of $6,737,318 annually.

*Census areas with over 30,000 people were assumed to need their own Community Alignment staff. Statistics Canada Census 2011 reveals 14 such subdivisions:

1. Vancouver 603,502
2. Surrey 468,251
3. Burnaby 223,218
4. Richmond 190,473
5. Coquitlam 126,456
6. Langley 104,177
7. Delta 99,863
8. North Vancouver 84,412
9. Maple Ridge 76,052
10. New Westminster 65,976
11. Port Coquitlam 56,342
12. North Vancouver 48,196
13. West Vancouver 42,694
14. Port Moody 32,975

[17] Family Connects assumes an enrollment of 70% while the current analysis used 100% of eligible families. If only 70% of eligible families in Vancouver CMA enroll (22,418), the costs will be approximately $16 million.

Population Vancouver CMA (2016 Census): 2,463,431

Birth rate: 9.5 per 1,000 (2005-2011; BC Vital Statistics Agency (VISTA) June 16, 2011 accessed; Vancouver Coastal Health, 2013).

Birth rate: ~ **23,403**

(2,463,431/1000 x 9.5)

Appendix E: Interview Schedule

Participant No.	Name	Professional Role(s)	Interview Date
1	---	BC Association of Family Resource Programs *Research Director*	January 18, 2017
2	Tracy Beshara	Family Resource Centre, Marpole Oakridge *Executive Director*	February 1, 2017
3	Alison Stancil	Policy & Provincial Services, MCFD *Child Welfare Policy Analyst*	February 8, 2017
4	Carol Ross	British Columbia Association of Social Workers *Social Worker (25 years, retired), Non-Profit Director*	February 16, 2017
5	Charlotte Waddell	Nurse Family Practitioner Pilot Project in British Columbia; School of Public Health, Simon Fraser University *Nurse Family Practitioner, Professor*	February 14, 2017
6	Jeff Quinn	Family Connects (formerly “Durham Connects”) *Director of Community Outreach*	February 14, 2017
7	Paul Hole	Family Development Response Vancouver North Intake Team *Team Leader*	February 23, 2017
8	Abe Brown	Inn from the Cold, Calgary; Momentum Coaching Association *Non-Profit Director, Business Coach and Consultant*	February 19, 2017