

A REVIEW OF BEST PRACTICES IN CHILD WELFARE

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Introduction

The Canadian child welfare system is complex, based in federal, provincial, and territorial legislation and policies, encompassing a range of services to Canada's diverse population. The child welfare system faces many challenges such as supporting and preserving families while ensuring the right of a child for protection from harm, and respecting the rights of parents to have minimal state intervention (Bala, 2011). The current system is generally considered to reflect an "institutional" approach to child welfare in that the family is viewed as a "private" entity that requires and receives social services when faced with hardships to ensure functioning (Armitage, 1993, p. 42). Mandated child welfare services are provided through government offices, private, not-for profit agencies, and health centres, and child welfare services can range from prevention to protection (such as community empowerment and family support initiatives, abuse investigations, legal, alternate care), involve multiple service providers (family services workers, counsellors/therapists, nurses), and across numerous fields (social work, education, mental health, addictions, criminal justice, medical).

The Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) (a national surveillance program of the Public Health Agency of Canada) reported an estimated 235,842 child maltreatment investigations in 2008 in Canada with over 60,000 cases requiring ongoing services (Public Health Agency of Canada, 2010, p. 25). Of the initial cases, 36% were substantiated, reflecting a child maltreatment rate of 14 per 1000 children. The CIS reported that 22% of substantiated cases involved Aboriginal children. In Manitoba, in 2010-2011, the Department of Family Services and Consumer Affairs reported that there were 19,000 children and families receiving child welfare services (Government of Manitoba, 2011). The social, cognitive, emotional, psychological, and behavioural costs of child maltreatment are high (Goldman, Salus, Wolcott, & Kennedy, 2003). In Canada annual costs have been conservatively estimated to reach 16 billion dollars (based on a calculation of judicial, social services, education, health, employment and personal costs in 1998) (Bowlus, McKenna, Day, & Wright, 2003).

Child welfare policies and services often reflect diverging political, legal, economic, and cultural perspectives and understanding, and explanations of the causes of child maltreatment and corresponding solutions reflect those differences. In this challenging policy and practice context, services are expected to meet legislated requirements in a professional manner, ensuring that minimal standards of service are met. Best Practices (BP) are a relevant and important topic in the child welfare field as BP provide the identification of standards for service planning and delivery and provide guidance to improve policies and services for children and their families. Ultimately the benefits of BP should ensure the safety, health, and well-being of children, families, and communities.

This document provides an overview of BP in child welfare and builds on a prior literature review written for the Office of the Children’s Advocate and the Ombudsman in 2006. Given the publication of significant contributions to the field, the paper has been updated and greatly revised. Certain sections are expanded (i.e. community approaches to child welfare) whereas others have been reduced (i.e. direct practice with families). The paper is structured to present BP on a system level, community level, organizational level and direct service (practice) level, reflecting an ecological and critical perspective of child welfare that emphasizes the context of children within their families, their community, and the broader social system, as well as in the relationship with child welfare agencies and other service organizations.

The paper highlights practices based on research findings and conceptual contributions considered to support effective child welfare services. Given the extent of writing on the topic of child welfare, the paper provides an overview of principal elements important to consider within this topic. The paper does not provide a complete review of all research papers or conceptual writing on child welfare, and in certain sections, the paper directs the reader to useful resources (such as seminal texts or practice guides). Kufeldt’s and McKenzie’s “*Child Welfare, Connecting Research, Policy, and Practice*” (2011) provides an excellent example of a recent contribution addressing child welfare issues that should be required reading for any child welfare policy maker or service provider. The joint publications from the Prairie Child Welfare Consortium and the Centre of Excellence Child Welfare (2007, 2009, & 2012) also provide examples of research findings, conceptual frameworks, practice approaches, and policy analysis based on the Prairie child welfare context. Consequently this review does not purport to be an exhaustive summary of all BP in child welfare planning and service delivery, rather it intends to provide the reader with a

basic review of key issues and contributions to this topic area, and a framework within which to order the information.

The paper begins with a definition of BP and an explanation of an ecological and a critical structural perspective. The paper then proceeds to present relevant child welfare issues in the following sections: system, community, organizational, and direct practice level. Each section concludes with key points and recommendations. Throughout the paper, the term *child welfare workers* and *service providers* are frequently interchanged with *social workers*, as graduates with a social work degree frequently provide child welfare services.

Best Practices in Child Welfare

A basic tenet of this paper is that BP should be incorporated as a systemic approach to child welfare planning, provision, and evaluation. Best Practices can be defined as “the measurement, benchmarking, and identification of processes that result in better outcomes” (Kramer & Glazer, 2001, p. 157). A variety of terms, based on the use of evidence to inform decision-making can be used to describe ‘Best practices’ in child welfare. For example the terms “standards”, “quality”, and “evidence-based” (EB) practice are frequently used to describe BP and are approaches used to achieve BP in child welfare (Corcoran & Vandiver, 2006; Holden et al., 2012). The use of evidence in social work practice provides social workers with the means to manage uncertainty in complex and challenging work environments (Holden et al., 2012).

Evidence-based (EB) social work has its origins in the 1970s with advocates arguing that the interventions provided should be based on the best available evidence (for a thorough review of EB practice please refer to Roberts & Yeager, 2006 and McAuley, Pecora, & Rose, 2006). EB practice is “a way of doing practice which involves an individualized, thoughtful process of using evidence to make collaborative decisions with actual or potential services users” (Mullen & Streiner, 2006, p. 24). EB practices are based on three elements:

- Best research evidence
- Best clinical experience
- Consistent with family/client values

(American Public Human Services Association (APHSA), 2005)

Gilgun (2005) adds a fourth element, the “practitioner” or worker’s personal “assumptions, values, biases, and world views” and the importance of self-reflection (p. 52). Generally

however, EP practice requires the consideration of the three elements whenever possible, in decision making (Thyer & Myers, 2012). EB practice also encompasses broader organizational issues such as governance, administration, management and policy (Mullen & Streiner, 2006) and is based on the premise that all aspects of the service delivery system should be organized and provided based on research that provides evidence of effectiveness (Wilson, 2006).

Similarly, the term ‘outcomes-based practice’ is a means to identify effectiveness of interventions based on research/evaluation (Trocmé, 2003). The focus of outcomes-based research is outcomes, as opposed to processes, and outcomes are identified via indicators or measures considered to reflect successful dimensions of child and family services (Kufeldt & Thériault, 1995). This shift to an outcomes-based focus is partly due to past limitations that emphasized responding to needs with insufficient focus on the effectiveness of services in addressing the needs (Trocmé, 2003). Trocmé (2003) presents the rationale for outcomes measurement and four areas of measurement used to define child welfare outcomes. He highlights the need to differentiate between different users of outcome measurement (i.e. front-line workers, administrators, researchers) and different uses of outcomes measurement: clinical tools, management tools, and more complex research designs. The author argues that proxy measures can be used to reflect outcomes and that data from both clinical and administrative measures can be integrated (ultimately with research outcome measures) to meet both front-line and management needs. Trocmé, MacLaurin, and Fallon, (2000) developed the “Child Welfare Outcome Indicator Matrix”, a tool used to measure child welfare outcomes in four areas:

- Child safety: recurrence of maltreatment; serious injuries/deaths
- Child well-being: school performance; child behaviour
- Permanence: placement rate; moves in care; time to achieving permanent placement
- Family and community support: family moves; parenting capacity; ethno-cultural placement matching

The Canadian Incidence Study of Reported Child Abuse and Neglect provides an excellent example of outcomes based research and a national baseline of child welfare data (Trocmé, Fallon, & MacLaurin, 2011).

Other outcomes or indicators for BP could include: income and social status, social support networks, education, employment and working conditions, social and physical environments, early childhood development, culture, health services, biology and genetic

endowments, gender, personal health practices, individual capacity and coping skills, and health and social services (Health Canada, 1999). Caution is advised in implementing an outcome-based approach to the exclusion of process evaluations/research. Ideally processes should reflect standards and procedures deemed necessary to attain favorable outcomes.

There is growing demand for evidence-based or outcome-based practice from clinical, administrative, funding bodies, research and social work education (Manela & Moxley, 2002; National Association of Public Child Welfare Administrators, 2005; Thyer & Myers, 2012). However, potential for the misuse of EB include the exclusion of certain services or processes in some evaluations, or an overlooking of important work due to a specific stakeholder's interest (i.e. targeted funding). Evaluations can be skewed to support outcomes that are likely to be funded. As well, funders (usually provincial governments and in the case of Aboriginal agencies, the federal government) can be concerned that evaluations result in greater demands for resources (Trocmé, 2003). Webb (2001) raises concerns about EB practice as being a rational approach to social work with an emphasis on empiricism neglecting to address the complexity of social work and attempts to limit the discretion of social workers. Sheldon (2001) however argues that EB practice provides a basis for judgment in the context of complex decision-making. Others note that there is limited and inconclusive evidence on the effectiveness of child welfare interventions and call for greater research on effectiveness (McAuley, Pecora, & Rose, 2006). The authors identify a need for rigour in evaluations and more longitudinal evaluation. Similar challenges to EB practice are raised by Kufeldt and McKenzie (2011), however, the authors note that "The challenge is to connect our growing knowledge about child welfare to policy development and evidence-based practice in order to achieve good outcomes for children..." (p. xiii). Holden et al. (2012) note that challenges to the use of evidence in social work practice also include access to research (both in terms of time and physical access) and the understanding research findings. The authors purport however that in order to improve services, the use of evidence in social work is necessary "to help practitioners incorporate the best available evidence into their practice" (p. 486).

An Ecological Approach to Child Welfare Service Planning and Provision

An ecological approach (Bronfenbrenner, 1977) provides a useful conceptual framework to review different levels of child welfare service planning and provision. Best

Practices can be integrated into basic elements of child welfare practice within the framework of an ecological approach as this approach encompasses the child welfare system as a whole. Child welfare services, from protection to support, are provided within the context of organizations, implemented by social workers. The larger system impacts directly and indirectly on service delivery policies and procedures and ultimately, the people they serve (Glazer, 1998; Rosenthal, 2006).

