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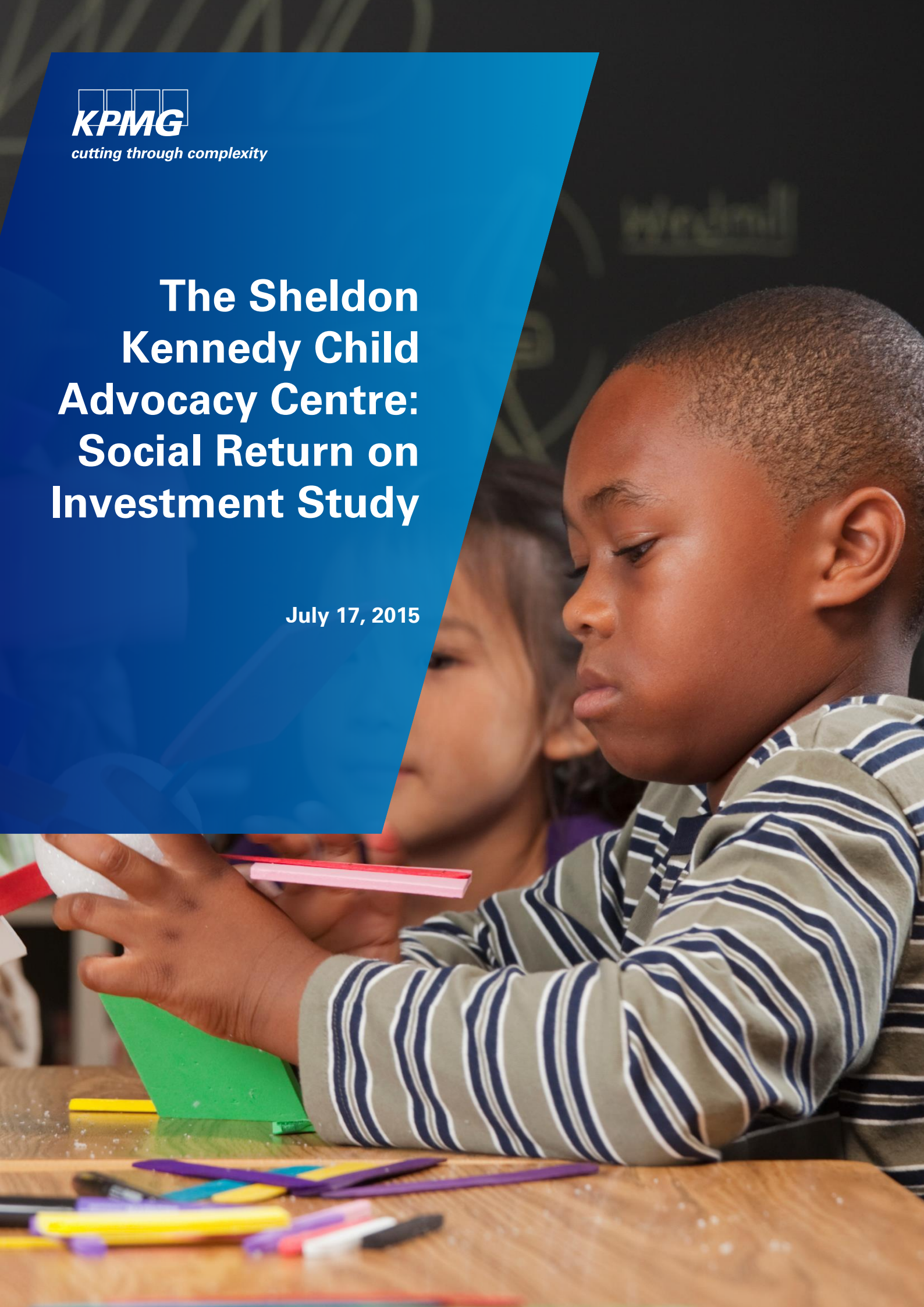
# The Sheldon Kennedy Child Advocacy Centre: Social Return on Investment Study

July 17, 2015



# Glossary

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| **AHS** | Alberta Health Services |
| **AE** | Alberta Education |
| **CAC** | Child Advocacy Centre |
| **CFS** | Calgary Region Child and Family Services |
| **CPS** | Calgary Police Services |
| **Crown** | Alberta Justice – Crown Prosecutor's Office |
| **RCMP** | Royal Canadian Mounted Police |
| **SKCAC** | Sheldon Kennedy Child Advocacy Centre |

# Contents

# 1 Executive Summary

The Sheldon Kennedy Child Advocacy Centre (SKCAC) engaged KPMG to conduct a Social Return of Investment (SROI) study with the objective of identifying and where possible quantifying the social and economic value created by the organization via its integrated model of practice. Over the course of the study, KPMG engaged with a broad spectrum of stakeholders involved in the intake, investigation, intervention and treatment of child abuse cases, including SKCAC leadership and staff, Calgary Police Service, Calgary Region Child and Family Services, Alberta Health Services, Alberta Justice – Calgary Crown Prosecutor's Office, RCMP, and Alberta Education. This study has been instrumental in allowing SKCAC and partner organizations to:

- Develop a deeper understanding of how the SKCAC's integrated practice model drives value for stakeholders, and how it is differentiated from other CAC models, and traditional service delivery
- Systematically identify the mechanisms via which SKCAC's activities translate into short-term and long-term outcomes for stakeholders
- Evaluate, where possible, the degree to which those outcomes are being achieved, and recommend ways to enable a more complete impact evaluation in the future

There are 5 key findings from the study:

1 The SKCAC is a unique model of service delivery which offers a high level of integration across partner organizations, beyond simply co-locating staff and co-ordinating activities. A number of unique features set the SKCAC model apart from other CACs, or traditional service delivery models, as detailed in section 3.2.

2 The benefits of the SKCAC integrated practice model can be grouped in three categories: 1) productivity improvements across partner agencies, 2) improved effectiveness/ quality of service delivery, 3) reduced long-term impacts/ costs of child abuse for children, families and support systems, and 4) policy and practice leadership. Among the key drivers for these benefits are:

- Greater information sharing and better information availability to make key decisions
- Improved role understanding among partner organizations
- Integrated case triaging and early intervention
- Transition of effort from low-value administrative tasks (or reduced duplication) to case assessment, investigation and intervention
- Single access to services for children and families
- Child-friendly environment and trauma-based approach focused on reducing child stress
- Specialized techniques focused on improving disclosure by children
- Greater trust and shared accountability among partner agencies
- Integrating data on victims of child abuse
- Setting operational standards and leading practices

3 We estimate that the productivity improvements introduced by the SKCAC amount to ~$550,000 annually, across stakeholders. This represents a measure of the additional time that would be required in the absence of SKCAC, to achieve the level of service delivered today. This amount does not represent a reduction of budgets or headcount across stakeholders as the time saved from productivity improvements has been redirected to delivering service. Examples of productivity improvements include:

- Time saved in collecting information at the front end of the case
- Time saved in assigning personnel for investigation and treatment following initial presentation
- Time saved in travelling between agencies
- Time saved in unnecessary visits to the emergency department

This assessment of productivity improvements is limited to an analysis of the JICAT program (which sees ~972 cases a year) due to the availability of data, and as such, likely underestimates the total productivity impact that is being realized by the system. As well, this assessment does not include broader productivity improvements that are occurring in partner agencies due to the specialization of staff, and channelling of the most complex cases of abuse through the SKCAC, which are likely reducing the burden on the rest of the system.

4 In addition to the productivity improvements, we believe the SKCAC model is more effective at delivering health, safety and justice outcomes. While the data available today does not make it possible to quantify these outcomes, some indicators of that impact include:

- expedited delivery of care to the most urgent cases of abuse
- more appropriate referrals to mental health exams and therapy
- higher quality safety plans for children
- reduced repeat instances of abuse by perpetrators
- reduced unsafe home visits by staff
- more just court outcomes as a result of better evidence
- improved ability of non-offending caregivers to support victims of child abuse

5 Since the SKCAC has only been operational for two years, it is not yet possible to quantify the long-term impacts on victims of child abuse, and the long-term implications to the health care, mental health and judicial systems. However, we estimate that the annual cost of child abuse in Alberta alone are ~2.4 billion. Given annual SKCAC related costs (including value of pro-bono time) of ~$2.2 million, this implies that SKCAC needs to achieve less than 0.1% (one tenth of one percent) reduction in the annual costs of child abuse in Alberta in order to have a positive SROI.

6 Although calculating an SROI statistic is one method of measuring impact, understanding the true value of the SKCAC model requires a focus on how long-term social outcomes are being improved, even when those are not possible to express in financial terms. Ultimately, we believe that investing in child advocacy and protection is a matter of human rights and should not be driven by financial considerations alone. As such, we recommend that future efforts are directed towards measuring improved effectiveness across health, safety and justice outcomes, as detailed in section 6.

# 2 Introduction

## 2.1 Assignment Summary

The SKCAC is a unique, integrated model of practice between multiple public agencies that are responsible for responding to child abuse, with the aim to strengthen the partners' collective ability to provide effective care. It is the result of a conscious co-locate resources at the centre, in order to operationalize an integrated practice model. KPMG was engaged by the Sheldon Kennedy Child Advocacy Centre (SKCAC) to assess the social and economic value created by the organization via its unique integrated model of practice. The objective of this study was to identify, and where possible, quantify the impact SKCAC creates across its stakeholders. The study scope included a number of operational activities currently undertaken by SKCAC, such as joint triage/ consultation, joint assessment and investigation, coordination of therapy, intervention, ongoing support and follow-up, and coordination of prosecution activities. The study also includes ongoing prevention efforts, both in day to day operations, and policy and practice leadership initiatives.[1] The assessment was conducted across multiple stakeholders, including the Calgary Region Child and Family Services (CFS), Calgary Police Services (CPS), Alberta Health Services (AHS), Alberta Justice – Calgary Crown Prosecutor's Office (Crown), RCMP, and Alberta Education. The study is based on internal data provided by SKCAC, expert input provided by each stakeholder, and secondary research conducted by KPMG.

