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# Executive Summary

## Background

In February/2009, the Southern First Nations Network of Care (SFNNC), jointly with the Child Protection Branch (CPB), began a review of the service model of the Child and Family Services All Nations Coordinated Response (ANCR) Agency. The review was initiated in response to a condition in the Agency's mandate review report that the service model be reviewed within two years of the Agency receiving its mandate.

The 2006 Mandate Review noted that the service delivery model being used was similar to what had been used at WCFS. It was recognized that while this model had known challenges, major changes should be made only after some experience was gained in working in a concurrent jurisdictional system. The 2006 Review subsequently made the ANCR mandate conditional on such a review being undertaken within a two year period. This Review satisfies that requirement.

The Review examined the effectiveness of the existing service model at ANCR in four program areas: the After-Hours Unit (AHU), the Crisis Response Unit (CRU), the Tier II Intake Unit and the Abuse Investigation Unit (AIU). The efficiency and effectiveness of the telephone services was also examined.

The Family Enhancement Unit was not included in this review. This Unit is in the process of revising its structure and programs to be consistent with the implementation of a province wide differential response service model.

A separate review on the Human Resources Program was completed by an external consultant in January/2009. Change Management consultants were contracted in October/2009 to begin the implementation of the recommendations from this Report.

## The Review Process

The review was done by examining the structure and design of each program area, staff numbers and configurations, telephone system adequacy and the ability to meet service demands effectively, in relation to service volume.

The review process included an examination of data collected from the CFS Information System Intake Module (IM), a review of policies, procedures and program information and an examination of data maintained by each program area. Service requests made to the After Hours Unit (AHU) by other CFS Agencies were reviewed along with manual records of responses to Intake referrals by the AHU. A file audit was conducted on a sample of files from the Tier II Intake Unit, including files where an abuse investigation was required. The file audit examined compliance with standards in several areas of service delivery and information management.



In addition, the Review Committee requested a literature review of Intake service models in four different countries: Canada, the United States of America, Australia and New Zealand. The literature review provided insight into other methods of intake screening and decision-making through the use of clear guidelines and clinical tools. These tools assist Intake workers with decision-making and ensure the application of consistent standards in intake screening and investigations.

Valuable information came from the staff and managers employed at ANCR, staff and managers employed with other CFS agencies in the province that work closely with different ANCR programs, and representatives from the many organizations and agencies in Winnipeg who utilize the services provided by ANCR on behalf of children and families.

### ***Section 1: Crisis Response Unit, After Hours Unit, Tier II Intake***

The CRU operates in an intensive, fast-paced environment. CRU workers respond to all initial requests for services and/or child protection referrals. Two staff teams rotate between the telephone screening function and the function of responding to all written referrals, walk in clientele, and emergency field visits. The review found that this rotation of staff does not appear to be effective.

There is a lack of clarity about the specific functions of the CRU in relation to the other general intake functions provided by Tier II Intake. This lack of clarity exists for ANCR staff as well as for the other CFS agencies and collateral organizations. The review found that there is a duplication of services between the CRU and Tier II Intake.

Services provided by the Tier II Intake program lack consistency. Some services are intensive and directly address crisis and stabilize the family, others are brief and focus on gathering information for the purpose of transferring. This results in uneven workload among the staff teams at Tier II.

There are a number of factors that contribute to workload issues for CRU and Tier II. These include the transfers under section 28 of the CFS Act; the Authority Determination Protocol (ADP); the inconsistency in the use of CFSIS by all CFS agencies; and the non-emergency service requests from CFS agencies.

The impacts of the Workforce Adjustment Strategy have been a factor on staff turnover, both at the front line and supervisor level, resulting in numbers of staff who are less experienced in Intake. Tier II has a large number of staff from Winnipeg CFS who are permanent or temporary secondees at ANCR.

The After Hours Unit (AHU) provides emergency services after regular working hours. This Unit is staffed by a combination of full and part time staff, with casual staff used on an as needed basis. The part time and casual employees bring with them high levels of experience providing benefits such as flexibility and experience to new full time staff. Reliance on casual staff, however, can be problematic.

AHU staff is responsible to screen telephone calls, respond to walk-ins, and go out on required field visits. They also respond to service requests from agencies. The review found that these requests do not always provide complete information and are not always emergencies. They take up considerable worker time.



The majority of the referrals to the AHU occur by telephone. When staff is out on a field visit, there is no one to answer the phone at ANCR and the calls are directed to an answering service. The review found that the answering service personnel make decisions about priority of calls but they are not trained CFS staff.

The lack of consistent use of CFSIS by all agencies was identified as a high priority concern. AHU workers are not able to contact case workers and rely on available information. Not having this information up to date and readily available can compromise services.

Recommendations include:

- That ANCR reconfigure the service functions of the CRU, Tier II and some elements of the AHU, into a revised model that will streamline services.
- That the new model includes a 24 Hour Intake Screening and Assessment Unit, and Investigation and Stabilization Unit, an After Hours Unit, and an Abuse Investigation Unit.
- It is recommended that ANCR establish a committee to review service volumes, develop practice standards, service guidelines, criteria for decision making and workload management standards to ensure service time frames are met and gap or breaks do not occur in service because of workload issues.
- That a working committee be developed to address the human resource issues in the AHU including the part time staff equivalency and reliance on casual staff.
- That a stronger criteria and framework be developed for service requests from CFS agencies and that this includes a plan for training all CFS workers in the criteria.
- That a working committee with ANCR staff and representatives from other CFS agencies be established to develop guidelines for effective communication and sharing of information after hours.

## ***Section 2: Abuse Investigations Unit***

The Abuse Investigations Unit (AIU) investigates all referrals of child abuse. These come from new intakes at ANCR and from CFS agencies. The Review Team found that in 2008, 78% of the referrals to the AIU came from ANCR Intake services and 22% from other CFS Agencies.

An analysis of the data showed that abuse was substantiated in 11% of the referrals. In 53% of the referrals, investigations resulted in findings that child abuse did not occur or the matter involved inappropriate behavior by a parent and was not abuse. This data raises questions about the appropriateness of the existing referral criteria.

The review found that the workload in the AIU was substantial. Caseload sizes averaged approximately 60 per worker, although in a large number of those cases, the investigation and services had been completed and the file closure was pending the completion of the closing summary by the worker.



The Review found that the AIU had been impacted by the Workforce Adjustment Strategy. Of the original 16 abuse investigator positions, 14 were staffed with temporary secondees. With the plan to find reasonable job offers for the temporary secondees within a relatively short period of time, it was inevitable that the AIU would experience significant staff turnover. Together with staff resignations and the creation of a third abuse team it has left ANCR with abuse investigators that, although having CFS experience, are relatively inexperienced in abuse investigations.

Abuse investigators are not case managers and the referring worker remains involved as the case manager. This appears to work well if a referral is made from another CFS agency. With 78% of all referrals to the AIU coming from within ANCR, the efficacy of having two ANCR workers involved in a case, while still maintaining specialized abuse investigative services, requires further review.

The Review found that in abuse only cases (cases where an abuse investigation was underway, but no other child protection concerns existed, as for example in a third party assault) ANCR assigned the case to an Intake supervisor. This was to meet the requirement that a case manager be assigned to every case. A high number of cases, where no active case management services are required, are assigned to supervisors. The client family remains involved with the AIU workers throughout this process. In May/2009, the Review Team found 978 cases, referred for an abuse investigation only, assigned to Intake Supervisors.

Recommendations include:

- That to better identify and target actual child abuse, streamlined and strengthened abuse referral criteria be developed for all referrals for abuse investigation and that this be done based on further analysis of the referral criteria, including research into criteria used by other abuse programs nationally and internationally.
- That AIU staffing levels and further expansion should be based on an analysis of referral data, abuse investigation findings, and closing/transfers.
- That a committee be established to immediately review the abuse only cases assigned to Intake supervisors and to recommend an alternate method to deal with such cases.
- That the hiring of additional abuse investigators be suspended pending a further review of the referral data and abuse investigation conclusions.
- That an in house Abuse Trainer/mentor position be established.
- That a Child Abuse Committee Coordinator position be established.

### ***Section 3: Family Enhancement Unit***

The Family Enhancement Unit was not included in the scope of the Service Model Review. This Unit is undergoing substantive change as part of a province wide initiative to implement a differential response service delivery model for CFS. The Review recommended that a quality assurance review of the FE Unit be undertaken by the SFN Network of Care no later than 2013/2014.



#### **Section 4: Telephone System**

An effective telephone system, understood and properly staffed, is critical to the work of ANCR in responding to child protection emergencies.

The majority of referrals to ANCR are made by telephone. During a one week review period, it was determined that 1093 calls were received during regular working hours and 907 calls were received after hours. After hours, the majority of the calls occur between 4:30 p.m. and 10:00 p.m. The Review found that 91% of all callers during daytime hours required personal assistance from the receptionists. After hours, calls requiring personal assistance are routed to a telephone answering service when there is no worker available to take the call.

A common concern heard throughout the review process was the difficulty that callers experienced when trying to reach an Intake worker. A review of the telephone system confirmed that a significant number of telephone calls were not reaching an Intake worker, but rather were routed back to the reception desk, or to an answering service after regular work hours. Based on data collected from selected time periods, it was projected that about 13% of the calls made to ANCR are abandoned by the callers before the call is answered. It was found that the telephone screening function was adversely affected as CRU workers tried to manage responsibilities for both telephone screening and providing emergency responses.

The Review found that the telephone system in place at ANCR has the capability to meet the requirements of ANCR. ANCR staff is not using this telephone system to its full capacity. Staff is not trained in the functions available, and is unaware of the detailed operations of the phone system, including the capacity of the system to generate monitoring reports. No one is assigned to manage the telephone system, including the maintenance of the phone directory and ensuring that there is training and support for staff in the use of the telephone system.

The Review found that the telephone answering service provided almost 47 hours of telephone answering services to ANCR monthly, primarily during after hours. The same telephone answering service was used by Winnipeg CFS since March/1986. No new contract was signed when ANCR was established in February/2007.

This Review has recommended a reconfiguration of the service model to include a Screening and Assessment Unit. This Unit would have responsibility for all telephone screening on a 24 hour a day, seven day a week basis.

Other recommendations include:

- That management and staff are fully trained in the capabilities of the current phone system and that the phone system is fully utilized.
- That an appropriate staff person be assigned the responsibility to ensure the management of the system and the training and support to staff in the use of the telephone system.



- That ANCR sign a service agreement with the telephone answering service.

***Other Key General Recommendations include:***

- That a position of Director of Services be established with responsibility for the management and oversight of programs and services.
- That the Province and the four CFS Authorities make it a priority to ensure that all CFS agencies in the province are fully utilizing CFSIS and the IM as a case management tool, and that the Province immediately address the outstanding connectivity issues so that all CFS agencies have the capacity to do this from all of their sites.
- That a quality assurance review of the ADP process be conducted and that annual training in the ADP process is provided to all CFS agencies on a regular basis.
- That a working group be established to review the section 28 transfers and recommend changes for improvements.
- That a communication strategy be developed for the effective communication and sharing of information between program areas at ANCR and the CFS agencies.
- That an implementation process and structure be established to oversee the change management/ transition work and that this process be resourced.

***Actions taken to date include:***

- In response to workload pressures, the Province approved additional staffing positions in the AIU in November/2008. This led to the creation of the third abuse team in the AIU.
- As part of *Tracia's Trust*, funding for two investigators specializing in working with sexually exploited youth was provided by the Province in February/2009.
- A plan to address the backlog of cases in the AIU was developed by ANCR, the four CFS Authorities and the Child Protection Branch. This positive, systemic response was implemented and successfully completed.
- The number of "abuse only" cases has been reduced to 745. A working group at ANCR continues to review these files and anticipates having this completed by April 19/2010.
- A revised service request form was developed and rolled out to CFS agencies in December/2009.
- In January/2010, the ANCR Board of Directors announced the start of a three year development and change management process.
- A Change Management process and structure has been established and implemented, including the establishing of change committees and development teams which include staff, management, MGEU, CFS Authority, and Child Protection Branch representation.
- A Human Resource consultant and a Change Management team have been contracted to provide additional support to the change management process.



ANCR is a new organization working within a system that is undergoing significant change. Areas of concern and shortcomings that have been identified in this Review reflect that ANCR is an organization adapting to these major changes. The findings and recommendations in this Report will contribute to ANCR evolving into a stronger, more vibrant organization that can become a center of excellence for the provision of child abuse investigative services, and child and family intake services delivered within a differential response service delivery model.

***Almost always, the creative dedicated minority has made the world better.***

*- Martin Luther King, Jr.*





# Introduction

## *Overview of ANCR*

### Organizational Structure

There are 18 Child and Family Services (CFS) agencies, in addition to the Child and Family Services All Nations Coordinated Response Network (ANCR), operating in the City of Winnipeg. ANCR provides a single point of entry to the CFS system in the City of Winnipeg, Headingley, and East and West St. Paul.