An ecological approach to child welfare practice emphasizes the relationship between the service user, their family, the broader community and the larger society and how a person adapts to, and interacts with, their environment (Bronfenbrenner, 1977; Compton & Galaway, 1989; Maidman, 1984). The focus of child welfare practice from an ecological perspective situates the child within their environment recognizing the various elements of an individual's and family's life, and identifying areas for change the service user. This perspective incorporates a critical perspective which recognizes the impact of structural oppression confronting families (Mullaly, 2002). "Social institutions, policies, laws, and economic and political systems" must be challenged and changed to work against the oppressive forces that include sexism, racism, poverty, ableism, and heterosexism (Mullaly, 2002, p. 193). An ecological approach to working in child welfare integrates individual, familial, community, environmental, and cultural factors as important contributors to, as well as solutions to, child maltreatment. The confronting issues a person faces can be due to psychological or social issues, or a combination of both. "Child maltreatment is viewed as the consequence of the interplay between a complex set of risk and protective factors at the individual, family, community, and society levels" (DePanfilis & Salus, 2003, p. 11).

The following section reviews issues on the broader system, community, organizational, and direct practice levels of intervention. These levels can have overlapping challenges (i.e. poverty, housing as a system issue or a community focus) and impact across boundaries.

The System Level

This section provides a brief overview of how system level structural issues (such as poverty, racism, and sexism) impact children and families. The child welfare system, a system that encompasses a continuum of services, involving a variety of professionals across multiple disciplines, occurs within economic, cultural, political, and social contexts. The following discussion provides a review of some key literature highlighting the association

between these effects and the well-being of families. In order to address issues of child maltreatment, these larger systemic and societal issues cannot be ignored:

...poverty; the residual nature of child protection work; little investment in prevention and early intervention; power imbalances that have detrimental effects on women, children and minority groups; negative public attitudes towards poor and disadvantaged citizens; and being driven by neglect and abuse investigations rather than family strengthening. (Barter, 2001, p. 266)

In a seminal article addressing the issue of poverty and child maltreatment, Pelton (1978) argued that children in poor families are more likely than children from non-poor families to experience child maltreatment due to decreased supports in the community, and higher stressors. Pelton clarified that making the link between poverty and maltreatment is not intended to blame people who are poor, and emphasizes that it is a minority of poor people who maltreat their children. The author theorized that the reluctance of professionals and politicians to acknowledge an association between poverty and child abuse was based on the acceptance of a medical model of child maltreatment (and corresponding funding allotted to those services), and to avoid effective solutions to the issue, for example poverty reduction strategies. Maintaining the position that maltreatment is classless allows "...professionals to view child abuse and neglect as psychodynamic problems, in the context of a medical model of "disease," "treatment," and "cure," rather than as predominantly sociological and poverty-related problems (p. 613)." As part of child welfare intervention, Pelton recommended the provision of services to minimize the negative effects of poverty through concrete services such as advocacy for better housing, child care, and emergency cash.

More recently, Jonson-Reid, Drake and Kohl's (2009) study compared data on poor children with "non-poor" children. Findings showed that poor children reported to the child welfare system had more severe forms of maltreatment, experienced higher parental and neighbourhood risk factors, and reported higher rates of negative outcomes compared with non-poor children reported to child welfare, and poor children not reported to the child welfare system. These findings suggest that the overrepresentation of children involved with the child welfare system is not due to class bias or greater visibility, but because of their environment: "...poor families are over-represented in the child welfare system because poverty and conditions associated with poverty place families at greater risk of abusive and neglecting behaviors" (Jonson-Reid, Drake & Kohl, 2009, pp. 426-427).

Poverty is of particular importance when considering Aboriginal children and women with children. For example, a higher percentage of Aboriginal children reside in low-income families compared to non-Aboriginal children in urban settings (excluding reserves). In 2006, 21% of non-Aboriginal children lived in low income families compared with 57% of First Nation, 45% of Inuit and 42% of Métis children (Statistics Canada, 2008a). A community without the capacity for economic independence will be significantly impaired relative to a community that has an economic sustainability. This impairment has negative impacts on families, including children. In 2008, 600,000 Canadian children were in low-income families. Of those children, 36% lived in a female headed single parent family (Williams, 2010). In 2011, 16% of Canadian families were lone parent, and eight in ten of lone parent families were headed by a woman (Statistics Canada, 2012).

Consequently, a BP approach suggests that interventions aimed at alleviating poverty should benefit some families. The United National Educational, Scientific and Cultural Organization (UNESCO) provides examples of BP related to poverty and social exclusion on their MOST database (No date). In Canada, “Campaign 2000”, started in 1991 is a movement that advocates for the elimination of child poverty in Canada (Campaign 2000, no date). More recently, the government of Manitoba’s “Poverty Reduction and Social Inclusion Strategy (ALL Aboard)” focuses on poverty reduction and promotes social inclusion. This initiative became law in 2011 with the passing of the “Poverty Reduction Strategy Act” (Government of Manitoba, 2012).

On a system level, policies have the capacity to influence and set BP standards in child welfare. For example, on an international policy level, the United Nations Convention on the Rights of the Child (the Convention), ratified by the Canadian government in 1991, recognizes children’s rights as separate from parental rights. The Convention has three key principles: anti-discrimination guarantees made by the Convention (Article 2), primary consideration of the child’s best interests in decisions affecting them (Article 3), and the views of the child to be taken into account in all matters affecting him/her (Article 12). This document emphasizes the protection of children, as well as the provision of services to meet their needs (Hill, Murray & Tisdall, 1998). The importance of culture in a child’s life features predominantly in the Convention, and as a result Canada ascribes to supporting a “...child’s achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development” (United Nations, 1989). Cultural identity as a fundamental aspect of human development has been highlighted again by the United Nations

(2004) arguing that governments must support the role of cultural identity and cultural liberty in human development.

Provincial legislation is obviously critical to the provision of child welfare services in Canada (Bala, 2011). The implementation of legislation through standards and guidelines sets a minimal level of practice for organizations through the provision of their services. In Manitoba, The Child and Family Services Act (C.C.S.M. c.C80) (the “CFS Act”) emphasizes societal responsibility for the best interests of children. In the “Declaration of Principles” parents are identified as having the “primary responsibility” to care for their children with the family unit valued as the best place to raise children. The legislation also emphasizes that families and children “have the right to the least interference with their affairs to the extent compatible with the best interests of children and the responsibilities of society”. The value that the best place for children is with their family remains a base to legal acts pertaining to the child (Hill & Aldgate, 1996) and is evident in legal decisions regarding the care and custody of children (Connor, 2003).

Child protection legislation tries to balance the protection of children from harm with the parental rights to privacy as well as to procedures and mechanisms which protect them from unjustified allegations (Sarage, 1998; Hill & Aldgate, 1996; Tisdall, 1996); however, this balance can be difficult to achieve. While front-line service providers implement child welfare policies through practice, this can be a difficult task resulting in variation in the interpretation of these policies (Lipsky, 1980). For example, The CFS Act mandates social workers to act in the "best interests" of the children and families; however, there is little support in the implementation of the policy when the best interests of the child appear to be in conflict with the parent(s)' standard of, or ability to provide care to the child. The CFS Act states that the child's best interests should be given “paramount consideration... in all proceedings under this Act affecting a child, other than proceedings to determine whether a child is in need of protection” (s.2(1)).

As with the UN Convention on the Rights of the Child, the importance of culture is also evident in provincial legislation. In Manitoba, the child's “cultural, linguistic, racial and religious heritage” is listed as a relevant matter in determining the child's best interests. *The Child and Family Services Authorities Act*, (C.C.S.M. c.C90) states in the preamble that the “values, beliefs customs and traditional communities” must be respected in service planning and delivery to Aboriginal people (Government of Manitoba, 2012b). In addition, s.19(c) of the same Act requires authorities to “ensure that culturally appropriate standards for services, practices and procedures are developed” while ensuring consistency with provincial

standards. This provision is relevant when planning and providing services for Canada's and Manitoba's diverse population. For example, while the Aboriginal population in Canada is recorded as 3.8% of the general population, in Manitoba, the figures increase to 16% (Statistics Canada, 2008). In addition, in 2006, 16.2% of Canadians self-identified as visible minorities, and 19.8% of the population reported being born outside of Canada (Statistics Canada, 2007). Ten percent of Manitobans self-reported as a visible minority (Statistics Canada, 2008b) and 20% reported a mother tongue other than English or French (Statistics Canada, 2007b).

Policy implementation, through service delivery also occurs within a gendered, class and frequently race-based context. Callahan (1993) argues that social work, traditionally a field dominated by women, saw male social workers permeate positions of organizational power while women widely maintained direct practice positions. Child welfare workers are often middle class, providing services to women, often from lower socio-economic class, and of a minority context, frequently resulting in the disempowerment of the service user (Swift, 1995). Even within women's work, there is a "hierarchy of caregiving" with more powerful social workers at the top, homemakers, foster providers, and service users ordered below (Swift, 1995, p. 492). Proposed solutions to entrenched sexism include the valuing of caregiving work, the formation of alliances for validation and influence, and the infusion of feminist theory and thought in child welfare to ensure that public policy and associated services reflect the needs of women and children (Callahan, 1993; Swift, 1995).

The negative effects of colonization on the Aboriginal community, through government sanctioned practices such as residential schools and the apprehension of children, continue to permeate the health and well-being of Aboriginal families (Ball, 2008; Blackstock & Trocmé, 2004; Sinha, Trocmé, Blackstock, MacLaurin, & Fallon, 2011). Issues such as high levels of substance abuse, suicide, family violence, mental health issues and parenting are considered to result from "long-term social and economic impacts of colonization on Indigenous family life" (Tilbury & Thoburn, 2011, p. 294).

Research findings concur with this concern and support the call for services for Aboriginal people that are "provided in a way that supports their cultural identity and are culturally appropriate" (Wright, Hiebert-Murphy, & Gosek, 2005, p. 68). Wright et al. (2005) examined Aboriginal children with special needs in the care of First Nations child and family service agencies across Canada and identified that existing federal-provincial and band government jurisdictional divides resulted in a lack of responsibility for these children. The study's findings identified a need for greater, sustainable, and more flexible funding,

development of the voluntary sector's provision of services to reserve communities, integrated services and culturally appropriate services (Wright et al., 2005).