## 2.2 Approach

Social return on investment is a methodology that is used to assess both the economic and the social value generated by an organization's activities, against the costs associated with those activities. It is a methodical approach to impact evaluation, wherein outcomes are quantified and valued, with a commitment to isolating the contribution of the organization in achieving those outcomes. As such, an evaluative SROI study requires robust data on inputs and outcomes, for both intervention and counter-factual groups.

Given that the SKCAC has only been in existence for two years, the data that is required to conduct an evaluative SROI did not exist at the time of this study. This study is therefore a forecast evaluation of the benefits created by the SKCAC integrated practice model, which was conducted in the following steps:

1. **Identification of Stakeholder and Activity Scope:** established the scope of activities that are to be included in the analysis, and identified stakeholder groups that experience change or are part of delivering change. Key activities identified to be in scope included joint triage/ consultation, joint assessment and investigation, coordination of therapy, intervention, ongoing support and follow-up, coordination of prosecution activities, and prevention initiatives. Key stakeholders included the CFS, CPS, AHS, Crown, RCMP, AE, SKCAC, and children and families.
2. **Mapping of Key Activities and Outcomes**: mapped the relationship between inputs, outputs and outcomes of CAC's various activities by way of a logic model, identifying indicators of end outcomes that can be valued. This model is presented in section 3.3 of this report.
3. **Stakeholder Consultation and Data Collection**: conducted 8 consultation sessions with staff members of the various partner agencies. These included members of partner organizations at all levels of service delivery, including managers and team leaders, frontline staff, and senior

[1] This is not an exhaustive list of activities undertaken by the SKCAC. The scope of the SROI study is narrower than the full host of activities undertaken at the centre, such as growing the partnership, developing a research and knowledge base among others.

leadership

4 **Impact Assessment**: analysed existing data and evidence for change, and developed an assessment of the impact created by the CAC, with a focus on isolating the impact of SKCAC among other factors that may have contributed to the outcomes.

5 **Stakeholder Review and Validation of Study Results**: the results of this study were socialized with senior leadership from SKCAC and partner agencies to validate the findings of the study and to collect and incorporate any feedback.

This study was conducted in a manner consistent with the principles established by the SROI Network, as follows:

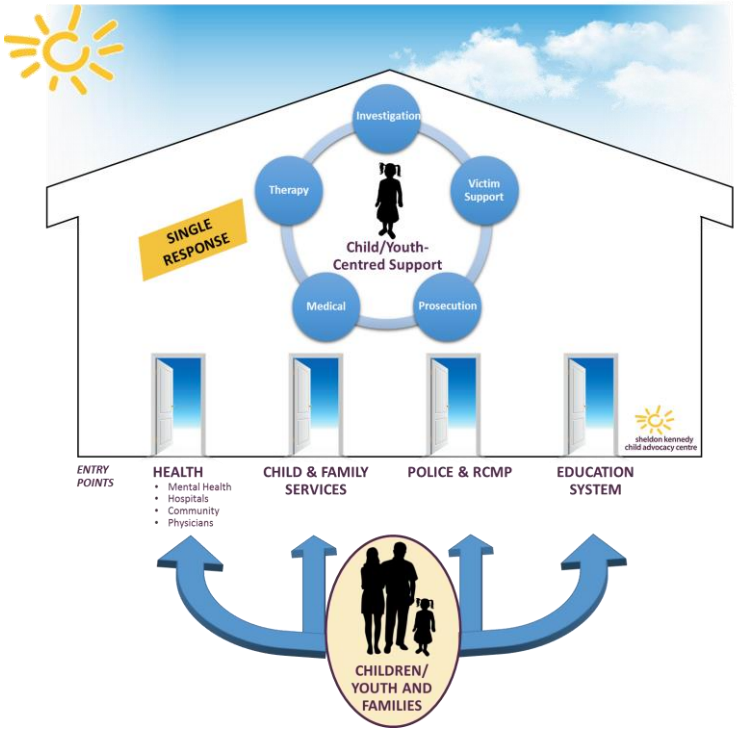
- Involving stakeholders throughout the engagement
- Taking an evidence-based approach to evaluate impact
- Valuing the things that matter
- Only including what is material
- Not over-claiming value
- Being transparent
- Verifying results with stakeholders

# 3 Key Activities and Target Outcomes

## 3.1 Introduction to SKCAC

The SKCAC is a collaborative model of practice between multiple public agencies that are involved in the response to cases of child abuse in Calgary and surrounding communities. Specifically, the SKCAC is a non-profit organization that works in collaborative partnership with Calgary Police Service, Calgary Region Child and Family Services, Alberta Health Services, Alberta Justice – Calgary Crown Prosecutor's Office, RCMP, and Alberta Education in order to streamline and better serve the needs of children and families who are involved in the investigation, intervention and treatment of child abuse. A key goal of the SKCAC model is to prevent abuse, which underlies the SKCAC's many initiatives in its day to day operations, its community engagement, and its policy and practice leadership.

Figure 1. SKCAC Collaborative Partnership




The SKCAC is a physical site which co-locates upwards of 100 professionals in total, drawn from each of the partnering agencies, who deal with the criminal, child protection, medical and psychosocial needs of child victims and their families. The SKCAC premises are also in close proximity to the Alberta Children's Hospital, so as to enable close collaboration with medical staff and services that are located at the hospital.

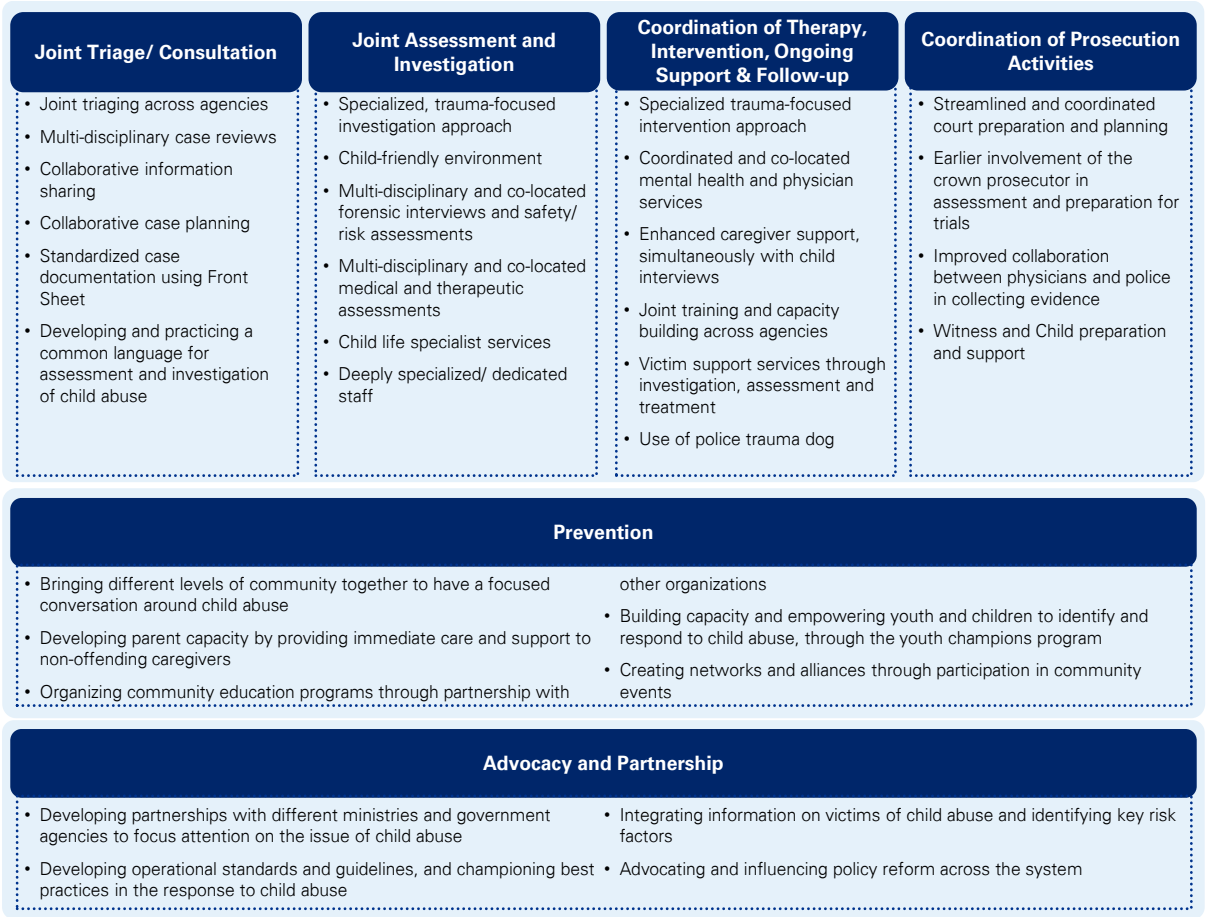
The SKCAC model commenced development in 2011 and became fully operational with all partners on site in April 2013.

## 3.2 Key Features of the SKCAC Integrated Practice Model

The SKCAC is a unique model of service delivery which offers a high level of integration across partner organizations, beyond simply co-locating staff and coordinating activities. Integrated practice refers to a model of shared responsibility in which the SKCAC serves as a single entity accountable to the child, and integrates functions such as triage, case planning, interviews and assessments, data collection etc.