Centralized Intake is a feature of the restructured CFS system, which saw the development of concurrent agency mandates. Prior to the Aboriginal Justice Inquiry-Child Welfare Initiative (AJI-CWI), agency mandates were based on specific geographic areas within the province. Winnipeg Child and Family Services (WCFS) was the sole agency providing child and family services, including Intake, After Hours, and Crisis Response, in Winnipeg. In June/2005, when the transfer of work and resources from WCFS was completed, a joint intake and response unit, known as JIRU, was set up. JIRU provided centralized intake services, but did so under WCFS and its mandating CFS Authority, the General Authority. JIRU continued to use essentially the service delivery model previously used by WCFS.

In the fall of 2006, a mandate review was undertaken by the SFN Network of Care to determine if JIRU had the capacity to be a standalone agency. The mandate was established in regulation in February/2007 and the new agency became known as ANCR. The mandating CFS Authority is the Southern First Nations Network of Care<sup>1</sup>.

When JIRU was established in June/2005, the program model set out four main program units:

1. First Response (CRU/AHU) and Intake (Tier II)
2. Abuse
3. Community Programs
4. EPR

The organizational chart on the following page shows the program structure as of June/2005.

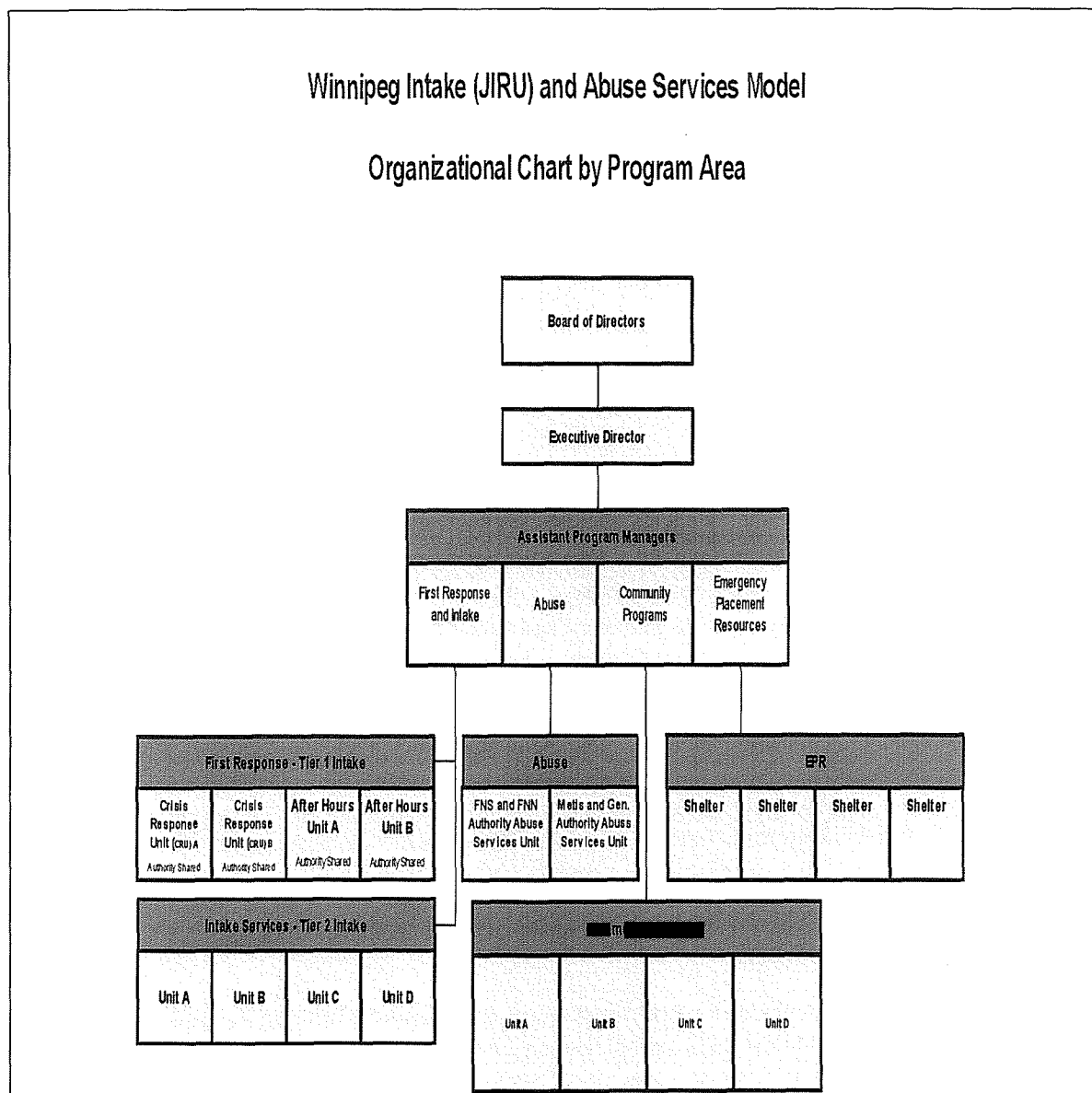
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<sup>1</sup> The Southern First Nations CFS Authority (Southern Authority) operates as the Southern First Nations Network of Care.





Figure 1: Winnipeg Intake (JIRU) and Abuse Services Model Organizational Chart by Program Area

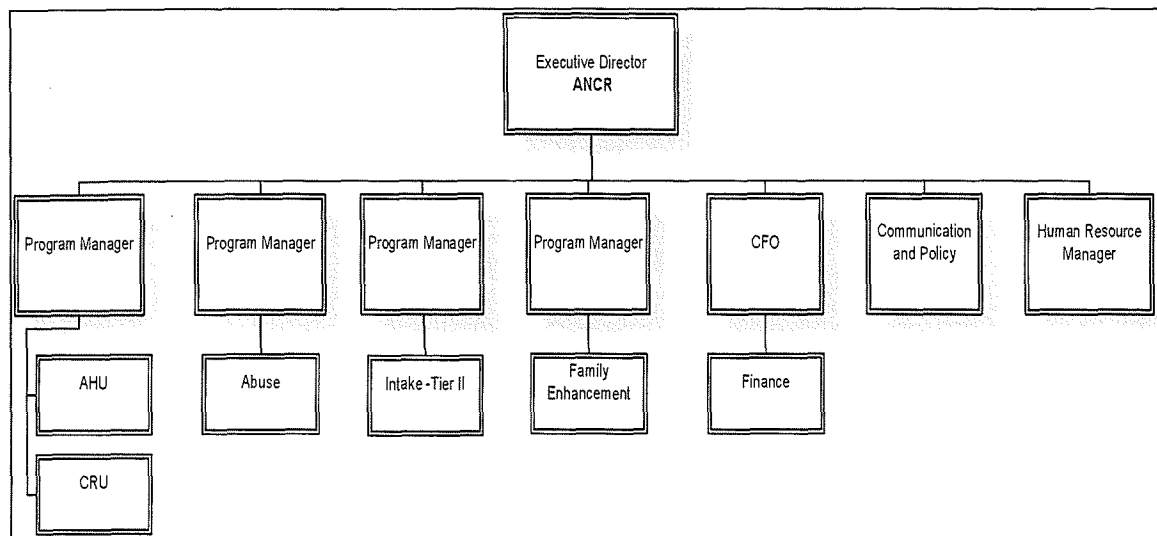


Prior to being mandated as a separate agency, changes were made to the structure by separating CRU and AHU from Tier II and adding Tier II to the responsibility of the Abuse Unit Program Manager. In the spring of 2009, a further change separated Tier II and the Abuse Unit under two separate program managers.

The current program structure is depicted by the following chart:



Figure 2: ANCR Program Organizational Chart



EPR remains a program of WCFS. The Program Manager for EPR reports to WCFS, but has established a close working relationship with ANCR.

ANCR provides crisis response services, afterhours services, intake services, child abuse investigations, and family enhancement services on behalf of the four CFS Authorities and their agencies. With the exception of two resource centers, all staff work out of one physical location.

The Crisis Response Unit (CRU) provides the first response to new intakes during regular working hours. The After Hours Unit (AHU) provides essentially the same service after working hours and on weekends and holidays. Intake services (Tier II) provides follow up services for those intakes that require a longer period of time to conclude. Tier II is responsible for the completion of the Authority Determination Protocol (ADP) and the transfer of cases to the other CFS agencies where required.

The Child Abuse Investigations Unit (AIU) completes child abuse investigations on new intakes and provides centralized child abuse investigative services to the existing cases open to the CFS agencies operating in the City of Winnipeg.

ANCR has a Family Enhancement Unit (FE Unit) which is currently developing its programs and services as part of the implementation of a differential response service delivery model in the province of Manitoba. Two family resource centers are part of this Unit.

The Emergency Placement Resource Program (EPR), which manages the shelter system, continues under WCFS. EPR works closely with ANCR where emergency placements for children are required. There is currently a resource transfer table working on the details of transferring this program to ANCR. Some of the EPR managers are located in the same building as ANCR.

In addition to the executive director, the senior management team at ANCR includes a program manager responsible for the CRU and the AHU; a program manager for Tier II Intake; a program manager for the AIU; a program manager for the family enhancement unit; a policy and communication



manager; a human resource manager; and a chief financial officer. Other corporate positions include information technology staff, finance staff, and centralized administrative support.

The following chart provides an overview of the corporate positions:

Figure 3: Corporate Management Positions

Senior Management	8
Finance	5
Administrative Support	7
Other Professionals	1
Total positions	21
Direct Hires	100%
Positions designated 'Aboriginal'	57%
Positions designated 'General'	38%
Not designated	5%
Position filled according to designation	89%
Aboriginal	50%
Vacancies	
Abuse Program Manager	
2 Admin Floats	

There is currently an interim Executive Director at ANCR. This person was previously the Abuse Program Manager; that position is currently vacant. There is an acting program manager for Tier II Intake.

All of the senior management and central administrative support staff are direct hires. Excluding the Executive Director, there are 20 positions and 57% are designated as 'Aboriginal' positions. 89% of the positions are filled according to their designation of 'Aboriginal' or 'General'.

## **Funding**

ANCR received its resources from the WCFS transfer process. As with all regions in the Province, there was an expectation that the AJI-CWI transfers remained within the existing resource envelope. A Winnipeg Resource Transfer Table (RTT) was established to determine the amounts to be transferred to the various agencies. The allocation for ANCR was determined through this process.

Since that time, additional funds have been provided through the *Changes for Children* initiative (workload relief and differential response development funds) and general increases (2.5% in each of 2007/2008 and 2008/2009).

Funding for ANCR (JIRU) from 2006/2007 to 2008/2009 was as follows<sup>2</sup>:

<sup>2</sup> These figures are from the SFN Network of Care records on the funding provided to ANCR. There are some differences between the ANCR annual audit and these figures due mainly to how deferred revenue was reported.



Figure 4: Funding for ANCR (2006 to 2009)

	2006-2007	2007-2008	2008-2009
Central Support*	\$789,700.00	\$6,076,632.00	\$7,548,888.00
Family Support	\$296,700.00	\$ 493,800.00	\$504,200.00
Workload Relief	\$ 33,700.00	\$175,400.00	\$220,600.00
Total **	\$ 1,120,100.00	\$ 6,745,832.00	\$ 8,273,688.00
Maintenance ***	\$11,600.00	\$ 206,231.00	\$365,441.00

\* Seconded employees are paid by the Province of Manitoba. Salary dollars for these positions become part of ANCR Central Support funding as positions are filled with direct hires. Funding for seconded positions is not included in the above table.

\*\* Funded by the SFN Network of Care

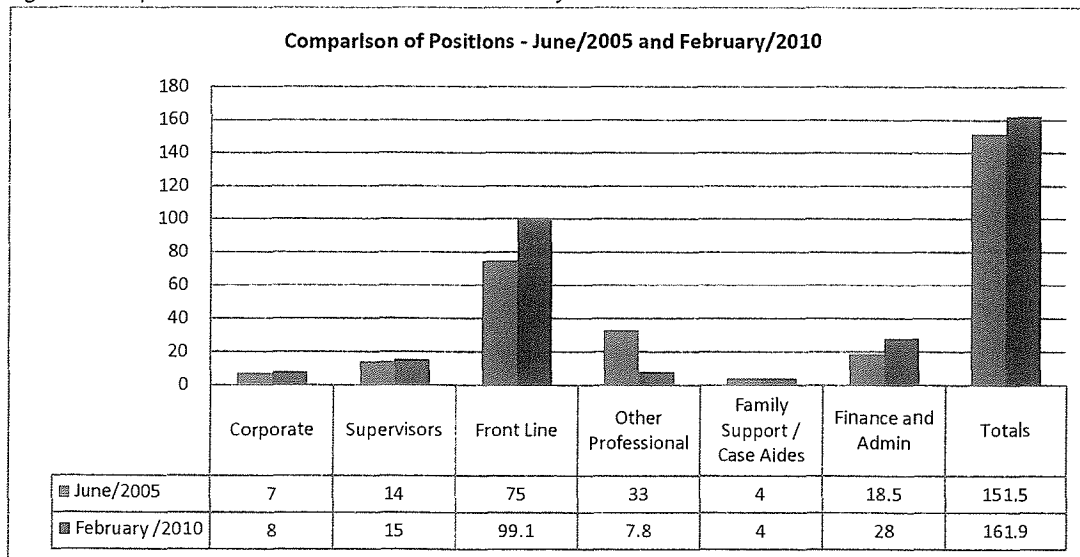
\*\*\* Paid directly by Province of Manitoba, as per audit

In June/2005, the staff at JIRU was employees of WCFS; the salary dollars for these employees were with WCFS. Subsequent to receiving status as a separate agency, ANCR began recruiting and hiring staff to replace the seconded employees. Salary dollars are transferred to ANCR with every direct hire.