Among many recommendations, the Aboriginal Justice Inquiry Report advocated for increased funding for Aboriginal agencies to ensure the provision of protection and preventive services:

Aboriginal and non-Aboriginal child and family service agencies be provided with sufficient resources to enable them to provide the communities they serve with the full range of direct service and preventive programs mandated by the Child and Family Services Act. (Hamilton & Sinclair, 1992)

This recommendation echoes findings by other reviews (Sigurdson & Reid, 1987, Giesbrecht, 1992).

Services to First Nations children and families on reserve fall under federal jurisdiction and federal and provincial disputes have proved problematic for quality service provision (Ball, 2008). Funding models are particularly important in allowing child welfare agencies the ability to provide prevention services. Prevention can be viewed as occurring on three levels: primary, secondary, and tertiary. Prevention on a primary level includes activities such as public awareness campaigns and attempts to prevent child welfare issues from occurring. Prevention on a secondary level provides services related to identified risks (i.e. substance abuse treatment, respite). Tertiary level prevention activities focus on services to families after maltreatment has occurred and efforts are made to prevent a reoccurrence (Goldman et al., 2003). Most preventive services are limited due to budget constraints and the current child welfare system focuses primarily on tertiary levels of preventive services. Healthy Child Manitoba provides examples of some programs that target programs on various prevention levels (Healthy Child Manitoba, no date).

With regards to Aboriginal agencies, because of jurisdictional divisions, funding challenges are especially noteworthy. As Blackstock (2012) notes,

The failure to pay adequate attention to neglect and its underlying factors of poverty, poor housing, substance misuse and, in the case of First Nations children on reserves, dramatic child welfare funding inequalities, has contributed to growing numbers of First Nations children being placed in child welfare care. (p. ix).

Compared with the provision of services to non-Aboriginal children, services for Aboriginal children can be more costly due to factors such as geographic distances (and required time necessary to meet with people), and staff professional development (Trocmé, Knoke, Shangreux, Fallon, & MacLaurin, 2005, p. 84).

The 2005 First Nation's Child and Family Caring Society of Canada's (FNCFSC) publication "Wen: De We are Coming to the Light of Day" (2005) advocates for sufficient, flexible funding and necessary for services that are "culturally based" (FNCFCS, 2005, p. 10). The authors also advocate for the implementation of the "Jordan's" principle or "Child First" principle in which the federal or provincial government pays for the identified service for the child and proceeds to a "jurisdictional dispute resolution table" in order to determine fiduciary responsibility (MacDonald & Walman, 2005, p. 107). The recent development of the tripartite agreement between the Assembly of Manitoba Chiefs, the province of Manitoba and the federal government to support prevention for First Nations children and families on reserve is a promising move forward (Government of Canada, 2012). This initiative, the Enhanced Prevention Focused Approach aims to increase services to children and families on reserves.

In writing of the need for government to increase investment in prevention and treatment programs, Bowlus et al. (2003) note that benefits to society would result in a decrease in overall costs and reduce "the multiplier effects" of maltreatment (p. 92).

The investment of Canadian government at all levels in social service directed at this serious social problem represents only a small fraction of the billions of dollars lost each year. A well-planned and thoughtful investment of significant public funds in early detection, prevention and treatment of all forms of child abuse is not only a moral necessity for Canadian society, it is also sound fiscal policy that would directly benefit us all. (Bowlus et al., 2003, p. v)

On a systems' level, there has been a call for a national coordinated approach to monitor and evaluate policies and services for Aboriginal children across Canada (Ball, 2008). A federal approach to the monitoring, and evaluation of child welfare policies and services across Canada for all children would benefit children and their families and set standards for BP. The National Child Welfare Outcomes Matrix initiative appears to be a positive policy and service planning framework aimed to track and evaluate child welfare

services outcomes nationally, across jurisdictions (Trocmé, Knoke, Fallon, & MacLaurin, 2009).

Key points of consideration and recommendation regarding BP and the larger system level include:

- The negative effects of structural issues such as poverty, sexism, and racism, including the impact of colonization on Aboriginal communities, children, and families should be acknowledged.
- Planning and services should ensure sufficient funding for culturally appropriate services.
- Eliminate jurisdictional disputes in order to put the child's, and family's needs first.
- The need for a comprehensive, national strategy to resource, monitor, maintain, and evaluate the well-being of Canada's children.

The Community Level

This section provides a brief overview of key issues related to community approaches to child welfare. The discussion defines the term community and community approaches and provides examples of community approaches in child welfare. The importance of the child and family's community in a child welfare context is not new (see for example Garbarino, 1976) and is considered an "essential" aspect of child welfare work (Hornberger & Briar-Larson, 2005, p. 101; Wharf, 2002). In the USA, the Child Welfare League of America's National Framework for Community Action (no date) provides a useful tool for building community. Community is defined as when:

- People have a sense of belonging;
- People have shared values and interests;
- Some common goals can be identified;
- Boundaries define the geographic location of the community;
- The people share common demographic characteristics such as race and class;
- The people have a sense of shared history. (Wharf, 2002, pp. 16-17).

Within the context of child welfare, community intervention focuses on community building that engages and empowers the community to identify and solve problems, and to build strengths and develop community resources. Community approaches to child welfare

intervention reflect a dual position that: 1) communities have the right to determine what is best for their children; and 2) communities have the responsibility to ensure their children's well-being and protection from harm. From a community building approach, children are "a community responsibility" in which children's protection is a "collective concern" (Barter, 2001, p. 271).

Wharf (2002) provides a helpful review of the conceptual differences of community interventions and defines "community approaches" as a combination of community organization, community social work, and community control (p. 15). The author defines these community approaches, including community organization as "locality development, social planning, social action, and social reform", community social work as "practice that is family and community-centred", and community control "where communities have taken over responsibility for child welfare" (p. 15). Wharf characterizes community approaches in child welfare as including efforts and activities to "develop community capacity" to:

- Develop and control resources based on local needs,
- Advocate for policy changes at the local, provincial and national levels, and
- "Address issues of race, class, and gender" (Wharf, 2002, p. 16).

Issues such as poverty, housing, and neighborhoods are within the scope of community approaches. Community empowerment "...is a model of practice that simply means people know what is best for their own community" (Brown, Haddock, & Kovach, 2002, p. 147). Community approaches are considered unlike traditional child welfare practice as they necessarily include community members in "defining and suggesting responses to their problems" (Wharf, 2002, p. 22).

Barter (2001) advocates for a community building framework in which child welfare intervention occurs on four levels: families and children at risk, service organizations, service providers, and community. Prevention services play a significant role ensuring that child welfare intervention includes early intervention aimed at supporting and enabling families and building healthy communities. From this perspective, community plays an equal role in child welfare planning and services:

...the community is being approached as a place where people, if given the opportunity to be empowered and to work together, can begin to renegotiate relationships as well as collaborate to not only redefine problems but be innovative in attempts to do things

differently. Providing this opportunity underpins the community-building approach to reclaim children and families at risk. (Barter, 2001, p. 271)

A community building approach recognizes that the welfare of children is the responsibility of the community in which the child resides or to which the child belongs and that child welfare services and the professionals who provide the services and implement policy cannot have the sole responsibility or authority for the protection of children. Strong-Boag (2002) notes that while some children will not be able to live with their families due to maltreatment concerns, and alternative care arrangements must be ensured, the community must "...accept youngsters in distress as collectively theirs, full citizens with equal rights" (p. 44). Strong-Boag argues that policy-makers and service-providers need to consider children at risk as if they were their own "offspring" and ensure a "guaranteed annual income, publicly funded day care, and inclusive schooling" so that no child is stigmatized and all children are supported (p. 44).

Best Practices can incorporate social support programs (Cameron & Vanderwoerd, 1997). Intervention on a community level attempts to engage and build the community's capacity to enable sufficient resources necessary for child safety. Interventions such as the use of family group decision-making provide an example of an alternative approach to dealing with child protection based on the premise that "...halting family violence requires a collaborative effort by families, their communities, and public authorities" (Burford & Pennell, 1995, p. 140). Practice on a community level should recognize and acknowledge the context of the community within the broader environment.

McKenzie (2002) notes that factors associated with BP in community organizing include:

- Clarity in role and functions to be performed
- The development of program goals and technology
- Staff commitment, training, and skills
- Organizational commitment and support
- Other allied professionals committed to collaborative work
- Community or neighbourhood characteristics
- The commitment of local leaders. (p. 90)

Challenges to using a community intervention approach include a commitment to the process in terms of time necessary to build trust and relationships and to see change occur

(McKenzie, 2002). Others note a tension in the requirement for “professional” social workers versus experienced local people providing services and argue that “Valuing the different kinds of knowledge and expertise is critical to effective community empowerment work” (Brown et al., 2002, p. 141).

Hornberger and Briar-Lawson argue that community building as part of child welfare practice produces better results:

Community building is becoming an essential part of all child and family practice. When we who work in or influence these systems: fundamentally change our roles with one another; change our relationships with the children, youth, and families we serve; and actively engage community stakeholders, we provide more strategic supports and can collaboratively achieve more effective outcomes for this most vulnerable population.(2005, p. 101)

Jack and Gill (2010) argue that a key measure of child well-being “...is the ability of a society to safeguard its children and young people from injury and abuse” (p. 82). Founded on an ecological framework, community practice aims to provide a broader range of preventive services and activities that emphasize individual and family engagement in the community, the development and use of informal support networks, and “promoting community responsibility for the protection of children” (p. 84). In their review of community oriented practice in the United Kingdom, the authors report that unless professionals and service organizations change, the success of community focused intervention will be limited to professional and individually focused interventions. They identified three key elements of community-oriented practice: 1) Developing a culture of listening to child and adults; 2) Recognizing and supporting the safeguarding activities of local people; and 3) Promoting partnership approaches to extending local provision (p. 88). This approach requires involvement from the community members as well as potential risks.