The core activities undertaken by the SKCAC include joint triage/ consultation, joint assessment and investigation, coordination of therapy, intervention, ongoing support and follow-up, coordination of prosecution activities, prevention initiatives, and advocacy and partnership development. A number of key features set the SKCAC model apart from other CACs, or traditional service delivery models. These activities and the key distinguishing features of the SKCAC integrated practice model are summarized below.

Figure 2. The Sheldon Kennedy CAC Integrated Practice Model




### Joint Triage and Consultation

Triaging, in the context of responding to child abuse cases, is the practice of assessing the specific needs of each child, determining an appropriate level of response, and dividing them into different levels of priority based on the severity or urgency of the presenting concern.[2] This allows for

[2] CAC Practice Framework and Implementation Plan, 2012

emergency cases to be identified and handled first, followed by cases with lower levels of severity. Since the establishment of the SKCAC, this practice of triaging has been conducted jointly by multiple partner agencies. That is, each day, members of CFS, CPS, and AHS jointly review referred cases and determine the nature and level of response to be mounted. This practice in itself is a distinguishing feature of the SKCAC as it creates an enabling environment for multi-disciplinary review of case information, collaborative information sharing across agencies, standardized documentation of case information, collaborative case planning, and developing and practicing a common language for assessment and investigation of child abuse.

### Joint Assessment and Investigation

Assessment and Investigation activities typically involve forensic interviews with children, safety/ risk assessments and collection of collateral information, medical and therapeutic assessments of the child and family members, background checks, and case conferencing.[3] What distinguishes the SKCAC model is the fact that the forensic interviews and assessments are co-located and multi-disciplinary in nature. This means that multiple agencies come together in one location in order to interview the child, rather than the child having to visit individual agencies for multiple interviews. Other distinguishing features of the SKCAC are that it provides a child-friendly facility in which to conduct the interview and a Child-Life Specialist to engage with children in therapeutic play and preparation for interviews and physical exams. Lastly, each agency takes a specialized, trauma-focussed approach to investigation and assessment, which is coordinated across agencies

### Coordination of Therapy, Intervention and Treatment, and Ongoing Support and Follow-up

Once a case has been investigated and appropriate medical and therapeutic assessments have taken place, based on the findings, a response is determined and executed by various partnering agencies. These could include mental health clinician, therapist and physician services for the child, counselling and support services for the family, and ongoing follow-up services for the family to support them in meeting their intervention goals.[4] A distinguishing feature of the SKCAC model is that the various service providers are co-located, or located in close proximity to one-another, which enables easier flows of information between investigation and intervention personnel, and timely and proximal access to treatment services for children and families. Further, non-offending caregivers are supported and counselled simultaneously with the child, through the provision of by victim support and therapist services, thereby allowing agencies to attend to caregiver needs and enhancing their capacity to continue supporting their children.

### Coordination of Prosecution Activities

Once a case has been investigated and evidence of abuse has been gathered, some cases may involve prosecution activities. For these cases, the SKCAC coordinates activities relating to the preparation of victims and witnesses for testimony in court, and providing support to the child and family throughout the court process.[5] The key differentiating aspects of the prosecution support activities in this phase include streamlined and coordinated court preparation and planning across multiple agencies, earlier involvement of the crown prosecutor in assessment of the case and preparation for trials, improved collaboration between police, physicians, CFS and other services providers in collecting evidence of abuse, and specialized witness and child preparation for court proceedings.

### Prevention Activities

[3] CAC Practice Framework and Implementation Plan, 2012

[4] CAC Practice Framework and Implementation Plan, 2012

[5] CAC Practice Framework and Implementation Plan, 2012

The SKCAC is committed to halting abuse before it has happened. Key activities within this stage include bringing different levels of community together to have a focussed conversation around child abuse; developing parent capacity by providing immediate care and support to non-offending caregivers; organizing community education programs through partnership with other organizations; building capacity and empowering youth and children to identify and respond to child abuse, through the youth champions program, and creating networks and alliances through participation in community events, media engagement, and sponsorship.

#### Advocacy and Partnership

A key activity underlying much of the SKCAC's day-to-day operational work is the organization's advocacy and partnership development initiatives. SKCAC plays an active role in developing partnerships with different ministries and government agencies, to focus attention on the issue of child abuse, and advocate for system wide policy reform. It is also committed to developing operational standards and guidelines, and championing best practices in the response to child abuse. As well, the SKCAC invests in creating a data-driven evidence base to develop a profile of child abuse in the region, evaluating the effectiveness of service delivery, and identifying key risk factors.

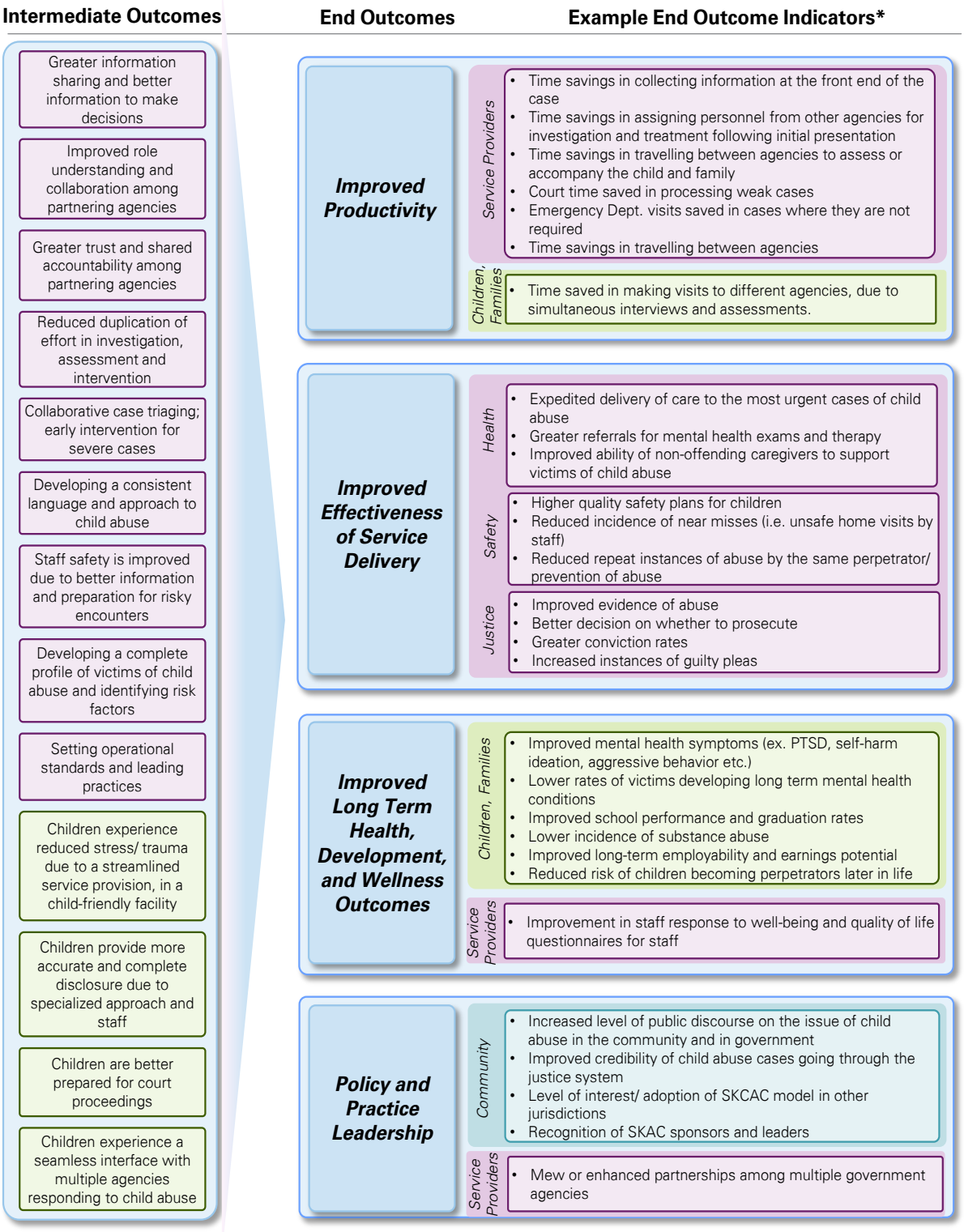
## 3.3 Theoretical Analysis of Outcomes

Our research of the SKCAC has identified a number of direct (intermediary) outcomes resulting from the unique features of the SKCAC integrated practice model as follows. These include:

- Greater information sharing and better information availability to make key decisions
- Improved role understanding among partner organizations
- Greater trust and shared accountability among partnering agencies
- Reduced duplication of effort in investigation, assessment and intervention
- Collaborative case triaging
- Early intervention for severe cases
- Staff safety is improved due to better information and preparation for risky encounters
- Children experience reduced stress/ trauma due to streamlined service provision, in a child-friendly facility
- Children provide more accurate and complete disclosure due to child-friendly environment and trauma-focussed approach
- Children are better prepared for court proceedings
- Children experience a seamless interface with multiple agencies responding to child abuse
- Developing integrated profile of victims of child abuse and identifying key risk factors
- Setting operational standards and leading practices

These intermediate outcomes in turn contribute to three groups of benefits (end outcomes) across stakeholders: 1) productivity improvements across partner agencies, 2) improved effectiveness/ quality of service delivery, and 3) reduced long-term impacts/ costs of child abuse for children, families and support systems. The diagram below illustrates these outcomes, and provides examples of potential indicators that may be used in their assessment.