## Staffing at ANCR

As part of the Winnipeg RTT process in June/2005, JIRU/ANCR was allocated 151.5 full year equivalent (FYE) positions. Additional positions were added as part of the Changes for Children workload relief initiative. Positions have also been added to the Abuse Investigations Unit. The following figure shows the position distribution in June/2005 and in February/2010.

Figure 5: Comparison of Positions – June 2005 and February 2010





There are eight positions located at ANCR that are part of the Emergency Placement Resource (EPR) program which operates under WCFS. A process is underway to transfer this program to ANCR. Most of the employees of the EPR program are employees of WCFS (Province of Manitoba). In anticipation of the program transfer, and where vacancies in EPR have arisen, ANCR has hired staff and seconded them to WCFS. EPR staff have not been included in this Review.

A workforce adjustment strategy (WFA) was developed and implemented as part of the AJI-CWI process. The Province of Manitoba gave existing staff a job guarantee, with an expectation that they would accept secondments until such time as they were given a reasonable job offer (RJO). This strategy called for staff to be seconded to the Aboriginal agencies and to ANCR.

Within ANCR, the more senior staff was designated by WCFS as "permanent secondees". Their position at ANCR was considered their RJO, and their ability to seek employment elsewhere within government was limited by the WFA strategy. These staff were not subject to being returned by ANCR once qualified Aboriginal staff were hired.

Those staff designated as "temporary secondees" were subject to return to WCFS when a qualified Aboriginal person was hired. Government committed to making RJOs to the temporary secondees. This resulted in "planned" staff turnover at ANCR, as temporary secondees were either given an RJO and left or Aboriginal staff was hired and temporary secondees returned to their employer.

The following figures compare the employment status of staff in August/2007 and February/2010.

Figure 6: Employment Status of ANCR Staff in August/2007

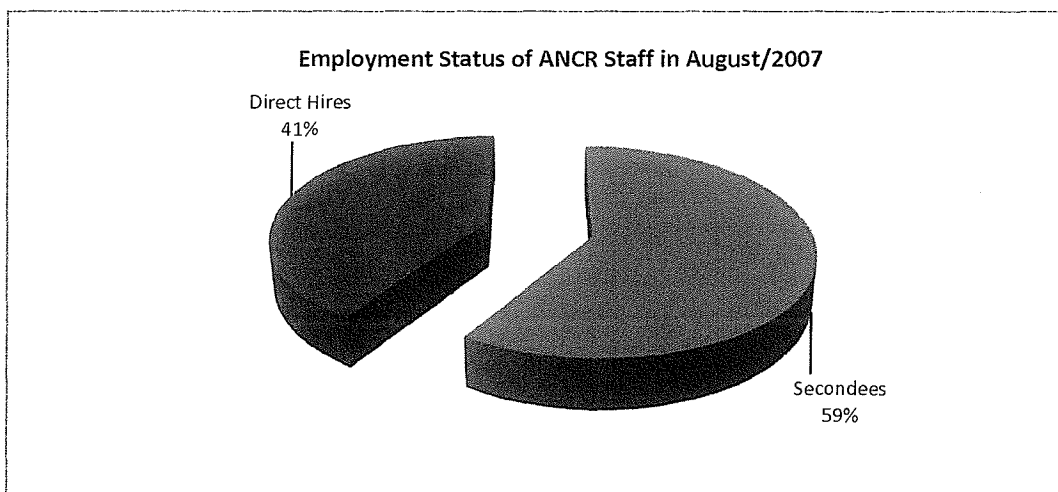
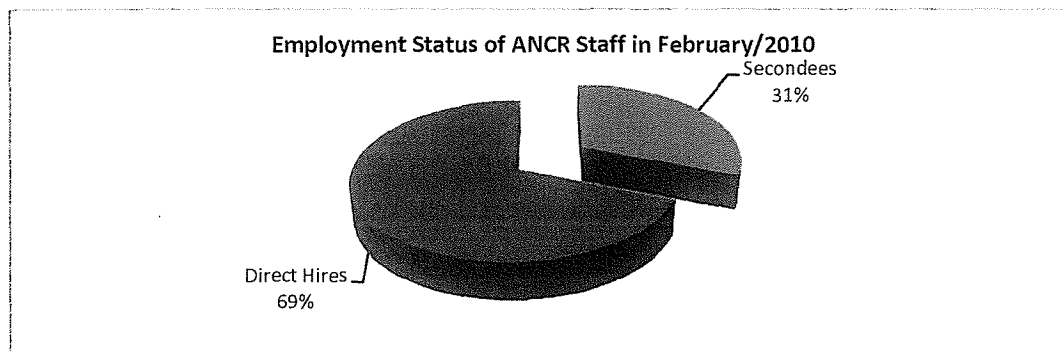




Figure 7: Employment Status of ANCR Staff in February/2010



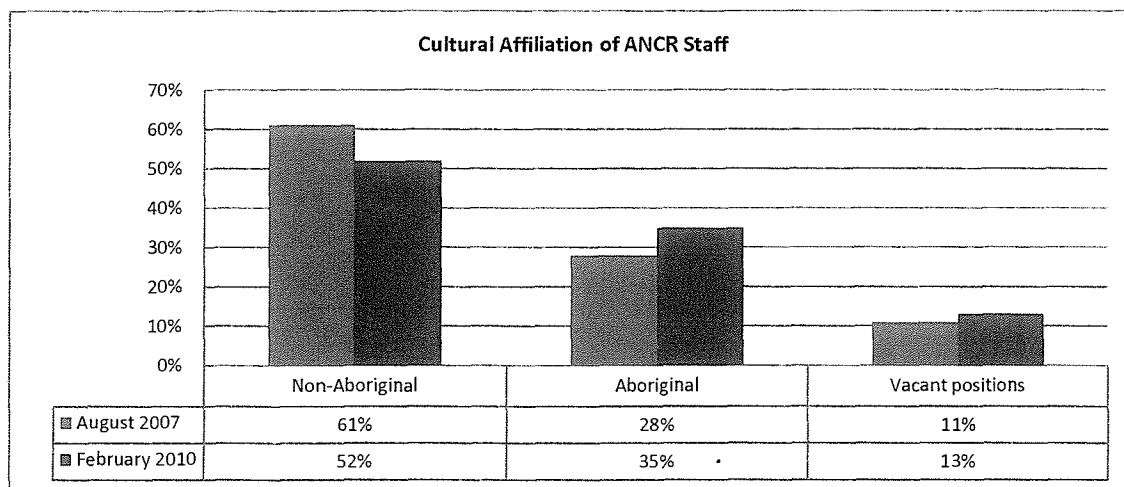
In August/2007, 59% of the staff at ANCR was seconded from WCFS. In February/2010, secondments made up 31% of the staff. Some of the secondees were directly hired by ANCR. Other secondees left ANCR when their secondment ended.

The WFA had some unintended consequences. For example, the abuse teams at ANCR were staffed almost entirely with temporary secondees. Out of the 16 original abuse investigator positions, 14 were temporary secondees. RJOs were made to the temporary secondees based on seniority. This, coupled with turnover, attrition, and leaves, resulted in many of the staff within the abuse teams leaving ANCR in a relatively short period of time. The lag time between a staff person leaving and a new hire being completed resulted in backlogs and increased workloads. Together with the creation of a new third abuse team, it has left ANCR with abuse investigators that, although having CFS experience, are relatively inexperienced in abuse investigations.

A review of the families receiving service from ANCR in 2004/2005 found that 53% were Aboriginal families. An employment equity strategy was implemented to establish a workforce that would better reflect the cultural make-up of the service recipients at ANCR. The 53% Aboriginal staffing ratio is to be realized in each program area, and within each staff category: management, supervisor, direct service workers, and administrative support.

The following chart compares the cultural affiliation of ANCR staff in August/2007 and in February/2010.

Figure 8: Cultural Affiliation of ANCR Staff





As part of the employment equity strategy, 53% of the positions at ANCR are designated as 'Aboriginal' hires while 47% are designated as 'General'. In February/2010, 54% of the positions were designated as 'Aboriginal', 45% as 'General', with 1% not designated. 77% of the filled positions were hired according to the position designation.

The number of Aboriginal staff increased from 28% to 35%, while the non-Aboriginal staff decreased by 9% over the same time period. Vacancies increased by 2%.

77% of the staff at ANCR is directly hired by ANCR. 23% are seconded, with 16% as permanent secondees.

The human resource environment at ANCR is a challenging one. There are staff who are direct hires, permanent secondees, and temporary secondees. Staff is on term, permanent, or contract employment. At the present time, at least half of the workforce is seconded staff. Their employer is the Government of Manitoba/WCFS. As with CFS agencies across North America, ANCR faces challenges on recruitment and retention of social work staff.

Staff at ANCR is under a collective agreement with the Manitoba Government Employees Union (MGEU).

## **Governance of ANCR**

ANCR has a Board of Directors representative of the four CFS Authorities on whose behalf ANCR provides services. Board members are appointed to the Board by their respective Authority. Currently, there are eight Board positions.<sup>3</sup>

The Board is responsible to set policy direction and monitor the work of ANCR, including the supervision of the Executive Director. The Board is required to use a policy governance model to guide its work.

The Board meets on a regular basis with the CEOs of the four CFS Authorities, a group known as the Joint Management Group (JMG). The JMG receives reports from the Board on its activities, and ensures that the Board's policy direction is acceptable to the CFS Authorities. ANCR provides services on behalf of all four CFS Authorities.

The SFN Network of Care is the mandating Authority for ANCR and has responsibility to fund, monitor and oversee the Agency.

## ***Service Model Review***

### **Factors Leading to the Review**

In February/2009, the SFN Network of Care, jointly with the Child Protection Branch (CPB), Manitoba Family Services and Consumer Affairs (then known as Manitoba Family Services and Housing),

<sup>3</sup> The first three years – February/2007 to February/2010 – there were six Board members. Changes to the ANCR By-law were approved August 11/2009. These changes provide for a Board of eight members as of February/2010.



undertook a review of the service model of ANCR, with a particular focus on evaluating the effectiveness of the existing structure in meeting service demands.

A review of the service model, to be undertaken within two years, was a condition set out by the SFN Network of Care when ANCR received a mandate in February/2007. It was noted that the current model was essentially one that had been used previously by WCFS. Given that the CFS system had seen a major restructuring, it was recognized that changes to the model might be required.

## **Scope of the Review**

The review focused on four primary program areas:

- Crisis Response Unit (CRU)
- Tier II Intake Unit
- After Hours Unit (AHU)
- Abuse Investigation Unit (AIU)

A comprehensive analysis was completed on each program area, examining structure, design, staffing, operations, and service effectiveness.

In addition, the capacity and effectiveness of the telephone system was reviewed. This was a response to the criticisms that had been received about wait times and difficulties accessing Intake workers.

A fifth program area, Family Enhancement Unit (FE Unit), was not included in this review. The FE Unit is in a developmental process as part of the implementation of a provincial differential response service delivery system. This report provides a brief description of the FE Unit and identifies areas that ANCR will need to address.

A review of the Human Resource Department was conducted separately by an external consultant. This report was released in January/2009.<sup>4</sup>

The scope of this review did not include a survey of families and youth who receive services from ANCR.

## **Reviewers**

Staff from the SFN Network of Care and from the Child Protection Branch (CPB) were co-leaders of the review team. A number of reviewers, investigators, and consultants were contracted to assist in the review.

## **Confidentiality**

The SFN Network of Care is bound by the confidentiality provisions and protections contained in *The Child and Family Services Act*. It is also noted that if the confidentiality sections of the CFS Act are

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<sup>4</sup> This Report can be viewed at [http://www.southernauthority.org/docs/ANCR\\_Employee\\_Satisfaction\\_Survey.pdf](http://www.southernauthority.org/docs/ANCR_Employee_Satisfaction_Survey.pdf)





inconsistent or in conflict with the provisions of *The Freedom of Information and Protection of Privacy Act* (FIPPA), the provisions of the CFS Act prevail.

## **Time Period of the Review**

The review began in February/2009. A draft was provided to key stakeholders in December/2009 for their review and feedback. Where appropriate, this feedback has been incorporated into the final report.