Based on an analysis of a developmental assets framework, and within an ecological perspective, Mannes, Roehlkepartain, and Benson (2005) argue that building community can foster developmental assets that act as preventive or protective factors and reduce high risk behaviours of youth from different ethnic backgrounds. The authors contend that community-based approaches include “building the capacity of individuals, organizations, and networks” that focus on developing strengths of all youth (as opposed to those deemed “at risk”). Three elements form the basis of this approach: 1) Cultivate community readiness, energy and

commitment; 2) Create an operational infrastructure; and 3) Build community capacity through engagement with adults, the mobilization of youth, making programs available to all children and youth, activation of community sectors; and the influence of decision-makers. These three elements result in the accumulations of developmental assets and optimal development (or “thriving”) and a reduction in high-risk behaviours (2005, p. 245).

Several studies have noted success with community approaches in child welfare. For example, the Tilbury Safe Kids project in England attempted to use community involvement as a means to improve the safety of children and the community’s conditions through engagement and decision-making (Wright, 2004). In this project, community development was considered a way to prevent maltreatment. One objective of the project was to increase community responsibility for the safety of the children through the development of activities, partnerships, a conference, and a youth forum. Wright (2004) notes that community development is a long process requiring a commitment and support for the long-term. Ultimately the author posits that community development “offers a model for engaging communities more actively in promoting the welfare of children and for extending the responsibility for safeguarding children beyond being merely the domain of professionals” (Wright, 2004, p. 397). Wright advocates for a community development approach as a child welfare intervention in order to build the capacity of communities to make children safer.

In Canada, the data shows an over-representation of Aboriginal families involved with the child welfare system, as well as an over-representation of Aboriginal children and youth in the care of child welfare agencies. The Public Health Agency of Canada (2010) reports that “children of Aboriginal heritage” comprised 22% of substantiated cases of child maltreatment, yet account for a much smaller percentage of the general population. The inception and growth of Aboriginal child and family services agencies reflects in part the perspective that Aboriginal communities should have the authority and consequent responsibility for Aboriginal children, as well an inherent right to look after their children (Brown et al., 2002). The importance of healing the community to reverse the negative impact of colonization has been identified as a key aspect of Aboriginal child and family services (Connors & Maidman, 2001; McKenzie, 2002; Brown et al., 2002; Timpson, 1995). Timpson argues that the high rates of First Nations children in care, suicide, domestic violence, and an overall loss of culture must be dealt with on a community level:

These conditions reflect generations of cultural and spiritual destruction. These problems are not individual problems requiring individual approaches. They affect

entire communities and require community healing and the prevention of further intergenerational damage. Native agencies face the challenge of providing services that treat underlying causes by community healing. (Timpson, 1995)

An Aboriginal approach to child welfare acknowledges the negative effects of colonization and also strives to maintain children within their communities and apply traditional values to the child welfare practices (i.e. use of elders and extended family) (Brown et al., 2002). In addition, an Aboriginal approach to child welfare emphasizes the community as the focus of support and empowerment (Brown et al., 2002; Riggs et al., no date).

When considering Aboriginal child welfare in the context of a BP approach, the literature provides some direction. A common theme to BP in relation to Aboriginal people is the integration of respect for, and application of, traditional cultural practices and beliefs, with the use of evidence-based knowledge. McKenzie and Morrissette (2003) provide a framework for “respectful” social work practice with Aboriginal people while recognizing the diversity that exists within the Aboriginal peoples. Five factors form the basis of their proposed framework and are necessary to the development of this practice:

1. An understanding of the world view of Aboriginal people and how this differs from the dominant Euro-Canadian world view;
2. Recognition of the effects of the colonization process;
3. Recognition of the importance of Aboriginal identity or consciousness;
4. Appreciation for the value of cultural knowledge and tradition in promoting healing and empowerment; and
5. An understanding of the diversity of Aboriginal cultural expression (p. 258)

The importance of “holism” (the interconnection of all aspects of life and “achieving the harmony and balance between the spiritual, physical, mental, and emotional components of one’s being”, (p. 272)), the importance of the natural world, the collective, and healing and empowerment are aspects of social work practice with Aboriginal people. As a means to reflect the variation in individuals’ integration of and expression of Aboriginal identity, the authors describe three types of cultural expression which assist in the provision of culturally appropriate services. These categories are not rigidly fixed and an individual may reflect aspects of each. Briefly summarized, they are described as follows:

1. The Traditional: General rejection of mainstream lifestyle for Aboriginal world view/values.
2. The Aboriginal/Mainstream; Differing levels of integration of Aboriginal and Euro-Canadian world views.
3. The Non-Traditional: General rejection of Aboriginal world view/values for mainstream. (p. 270)

The authors argue that social work practice with Aboriginal people must be empowering and attend to culture on three levels of intervention: “Intrapersonal, interpersonal, and community” (p. 273). Cultural practice includes the use of sharing circles, the role of elders, ceremonies, and the medicine wheel which integrates the emotional, mental, physical and spiritual (p. 260), although all use of cultural approaches must be respectful of the service user’s needs. In addition, the authors state that cultural standards should be included in evaluations. McKenzie and Morrissette (2003) note that some Aboriginal people are not happy with the need to comply with provincial standards as they consider this in conflict with their “inherent right to self-government” (p. 257).

A world view has also been identified as a key element of Aboriginal culture (Connors & Maidman, 2001; Cross, 1998; Gosek, 2002; Riggs et al., no date). Cross stresses the importance of the integration of a “relational” world view when working with Aboriginal people and other world cultures. A world view is “the collective thought process of a people or a cultural group” (Cross, 1998, p. 144). The Aboriginal world view is considered to be “relational” or “cyclical” (Cross, 1998, p. 145). From this perspective

The balance and harmony in relationships among multiple variables, including metaphysical forces, make up the core of the thought system. Every event is in relation to all other events regardless of time, space, or physical existence. Health is said to exist only when things are in balance or harmony. (p. 147)

Cross presents the relational world view as a four quadrant circle which reflects the context (i.e. culture, community, family, social history, etc.), the mind, the body and the spirit. From a relational world view, workers focus interventions on “bringing the person back into balance” (p. 147) with their relational world.

Culturally appropriate services include the use of natural helpers or healers, medicine man, spiritual teachers, the practice of fasting, using a sweat lodge (Cross, 1998), elders (Brown, Haddock, & Kovach, 2002), and the medicine wheel (Connors & Maidman, 2001; Longclaws, 1994). Ensuring that a strengths-based assessment is used, an Aboriginal approach to child welfare takes into account the existing or potential family support (Brown et al., 2002). Riggs et al. (no date) explains that Aboriginal perspective uses the concept of “harmony circles” in which the child is the centre, surrounded by family (including extended family), community, the clan, and the nation (p. 19). These circles reflect interconnectedness and a need for balance within the system to ensure health and well-being of all:

In all Indigenous cultures is a consistent recognition that we are interconnected and must rely and care for each other in order to survive and do well in life. This interconnectedness is sometimes referred to as the natural protective network principle (p. 18).

In Canada, many Aboriginal treatment programs use culturally appropriate practices such as the Alkali Lake program (BC), Poundmaker’s Lodge (Alberta), Hollow Water (Manitoba) among others (see for example the Prairie Child Welfare Consortium – Centre of Excellence published texts, *Passion for Action in Child and Family Services: Voices from the Prairies*, *Awakening the Spirit: Moving Forward in Child Welfare*, and *Putting a Human Face on Child Welfare*, that also provide examples). The Ma Mawi Wi Chi Itata Centre is committed to providing culturally relevant services to Aboriginal families in Manitoba.

The First Nations and Inuit Health Branch (FNIH) of the federal government advocates for the use of a BP approach to develop alternatives to tobacco use (non-traditional) in the document *Building Best Practices with Community* (2002). This model is built on:

...the traditional values of respect for others, building trust in relationships, responsibility of the individual and community, freedom of the individual, holism, kindness, compassion and humility. (p. 1)

Based on the World Health Organization’s work, the model promotes the accessibility of “practical, scientifically based and proven interventions...” as part of their approach to evidence-based interventions (p. 6). In addition, the FNIH argue that there must be an evaluative component to determine successes and to actively implement strategies that work

through the use of participatory development (2002, p. 16).

Hardisty, Martin, Murray and Ramdatt (no date) identify promising practices in child welfare governance and service delivery in a First Nation organization in Ontario. The authors state that the Kunuwanimano Child and Family Services agency must reverse the negative impact of colonization through the development of community strength “by respecting, practicing and teaching traditional ways passed on by Elders” and through “strengthening the family unit and focusing on the future generation” (p. 2). The role of Elders is esteemed and they are also voting members of the Board of Directors. Staff recruitment from within the community is considered optimal. The agency advocates for the use of a strengths based approach incorporating culturally appropriate approaches for service delivery. Direct practice elements include “role models, parenting techniques, ceremonies, values, teachings” (p. 3), empowerment and working in partnership with the service user. This agency rejected the use of a risk assessment model on the basis that the ‘standardization of human services is not possible’ (p.4).

Indigenous approaches to child welfare service planning and delivery are also evident in other parts of the world. For example, in New Zealand, a social justice community agency called the “Family Centre” provides services in social policy research, family therapy, community development, and education and teaching. The organizational structure is based on “... a three tikanga (cultural) organisational structure of Maori, Pacific Island and Pakeha (European) sections” (Family Centre, 2006). Research contributes to an evidence based approach and influences policy decisions in New Zealand. Their “Just Therapy” program is based on a “commitment to the eradication of racism, sexism and poverty” through a recognition of the service user’s macro environment, the “broad context of cultural, gender, social, spiritual, economic and psychological factors underlying the problems experienced by those with whom our therapists work” (Family Centre, 2006).

In the USA, Belone, Gonzalez-Santin, Gustavsson, MacEachron, & Perry, (2002) describe culturally appropriate child welfare services based on Navajo traditions. The authors provide a visual representation of case management from a Navajo perspective. Staff is expected to include “traditional healing services” with conventional services (p. 781). Traditional practices include the use of Navajo healers, rituals, language, and identity based on clan affiliation (p. 785) In terms of education, professional competence is valued and front-line workers are expected to have a university degree and managers an MSW. The spiritual themes of ‘Harmony and beauty...form the basis for intervention’ (p. 781).

Encouragement versus the use of threats is incorporated as part of the practice model and the importance of extended family. Workers also use a risk assessment as part of their work.