Figure 3. SKCAC Logic Model




** Please refer to Section 4 of this report for a detailed list of outcome indicators for each stakeholder*

***Legend:*** Service Providers: CFS, CPS, RCMP, AHS, Crown, SKCAC; Children and Families; Community at Large

### 3.3.1 SKCAC Intermediate Outcomes

It is believed that the SKCAC achieves the following outcomes as an immediate consequence of their unique integrated practice model. These in turn serve as drivers in the pursuit of a series of end outcomes, as discussed in Section 4 of this report.

- **Greater information sharing and better information to make decisions:** a key benefit of the SKCAC model is that as a result of the SKCAC partnership, there is now more open sharing of information among agencies, which enables each of them to capture more complete information about the case than they would have been able to do otherwise. This collaborative information sharing has many benefits including: an ability to triage more affectively, ability conduct safety and risk assessments more effectively, higher quality of prosecutions, better understanding of the case, and an improved ability to determine and plan the best course of action. Moreover, it is believed that fewer children fall through the cracks, as there is more information and evidence on which to keep the case open. Further, information sharing also helps to create a shared database for the capturing operational and outcome indicators, and for developing a statistical profile of child abuse in the region, and developing evidence-based practices in providing care.

- **Improved role understanding and collaboration among partnering agencies**: a key target outcome for the SKCAC is that each agency in the collaborative SKCAC partnership has a more intimate understanding of each other's roles and responsibilities, and the value they bring to delivering care for victims of child abuse. For instance, since staff members from various agencies are physically present to watch interviews rather than getting a summary from other agencies, it is felt that this practice helps in developing an understanding of what information is valuable to each agency. This in turn enhances the investigation and assessment process, as each agency is mindful of the needs of other agencies. For example, CPS now asks children and families questions that may be relevant for CFS or AHS; CFS focuses on sexual abuse and mental health because those are relevant for AHS.

- **Greater trust and shared accountability among partnering agencies**: working together on a day-to-day basis contributes to improved levels of trust among agencies and promotes accountability across agencies, while maintaining the confidentiality of cases. During interviews for instance, they have an ability to switch between partners in the event that one agency's approach does not seem to work with the child. This the result of a sense of shared accountability for the case across partners agencies. Moreover, being located in close proximity to one another allows for easy follow-up by members of different agencies, as staff members can leverage their relationships with members of other agencies to encourage follow-up with families.

- **Reduced duplication of effort in investigation, assessment and intervention:** the improved information collection and sharing across partner agencies, and joint interviews reduces the instances of multiple repetitive interviews and multiple home visits to investigate, assess and intervene in the case.

- **Collaborative case triaging and early intervention:** collaborative case triaging among the various partner agencies at the front-end of the case is a unique feature of the SKCAC model, which leads to more timely determination of the most appropriate course of action and an improved ability to expedite severe cases which is seen as a critical success factor in reducing the long-term consequences of abuse. Further, co-location of the different agencies enables implementation of a rapid response which can go a long way in achieving positive long term health and developmental outcomes for children.

- **Developing a consistent language and approach to child abuse:** the co-location of staff, multi-disciplinary nature of case reviews, case planning, investigation and intervention means that agencies with mandates to serve victims of child abuse can now speak a common language on child abuse, and develop a consistent approach to serving the needs of children, keeping the child, rather than the system at the centre of the service. This facilitates consistency in communication and enhances community awareness and discourse on this issue.

- **Staff safety is improved due to better information and preparation for risky encounters:** greater information sharing among partner agencies means that each agency has potentially greater background information on a case. This includes information relating the risk and safety level in

households, which is important for staff that may otherwise be placed at great risk without this information. Further, the presence of RCMP and CPS on site often means that CFS workers can be accompanied during their home visits, ensuring the safety of children and members of the household, but also of the CFS staff.

- **Developing a complete profile of victims of child abuse, and identifying key risk factors:** the commitment to collect and evaluate information about victims of child abuse that are served through the centre is helping to develop a comprehensive data profile of the incidence and nature of child abuse in Canada. This creates a huge potential to improve the ability of the system to identify risk factors of abuse in the region, to respond to abuse, and to prevent abuse in the future.
- **Setting operational standards and leading practices**: given the level of partnerships that have been developed at the SKCAC, between the entire spectrum of agencies responding to child abuse, there is a commitment and potential to develop operational standards and best practice guidelines that may be scaled up to reach more children across the province and the country. Over the past 2 years, there has been an increased interest in the centre from other jurisdictions. The recent Order of Canada award to Sheldon Kennedy is an indicator of the growing recognition of the leadership role that the center is playing the response to child abuse.
- **Children experience reduced stress and trauma:** a number of factors are believed to create a sense of safety and security for children presenting with child abuse at the SKCAC. The child-friendly environment in which children are interviewed is believed to make children feel more comfortable than for instance, being interviewed at a police station. Moreover, the child-life specialist prepares the child for sexual abuse exams or forensic interviews, which lowers the chances that these investigative procedures re-traumatize the victim. Further, it is believed that due to the trauma-focussed approach exercised by each member of the SKCAC integrated practice, and the fact that the child has to sit through fewer interviews means that children experience fewer traumatic flashbacks of abuse.
- **Children provide more accurate and complete disclosure:** it is believed that since children experience lower stress being interviewed at the child-friendly SKCAC facility, rather than at the police station, they provide a more complete account of abuse and more quality disclosure than would otherwise be the case. It is suggested by partner agencies that disclosure is integral to any criminal proceedings that follow in a child abuse case, whereby the quality of the account can make or break a case. More accurate and complete disclosures resulting from the unique features of the SKCAC integrated practice model can therefore greatly enhance the quality of child abuse prosecutions.
- **Children are better prepared for court proceedings:** helping children and families get acclimated to court proceedings, and preparing them for the criminal process and for testimonies is a unique feature of the model. This practice can have a significant consequence for the investigation, as well as court outcomes for each case.
- **Children and families experience a seamless interface with the system:** being a one-stop centre for services responding to child abuse, it is felt that children and families are more easily able to navigate the vast array of services and assistance that is available to them. This not only helps improve system-wide productivity, but also, it increases access to a variety of services for victims of child abuse, since agencies are co-located and immediately available to provide their services when a family is referred to them. Having a one-stop centre also reduces the need for families to travel to multiple sites to receive the care that they need.

Each of these intermediate outcomes is believed to contribute to achieving the end outcomes of the SKCAC integrated practice model. At a high level, these outcomes include improved productivity, more effective service delivery, improved safety and protection, and improved long-term health and development outcomes. The following section delves into a discussion of these end outcomes by each stakeholder.

# 4 SKCAC Impact Assessment

## 4.1 Improved Productivity

The partners involved in the delivery of services to victims of child abuse have suggested that since the SKCAC came into being, there has been a change in the way services are delivered to children and families. That is, the integrated practice model has introduced an improvement to the 'business process' of responding to child abuse, such that the system is delivering a higher level of service without introducing new costs. All partners involved in the delivery of services are able to save excess effort spent in such activities as collecting information at the front end of the case, assigning personnel from other agencies to the case etc. This is not a direct cost saving to the system, as time is re-invested in the delivery of care.

The productivity improvements observed by each of the different agencies involved in the day-to-day response to child abuse cases are summarized in detail in the following table, and quantified in Section 5 of this report. This assessment of productivity improvements is limited to an analysis of the JICAT program due to the availability of data, and as such, likely underestimates the total productivity impact that is being realized by the system.[6] As well, this assessment does not include broader productivity improvements that are occurring in partner agencies due to the specialization of staff, and channelling of the most complex cases of abuse through the SKCAC, which are likely reducing the burden on the rest of the system.

Table 1. Improved Productivity across Partner Agencies

| Stakeholder | Description of Productivity Improvements |
|---|---|
| **CFS** | • Time saved in making phone calls to different agencies to obtain complete information about the case, due to collaborative case reviews at triage<br>• Time saved in identifying appropriate personnel from other agencies, such as CPS detectives, RCMP officers, and AHS workers due to collaborative case planning and co-location of personnel from different agencies<br>• Time saved due to better documentation of case information, each time a case is re-opened<br>• For cases presenting at the hospital, time is saved in travelling from the previous CFS office to the hospital due to closer proximity of CFS workers stationed at the CAC<br>• For emergency cases requiring CFS accompaniment to the hospital, CFS worker travel time is saved due to co-location at CAC |
| **CPS** | • Time saved in making phone calls to different agencies to obtain complete information about the case, due to collaborative case reviews at triage<br>• Time saved in identifying appropriate personnel from other agencies, such as CFS workers and AHS workers due to collaborative case planning and co-location of personnel from different agencies |
| **RCMP** | • Time saved in making phone calls to different agencies to obtain complete information about the case, due to collaborative case reviews at triage |

[6] There were ~972 cases seen through JICAT, which involved a coordinated response by ~45 – 50 staff members in total, from SKCAC and the partner agencies.

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|---|---|
| | • Time saved in identifying appropriate personnel from other agencies, such as CFS workers and AHS workers due to collaborative case planning and co-location of personnel from different agencies |
| **AHS – Health** | • Time saved in making phone calls to different agencies to obtain complete information about the case, due to collaborative case reviews at triage<br>• Time saved in identifying appropriate personnel from other agencies, such as CFS workers and AHS workers due to collaborative case planning and co-location of personnel from different agencies. Previously, they would rely on parents' reports or other secondary sources of information to determine who is involved, and getting a hold of them could delay the start of an assessment by weeks because of the need to connect with other professionals first<br>• Physician and nursing time is saved during sexual abuse exams and medical exams due to better child preparation using the child life specialist<br>• Fewer cases are referred to emergency due to earlier physician consultation and therefore earlier determination of child needs |
| **AHS – Mental Health** | • Once mental health therapy is prescribed, the therapist's time is saved in making calls to other agencies, parents, schools etc. to obtain complete information about the child's history |
| **Courts** | • Court time is saved due to better assessment of the strength of cases (i.e. those that are weak are not sent to court) |
| **Children and Families** | • Time is saved in making visits to different agencies due to simultaneous interviews and assessments |

## 4.2 Improved Effectiveness of Service Delivery

The SKCAC primary value-added is in improving the effectiveness of delivering services to victims of child abuse. These efficacy improvements are believed to be realized across health, safety and justice outcomes for children. At a high level, some of these improvements include: expedited and improved quality of care to the most urgent cases of child abuse, improved ability to develop safety plans and protect children from perpetrators of abuse, and more just court outcomes for perpetrators that were prosecuted. The SKCAC has not been in operation long enough to be able to observe efficacy improvements over time. Instead, summarized below is a formative assessment of the social return that may be realized as a result of the SKCAC integrated practice.