## **Terms of Reference**

The Terms of Reference stipulated that reviewers were to do the following:

- Conduct a comprehensive review and assessment of the service functions at ANCR that are delivered by the following program units: After Hours Unit (AHU); Crisis Response Unit (CRU); Tier II Intake Unit; and the Abuse Investigation Unit (AIU)
- As a key aspect of the review, focus on the volume, management, and effectiveness of service delivery within each unit; the quality of assessments conducted; and the decisions that are made in regard to closure or transfer of cases both within ANCR and to other agencies.
- Assess service quality and effectiveness in relation to relevant program standards and regulations.
- Conduct a review and assessment of the service relationship between ANCR and its receiving agencies and the effectiveness of the case transfer process, including:
  - The length of time it takes to transfer cases to other agencies for ongoing services.
  - The quality of documentation that is included in transfer summaries.
  - The effectiveness of the transfer process in relation to standards and regulations.
  - The established communication between ANCR and the designated receiving agencies.
- Utilize mechanisms and tools that will result in the development of a comprehensive report that contains both an effective analysis of current services at ANCR and key recommendations that are designed to enhance and improve service effectiveness and delivery within each of the program units.

## **Methodology**

The review and analysis had three phases.

### ***Phase 1: Information Gathering***

Activities in this phase included the following:

- Conducting an analysis of adequate service administration and operations within each unit including staff coverage/ scheduling, job functions/responsibilities, staff training/supervision, effectiveness of phone system to handle capacity, adequate communication/documentation.
- Collecting and reviewing all documentation related to ANCR's program units including Annual Reports, Mandate Review Report, Operational Plans, Program Manuals, generated Child and Family Services Information System - CFSIS / IM Reports, and Intake logs.



- Conducting a random sample case documentation review within each program unit.
- Conducting team meetings with staff and supervisors of each unit, to coordinate information for the review and to gather feedback from the staff.
- Conducting key informant interviews with collaterals and CFS agencies serviced by ANCR, using a standardized interview process. The collaterals were selected from a list provided by the CPB.

### ***Phase 2: Information Analysis***

The following activities were completed as part of analyzing the information collected:

- Documenting the results of the information gathered through document analysis and interviews.
- Reviewing findings in relation to the effectiveness and quality of services delivered.
- Assessing findings against relevant legislation, program standards, and/or regulations.
- Assessing findings within the context of the strategic profile of the organization and its service operational model.
- Assessing findings within the context of the effectiveness of the management and supervisory systems at ANCR and their impact on functioning.
- Reporting results in a format that documents key findings, program strengths and weaknesses, and key aspects of service delivery.
- Refining details and revising analysis and documentation as necessary.

### ***Phase 3: Results Analysis***

The following activities were completed as part of analyzing the results:

- Assessing the overall quality and effectiveness of the services provided by the organization (program units) and presenting recommendations of how this can be enhanced or improved.
- Examining the strengths and weakness of the service capacity and delivery within each of the program units.
- Providing recommendations for corrective action as a means to enhance or improve service delivery.

The following is a list of the documents, reports, and records reviewed and analyzed, and the interviews and consultations that occurred in the preparation of the final report.

- Data from the Child and Family Services Intake Module (IM) for a 12 month time frame from February/2008 – February/2009.
- Data from internal record keeping systems within program units at ANCR, such as transfer data.
- Service requests and copies of correspondence from afterhours workers to CFS workers.
- Reports, program manuals and policies specific to program units within ANCR.
- Service reports provided by the Manitoba Telephone System (MTS) on the Interactive Voice Recognition (IVR), the Universal Call Distribution (UCD) and the Perimeter Automatic Call Distribution (ACD) telephone systems.
- Consultations with a Communications Coordinator from MTS regarding the telephone systems.
- Interview with the Customer Service Representative at the Tiger Tel Communication Inc.
- Meetings with staff, supervisors and managers in specific program areas at ANCR.



- Attendance at staff meetings and program meetings.
- Interviews with a sample of staff from other CFS agencies in the province, (some of which were previously employed at ANCR).
- Interviews with representatives from other community organizations and agencies working collaterally with ANCR.
- File Audits on samples of Intake and Abuse cases.
- A literature review of referral screening and investigation/assessment models in several agencies in Canada, the United States of America, Australia and New Zealand.

## **Acknowledgements**

The Review team is grateful to the large number of individuals and organizations who gave of their time by offering clear and concise information regarding their experiences, thoughts and suggestions for an effective CFS intake and investigation agency for Winnipeg.

Special gratitude is extended to the staff and management of ANCR for their suggestions and recommendations, and their cooperation and willingness in providing information and assistance at all levels of this review.

Many thanks go to the staff and management from other CFS agencies in Manitoba who shared their experiences, suggestions and recommendations.

The representatives from community organizations and collateral agencies were very helpful in sharing their experiences and offering their suggestions for strengthening the CFS intake and investigation system in Winnipeg.



## Section I: Crisis Response, Tier II Intake, and After Hours

### *The Crisis Response Unit (CRU)*

The Crisis Response Unit (CRU) functions as the first point of contact and as “first responder” during daytime working hours for emergency calls and intake reports involving the safety of children. According to the draft *CRU Program Manual December/2008*, the responsibility of the CRU is to provide intake and emergency services on behalf of ANCR to children and families in the City of Winnipeg and appropriate geographic areas in accordance with the *Joint Intake and Emergency Services by Designated Agencies Regulation, 183/2003*. The CRU provides this service during regular business hours, Monday to Friday, 8:30 a.m. to 4:30 p.m.

The review of the CRU included the following tasks:

- Overview and analysis of service volume at the CRU.
- Overview and analysis of current staff resources.
- Overview of the CRU Program Model and management.
- Overview and analysis of the case transfer process.
- Review of the CRU program model, its unique situation in the ANCR system, and its division of responsibilities to determine if the structure and operations are efficient and effective.

The methodology included the following:

- A review of specific data obtained from the Child and Family Services Intake Module (IM).
- A review of data contained in manual record-keeping processes in different program areas of ANCR.
- A review of the January/2008 *Revised Draft Report – Crisis Response Unit Workshop*, provided by an independent consultant.
- A review of the draft *Crisis Response Unit Program Manual December/2008*.
- A review of the telephone systems utilized in the delivery of services by the CRU (contained in a separate section of this Report).
- Meetings with managers and staff working in the CRU and Tier II Intake Units.
- Interviews with staff from other CFS agencies using CRU services.

### **Program Structure**

The ANCR service model consists of two distinct intake functions: screening and emergency response (CRU), and investigation, assessment and crisis stabilization (Tier II). This mirrors the JIRU, and former WCFS, model.



For the most part, community members and staff of other CFS and collateral agencies do not distinguish between the CRU and the Tier II Intake Program. Both are regarded as the ANCR Intake Service.

The CRU has a distinct role and responsibility in the continuum of intake service delivery. According to the draft *CRU Program Manual (2008)*, the CRU is organized along two teams, which perform two differently defined functions. One team of the CRU program responds to all initial requests for service and/or all child protection referrals. The referrals are accepted via the following mechanisms: phone, fax, e-mail, mail or walk-in. All referrals are screened to determine if a child welfare response is required. The CRU worker will then gather all needed information to determine the appropriate course of action.

Where an emergency response is warranted, the matter is referred to a second team at CRU which completes all needed field visits and responds to all emergency matters including walk in clientele.

The two CRU teams rotate on a three-day schedule. One team is responsible for all telephone screening. The second team is responsible to respond to all written referrals, walk-in clientele and emergency field visits. Once either team has determined that the family requires service by the CFS system, an intake case is opened and referred to the appropriate ANCR program for further assessment or service. These programs include Tier II Intake, Abuse Investigation, and Family Enhancement.

## **Staffing**

The *CRU Program Manual* states that the Unit consists of 18 staff members, including: 1 program manager (PM)<sup>5</sup>, 2 supervisors, 12 social workers, 1 administrative assistant and 2 receptionists. Each supervisor manages a team of six social workers for a total of two CRU teams. The administrative assistant, two receptionists and two supervisors report to the program manager, who in turn reports to the ANCR executive director.

The staff composition at CRU has been relatively stable this past year. In April/2009, the program was functioning with one vacant staff position and a temporary program manager. In February/2010, there were two vacancies in the CRU worker positions.

The current Program Manager is new to ANCR but came with numerous years of related child welfare experience and easily transitioned into the position.

According to the Human Resources (HR) department, employees with the CRU are scheduled to work 7 ¼ continuous hours per day yielding 36 ¼ hours of work per week. The work week is Monday to Friday, 8:30 a.m. to 4:30 p.m.

As of February/2010, the staffing of the CRU was as follows:

Figure 9: CRU Staffing (February 2009)

Number of FTE positions	
Supervisor	2
Front Line	12
Admin Support	3

<sup>5</sup> Program Managers are included as Senior Management / Corporate positions throughout this Report.



Staffing Data	
Direct Hires	59%
Seconded (Permanent)	29%
Seconded (Temporary)	12%
Positions designated 'Aboriginal'	47%
Positions designated 'General'	53%
Not designated	0%
Positions filled according to designation	73%
Aboriginal Staff	33%
Vacancies	
2 CRU worker positions	

Qualifications of Social Work Staff	
BSW/MSW	62%
Other related degree	23%
CFS Diploma	8%
Other	8%
10+ yrs of experience	46%
6-10 yrs experience	0
3-5 yrs experience	46%
1-2 yrs experience	8%
Less than 1 yr experience	0

## **Service Volume**

*The CFS Intake Module (IM) is a formal data collection program utilized by CRU workers as required in the provincial CFS Standards Manual. According to the Standards Manual, "...all child and family services agencies must use the provincial automated Intake Module for services to family and child protection interventions under The Child and Family Services Act."* Agencies must use the module in the following circumstances:

- For all new referrals.
- Upon receipt of a report that a child is in need of protection regardless of the status of the case (open, closed or new).
- Upon receipt of new information that causes a worker to believe that a child is in need of protection.

The IM is a significant source of information on service volume. A collection of specific data reflecting the volume and category of referrals and openings, sources of referral, time management and service demands, and the management of intake referrals to the point of closing or transfer was obtained and analyzed.



The CRU responds to all initial requests for service and all matters involving child protection concerns during regular business hours, Monday to Friday, 8:30 a.m. to 4:30 p.m. Requests for service occur through two distinct avenues:

- Telephone, e-mail, fax, regular mail or walk-in methods.
- Referrals from the AHU if the response time is 24 to 48 hours.

The referral is screened to determine if a child welfare response is needed. Once confirmed, the CRU worker gathers information and determines the course of action that will follow. Matters that require a response time of over 48 hours are forwarded to Tier II Intake for follow up.

The data obtained from the IM is limited to referrals made directly to the CRU during day time hours and entered into the IM database by a CRU worker. If the intake or referral was received after hours and entered into the IM by the AHU, the data would be included in the review of the After Hours program. While all referrals are forwarded to the CRU at the end of the afterhours shifts for review and disposition, this data is not reflected in the IM. Manual data is maintained by the CRU showing the number of referrals transferred from the AHU to the CRU on a daily basis. As data was reviewed and analyzed separately for each program area, the CRU information does not include the work that follows on all AHU referrals. As a result, the information contained in the IM database is not a true reflection of the service volume in the CRU. Manual data kept by the CRU will be included in the analysis of service volume.

To obtain a broad perspective on incoming referrals, data reflecting service volume in the CRU was gathered for eight one-week time periods. These time periods were strategically selected to reflect service volume during winter months, summer months and at varying points within a month such as the beginning, mid and end of a month. For each time period, data was analyzed for variations in service volume.

The time periods selected for review were:

- February 24/2008 to March 1/2008
- April 27/2008 to May 3/2008
- June 8/2008 to June 14/2008
- July 20/2008 to July 26/2008
- August 31/2008 to September 6/2008
- October 26/2008 to November 1/2008
- December 14/2008 to December 20/2008
- February 1/2009 to February 7/2009

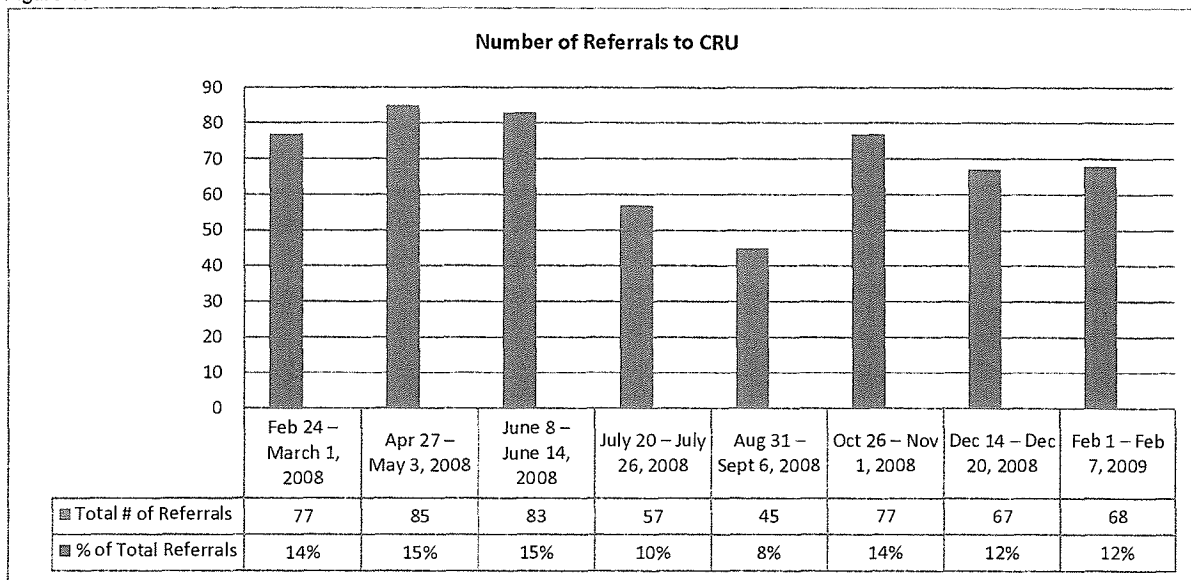


## **Referrals**

### ***Volume***

The following chart shows the total number of referrals to the CRU for the selected time periods.