In an attempt to ascertain what social workers require in order to deliver “culturally competent” services, Weaver (1999) surveyed the perspectives of Native American social workers and social work students. The author found that three principle elements were identified in the area of knowledge: Diversity, history, and culture. Social workers must have an understanding that variation exists in the Native culture as well as have an understanding of the history, particularly of the effects of colonization on Native communities. As well, Weaver found that respondents believed that social workers require knowledge of culture. This includes ‘communication patterns, worldviews, belief systems, and values’ (p. 221). Two areas for skills emerged from the data: general skills and containment skills. Using a strengths perspective, the ability to communicate and problem solve were considered to be general skills. ‘Containment’ skills include “being patient” and being able to “tolerate silence, and listening” (p. 221). Finally, four value themes were identified. Respondents believed that social workers should demonstrate “wellness and self-awareness” as well as show “humility” and openness to learning from the service user, “Respect, open-mindedness and the ability to be non-judgmental” was the third value identified. The fourth value considered to be necessary for social workers to practice culturally competent services with Aboriginal people was a belief in “social justice”, which acknowledges the effects of colonization on Aboriginal people (p. 222).

Best Practices should reflect culturally appropriate services, and culturally appropriate services should reflect BP (Kufeldt, Este, McKenzie, & Wharf, 2003). For example, based on responses from elders, child and family committee members, chief, band councilors, staff, parents, foster parents and youth in a First Nations child welfare agency in Manitoba, McKenzie, Seidl and Bone (1995) found that culturally appropriate standards of practice for Aboriginal child welfare are similar to “conventional standards of good child welfare practice” (p. 63). Using the best interests of a child as an example, the authors purport that “emotional care, guidance, and physical care...are likely to be generally acceptable in most communities” (p. 63). They caution however that differences in standards based on cultural traditions exist, particularly in respect of the Aboriginal emphasis on respect, extended family, custom adoption and concern for community. Brown et al., (2002) note that the province and Aboriginal agencies can share the view “that children must be protected and given the opportunity to thrive” (p. 146) however the way in which this view is implemented can cause tension and division.

While service planners and providers need to increase their knowledge and understanding of Aboriginal peoples, caution is advised to ensure overgeneralizations about Aboriginal culture do not obscure individual needs and the variation within the Aboriginal population (Gross, 1995; McKenzie & Morrisette, 2003). Gosek (2002) examined suicide among Aboriginal people from a culturally appropriate perspective and the particular application of the Medicine Wheel as a means to provide services. The author concludes that the Medicine Wheel may be appropriate for some individuals and communities, but it should not be considered to reflect all Aboriginal communities or cultures. Gosek recommends that one should

...return to the communities for direction on how they view the issues and how they need to address them. While there are similarities among Aboriginal communities, there are also differences in terms of culture, the needs, the strengths and the circumstances of each community. (2002, p. 205)

Key points of consideration and recommendation regarding BP and the community level include:

- The importance of community and seeing the child's needs and strengths within the context of the family and community.
- The focus of community intervention on engagement and empowerment and the necessity for culturally respectful and appropriate services for all service users.
- An acknowledgement of the negative effects of colonization on Aboriginal people, families, and communities and the need to return to community to seek solutions.

The Organizational Level

This section provides an overview of key organizational topics related to BP. Child welfare service planning and provision is challenging and frequently stressful (Regehr, Leslie, Howe & Chau, 2000) and is often described as “crisis driven” (Barter, 2007, p. 1). Given the role child welfare services organizations play in the implementation of legislative and public policy, all aspects of the organization should incorporate BP in order to improve “agency operations” to benefit service users (Manela & Moxley, 2002, p. 4). Organizational components include administration (governance and management), human resources (communication, policies, recruitment and retention, training and professional development, remuneration, performance reviews); program administration (planning, design, delivery, and

evaluation), workload factors (case intensity, travel, support), community relations (service user input, collaborative initiatives, public relations and information) and information technology (Mullen & Streiner, 2006). Best practices provide organizations with standards for service and planning excellence, and support other important areas such as budget justifications, and rationales for resource requests (CWLA, 1996-2005).

Best Practices stems from administrative and management approaches to organizational functioning in order to address the quality of services. Terms such as “Total Quality Management”, “Quality Management”, “Continuous Learning” and “Continuous Quality Improvement” refer to organizations in which all staff have an active role in ensuring all organizational components are integrated and connected in a continuous learning environment (Cherin & Meezan, 1998; Manela & Moxley, 2002; Rapp & Poertner, 1992; Senge, 1990). From a quality perspective, all programs, including service delivery are linked to the organization’s strategic plan and reflect the organization’s mission and value statements. Service evaluation is built into all organizational functions. Approaches such as “continuous quality improvement” (CQI) reflect this approach to BP. CQI can be defined as:

...the complete process of identifying, describing, and analyzing strengths and problems and then testing, implementing, learning from, and revising solutions. It relies on an organizational culture that is proactive and supports continuous learning. (Casey Family Programs and National Child Welfare Resource Centre for Organizational Improvement, 2005, p. 1)

As such, CQI employs an evidence-based approach to all aspects of the organization in which BP knowledge, based on evidence, is disseminated and implemented in a continuous process. Some BP models also use ‘program logic models’ (PLM) to sequence and detail organizational responsibilities and functions (and provide a clear summary of ‘inputs’, ‘activities’, ‘outputs’ and ‘outcomes’). Johnson and Austin (2005) argue that organizations must modify their culture to “support and sustain” and emphasize a role for managers and supervisors in order that BP be adopted (p. 91).

One means to implement BP on an organizational level is the adoption of accreditation standards through accrediting bodies such as the Council on Accreditation (COA) (founded by the Child Welfare League of America and the Family Service America) for service delivery planning, implementation, and evaluation . The Child Welfare League of America’s (CWLA) standards of excellence for child welfare services reflect practices which are

“...most desirable in providing services and are considered goals for service improvement” (CWLA, 1996-2005, p. 1).

One Canadian study examined good practice in child welfare drawing on responses from close to 1,000 child welfare staff through the use of surveys and focus groups (Herbert, 2007). The survey asked front-line social workers to identify factors that are supportive of good practice, factors that enhance good practice, as well as define good practice. The study also probed managers’, supervisors’ and front-line workers’ experiences of good practice through focus groups. Focus groups included urban/rural representation as well as First Nation social workers. Based on results, the definition of good practice was expanded to include:

... creating the capacity and conditions for positive change within families so that children can maximize their potential within stable and safe environments. Good practice must be based on strong, personal commitment to serve children and families and dedication to positive outcomes. Good practice implies the creative use of resources to support each family’s plan for their children. (Herbert, 2007, p. 230)

Respondents stated that good practice necessitates organizational support to ensure service user needs are met. The respect of cultural diversity, engaging with families and communities, and focusing on strengths were considered elements of good practice. Factors considered impediments to good practice are paraphrased:

- Caseload size, staff turnover, and vacancies which negatively impacted relationship-based work
- Practice decisions based on fiscal economizing
- General resource limitation in the service delivery system
- A lack of recognition for good practice: child protection social workers feel vulnerable, fear liability and lack confidence in the employer’s support should a crisis occur
- Inadequate and badly timed training
- Failure to implement recommendations from previous reports/projects
- Front-line service provider remuneration
- Lack of supervisory expertise

- Limited ability to do relationship-based social work practice (Herbert, 2007, p. 234-235)

In this context, in addition to social worker commitment, the study findings showed that organizational factors necessary to support BP included increased resources to meet the legislated mandate; an “acknowledgment” by the employer of child welfare work challenges and complexities; a team perspective and approach to the job; the inclusion of social work ethics in management decision making; adequate, appropriate and accessible resources; flexibility and creativity in the service system; a positive, supportive and encouraging work environment; and social workers having a sense of pride in their work with a positive public profile (Herbert, 2007, p. 231-232). The need for child welfare organizations to view the service user within the context of a family, community, and larger society and services has been noted in other studies (Lovell & Thompson, 1995). The need for social workers to have sufficient time when working with families is consistent with other studies. For instance, Smith and Donovan (2003) found that child welfare workers (foster care and juvenile justice workers) expressly limited the engagement with parents due to time restrictions, resulting in service provision that contradicted BP policy.

Callahan, Field, Hubberstey, and Wharf (1998) recommend that child welfare organizations should mirror “workers best efforts with clients” (p. viii). They suggest six changes to improve the organization and service delivery:

1. Taking a stance on relationships and strengths (among recommendations include adequate salaries, education, training, policy making opportunities, adequate time to do good work and supervision)
2. Learning about child welfare
3. Acknowledging fear and the realities of child protection
4. Redesigning work
5. Shared management
6. Community involvement that counts (pp. ix-xii).

The authors note that BP also requires a commitment from organizational leadership. Preston (2004) argues that child welfare management training should reflect the complexity of child welfare environments and proposes a management training model to address identified needs. The author argues that managers frequently aren’t knowledgeable or skilled

in working with the external environment and suggests that the inclusion of training in organizational adaptability and survival, will better prepare managers to deal with the demands of service planning and delivery.

Education and training

The importance of qualified staff in child welfare services has also been found as important to ensure effective services and is a relevant BP issue. The need for improvement in child welfare staff education and training has been noted in previous reviews and inquiries (Connor, 2003; Kimelman, 1985; Ryant, 1975; Sigurdson & Reid, 1987) and more recently, in their examination of good practice in child welfare, the CASW (2003) echoed the need for “competent and qualified staff” with opportunity for specialization in child protection and regular professional development opportunities (p. 11).

A study by Anderson and Gobeil (2002) examined recruitment and retention issues in child welfare in Canada based on Child Welfare League of Canada members’ responses. The authors found that high turnover rates (particularly in the first two years of employment), difficulty in recruitment (for example, qualifications and remuneration), problematic vacancy rates, and inadequate training proved to be obstacles in maintaining a stable workforce. In terms of the work environment, recommendations included: increase training (supervisory and staff), the promotion of the agency’s mission and values, increase morale and effectiveness through agency-specific strategies, reassess ‘goodness of fit’ between employees and their jobs on a regular basis (p. 16). Sufficient remuneration of workers to reflect the demands of their work was also recommended.