Table 2. Improved Effectiveness of Service Delivery

| Type of Benefit | Description of Effectiveness Improvements |
|---|---|
| **Health** | • It was suggested that a report of severe child abuse now receives a coordinated response within 90 minutes rather than hours or days, as was the case under the old system. This means that children and their caregivers are immediately provided with the care they need, lowering the child's long term need for invasive interviews. This rapid, trauma-focussed response can have significant long-term health and developmental consequences for children, which are discussed in more detail in sections 4.3 and 4.4. Moreover, responding effectively to the most severe cases of child abuse allows the system to specialize in these cases, reducing the burden on individual partner agencies and allowing them to effectively respond to less complex cases<br>• It is suggested that increased physician involvement in case review and planning has meant that more appropriate health interventions are prescribed. This could mean that some files are closed without follow-up after physician review at triage i.e. children are not seen at physician's clinic, or at the hospital needlessly, while others are referred for medical exams or sexual abuse exams. The need for medical intervention is ultimately determined by the severity of the case, however, it is felt that SKCAC integrated practice model has facilitated the determination and implementation of appropriate interventions.<br>• Paediatricians suggested having experienced a greater degree of expertise with child abuse as a result of seeing severe cases of abuse on a regular basis through the SKCAC, and through collaboration with other agencies delivering care to child abuse victims.<br>• Due to the co-location of mental health in close proximity to CPS, CFS and other agencies, it is felt that there are potentially greater referrals for mental health services, and overall, greater recognition of the need for therapy for victims of child abuse.<br>• It is believed that co-location, collaborative case triaging, and collaborative information sharing has led to more effective crisis-intervention, i.e. the provision of timely and quality front-end support to the most severe cases of abuse. This can lower the child's long-term need for mental health support. This is explored in further detail in section 4.4 below.<br>• It is believed that AHS has an improved capacity to provide direct support to non-offending caregivers who are affected by the abuse, thereby better preparing them to support their children, and reducing the burden on the system. |
| **Safety & Protection** | • Increased consultation with police during case planning leads to greater access to background information on potential perpetrators, and therefore, better risk assessments. This enables CFS workers to make a more appropriate safety plan, which may include getting supervision or no-contact orders against potential perpetrators as identified through consultation with the police.<br>• It is believed that more children are protected from perpetrators of abuse, even without a court verdict, due to the improved ability of agencies to determine the risk level of the potential for child abuse as a result of improved information sharing and collaborative case planning. This can be achieved through court orders that prevent the perpetrator from seeing the child.<br>• It is believed that in the future, children will experience fewer repeat instances of abuse by the same perpetrator due to potentially greater convictions, and greater follow-up and follow-through with children that presented at the SKCAC. However, not enough time has passed since the |

| | |
|---|---|
| | launch of the SKCAC to be able to measure this outcome.<br>• It is felt that staff safety has improved as a result of greater information sharing and collaborative practice at the SKCAC. CFS staff safety for instance, has improved as workers are better aware of the risks associated with potential perpetrators, and are thus better able to plan their visits to children's homes in accompaniment with RCMP or CPS staff, who are present on site.<br>• The RCMP does not have a specialized child abuse unit like the CPS. Therefore, working within the CAC, alongside other agencies that are dedicated to providing trauma-focussed, child-centred services to victims of child abuse, RCMP officers have become specialized in dealing with child abuse victims, where previously, constables would be the frontline agents. A specialized, trauma-focused approach is crucial to avoid re-victimization that children may experience during the police investigation.<br>• In rural areas, collaboration between police and CFS is even less effective due to greater infrastructure and administrative hurdles. RCMP finds that the presence of the CAC as a one-stop centre thus improves access to services for victims of child abuse in rural areas, leading to greater ability of the system to protect these children from abuse. |
| **Justice** | • It is expected that due to higher quality of evidence collected in the investigation process, and better court preparation for victims and witnesses, over the long run, it is likely that there will be greater prosecution rates, greater conviction rate, greater number of guilty pleas, and more just sentencing. However it is too early to observe these outcomes as the SKCAC has not been in existence long enough to track the outcome of cases sent to court. At the Zebra Child Protection Centre in Edmonton, it is found that a specialized and multidisciplinary approach to child abuse investigations allows for stronger cases to be made against those who target and abuse children. The Zebra Child Protection Centre reports guilty pleas and conviction rates of between 60-80% versus 20% prior to the opening of the Centre.[7] If the SKCAC achieves similar results, this has implications for the community at large, as offenders are removed from the community and prevented from committing other child abuse offenses<br>• It is believed that the crown prosecutor's involvement in the case early on leads to better evidence collection and case preparation. Moreover, children and families are better prepared to testify in court due to adequate preparation by victim support services ahead of time. Therefore, it is believed that the overall strength of cases making it to court is greater, and fewer cases are stayed due to child no shows. |

## 4.3 Improved Long-Term Health and Development Outcomes

Achieving improvements in the long-term health and development of children and their families is a key target outcome for the SKCAC integrated model of practice. Since the SKCAC has not been in operation long enough to be able to track and assess the long term outcomes for children presenting at the centre, this benefits described in this section are believed to occur based on secondary research of other early intervention programs in Canada and the US.

[7] Driving towards and Integrated Provincial Model of Practice for Alberta's Children and their Families: Briefing Note, Jan 20, 2015

Figure 4. Improved Long-term Health and Development Outcomes

| Stakeholder | Description of Long-term Health and Development Improvements |
|---|---|
| **Children and Families** | Targeted early intervention programs are expected to contribute to a variety of long-term health and development outcomes for children and families presenting at the centre, as follows:[8]<br>• Improved health related indicators, such as PTSD, self-harm ideation, aggressive behaviour, depression in the medium-term, and Improved emotional and cognitive development over the long term<br>• Improved educational process and outcomes for the child, including better achievement in test scores, increased rates of school completion, faster promotion from grade to grade, reduced participation in special education programs<br>• Improved economic well-being and self-sufficiency, initially for the parent, and later for the child, through greater labour force participation, higher income, and lower welfare usage<br>• It is believed that timely and quality crisis intervention, as well as mental health therapy and support for the child can go a long way in improving the long-term mental health outcomes for victims of child abuse (more on this in Section 4.4). This in turn can have significant implications for the child's propensity to develop abusive tendencies later in life. Quality intervention early in life can therefore play a long-term preventative role in the incidence of child abuse. |
| **Service Providers** | • The SKCAC is committed to ensuring the well-being not only of children and families presenting at the center, but also the service providers that treat vicarious trauma on a day-to-day basis. As such, the SKCAC facility is equipped with facilities promoting yoga and other forms of fitness services to SKCAC and partner agency staff. This is likely to improve staff retention. |

[8] Investing in Our Children: What we know and Don't know about the cost and benefits of early childhood interventions, RAND, 1998

# 5 Valuation of Inputs and Outcomes

This section assigns economic value to the inputs and outcomes of the SKCAC integrated practice model. The valuation is based on a thorough analysis of existing SKCAC data and a number of interviews with SKCAC leadership, staff and experts from partner organization to resolve data gaps and validate key assumptions.

The evaluation of outcomes proved to be particularly challenging due to the following data limitations:

a. The SKCAC has not been in existence long enough to follow up with children and families and create the longitudinal data series that is required to evaluate the achievement of many of the target outcomes identified in this study

b. The majority of outcomes and outcome indicators that have been identified in this study are not currently being tracked by the SKCAC and partner agencies, which makes it challenging to ascertain the magnitude of impact achieved

c. There is a dearth of comparable counterfactual statistics on outcome indicators from before the SKCAC's time, or from other jurisdictions where a CAC is not present, which makes it challenging to ascertain and isolate the impact of SKCAC

Given the data limitations described above, the outcomes valuation has focussed on assessing the magnitude of productivity gains based on internal data provided by SKCAC, expert input provided by each stakeholder, and secondary research conducted by KPMG. The nature of the valuation should be considered a forecast, rather than an evaluative analysis.

The outcomes valuation exercise has been divided into productivity outcomes and long-term health, development, safety, and justice outcomes, as discussed below.

## 5.1 Valuation of Inputs

The valuation of inputs includes an estimate of the annual costs of SKCAC's ongoing operations (including capital and operating expenditures) as well as the value of time provided to the organization on a pro-bono basis.