Figure 10: Number of Referrals to CRU



A sample analysis of the IM data for the CRU during the above time periods indicates that the CRU responded to an average of 69.8 referrals a week or 275 referrals a month with the highest number of referrals occurring during the spring and early fall. The lowest number of referrals occurred during the summer months of July and August.

The IM database does not reflect the number of referrals that are forwarded from the AHU to the CRU for review and follow-up each day. The CRU maintains manual records on these transfers. A review of the manual information can be found later in the report. As the CRU only keeps this information for short periods of time, the manual data on the number of referrals transferred from the AHU to the CRU is not consistent with the above time periods. The information obtained from the manual records indicates that an average of 167 referrals per month is transferred from the AHU to the CRU for follow-up. As a result, the CRU processes approximately 442 intakes each month.

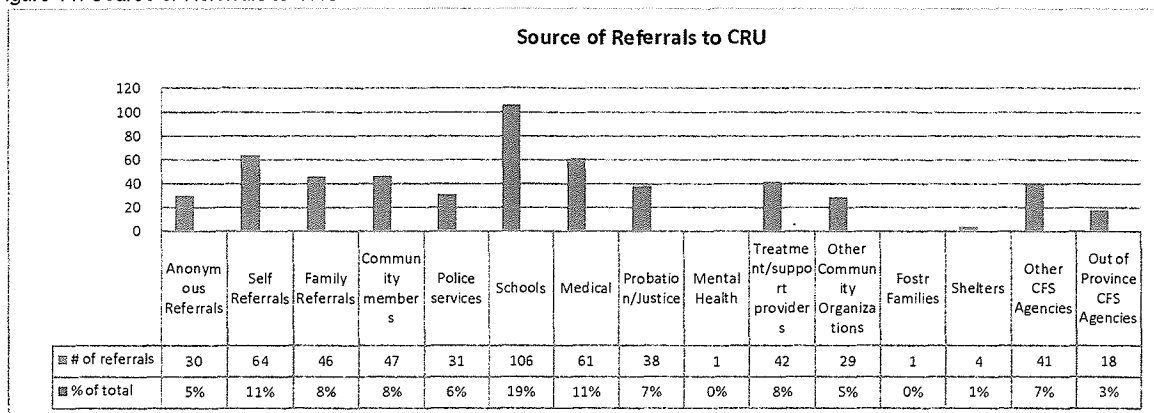
### ***Sources of Referral***

Over 30 categories listing sources of referral are available in the IM. Twenty-six referral sources were listed for the time period reviewed. Although most of the referrals occurred during the hours from 8:30 a.m. to 4:30 p.m., about 1% of all referrals occurred during other time categories. The chart that follows contains a small number of referrals to the CRU that arrived outside regular working hours.





Figure 11: Source of Referrals to CRU



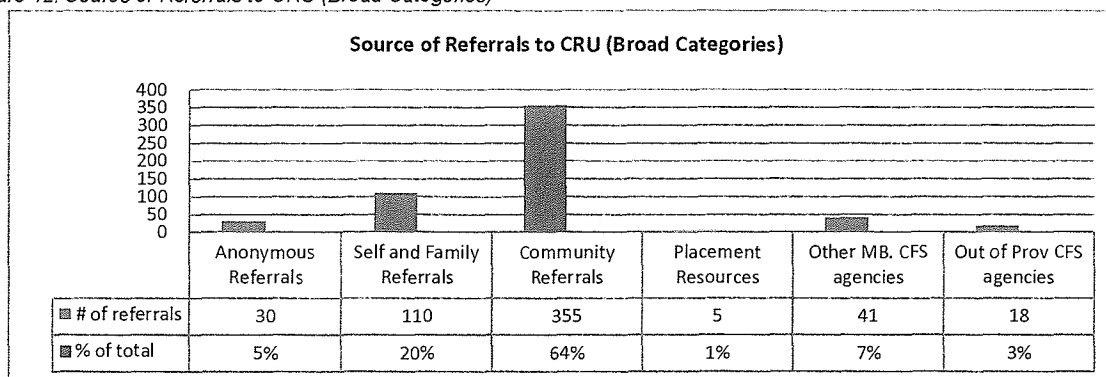
To obtain more meaningful information on the sources of referral, the above categories were condensed into six larger ones:

1. Anonymous Referrals
2. Self and Family Referrals
3. Community Referrals
4. Placement Resources for Children in Care
5. Other CFS Agencies in Manitoba
6. CFS Agencies Outside of Manitoba

Data on anonymous referrals is listed separately as the identity of the referral sources is not known. Any referrals from self or family members became one category and all referrals from community members, professionals, or organizations were combined under the category of Community Referrals. A separate category (Placement Resources) was created for all referrals to the CRU from foster families, shelters and residential care facilities. It is assumed that these referrals would have been made on behalf of children and youth already in the care of a CFS agency. The remaining two categories were already distinct categories in the IM database and were left intact.

These broad categories of sources of referrals are reported as percentages of the 559 referrals to the CRU during the above time period. This does not include the referrals that were transferred to the CRU from the AHU.

Figure 12: Source of Referrals to CRU (Broad Categories)





Community referrals were the most common type of referral. These accounted for 64% of the total number of referrals to the CRU. This category includes community organizations that have the responsibility to provide educational, medical and corrective services to children and youth. Most of the community referrals (30%) were received from schools. This was followed by medical professionals or hospitals, which accounted for 17% of the referrals. Community members not associated with a community organization accounted for 13% of the community referrals to the CRU.

Self-referrals and referrals by family members made up 20% of all referrals to the CRU. Of this number, 58% were self-referrals while the remaining 42% were referrals made by a member of the family.

Other CFS agencies in Manitoba accounted for 7% of the referrals to the CRU, compared with 18% of all referrals to the AHU for the same time period.

Placement resources for children in care, such as foster homes, shelters and residential treatment centers accounted for less than 1% of the referrals to the CRU. This is less than the 12% of referrals from this source to the AHU for the same time period.

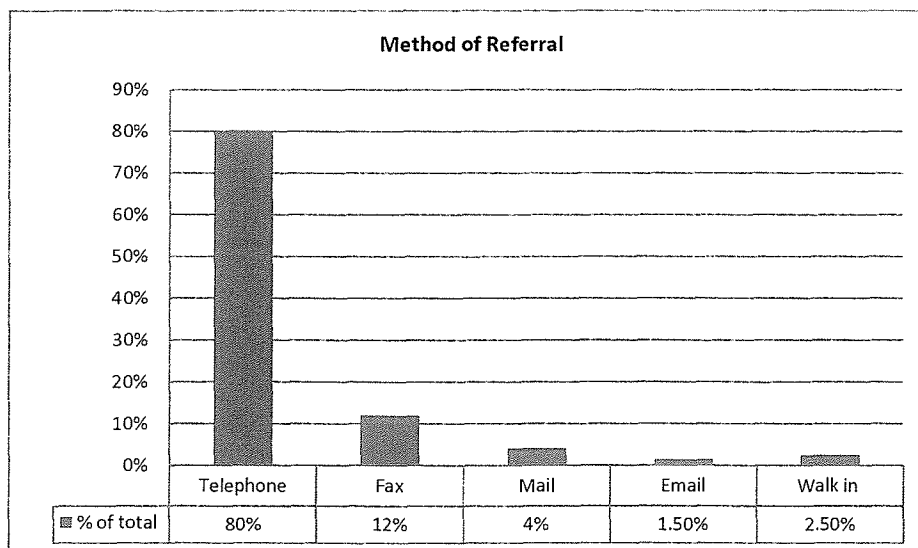
Both placement resources for children in care and other provincial CFS agencies have other staffing resources in place during day time hours to provide services and supports. These services and supports are not in place during after hours. This may account for the increased number of referrals and service requests to the AHU from placement resources for children in care and from other CFS agencies in the province.

5% of all referrals to the CRU were from anonymous sources.

### ***Method of Referral***

There are several methods by which referrals are received. Of 559 total referrals, 80% are by telephone. The following chart shows the percentage for each method of referral.

Figure 13: Method of Referral





2.5% of all referrals to the CRU are walk-ins, even though the CRU operates during daytime hours.

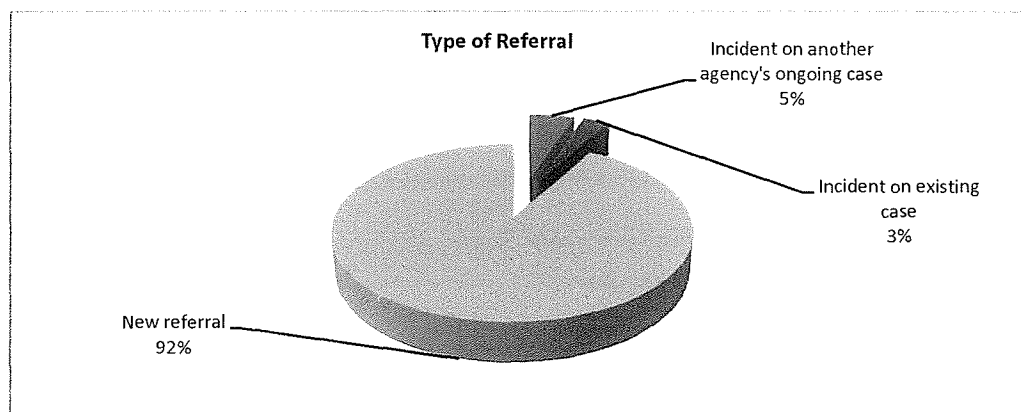
98% of all referrals to the CRU are received between 8:30 a.m. and 4:30 p.m.

### ***Types of Referrals***

The Intake Module (IM) requires that an Intake Type be selected whenever a referral is entered into the system. Three Intake Types are available for selection in the IM. These include:

1. Incident on another agency's ongoing case
2. Incident on existing case
3. New referral

*Figure 14: Type of Referral*



Of the total number of referrals received by the CRU during the time period reviewed, 92% involved service on a new referral. The remaining 8% of the referrals required services on cases that were already opened. 5% of the referrals were in response to an incident on another CFS agency's open case and 3% of the referrals required service on an existing ANCR case.

In summary, the majority of service requests or Intakes to the CRU involve services on new referrals. This contrasts with the referrals to the AHU, where 62% involves incidents on other agency's ongoing cases. 24% of referrals to the AHU were new referrals.

### ***Issues at Referral***

A total of 984 issues were reported to the CRU during the time periods reviewed. The IM requires that issues be identified and entered whenever a new referral is opened. A referral can have one or more issues. As a result, while 559 referrals were identified during the time period reviewed, a total of 984 issues were recorded on the IM for this time period.