Social work is frequently identified as the appropriate educational choice as it provides graduates with a knowledge base, practice experience, and skill development considered applicable to child welfare demands (DePanfilis & Salus, 2003; Council on Accreditation Standards, 2012). Given the complexity of the work, the requirement of a BSW degree is one means to ensure a minimal level of knowledge and abilities, which include the development of critical judgment and analysis, knowledge, and practice skills.

The personal commitment of individual workers that valued their work and the goal of empowering families was found to be an important variable in the recruitment and retention of social workers in terms of (Callahan et al., 1998; Herbert, 2007; Westbrook, Ellis, & Ellett, 2006). Ongoing, professional training should be provided to all staff (support staff, front-line service providers, supervisors, and managers) as well as on an inter-professional level (Reder, Duncan & Gray, 1993; Wright, 2012). In a review of thirty-five child fatalities inquiries in

the United Kingdom, Reder, Duncan, and Gray (1993) describe child welfare services as taking place "...against a backdrop of appalling resources, severe underfunding, little social or political encouragement and ever changing organizational structures" (p. 122). The authors advocate for investment in staff which includes regular supervision as well as professional development opportunities, adequate funding for resources necessary to support families (both staff and other services).

Anderson and Gobeil (2002) recommend connections between educational institutions and child welfare agencies to develop and sustain a workforce prepared for the demands in child welfare practice. A coordinated approach to strategized development and maintenance of a child welfare workforce could support prior recommendations (i.e. reviews, AJI-CWI) for increased education and training of child welfare service providers. For example, in Manitoba, the province identified 2,105 social work positions to be filled in the period 2008-2012 and child welfare workers were specifically classified as "high demand occupation" by the province (GOM, 2008, p. 7). Given the number of families currently being served and a staff turnover or absenteeism rate, a coordinated strategy to prepare staff in knowledge and skills necessary for BP in child welfare should be developed between the province, the service organizations, and the University of Manitoba. Kufeldt and McKenzie (2011) call for an increase in social work content related to child welfare practice as well as increased content related to Aboriginal practice. In addition, given the diversity in the Manitoba population, effectively educated and trained service providers must reflect culturally appropriate and respectful practice. In particular, because of the disproportionate number of Aboriginal children and youth in the care of child welfare agencies, as well as the high number of Aboriginal families receiving services from child welfare agencies, there is a need to ensure an educated and trained workforce that can provide culturally appropriate and respectful services.

Workload

Problems associated with high caseloads and workloads and their impact on the ability to provide BP has been identified in the reviewed literature as well as provincial child welfare reviews and inquiries (Anderson & Gobeil, 2002; Connor, 2003; Giesbrecht, 1992; Hardy, Schibler, & Hamilton, 2006; Herbert, 2007; Kimmelman, 1985; Sigurdson & Reid, 1987; Smith & Donovan, 2003). High caseloads were also identified as problematic in a review of 35 child deaths in Britain that found that social workers are "less able to monitor the child's safety when they had excessive case loads or inadequate supervision" (Reder, Duncan, &

Gray, 1993, p. 126). High caseloads and workloads can be even more problematic for those working in rural areas given travel requirements and fewer support services availability.

A caseload can be defined as “the amount of time workers devote to direct contacts with clients” whereas a workload is defined as “the amount of time require to perform a specific task” resulting in work units. Caseloads frequently list the number of children on a social worker’s list, regardless of whether the worker is engaged with other family members. In contrast, workload takes into consideration all work related tasks and responsibilities. The CWLA states that workload levels should be based on time studies within individual agencies. As a result, issues such as travel, outreach activities, court time, emergencies, supervision, consultations, community work, staff meetings, development, conferences, case management, reading of pertinent case documents, contacts, documentation and recordings, all should be considered when determining workload. A month period should be based on thirty days minus all days off (i.e. vacation, sick days, holidays, leave, and training). The CWLA bases its caseload estimates on what is possible in order to do BP: “These ratios of client to staff members offer guidance based upon the field’s consensus of what constitutes best practice” (CWLA, 1996-2005). The CWLA provides guidelines for computing caseload standards based on key principles:

- Workers must be able to spend quality time with service user face-to-face contacts;
- There is no one absolute size: “computing caseloads is an inexact science”, but err on the side of caution, lower numbers;
- Any formula used should result in caseloads equal to or less than the maximum recommended;
- Caseloads: can be expressed as cases per month or cases on any given work day;
- Caseloads should be computed based on the number of staff in specific job categories (p. 1).

The CWLA (1999) recommends 12 cases per month per social worker working in assessment and investigation, 17 active family cases per one social worker and “no more than one new case assigned for every six open cases”. For social workers with a combined function of assessment, investigations, and family services, the CWLA recommends ten active, ongoing cases and four active investigations per social worker.

Supervision

The provision of regular, planned, staff supervision is also an important feature of organizational BP in child welfare (Herbert, 2007; Salus, 2004). The CWLA (1999) recommends one supervisor per five social workers in child welfare service work. Supervision plays a critical role in achieving service provision efficiency and links the organization's mission with service provision (Bogo & McKnight, 2005). In addition, supervisors are key messengers in dispersing organizational learning (Austin & Hopkins, 2004). Ultimately supervision should benefit families due to increased service provider competence and service provision (Kadushin & Harkness, 2002; Munson, 2002).

Supervision should include more than just administrative functions such as completing necessary financial forms, and ensure that workers receive supportive and educative supervision (Kadushin & Harkness, 2002). Educational supervision identifies skills and knowledge necessary for child welfare workers to be effective in their work and supportive supervision refers to the supervisor providing encouragement, reassurance, and autonomy to the worker (Kadushin & Harkness, 2002; Shulman, 1993). Supervision includes the provision of annual performance evaluations in order to evaluate the social worker's work (Kadushin & Harkness, 2002). From an organizational perspective, good supervision is one means to ensure accountability to service users through the identification of poor service provision and the implementation of necessary improvements to service (Kadushin & Harkness, 2002; Munson, 2002; Shulman, 1993).

Supervisors must also have sufficient education and training to supervise staff (Falender & Shafranske, 2007; Herbert, 2007; Munson, 2002). This includes ongoing professional development opportunities (Kaiser & Barretta-Herman, 1999), as well as their own regular supervision (Kadushin & Harkness, 2002), and effective cross-cultural communication skills and support workplace diversity (McPhatter, 2004). Best Practices in supervision have been identified by Falender and Shafranske (2007) who believe that supervisors must:

- Self-assess on their expertise and skills;
- Work to create a working alliance with their supervisee;
- Use a contract to identify tasks and methods to attain expectations for supervisees;
- Use evidence-based practice;
- Have integrity and work ethically;
- Respect diversity;
- Include an evaluative component in the supervisory relationship;

- Develop self-awareness, reflective, and metacompetence in supervisees;
- Provide to, and accept feedback from the supervisee;
- Maintain communication and note problems in the relationship (p. 238).

Inter-professional coordination, collaboration, and integration

Inter-organizational coordination, collaboration, and integration are also considered to be beneficial for families involved in the child welfare system (Goldman et al., 2003). Service coordination refers to the provision of a variety of services to families through shared inter-agency planning and/or delivery, however with minimal formal joint agreements (Konrad, 1996; Scott, 2005; Stroul, 1995). Service coordination differs from collaboration in that the latter emphasises a reliance on formal inter-organizational policies and practices (Scott, 2005). Service integration differs from coordination and collaboration in that unified service planning and provision are planned, formalized, and implemented to ensure a seamless service experience for families and children, regardless of needs or age throughout the service continuum (Friesen & Poertner, 1995; King & Meyer, 2006).

Green, Rockhill, and Burrus, (2008) reported that collaborative or integrated service benefitted service user families with a substance abuse problem involved with the child welfare system. These benefits were due to collaborative efforts of shared value systems, better communication, and increased support between child welfare, treatment and court systems. In another study on service integration, Larsson (2000) found that families and professionals experienced an improved service experience through collaborative efforts. Families perceived inter-organizational teams as more family-centered and increased families' sense of control over service provision. Findings also showed that a shared inter-professional view and team approach also resulted from service integration efforts. The author concludes that inter-organizational teams are able to work with the system as a whole to the benefit of the service user. Callahan et al. (1998) found that cross-sectoral services were beneficial to service users as they ensured that services were provided based on the user's needs. Another study on the implementation of family-centered practice for families with children with special needs found that service coordination resulted in a common inter-professional language, policy, and practice (Wright, Hiebert-Murphy, & Trute, 2010).

Evaluation

Best Practices requires that child welfare organizations evaluate and monitor service provision and have demonstrated outcomes (Callahan et al., 1998). In-house evaluations and collaboration with external researchers can provide opportunities for greater understanding of challenges and strengths to service planning and provision (Reder, Duncan, & Gray, 1993). Tools such as “Matching Needs and Services” can help organizations identify, plan, provide and evaluate services based on assessed community needs and includes community perspectives (Melamid & Brodbar, 2003).

The Casey Family Programs (CSI) and the National Child Welfare Resource Center for Organizational Improvement (NCWRCOI) (2005) advocate for the implementation of Continuous Quality Improvement (CQI) in child welfare agencies in order to achieve BP. This results in a culture of organizational learning which is ongoing and all aspects of organization are considered to be inter-related, striving “to improve outcomes for children, youth and families” (p.4). It is important to note that CQI is aimed at promoting BP across all organizational levels and considers BP to be an outcome of an organization-wide implementation of a CQI system. Six component areas are identified as being (each with subcomponents) necessary to develop a CQI system. The key components are:

1. The organizational culture supports and actively promotes CQI;
2. The agency adopts specific outcomes, indicators, and practice standards that are grounded in the agency’s values and principles;
3. Agency leaders, staff, children, youth, families, and stakeholders receive training in the specific skills and abilities needed to participate actively in CQI;
4. Agencies collect qualitative and quantitative data and information from and about children, youth, families, and staff;
5. Staff, children, youth, families, and stakeholders review, analyze, and interpret qualitative and quantitative data to inform agency practices, policies, and programs; and
6. Agencies use CQI results to improve policies, practices, and programs. (p. 7)

The use of CQI includes the identification of BP based on the analyses and the prioritization of BP for implementation (p. 7).