Based on audited financial statements for fiscal 2013-2014 provided by SKCAC, the organization's total annual expenditures are estimated at $2.03 million:

| Cost Category | Annual Expenditure (2013-2014) |
|---|---|
| **Capital Expenditures** | $462,736 |
| **Operating Expenditures** | $1,568,329 |
| • Salaries and Benefits | $652,260 |
| • Occupancy Costs | $621,316 |
| • Program Development and Evaluation | $86,502 |
| • Advertising and Communications | $58,858 |
| • IT Support | $38,675 |

| | |
|---|---|
| • Other (training/development, office expenses, audit) | $ 110,718 |
| **Total Annual Expenditure** | **$2,031,065** |

In addition to the direct expenditures, the SKCAC receives support from Sheldon Kennedy, his executive assistant, and 15 members of the Board of Directors. While their time is provided on a pro-bono basis, we have chosen to include it as an input cost, given its importance to achieving the target outcomes of the SKCAC. Based on information provided by Sheldon Kennedy's office, we estimate the cost of his support to be ~$142K per year[9]. Based on information provided by the SKCAC, we estimate the cost of Board of Directors time to be ~$30K per year[10].

Adding up SKCAC's direct expenditures and the value of pro-bono support provided by Sheldon Kennedy, his executive assistant, and members of the Board of Directors, we estimate the annual value of inputs to the SKCAC to be **~$2.2 million**.

## 5.2 Valuation of Productivity Outcomes

As described in section 4.1, a number of system-wide productivity improvements have been experienced by each of the stakeholder groups studied. In order to quantify the magnitude of the productivity improvement and assign an economic value to it, we relied on internal SKCAC data, stakeholder input, and secondary research.

In total, we estimate that the productivity improvements introduced by the SKCAC amount to **~$550,000** annually, across stakeholders. This represents a measure of the additional time that would be required in the absence of SKCAC, to achieve the level of service delivered today. Examples of productivity improvements include:

- Time saved in collecting information at the front end of the case
- Time saved in assigning personnel for investigation and treatment following initial presentation
- Time saved in travelling between agencies
- Time saved in unnecessary visits to the emergency department

This amount does not represent a reduction of budgets or headcount across stakeholders. Further, this assessment of productivity improvements is limited to an analysis of the JICAT program due to the availability of data, and as such, likely underestimates the total productivity impact that is being realized by the system. As well, this assessment does not include broader productivity improvements that are occurring in partner agencies due to the specialization of staff, and channelling of the most complex cases of abuse through the SKCAC.

Summarized below is the estimated value of time saved by each agency participating in the SKCAC

[9] Based on data provided by Sheldon Kennedy's office, Sheldon Kennedy commits to the SKCAC ~35 hours per week on average. Given that this time is provided pro-bono to the SKCAC, we have used a proxy to estimate the cost. The financial proxy database by PayScale indicates that the total compensation of a Non-profit Executive Director ranges from $39,742 - $96,075 per year (based on 664 individuals reporting). Using the **top end** of this range, we estimate the cost of Sheldon Kennedy's time committed to the SKCAC to be ~$84,000 per year. Sheldon Kennedy's Executive Assistant is estimated to commit an average of 30 hours per week on SKCAC related matters at a cost of $40 per hour. Assuming 48 working weeks per year, this translates to a cost of ~$57,600 per year. Rounding up, the total cost of Sheldon Kennedy's support is therefore estimated at **~$142K per year**.

[10] The SKCAC estimates that the 15 members of the Board of Directors collectively spend ~600 hours per year on SKCAC related activities, such as quarterly Board meetings, Board led committee meetings, events, and additional time provided by Co-Chairs. Given that this time is provided pro-bono to the SKCAC, we have used a proxy to estimate the cost. The financial proxy database by PayScale indicates that the total compensation of a Non-profit Executive Director ranges from $39,742 - $96,075 per year (based on 664 individuals reporting). Using the **top end** of this range, and assuming 48 working weeks per year and 40 working hours per week, we estimate the cost of Board of Directors time to be **~$30K per year**.

integrated model of practice. A detailed breakdown of the value of time savings by each agency, and the data and assumptions underlying the estimation can be found in Appendix I.

Figure 5. Valuation of Productivity Outcomes

| Stakeholder | Effort saved/ year | Value of Time Savings |
|---|---|---|
| CFS | 2,875 hours | $199,696 |
| CPS | 822 hours | $59,200 |
| RCMP | 616 hours | $37,094 |
| AHS | 1,472 hours | $114,805 |
| Courts | 15 hours | $21,625 |
| Children and Families | 11,751 hours | $119,368 |
| **Total** | **17,551 hours** | **$551,788** |

## 5.3 Valuation of Long-term Health, Development, Safety and Justice Outcomes

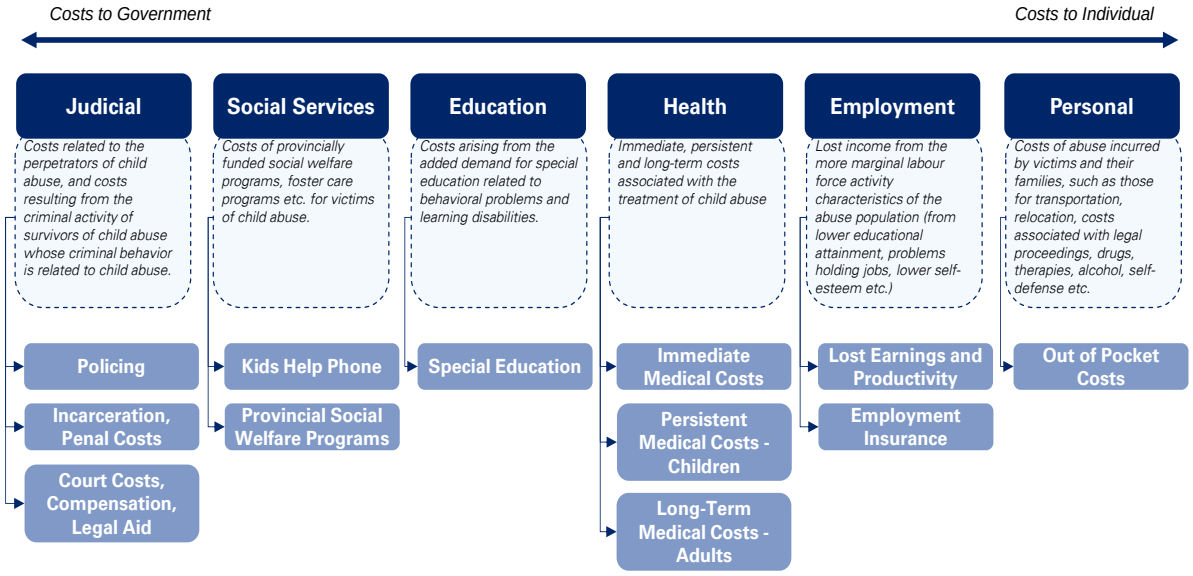
Ultimately, achieving improvements in the health, well-being and development of children is a key target outcome for the SKCAC integrated practice model. As described in section 4.3, early intervention programs are believed to lead to improvements in health (in such indicators as PTSD, self-harm tendencies, aggressive behaviour, suicidal ideation etc.), education (such as performance on standardized tests, graduation rates etc.), and economic well-being (labour force participation, improved income etc.). In monetary terms, these long-term outcomes for children are essentially cost-avoidance benefits e.g. the reduced need for therapy and health interventions and the reduced costs associated with that. To be able to estimate the long-term cost avoidance resulting from the SKCAC integrated practice model would require long-term follow-up with children and families, tracking various indicators of health, safety and development. Given that not enough time has passed to build a longitudinal database, since the SKCAC came into operations, the long-term health and development impacts that are expected to occur as a result of the SKCAC integrated practice model cannot be evaluated in a bottom-up way at this stage. However, significant peer-reviewed research has been conducted in the long-term costs of child abuse in Canada which allows us to take a top-down approach to this exercise, and draw conclusions about the magnitude of cost avoidance impact that is required to achieve a positive social return on investment for SKCAC.

### 5.3.1 The Long Term Costs of Child Abuse

The long term costs of child abuse in Canada have been the subject of rigorous study by researchers around Canada. Our study relies on secondary research to ascertain the cost-avoidance benefits that may be achieved as a results of the SKCAC integrated practice model. Specifically, this study takes cue from a 2003 report to the Law Commission of Canada titled 'The Economic Costs and Consequences of Child Abuse in Canada', which presents a model for evaluating the economic costs of child abuse in Canada, and endeavours to determine these costs for the year 1998 (the year for which they had complete data).[11] This model is depicted in the diagram below.

[11] Bowlus, McKenna, Day, Wright. The Economic Cost and Consequences of Child Abuse in Canada: Report to the Law Commission of Canada, March 2003

Figure 6. The Day Model of the Costs of Child Abuse[12]




In their paper, Bowlus et al develop a model of the costs of child abuse in Canada, which segments these costs into six categories: judicial, social services, education, health, employment, and personal costs. Judicial costs include costs related to perpetrators of child abuse, and also to the criminal activity of survivors of child abuse whose criminal behaviour is related to child abuse. These costs include policing, incarceration, penal costs, court costs, compensation, legal aid etc. Social services include costs of provincially funded social welfare programs, foster care programs, kids help lines etc. Education costs include those arising from the added demand for special education related to behavioural problems and learning disabilities. Health costs include the immediate, persistent and long-term costs associated with the treatment of child abuse. Employment costs include lost income from the more marginal labour force activity of the abused population, from lower educational attainment, problems holding jobs, lower self-esteem etc. Lastly, personal costs include out-of-pocket costs for survivors of abuse, including cost of drugs, therapies, proceedings, self-defence etc.

The cost estimation methodology employed in this study involves both top-down and bottom-up approaches. That is, for the first three categories of costs (judicial, social services and education), they use a top-down approach to estimation, take provincial financial data to estimate the total budget allocated to these services for child abuse. To estimate the health, employment and personal costs, their study uses survey data to evaluate the costs associated with child abuse in these categories. Given the limited availability of data to conduct their study, Bowlus et al suggest that their estimates of the cost of child abuse in Canada are **relatively conservative**. The find that the total annual cost of child abuse in Canada was at least $15.7 billion, across the different cost categories, in 1998. Expressed in 2014 dollars, the total cost of child abuse in Canada is estimated to be **$21.5 billion**. A detailed breakdown of costs is provided below.