Once the issues are entered into the IM, the responsibility for concluding the issues may or may not be that of the CRU worker who enters them. Issues may be concluded immediately, within a short period of time following an intervention or after a longer period following intervention. The IM database contains 157 different issue categories. The five issue categories most frequently reported in referrals to the CRU are shown below:



1. Concern about ongoing substance abuse affecting parental capacity
2. Parent exhibiting inappropriate parenting skills
3. Family violence
4. Parental capacity unknown
5. Concern ongoing gambling affecting parental capacity

## Written referrals

### Source and Volume

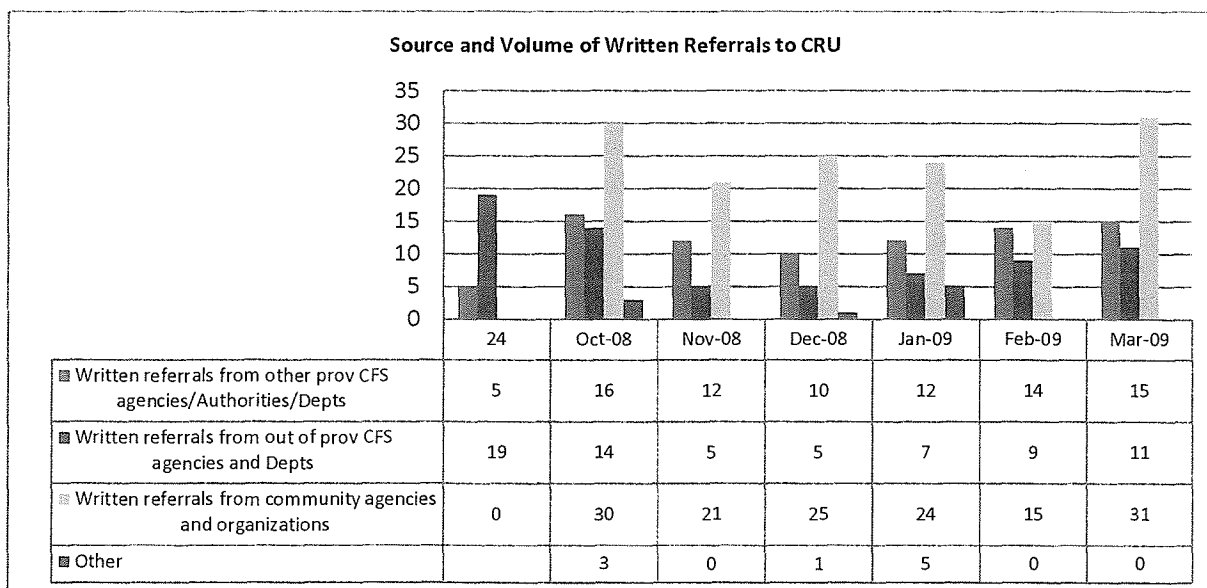
Less than 20% of all referrals to the CRU are received in written form through the mail, e-mail, fax, or walk-ins. 80% of referrals to the CRU are by way of telephone calls. The administrative assistant for the CRU maintains records of these referrals. The records were reviewed for September/2008 to March/2009 to determine the referral sources and identify trends in reporting.

The information presented below refers only to the written referrals and makes up one-fifth of the referrals or service requests to the CRU. While the statistical information from the written referrals is not significant, it provides insight on referral sources, issues and trends.

A total of 333 written referrals were reviewed by the CRU during the time period reviewed. These referrals generally fit into three categories:

- Referrals from other provincial CFS Agencies, Authorities and Child Protection Branch
- Referrals from out of province CFS agencies and government departments
- Referrals from community agencies and organizations

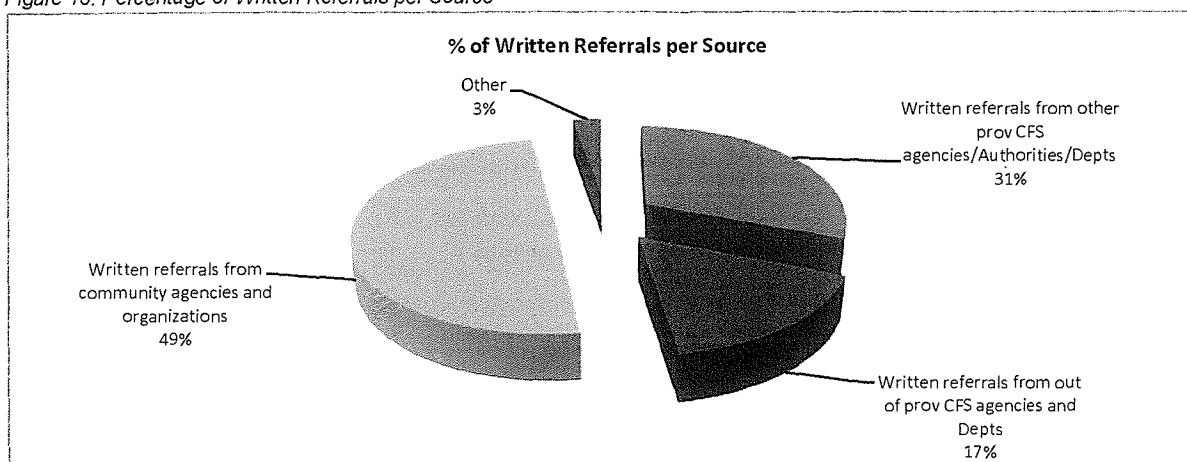
Figure 15: Source and Volume of Written Referrals to CRU





The following chart shows the % of total referrals from each referral source.

Figure 16: Percentage of Written Referrals per Source

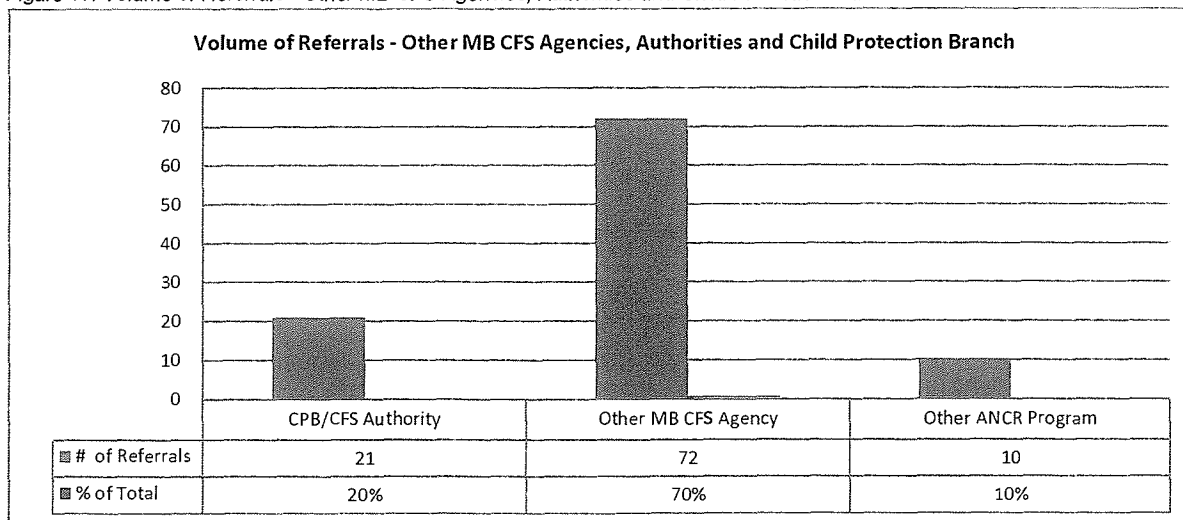


49% of the written referrals to the CRU came from community agencies and organizations. This was followed by 31% from other provincial CFS agencies and Authorities and 17% from out-of-province CFS agencies.

#### Manitoba CFS Agencies

Written referrals from other provincial CFS agencies, Authorities and departments (31% of total) were further divided into more specific categories; Child Protection Branch (CPB) / Child and Family Service Authority, Other Manitoba CFS Agency and Other ANCR Program.

Figure 17: Volume of Referrals - Other MB CFS Agencies, Authorities and Child Protection Branch



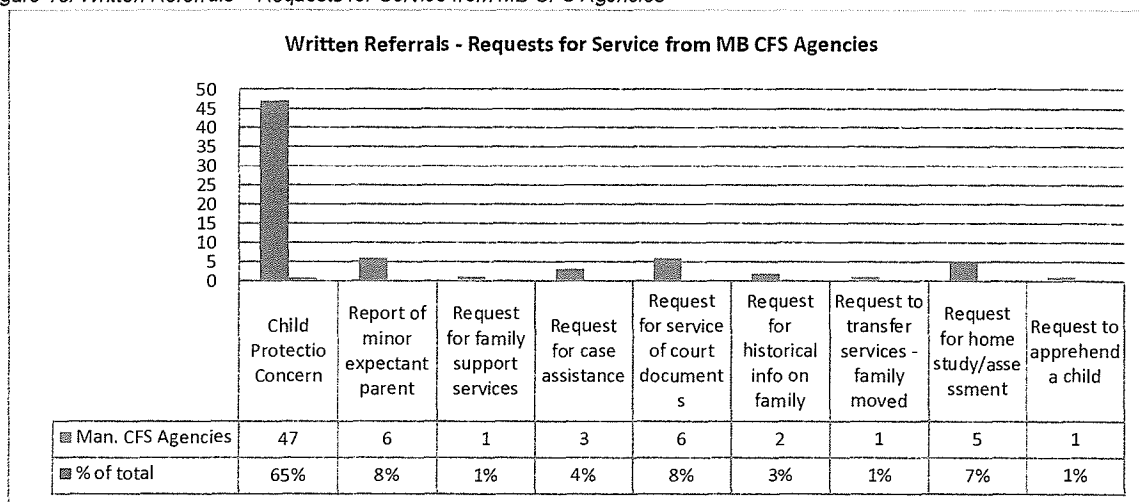


The largest number of written referrals came from other Manitoba CFS agencies (70%) followed by the CPB and CFS Authorities (20%). 10% of the written service requests came from other ANCR program areas.

Seventy-two written service requests were received from 18 different CFS agencies in the province during the review period.

The following chart shows the types and volume of written requests for service made by other Manitoba CFS agencies.

Figure 18: Written Referrals – Requests for Service from MB CFS Agencies

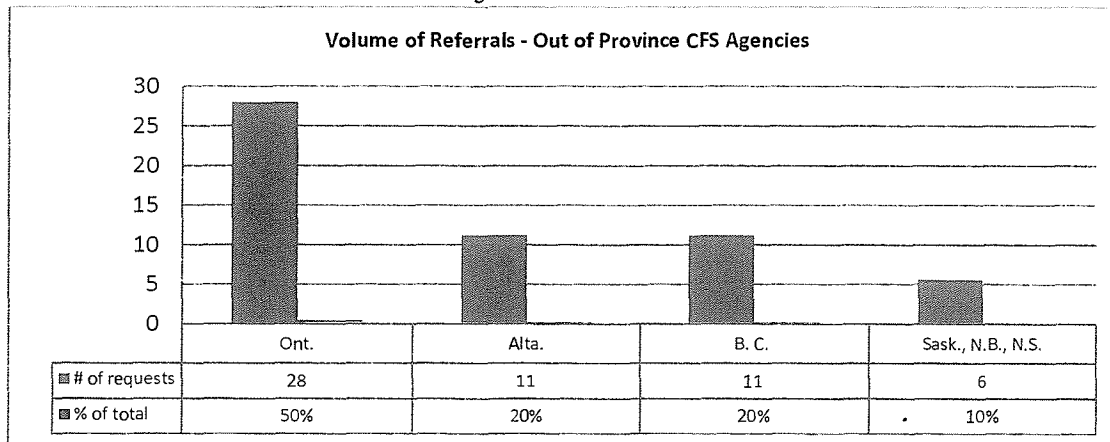


### Out of Province CFS Agencies

The Manitoba CFS system provides assistance to out of province CFS agencies, through a reciprocal agreement, on child welfare cases involving families residing within its jurisdiction.

56 written requests for service came from out-of-province CFS agencies. This accounted for 17% of the total number of written referrals to the CRU. The following chart shows the volume by province.

Figure 19: Volume of Referrals - Out of Province CFS Agencies

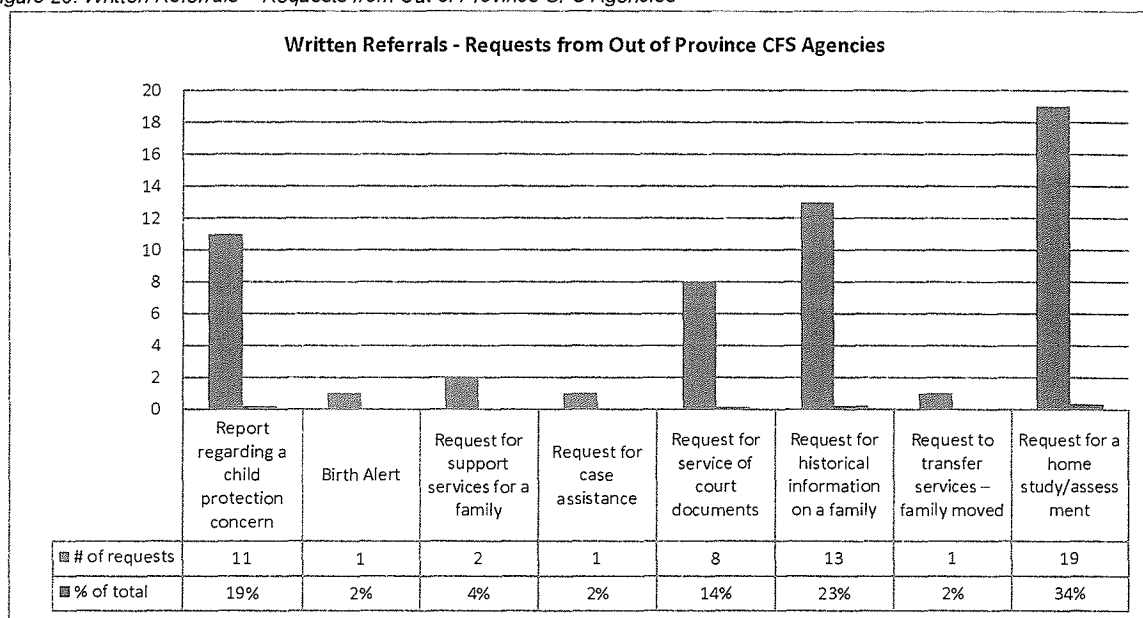




50% of these written service requests came from CFS agencies in Ontario. Agencies / government departments in Alberta and British Columbia each submitted 20% of the total written referrals. The remaining referrals came from agencies / government departments in Saskatchewan, New Brunswick and Nova Scotia.