In summary key points of consideration and recommendation regarding BP on the organizational level include:

- Recruitment and hiring requirements suggest a BSW with a child welfare and Aboriginal practice focus as well as ongoing opportunities for professional development and regular, qualified supervision.
- Workers should have a personal commitment to empower children and families and workloads that allow them to develop and maintain relationship-building with children, families, and communities.
- Organizational leadership must be supportive of the context of direct practice and the work challenges through workload assignments, flexibility in service provision, and accessible, relevant service options.
- The importance of evaluation as an integral component of service planning and delivery.

The Direct Practice Level

This section provides a brief review of some BP applicable to direct service provision. There are many useful manuals that provide guidance for service providers in the child welfare system, particularly when dealing with child maltreatment (see for example the Child Abuse and Neglect User Manual Series (2003), *Child Protective Services: A Guide for Case Workers*, or Goldman et al., (2003) *A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice* and the U.S. Department of Health and Human Services Administration for Children and Families Administration on Children, Youth and Families Children's Bureau Office on Child Abuse and Neglect). The Government of Manitoba, Department of Family Services and Labour also has standards clearly linked to the legislative requirements which provide a minimum level of service provision (Government of Manitoba, 2005). Riggs et al. (no date) provide a practice guide for child welfare workers working with First Nations, Inuit, and Métis families who are experiencing family violence and Strega and Aski Esquao (2009) provide a valuable edited text on anti-racist and anti-oppressive child welfare practice. All of these manuals outline BP to guide effective child protection services and generally include information such as the definitions of child maltreatment, the philosophical approach or values underlying child welfare services, the incidence of child maltreatment, theories explaining the causes of child maltreatment, the effects of maltreatment, resilience, the stages of service provision and methods of intervention, roles and responsibilities of various service providers, reference legal requirements and pertinent

legislation, the role of documentation, inter- and intra-agency collaboration, supervision and caseloads, worker health and safety.

Some studies report that BP is predominantly grounded in the social worker – service user relationship (Callahan et al., 1998; Herbert, 2007; Riggs et al., no date). Callahan et al. (1998) describe BP as a process in which service is client focused, and a genuine relationship exists between service users and the social worker in which both share their efforts to make real change. Their study identified six elements of BP in the provision of services:

- 1) Setting the tone: respect, strengths and honesty
- 2) Remaining curious and deepening knowledge
- 3) Navigating through fear
- 4) Attachments with a purpose
- 5) Understanding the limits of control and
- 6) Building resources with clients and community (Callahan et al., 1998, p. iii-iv)

Drawing from close to responses from 1,000 front-line workers in child welfare who were asked about what constitutes good practice, Herbert (2007) reports that indicators of good direct practice includes:

- Personal and professional job satisfaction
- Adherence to a professional Code of Ethics, and standards
- A focus on serving children and families
- The broader professional role understood and supported
- Opportunity for personal and professional development
- Employee wellness
- Accountability mechanisms (Herbert, 2007, p. 231)

When participants were asked what alternative practice methods could be used to enhance good practice, solutions identified included the use of:

- Resiliency models
- Structural social work
- Community based practice
- Group work
- Family preservation and reunification work

- Traditional healing/cultural practice
- Mediation
- Family group conferencing (p. 233)

The study also linked responses from a National Youth in Care Network project regarding their perspectives on social workers within the child welfare system, and noted that responses underscored the value of relationship-based work.

Based on a review of family centered and child welfare literature, Wright and Hiebert-Murphy (2011) produced a conceptual paper that integrates a family-centered (FC) approach to child welfare practice. The authors contend that the application of family-centered child welfare practice provides the worker "...with an approach to service practice that is based on respect, builds on family strengths, emphasizes safety, is culturally respectful and appropriate, and empowers families" (Wright & Hiebert-Murphy, 2011, p. 445). Reflecting an ecological perspective, family members are viewed within the context of their family, community, and society as a whole. In addition, service providers should ensure that their work is ethical, reflecting integrity, and a commitment to the best interests of the child (University of Chicago School of Social Service Administration, 2002). Throughout their work, social workers should practice reflexivity and self-awareness of personal biases that could affect their contextual understanding (Strega, 2009).

There are six general stages to child welfare practice: 1) intake, 2) investigation, 3) assessment (including risk assessment), 4) service provision, 5) evaluation, and 6) closure (or transfer for continued services as assessed) (Compton & Galaway, 1989; DePanfilis & Salus, 2003). Throughout the service stages, workers should ensure that they document relevant information and are familiar with any previous involvement (Reder, Duncan, & Gray, 1993). If an allegation of maltreatment is reported, the worker proceeds with an investigation and meets with family members to discuss concerns. Incongruities between the parents and child or other relevant parties should be considered as areas requiring further investigation to ensure the safety of the child (Falconer & Swift, 1983). The attachment between the child and the parental figure is also an important element of the assessment process (Riggs, et al., no date). When necessary, the child should be examined by a physician (Greenland, 1987).

Swift and Callahan (2009) raise valid concerns about the pervasiveness of risk and the assessment of risk throughout social services. Nevertheless, a risk assessment (RA) tool can be useful to systematically address variables that impact child well-being as part of the broader assessment focus. Risk assessment in child welfare requires the assessment of 1) the

vulnerability of the child; 2) the probability of future instances of abuse or neglect; and 3) and the probable severity of any future instances of abuse or neglect (Reid, Sigurdson, Christianson-Wood & Wright, 1987). A RA tool is not in conflict with cultural appropriate practices; rather, it is simply one piece of larger assessment, intervention and evaluation piece, provided within the context of culturally appropriate service planning and delivery. Christianson-Wood (2011) notes that risk assessment must be accompanied by “good clinical judgment” in order to effectively plan with families and can help “to reduce the negative effects of idiosyncratic assessment or poor supervision” (p. 383).

A thorough assessment provides the basis for service planning and evaluating effectiveness (Greenland, 1987; Tanner & Turney, 2006). Helpful assessment models and frameworks include the family resiliency framework (Walsh, 2003), the McMaster Model of Family Functioning (Epstein, Ryan, Bishop, Miller, & Keitner, 2003), and assessment domains as defined by Bailey & Simeonsson (1988). Maidman’s assessment framework (1984) also provides a useful outline from an ecological perspective that includes the examination of multiple aspects of a child’s and family’s life. The use of genograms and ecomaps are helpful in the assessment stage (Dunst et al., 1988; Reder, Duncan, & Gray, 1993) and can be used throughout the intervention process as a tool for clarification and understanding family structure and patterns, as well as social supports and other formal and informal networks.

The assessment process should include the service user’s (i.e. all family members) understanding of the situation and the referred problem, as well as the identification of strengths, problems, and potential areas for changes. In addition, other identified issues such as food, housing, or educational needs should be incorporated into the plan. Assessments should always include the identification of strengths, and ideally, all family members should participate in the service process even though some may be “involuntary” service users (see Rooney, 1992). Resilience in the context of adversity is also an important aspect of assessment (Riggs et al., no date) and is defined as “... the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their well-being, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways” (Ungar, no date).

Based on the assessment of the family’s needs and strengths, a service plan for intervention should then be created between the family members and the worker. Specific goals for family members and service providers are assigned with aligned tasks, roles, responsibilities, and timelines for the beginning and completion of tasks considered necessary

for change to occur. The assessment highlights the role that collateral service providers play with clear documentation of specific roles for different professionals involved (Reder, Duncan, & Gray, 1993). The service plan is the basis for evaluating the service process and effects, particularly family change (Mather & Lager, 2000). Throughout the intervention process and the provision of services, ongoing meetings between the worker and the family are used to identify successes in reaching goals, make modifications to the plan based on new information, and end services when “goals have been attained and family functioning is stable” (Wright & Hiebert-Murphy, 2011, p. 457).

Within the context of the initial and ongoing assessments, it is crucial that the worker has physical access to the children, and is able to meet with them as part of the assessment and intervention process to ensure their well-being (Greenland, 1987; Reder, Duncan, & Gray, 1993). Changes in the family’s composition (for example, a new partner) and the impact on the children should also be included as key parts of ongoing assessment (Reder, Duncan, & Gray, 1993). When working with involuntary service users in which past child maltreatment has occurred, the withdrawal of parents from contact with social workers and other professionals, also requires further assessment (Reder, Duncan, & Gray, 1993). In the context of families who avoid contact and have had a previous maltreatment concern workers must take an “authoritative and decisive” stance to ensure the child is protected, regardless of the discomfort a worker may have in taking on this role (Reder, Duncan, & Gray, 1993, p. 132). Wright and Hiebert-Murphy (2011) note that even in the context of involuntary service users, workers should maintain honesty in their work with families, and work respectfully with families reminding “the service user of his/her right to non-compliance and related consequences” (p. 456).

Out-of-Home Care

Child welfare services include the provision of out-of-home care (alternate care) for children and youth due to protection issues in the family home. Statistics Canada Census data (2012) shows that in 2011 there was a reported 29,590 foster children under the age of 14 living in private families’ homes, although Blackstock estimates the number of children in care ranges between 67,000 and 80,000, with approximately 27,500 First Nations children (Miller, 2012). In Manitoba, the Department of Family Services and Consumer Affairs reported 9,730 children in care in 2012, of whom 86% are Aboriginal (Government of Manitoba, 2011). There are no national standards for children in care (National Council of Welfare, 2007).

The Looking After Children (LAC) project is considered to be a best practice approach to improve outcomes for children involved with child welfare services (Kufeldt, Simard, Vachon, Baker, & Andrews, 2000). The model is premised on the belief that children in care deserve standards of care equal to loving families in the community, that partnership between child welfare workers is necessary for improved outcomes, and that knowledge of service outcomes and methods for improvement requires an assessment of intervention linked to the principles of child development, and a plan to build on strengths and address needs (Assessment and Action Records). Close to 300 children in care, their workers and foster parents participated in the project. The project collected information based on the assessment and monitoring of the child's development (health, education, family and social relationships, identity, social presentation, emotional and behavioural development, and self-care) over time and specific tasks, roles, and time frames are identified to meet needs. Data generated from the process can be used on a case level as well as a program or planning level. The project results indicate positive outcomes for the children involved in the project with the exception of education and improvements were noted in the relationship between the worker, child and foster parent and improvements in working with the child's natural parent. In addition the LAC has been successful in the promotion of resilience for children, workers, and foster parents as well as improving the working and caring relationships and communication (Kufeldt, McGilligan, Klein, & Rideout, 2006).