Figure 7. Estimated Annual Cost of Child Abuse in Canada[13]

| | 1998 | 2014 |
|---|---|---|
| Judicial | $0.6 B | $0.8 B |
| Social Services | $1.2 B | $1.6 B |

[12] Bowlus, McKenna, Day, Wright. The Economic Cost and Consequences of Child Abuse in Canada: Report to the Law Commission of Canada, March 2003

[13] The 1998 values are from the Bowlus et al, 2003 paper. The 2014 figures were derived by adjusting the 1998 figures for inflation using the CPI

| | | |
|---|---|---|
| Education | $0.02 B | $0.03 B |
| Health | $0.2 B | $0.3 B |
| Employment | $11.3 B | $15.5 B |
| Personal | $2.4 B | $3.2 B |
| **Total** | **$15.7 B** | **$21.5 B** |

In order to determine the cost of child abuse in Alberta, the 2014 Canadian totals were adjusted by a factor that is equivalent to the incidence of child abuse in Alberta. The Canadian Incidence Study of Reported Child Abuse and Neglect provides the best available estimates of the incidence of child maltreatment across Canada.[14] This study suggest that 12% of child maltreatment investigations in Canada occurred in Alberta.[15,16] Assuming that the cost of child abuse in Canada is equally distributed across the provinces, we calculate the total annual cost of child abuse in Alberta to be **$2.4 billion**. A detailed breakdown of costs is provided in the table below.

Figure 8. Estimated Annual Costs of Child Abuse in Alberta - 2014

| | Canada | Alberta |
|---|---|---|
| Judicial | $0.8 B | $0.09 B |
| Social Services | $1.6 B | $0.2 B |
| Education | $0.03 B | $0.004 B |
| Health | $0.3 B | $0.03 B |
| Employment | $15.5 B | $1.7 B |
| Personal | $3.2 B | $0.4 B |
| **Total** | **$21.5 B** | **$2.4 B** |

### 5.3.2 Implications to SKCAC Social Return on Investment

As evidenced by this research, the long-term costs of child abuse are so substantial that ultimately, delivering timely, effective, quality care can result in significant benefits to the child, and reduce the economic costs associated with child outcomes to a considerable degree. From a social return on investment perspective, in order to rationalize the SKCAC model of integrated practice, total economic cost savings would need to at least match the input costs associated with centre in order for the centre to have a positive social return on investment. Given a value of inputs to the SKCAC of ~$2.2 million annually, this amounts to less than 0.1% of the total cost of abuse in Alberta. That is, the SKCAC only needs to achieve a **0.1% reduction** in the costs associated with child abuse in Alberta in order to achieve a positive social return on investment.

[14] Canadian Incidence Study of Reported Child Abuse and Neglect, 2008 (CIS)

[15] Alberta Incidence Study of Reported Child Abuse and Neglect, 2008 (AIS)

[16] The AIS study finds that in 2008, the total number of child maltreatment investigations in Alberta was 27,147, and the CIS study finds that in Canada, this number was 217,897. As a percentage of total child maltreatment investigations in Canada, the incidence of abuse in Alberta is estimated to be 12%.

# 6 Future Directions for SKCAC Impact Evaluation

Although calculating an SROI statistic is one method of measuring impact, understanding the true value of the SKCAC model requires a focus long-term social outcomes. Ultimately, we believe that investing in child advocacy and protection is a matter of human rights and should not be driven by financial considerations alone. At the same time, evaluating the long-term health and development outcomes for children and families would require significant investment in following-up with SKCAC clients over long periods of time (10 to 15 years), and measuring indicators of mental health, physical health, education, and employment outcomes.

We therefore recommend that immediate evaluation efforts are directed towards measuring the effectiveness of the service delivery, which drive the achievement of long-term outcomes for children and families. Listed below are suggested areas of focus for data collection and evaluation, by type of outcome. Collecting this data would be critical in enabling partner agencies to:

- Improve the ability to predict and prevent child abuse
- Improve the ability to respond to child abuse
- Improve the wellness and safety of staff
- Introduce efficiencies and scale up the model

Figure 9. Potential Indicators for Future Evaluation

| **Type of Effectiveness Outcome** | **Potential Indicators** |
|---|---|
| Health | • Response time for cases, by severity of abuse<br>• Referrals for mental health exams<br>• Referrals for therapy<br>• Children's compliance to therapy<br>• Cases closed at consult, vs. referred to other services in the community<br>• Trend in prevalence of trauma symptoms, anxiety, depression, anger, PTS, dissociation among victims of abuse (at the start of therapy and at the end, as well as follow-up after they have left the center)<br>• Number of non-offending caregivers supported<br>• Caregiver and child satisfaction with service |
| Safety | • Number of no-contact orders issued to alleged perpetrators<br>• Number of children protected from alleged perpetrators of abuse (placed with kin, placed in foster care, perpetrator was removed etc.)<br>• Number of repeat instances of abuse (and whether it was by the same perpetrator or someone else)<br>• Number of near misses (unsafe home visits by CFS staff) |
| Justice | • Number of disclosures and levels of completeness (qualitative measure)<br>• Number of charges laid and severity<br>• Number of charges successfully concluded<br>• Prosecution rates<br>• Conviction rates (and severity of sentencing)<br>• Number of guilty pleas<br>• Number of cases closed due to child no-shows |

There are two ways of statistically evaluating the impact of SKCAC on system effectiveness:

- Comparing these metrics today to pre-SKCAC levels would help ascertain whether the intended outcomes of the SKCAC integrated practice model are being achieved. One limitation of this type of analysis is that robust data of this nature was not collected prior to 2013, when the SKCAC commenced operations. For this reason, even if this data was collected going forward, the efficacy of the baseline scenario where the SKCAC did not exist may remain unknown, making it challenging to identify the change that resulted from the SKCAC.
- Using other regions as benchmarks, where there is a more traditional service delivery model for victims of child abuse (i.e. individual partners deliver care, rather than an integrated practice). That is, comparing these metrics in SKCAC today to the same metrics in other regions that do not have a CAC model.

Both these methods would be cross-sectional analyses that would help determine the level of effectiveness impact, and attribute it to the SKCAC model. In addition to this type of evaluation, time-series data collection and analysis is also suggested, in order to monitor the improvements in the SKCAC model over time. Some examples of long-term data collection and evaluation include:

- Long-term health and development outcomes for children and families, which would require significant investment in following-up with SKCAC clients over long periods of time (10 to 15 years), and measuring indicators of mental health, physical health, education, and employment outcomes. In the immediate term, survey data could be collected on child and family experiences with the system.
- SKCAC's goal of preventing child abuse may be monitored in the community as the trend in the incidence of abuse.
- Lastly, achievement of the goal of policy and practice leadership can be evaluated by studying the adoption of the unique features of the SKCAC integrated practice model in other jurisdictions; the level of partnerships that are forged with other government agencies and organizations; and new legislation influenced by SKCAC's advocacy and community leadership efforts.