Out of province service requests were less likely to report a child protection concern. The majority of the service requests required assistance for case management purposes. The following chart shows the types of service requests from out of province CFS agencies.

Figure 20: Written Referrals – Requests from Out of Province CFS Agencies



Requests for services to conduct a home study on behalf of an out of province CFS agency made up 34% of the total requests. 23% were requests for historical information on a family and 14% were requests for assistance with serving court documents.

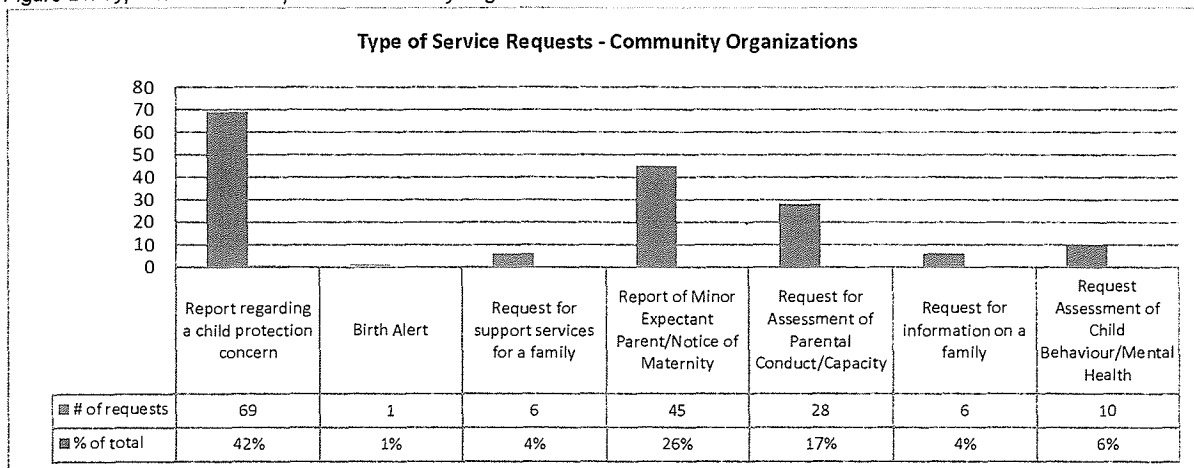
### Community Referrals

165 written service requests to the CRU came from approximately 32 different community groups, organizations or individuals.

The issues identified by written referrals from community organization and/or non-mandated agencies were categorized as follows:



Figure 21: Type of Service Requests - Community Organizations



42% of written requests from community members and collaterals involved reporting child protection concerns. 26% reported minor expectant parents or notified ANCR of pregnancy in potentially high-risk situations and 17% requesting assessment of parental conduct/capacity.

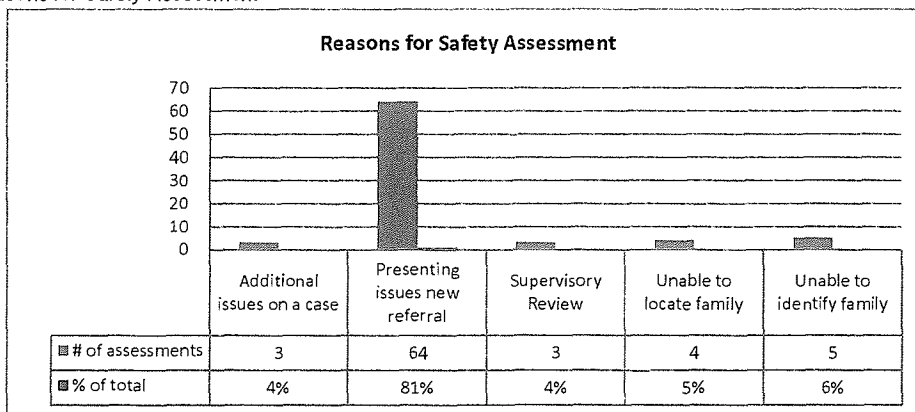
## **Issue Management**

### ***Safety Assessments***

The CRU is responsible for assessing identified issues to determine the level of response that is required. If an issue requires a response immediately and within 24 hours, the CRU worker completes a Safety Assessment within 24 hours from the time the referral is received, unless the supervisor approves an extension based on a review of the circumstances in the case. When the recommended response time is more than 24 hours, and there are concerns about the safety of a child, the CRU worker may complete a safety assessment.

Of the 559 referrals reviewed, safety assessments were completed for 79. The reasons for completing a safety assessment are shown on the following chart.

Figure 22: Reasons for Safety Assessment







81% of the safety assessments were completed on new referrals. Extensions or overrides occurred for the nine issues related to the category 'Unable to locate family' and 'Unable to identify family'.

## Field Visits

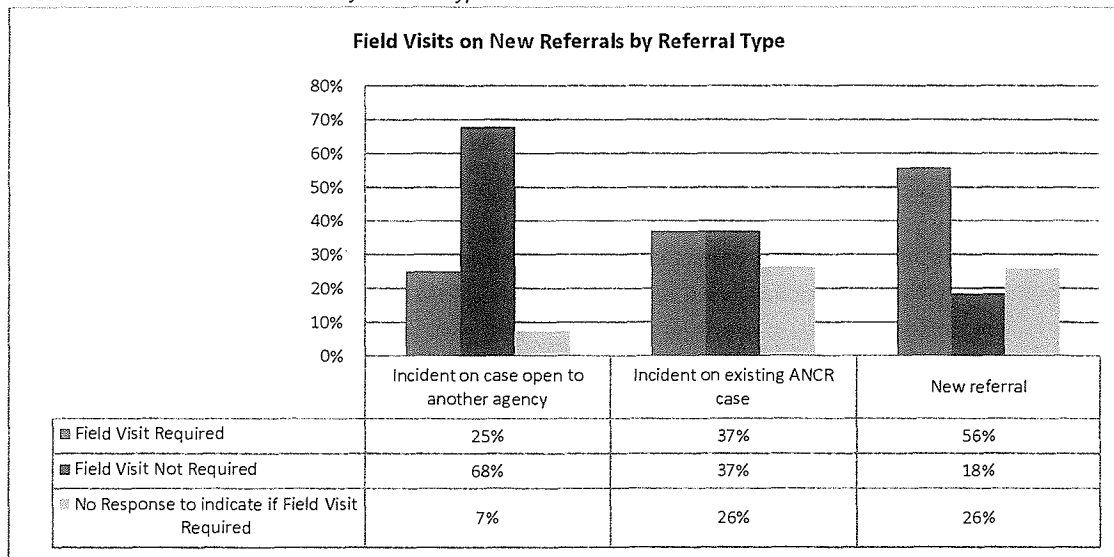
The CRU assesses whether a field visit is necessary, depending on the circumstances and urgency of a referral after screening and gathering information. The IM requires a notation indicating whether a field visit is required.

298 field visits were noted as being made. 120 referrals were noted as not requiring a field visit. No response was entered for 139 referrals. It is possible that a field visit took place, but there is no way of knowing this from the data. More than one-half of all referrals to the CRU required a field visit.

Of the 559 referrals, 92% were new referrals, 5% were on cases open to another CFS agency, and 3% were on existing cases open to ANCR.

The total number of referrals were reviewed for the number of field visits that occurred by referral type. The following chart provides information about the need for field visits for new referrals based on referral type.

Figure 23: Field Visits on New Referrals by Referral Type



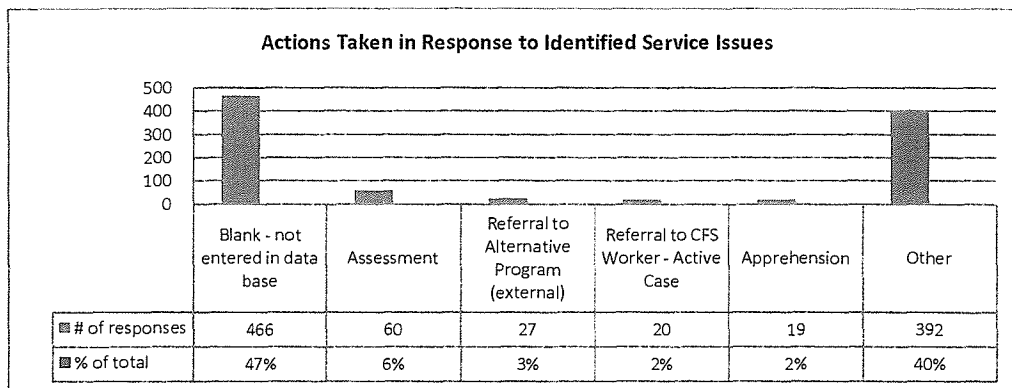
Field visits were more likely to occur when a new referral was received (56% of referrals) and least likely to occur on an incident on another agency's ongoing case (25% of referrals). A new incident on an existing ANCR case required a field visit in 37% of the referrals. There were no responses to indicate whether a field visit was required in 26% of the new referrals, 26% of existing ANCR cases where a new incident occurred, and 7% of the referrals on a case open to another agency.



## Service Actions Taken in Response to Issues

There are approximately 248 categories in the Intake Module that identify the actions taken in response to service issues. The following chart shows the reported actions taken in response to the 984 identified service issues. The top five categories have been listed separately; responses for all other categories have been grouped under "other".

Figure 24: Reported Actions Taken in Response to Identified Service Issues



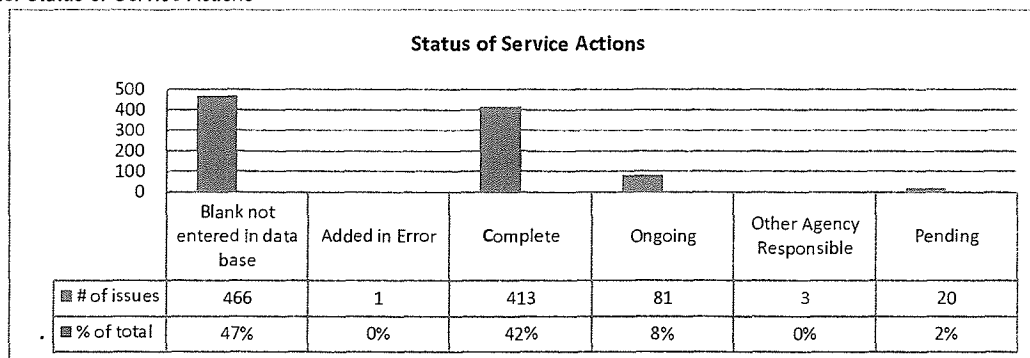
In 47% of the referrals, the service action that followed was not entered on the IM, which has the capacity to reflect actions taken on a case. If a referral is transferred, the sections of the IM that address service issues are meant to be completed by the assigned worker as interventions occur.

This section of the database is not being regularly and consistently completed. Further follow-up is required.

## Status of Service Actions

The status of the service actions taken by the CRU is tracked by six categories (fig. 19). It is expected that once work on the issues has been completed, this would be entered into the IM as "Complete". A review of the status of service actions shows that 47% of referrals in this category were missing this data.

Figure 25: Status of Service Actions





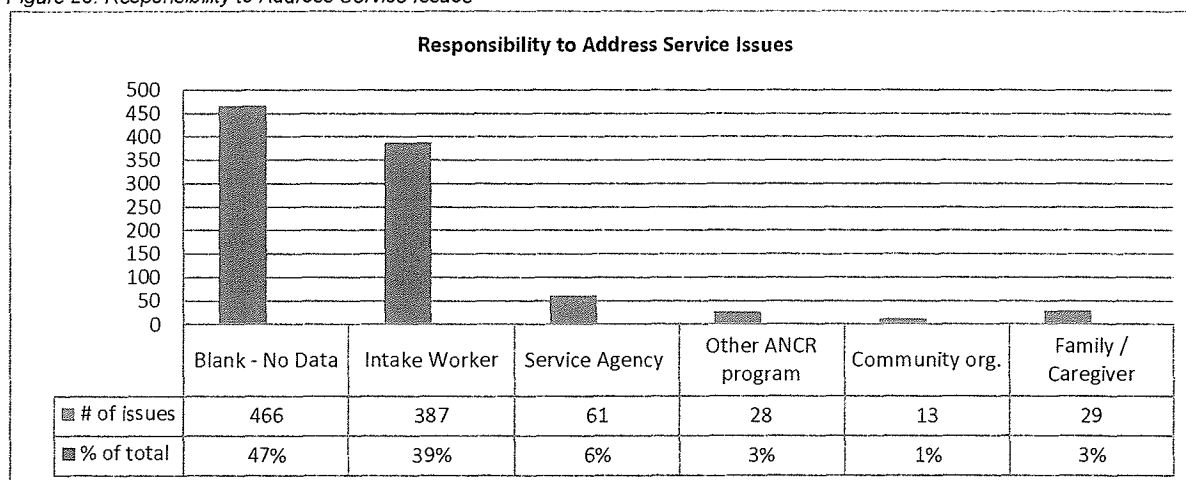
42% of all issues identified by the CRU indicate that they have been completed. Another 8% indicate that actions are ongoing and 2% indicate that action is pending. The status of 47% of the identified issues has not been entered into the IM database.