Kufeldt (2011) refers to "inclusive foster care" based on the concepts of attachment, a sense of continuity, and role differentiation (p. 161). The author proposes multiple roles for foster care. First, foster care can play a role in prevention through activities such as mentoring of families by foster families. Second, foster care can act as a means of family preservation, as it can maintain "the child's sense of family and belonging" through the "continuation of the family relationship" (p. 167). Third, foster care can help with reunification through the foster parents' support before, during, and after reunification. Foster care can also play a role in permanency planning through the provision of a "permanent" home.

Goodman, Anderson, and Cheung, (2008) provide a helpful overview of foster care practices with a look toward future challenges facing foster care services. The authors note that family-based alternate care (i.e. foster homes) is the preferred option for children and youth. Among other recommendations they also suggest a shift to a greater emphasis on the professionalization of foster care providers (training and remuneration), the use of kinship

care providers, and an emphasis on outcome data. In terms of foster care workload and caseload, the CWLA (1995) recommends 12 to 15 children per one social worker.

The General Assembly of the United Nations recently published Guidelines for the Alternative Care for Children to enhance implementation of the Convention on the Rights of the Child, and these are considered to set standards of BP (2010). These Guidelines emphasize family-based settings and alternate care and the role of the state to “ensure the supervision of the safety, well-being and development of any child placed in alternative care” (p. 3). Trocmé et al. (2009) note the importance of maintaining placements within the child’s cultural community and striving for stability whether through reunification with the child’s family or placement permanency:

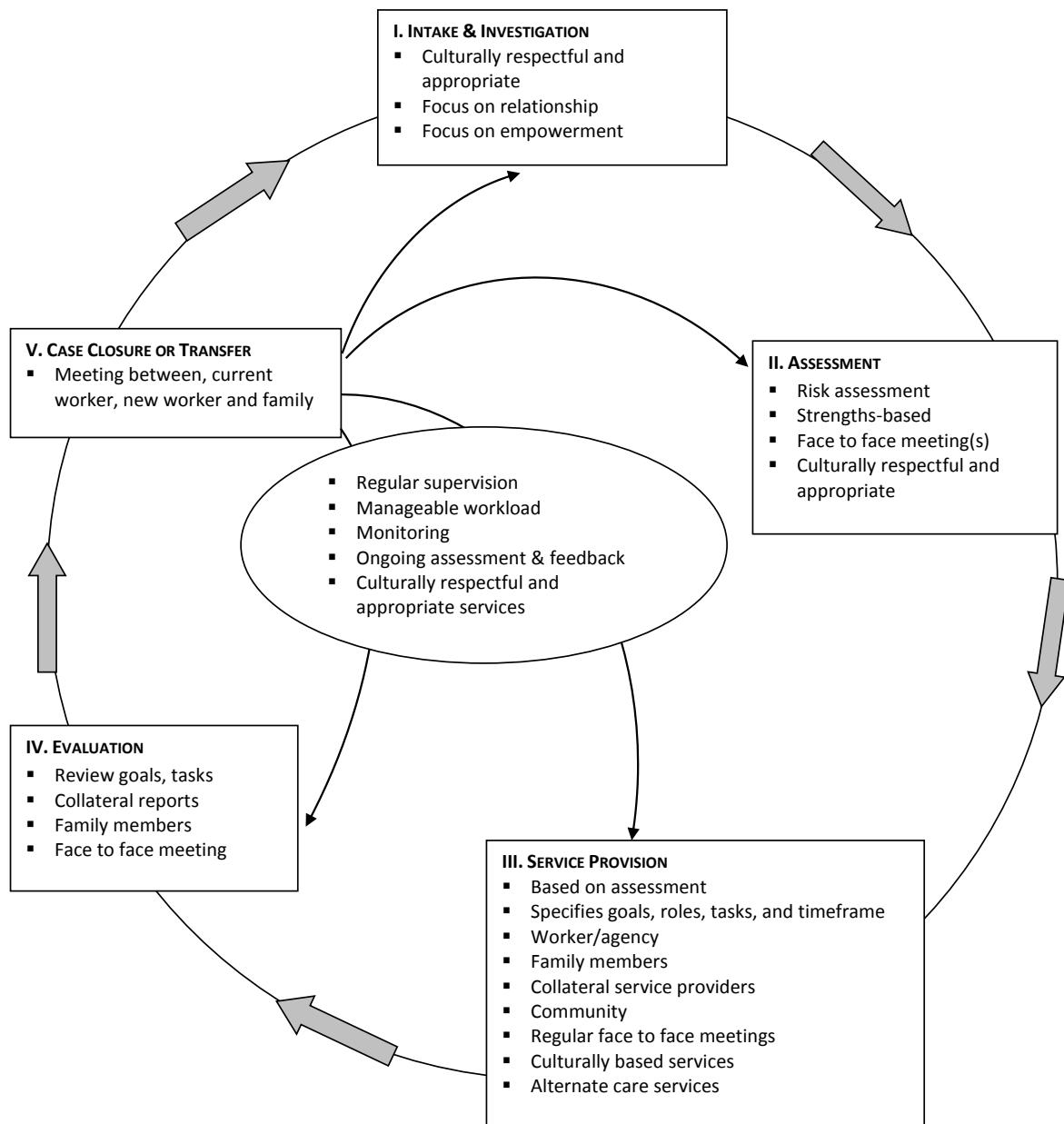
Providing children with permanency in placement promotes healthy development and encourages continuity in relationships and a sense of community and identity (Trocmé et al., 2009, p. 5).

The role of community was identified as an important aspect of kinship care provision in a study by Wright, Hiebert-Murphy, Mirwaldt and Muswaggon (2006). The study aimed to examine the factors that contributed to positive outcomes in kinship care placements with the Awasis Agency of Northern Manitoba in the Cross Lake Band First Nation. Youth in care, foster parents and staff were interviewed about their experiences and perceptions of kinship care. Findings showed that the agency was able to provide community foster homes to all those children and youth in the community who required out-of home placement. Research participants strongly believed that kinship care ensured a bond between the child and the community:

The community stakeholder, staff, and kinship foster parents identified a "connectedness" between the child, the caregiver, and the community. This was reflected in the emotional bond between the child and caregiver, and the child's or youth's connection to culture, language, and community. (p. 21)

The following diagram provides a visual representation of the direct practice process identifying five stages and some associated tasks (not an exhaustive list). The intent is to demonstrate the ongoing nature of direct practice work and the integration and revision of services and goals based on updated information and assessed needs.

Figure 1. Direct practice elements in child welfare



Points for consideration and recommendations regarding BP on the direct practice level include:

- The focus of direct practice should be on child and family health and well-being with the goal of empowerment.

- The importance of the relationship between the social worker and service user should be emphasized and supported, based on trust and respect, and culturally appropriate services.
- The importance of meeting with all family members, particularly children and their parents and the necessity of incorporating regular feedback into the intervention process, modifying goals and services as necessary.
- The importance of minimizing disruptions for children and families throughout, and across, the service continuum.
- The importance of national standards for children in care, and the implementation of an approach to service such as the LAC model.
- The maintenance of family-based care as the preferred form of alternate care and the development and support for kinship care.

BEST PRACTICES IN CHILD WELFARE: CONCLUDING POINTS

The complexity of the Canadian child welfare system urges policy makers, service planners, and service providers to implement Best Practices. Focusing on the best available evidence from research, clinical practice, and the family/service user values, BP provide direction for the planning and implementation of successful policies and services (APHSA, 2005). Ultimately, the goal of BP is to benefit children and families' well-being. The paper provides the reader with highlighted research findings and conceptual contributions that support BP in child welfare however should not be considered exhaustive and should be viewed as a stepping point for further inquiry. Bronfenbrenner's (1977) ecological approach, understood within a critical structural perspective (Mullaly, 2002), frames the context of children and families within the child welfare system. From this perspective, the broader societal system, community, and organization impact the well-being of children and their families and offer guidance for solutions to challenges faced by families and children. Issues such as sexism, racism, and poverty negatively affect family functioning and policy planning addressing these needs can be targeted for child welfare intervention. Moreover, child welfare organizations function in a context of insufficient resources to meet demands, within communities that frequently have insufficient services to meet demands. Attempts to address organizational problems without addressing community resource issues will likely result in minimal change for service users: "For the majority of families who come to the attention of

child protection systems, the realities of their lives—injustices associated with poverty, violence, isolation, discrimination, homelessness and a lack of opportunities—are being skirted” (Barter, 2008, p. 153).

Final recommendations include:

- The need for a comprehensive, national strategy to resource, monitor, maintain, and evaluate the well-being of Canada’s children.
- No child should suffer due to jurisdictional disputes between the federal government, provincial and territorial governments and bands. These issues require resolution to ensure BP occurs.
- Public support for required services could direct governments to sufficiently resource the child welfare system to ensure family well-being.
- Support and prevention services are necessary elements of child welfare. These services must be developed and maintained to enable BP.
- Planning and services should acknowledge the importance of community and include community building initiatives.
- On an organizational level, administrators and managers should acknowledge and recognize the importance of the direct practice work provided and the complexity and challenges faced by social workers. Organizations should ensure regular, qualified supervision to workers as well as resources sufficient for needed services.
- The importance of evaluation as an integral component of service planning and delivery.
- On a direct service level BP can only occur if workloads are manageable and allow the worker to implement BP approaches such as relationship building with family members, and to participate in ongoing professional development opportunities.
- The importance of culturally respectful and appropriate services for all service users. In particular, given the history of colonization, the importance of Aboriginal service planning and delivery models must be emphasized. The integration of Aboriginal practices and non-Aboriginal approaches to services are not incompatible and share commonalities such as the emphasis on relationship building, working respectfully, and focusing on strengths.
- The maintenance of family-based care as the preferred form of alternate care and the development and support for kinship care.

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