# 7 Appendix I: Valuation of Productivity Improvements

Figure 10. Quantification of Productivity Impact

| Stakeholder | **Indicator** | **Min hours/ case** | **Max hours/ case** | **% of Total Cases** | **# of simple cases** | **# of complex cases** | **Source/ Notes** | **Total hours min** | **Total hours max** |
|---|---|---|---|---|---|---|---|---|---|
| CFS | Time saved in making phone calls to different agencies to obtain complete information at the front end of the case | 4 | 6 | 100% | 89 | 209 | Hours/ case: stakeholder assessment<br>Total number of cases: JICAT data (% of total cases seen by CFS that were presented by CFS at triage) | 356 | 1252 |
| | Time saved in identifying and assigning appropriate personnel for investigation and assessment | 1 | 6 | 100% | 89 | 209 | Hours/ case: stakeholder assessment<br>Total number of cases: JICAT data (% of total cases seen by CFS that were presented by CFS at triage) | 89 | 1252 |
| | Time saved in subsequent case reviews, due to better documentation of case information | 0.75 | 3 | 10% | 89 | 209 | Hours/ case: stakeholder assessment<br>Total number of cases: JICAT data (% of total cases seen by CFS that were presented by CFS at triage) | 7 | 63 |
| | For cases presenting at hospital, time is saved in travelling from the previous CFS office to the hospital due to closer proximity | 4 | 6 | 5% | 89 | 513 | Hours/ case: stakeholder assessment<br>% of total cases: stakeholder assessment<br>Total number of cases: JICAT data (total cases seen by CFS) | 18 | 154 |
| | For emergency cases requiring CFS accompaniment to the hospital, CFS worker travel time is saved due to co-location at CAC | 4 | 6 | 5% | 89 | 513 | Hours/ case: stakeholder assessment<br>% of total cases: stakeholder assessment<br>Total number of cases: JICAT data (total cases seen by CFS) | 18 | 154 |
| CPS | Time saved in making phone calls to different agencies to obtain complete information at the front end of the case | 1 | 3 | 100% | 61 | 103 | Hours/ case: stakeholder assessment<br>Total number of cases: JICAT data (% of total cases seen by CPS that were presented by CPS at triage) | 61 | 308 |
| | Time saved in identifying and assigning appropriate personnel for investigation and assessment | 1 | 5 | 100% | 61 | 103 | Hours/ case: stakeholder assessment<br>Total number of cases: JICAT data (% of total cases seen by CPS that were presented by CPS at triage) | 61 | 514 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| RCMP | Time saved in making phone calls to different agencies to obtain complete information at the front end of the case | 1 | 3 | 100% | 14 | 56 | Hours/ case: stakeholder assessment<br>Total number of cases: stakeholder assessment | 14 | 168 |
| | Time saved in identifying and assigning appropriate personnel for investigation and assessment | 1 | 8 | 100% | 14 | 56 | Hours/ case: stakeholder assessment<br>Total number of cases: stakeholder assessment | 14 | 448 |
| AHS - Health | Time saved in making phone calls to different agencies to obtain complete information at the front end of the case | 1 | 3 | 100% | 144 | 174 | Hours/ case: stakeholder assessment<br>Total number of cases: JICAT data (% of total cases seen by AHS that were presented by AHS at triage) | 144 | 521 |
| | Time saved in identifying and assigning appropriate personnel for investigation and assessment | 1 | 5 | 100% | 144 | 174 | Hours/ case: stakeholder assessment<br>Total number of cases: JICAT data (% of total cases seen by AHS that were presented by AHS at triage) | 144 | 868 |
| | Physician time is saved during sexual abuse exams due to better child preparation using the child life specialist | | 0.5 | 100% | | 49 | Hours/ case: stakeholder assessment<br>Total number of cases: JICAT data (total number of sexual abuse exams); assumption: it is for sexual abuse exams that cooperation from the child is most challenging, and where the most significant time savings are seen by physicians, as a result of the child life specialist. | 0 | 25 |
| | Fewer cases are referred to emergency due to earlier physician consultation and therefore earlier determination of child needs | 1 | 1 | 51% | | 37 | Hours/ case: stakeholder assessment<br>Total number of cases: JICAT data (total number of physical abuse exams)<br>% of total cases: JICAT data (% of total physical abuse exams that did not require a case conference); assumption: physical abuse exams that require a case conference represent complex cases that may still require ED visits. Time savings from fewer ED visits are therefore likely only for those cases seen in outpatient care. | 0 | 19 |
| AHS - Mental Health | Once mental health therapy is prescribed, therapist's time is saved in making calls to other agencies, parents, schools etc. to obtain complete information about the child's history | 2 | 2 | 20% | 50 | 100 | Hours/ case: stakeholder assessment<br>Total number of cases: stakeholder assessment<br>% of total cases: stakeholder assessment (% of cases requiring follow-up by therapist) | 20 | 40 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Crown | Court time is saved due to better assessment of the strength of cases (those that are weak are not sent to court) | 1 | 1 | 25% | | 61 | Hours/ case: NA<br>Total number of cases: stakeholder assessment, JICAT data (total number of cases seen by CPS alone); assumption: cases seen by CPS directly have a higher likelihood of charges being laid<br>% of total cases: stakeholder assessment (% of time saved in court case); assumption: court cases take ~18 months instead of 24, therefore 25% reduction in time in court (so assuming equivalent reduction in court costs) | 0 | 15 |
| Children and Families | Time is saved in making visits to different agencies due to simultaneous interviews and assessments | | | | | | | | |
| | 1 partner seen | 1 | | 80% | 296 | | Hours/ case: stakeholder assessment<br>Total number of cases: JICAT data<br>% of total cases: stakeholder assessment (% of cases requiring families to travel to partners) | 237 | |
| | 2 partners seen | 1 | | 80% | 346 | | | 277 | |
| | 3 partners seen | 1 | | 80% | 268 | | | 214 | |
| | 4 partners seen | 1 | | 80% | 4 | | | 3 | |
| | Personal cost of taking time off work for interviews and assessments – absenteeism | | | | | | | | |
| | 1 partner seen | 8 | | 80% | 296 | | Hours/ case: stakeholder assessment (assuming one day of lost earnings, per agency seen)<br>Total number of cases: JICAT data<br>% of total cases: stakeholder assessment (% of cases requiring full day off) | 1894 | |
| | 2 partners seen | 16 | | 80% | 346 | | | 4429 | |
| | 3 partners seen | 24 | | 80% | 268 | | | 5146 | |
| | 4 partners seen | 32 | | 80% | 4 | | | 102 | |

Figure 11. Valuation of Productivity Improvements

| | | Quantity | | Financial Proxy | | | Impact | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Stakeholder | **Indicator** | **Total hours min** | **Total hours max** | **Description** | **Value per Hour/ Visit** | **Source** | **Min. Impact** | **Max. Impact** | **Total** | **Total by Partner** |
| CFS | Time saved in making phone calls to different agencies to obtain complete information at the front end of the case | 356 | 1252 | CFS Assessor Wage | $59.39 | Stakeholder Assessment of wage + 28% benefits adjustment | $21,143.55 | $74,378.00 | $95,522 | $199,696 |
| | Time saved in identifying and assigning appropriate personnel for investigation and assessment | 89 | 1252 | CFS Assessor Wage | $59.39 | Stakeholder Assessment of wage + 28% benefits adjustment | $5,285.89 | $74,378.00 | $79,664 | |
| | Time saved in subsequent case reviews, due to better documentation of case information | 7 | 63 | CFS Assessor Wage | $59.39 | Stakeholder Assessment of wage + 28% benefits adjustment | $396.44 | $3,718.90 | $4,115 | |
| | For cases presenting at hospital, time is saved in travelling from the previous CFS office to the hospital due to closer proximity | 18 | 154 | CFS Assessor Wage | $59.39 | Stakeholder Assessment of wage + 28% benefits adjustment | $1,057.18 | $9,140.43 | $10,198 | |
| | For emergency cases requiring CFS accompaniment to the hospital, CFS worker travel time is saved due to co-location at CAC | 18 | 154 | CFS Assessor Wage | $59.39 | Stakeholder Assessment of wage + 28% benefits adjustment | $1,057.18 | $9,140.43 | $10,198 | |
| CPS | Time saved in making phone calls to different agencies to obtain complete information at the front end of the case | 61 | 308 | CPS Detective Wage | $63 | Stakeholder Assessment of wage + 28% benefits adjustment | $3,825.92 | $19,330.67 | $23,157 | $59,200 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Time saved in identifying and assigning appropriate personnel for investigation and assessment | 61 | 514 | CPS Detective Wage | $63 | Stakeholder Assessment of wage + 28% benefits adjustment | $3,825.92 | $32,217.79 | $36,044 | |
| RCMP | Time saved in making phone calls to different agencies to obtain complete information at the front end of the case | 14 | 168 | RCMP Officer Wage | $58 | Stakeholder Assessment of wage + 28% benefits adjustment | $806.40 | $9,676.80 | $10,483 | $37,094 |
| | Time saved in identifying and assigning appropriate personnel for investigation and assessment | 14 | 448 | RCMP Officer Wage | $58 | Stakeholder Assessment of wage + 28% benefits adjustment | $806.40 | $25,804.80 | $26,611 | |
| AHS - Health | Time saved in making phone calls to different agencies to obtain complete information at the front end of the case | 144 | 521 | AHS Nurse Clinician Wage | $55.16 | AHS Website for hourly wage +28% benefits adjustment | $7,942.35 | $28,726.13 | $36,668 | $114,805 |
| | Time saved in identifying and assigning appropriate personnel for investigation and assessment | 144 | 868 | AHS Nurse Clinician Wage | $55.16 | AHS Website for hourly wage +28% benefits adjustment | $7,942.35 | $47,876.88 | $55,819 | |
| | Physician time is saved during sexual abuse exams due to better child preparation using the child life specialist | 0 | 25 | Pediatrician Wage | $300.00 | Stakeholder assessment | $0.00 | $7,350.00 | $7,350 | |
| | Fewer cases are referred to emergency due to earlier physician consultation and therefore earlier determination of child needs | 0 | 19 | Cost of Emergency Room Visit | $600 | Stakeholder assessment of cost of emergency department visit, adjusted down for cost of specialist consultation | $0.00 | $11,322.00 | $11,322 | |

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|---|---|---|---|---|---|---|---|---|---|---|
| AHS - Mental Health | Once mental health therapy is prescribed, therapist's time is saved in making calls to other agencies, parents, schools etc. to obtain complete information about the child's history | 20 | 40 | Therapist Wage | $61 | AHS Website for hourly wage +28% benefits adjustment | $1,215.10 | $2,430.21 | $3,645 | |
| Crown | Court time is saved due to better assessment of the strength of cases (those that are weak are not sent to court) | 0 | 15 | Cost of criminal court case | $1,418 | SROI Financial Proxy Database | $0.00 | $21,625.10 | $21,625 | $21,625 |
| Children and Families | Time is saved in making visits to different agencies due to simultaneous interviews and assessments | | | | | | | | | |
| | 1 partner seen | 237 | | Travel cost to interviews (mileage and gas)/ visit | $5 | Stakeholder assessment of distances and costs of travel for famiies prior the SKCAC | $1,184.00 | | $1,184 | $119,368 |
| | 2 partners seen | 277 | | | $5 | | $1,384.00 | | $1,384 | |
| | 3 partners seen | 214 | | | $5 | | $1,072.00 | | $1,072 | |
| | 4 partners seen | 3 | | | $5 | | $16.00 | | $16 | |
| | Personal cost of taking time off work for interviews and assessments – absenteeism | | | | | | | | | |
| | 1 partner seen | 1894 | | Personal cost of taking time off (minimum hourly wage) | $10 | Assuming minimum hourly wage as the opportunity cost of taking time off work | $18,944.00 | | $18,944 | |
| | 2 partners seen | 4429 | | | $10 | | $44,288.00 | | $44,288 | |
| | 3 partners seen | 5146 | | | $10 | | $51,456.00 | | $51,456 | |
| | 4 partners seen | 102 | | | $10 | | $1,024.00 | | $1,024 | |
| | | | | | | | | **Total Impact** | **$551,788** | |