The review indicated that more than one-third of the ongoing issues were identified almost one year earlier and were not reported completed at the time of this review.

Cases may be transferred out of CRU before all of the issues have been addressed. In this event, it would be up to the receiving unit or agency to update the IM on the status of the issue. The data does not allow us to determine if the identified issue was addressed by ANCR; it only indicates that the information has not been entered. It is important that workers complete the issues management section to ensure a record of how safety issues are being dealt with.

The IM database requires that staff identify who is responsible for addressing the identified issues. There are 20 possible responses which have been grouped into 5 categories. The chart below shows the number of issues for each of these five categories.

Figure 26: Responsibility to Address Service Issues



47% of the issues identified did not have any information in the IM. It is not known how many of these issues ANCR staff is responsible for.

42% of the issues were the responsibility of an ANCR Intake worker or another ANCR program.

A review of the 'Issues Management' section of the database should be undertaken, to determine why this data is not being completed. The lack of information in the IM on issue management impacts the ability to complete an analysis in this area.<sup>6</sup>

<sup>6</sup> The CRU was more likely to complete this part of the database than the After Hours Unit. While information was missing on the person responsible for dealing with an issue for 47% of the issues entered by the CRU, 83% of the issues entered by the AHU did not contain this information.

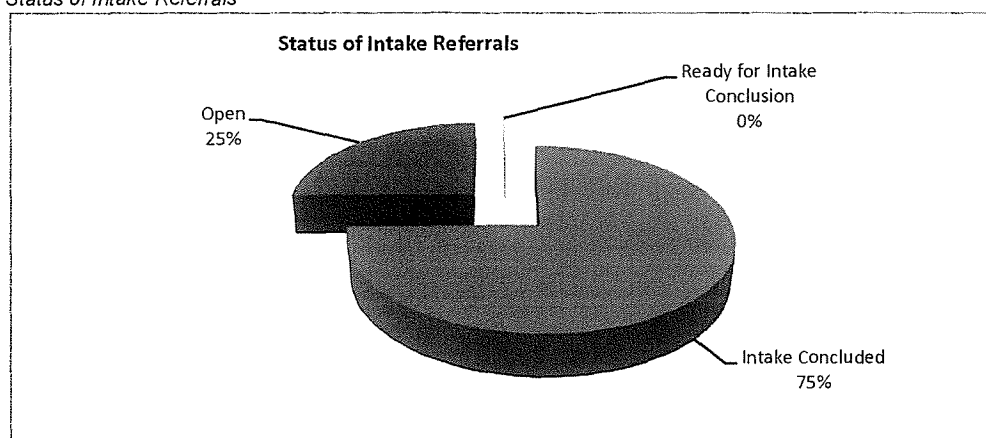


## Transfers and Closings

Upon completing an intake report, the CRU worker notifies the CRU supervisor within one working day with a recommendation to either open the case for further assessment and/or service by ANCR or close the intake at the CRU.

The chart below illustrates the status of intake referrals. Intake concluded can mean that the case was closed at Intake or the Intake was done and the case ready for transfer to another ANCR program or to a CFS agency for ongoing service.

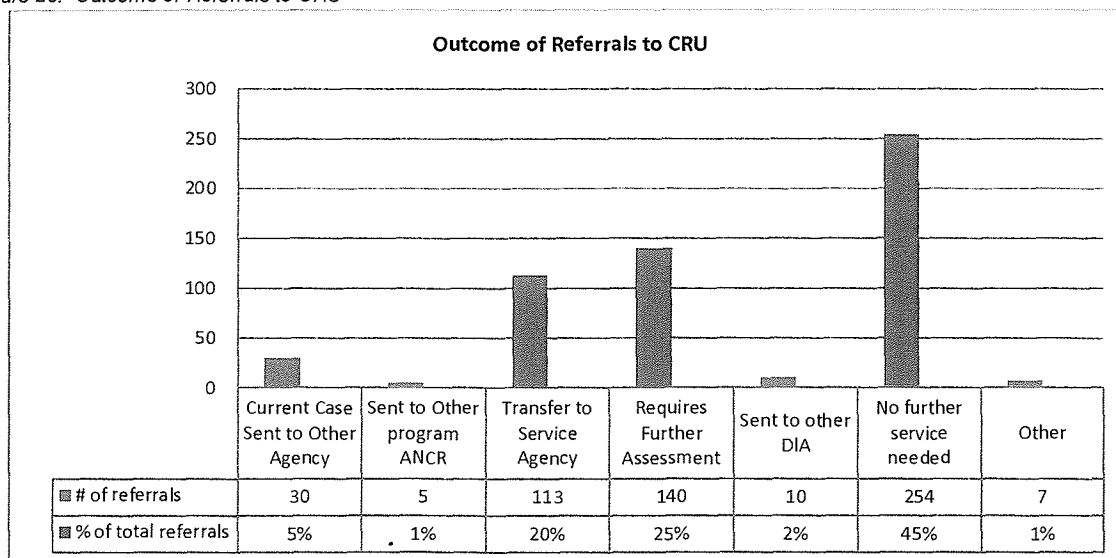
Figure 27: Status of Intake Referrals



According to the data for the time period reviewed, Intakes were concluded or ready to be concluded in 75% of the referrals to the CRU while 25% of the referrals were opened for further assessment / service.

The 559 referrals to the CRU were reviewed for outcome.

Figure 28: Outcome of Referrals to CRU





In 45% of the Intakes, no further service was required (Intake closed by CRU) and another 25% required further assessment. 1% of the referrals were sent to other ANCR program as the cases were already open with ANCR.

Of the remaining referrals, 22% were new intakes transferred to Manitoba CFS agencies / Designated Intake Agencies (DIA) for further service. 5% were cases already open to other agencies and the information was forwarded to that agency. The other category included files opened in error; non-electronic transfers; out of province referrals; and intakes ready to be concluded.

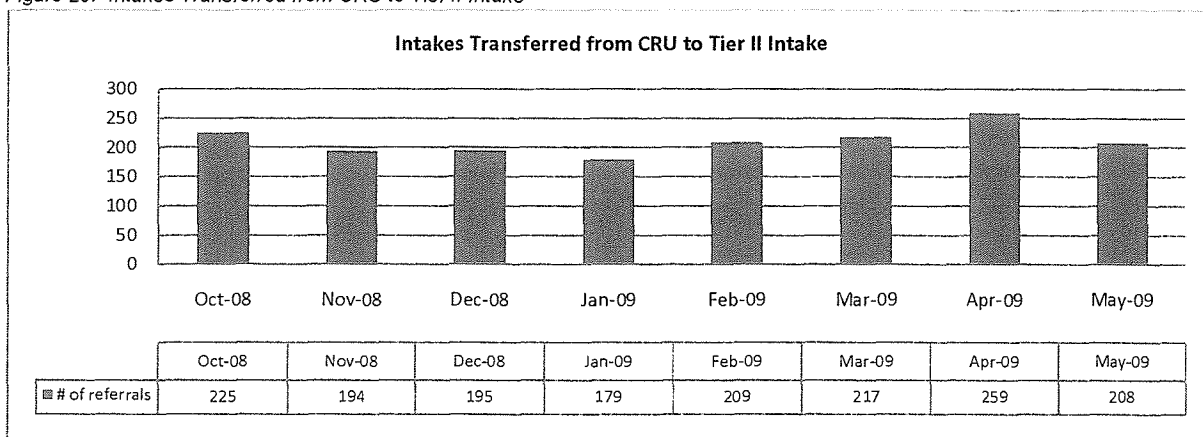
Following an initial assessment, if the CRU determines that a child or family requires further assessment or services, an intake case is opened and referred to the Tier II Intake Unit. Cases that are currently open to another CFS agency are immediately referred back to that agency for service.

The IM database does not differentiate between transfers to another ANCR program or another CFS agency in the province. As a result, access to specific information on the number of files transferred from the CRU to other CFS agencies and ANCR programs is limited. The Tier II Intake Unit maintains some data on the number of Intakes that they receive monthly from the CRU.

### ***Intakes Transferred from CRU to Tier II Intake***

The total number of Intakes includes those that are generated by the CRU during daytime hours and those forwarded to the CRU at the end of the shifts by the AHU. The following chart shows the number of transfers to Tier II Intake by the CRU over an eight month period.

Figure 29: Intakes Transferred from CRU to Tier II Intake



On average, 211 Intake referrals are transferred from the CRU to Tier II Intake monthly. As the CRU processes on average 442 Intakes<sup>7</sup> a month, an average of 48% of the total monthly Intakes are transferred to the Tier II Intake Unit for follow-up.

<sup>7</sup> Source of this data is found on page 24 of this report.



## ***Intakes Transferred to the Crisis Response Unit (CRU) from the After Hours Unit (AHU)***

Manual data is maintained in the CRU for some program functions. This data is kept only for a period of time and, therefore, the analysis of manual record-keeping data is not consistent with the time period for which IM data was collected. However, the manual records have been very useful in identifying trends and providing additional data from which comparative percentages can be calculated.

According to the *Child and Family All Nations Coordinated Response Network: After Hours Program Manual* (Draft 1, December/2008), the AHU worker notifies the AHU supervisor by the end of the shift about whether to open a case for further assessment and / or service by ANCR or close the intake at the AHU. This process involves submitting all service activity by AHU supervisors to the CRU supervisors at the end of the AHU shifts.

The CRU supervisors read all the service reports and determine whether they should be closed, transferred to another CFS agency, or assigned to ANCR staff. Those cases assigned to a CRU worker, Tier II Intake, or Abuse Investigation Units are sent to the CRU administrative assistant who opens a file and assigns the case. On cases already open to a CFS agency, the case notes are finalized and transferred to the appropriate CFS agency.

The IM does not clearly identify the actual number of referrals that are received by the CRU at the end of each AHU shift. This information is collected and maintained by the CRU administrative assistant. The manual record-keeping information was examined for the time period from January 1/2009 to April 17/2009.

Figure 30: Referrals from CRU by AHU

Referrals to CRU from AHU			
	# of Referrals	Referrals Already Active	% of Total Referrals
January/2009	150	38	25%
February/2009	135	33	24%
March/2009	200	52	26%
April 1-17/2009	100	21	21%
Total	585	144	25%
Monthly Average	167	41	25%

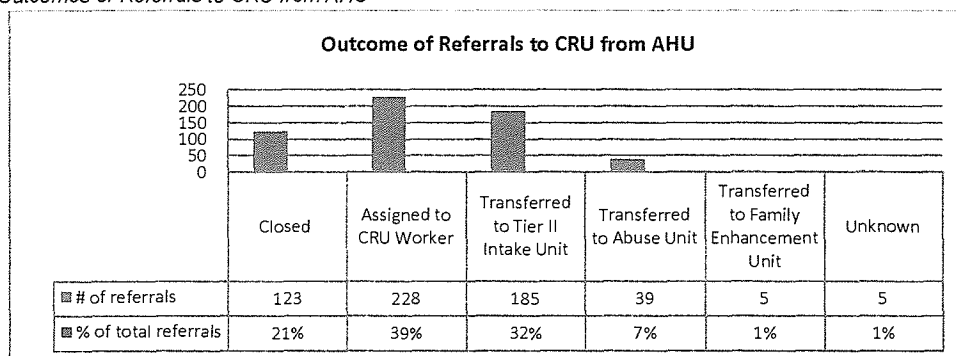
In the above time periods, 144 of the total 585 referrals were already active.



An average of 167 Intakes were forwarded to the CRU by the AHU every month and an average of 25% was already active.

The following chart shows the outcome of the referrals forwarded to the CRU by the AHU, in the above time period.

Figure 31: Outcomes of Referrals to CRU from AHU



21% of the intakes were closed in the CRU as service was no longer required or the information was forwarded to another CFS agency. 39% of the intakes were assigned to a CRU worker for follow-up. 32% of the intakes were immediately transferred to Tier II Intake, 7% were transferred to the Abuse Investigation Unit, and 1% was transferred to the Family Enhancement Unit. In 1% of the cases, data regarding outcomes was missing.

## **Job Functions**

According to the draft *CRU Program Manual* and interviews with workers and CRU managers, the primary job functions of the CRU can be divided into three specific categories:

1. Screening Referrals
2. Service Delivery
3. Ancillary Functions

### **Screening Referrals**

One of the primary tasks of the CRU is screening all referrals that come to the attention of ANCR during regular work hours, either by telephone, fax, letter or walk-in. This task requires significant experience, knowledge and exemplary interview skills, as all referrals must be screened to determine child protection concerns. The less experienced the staff, the more the demand on supervisors to provide consultation and recommendations.

Incoming referrals to the CRU by telephone are constant. Every time a CRU worker takes a call, the information is entered on the IM. Those matters that do not involve child welfare issues must be identified as such on the IM. According to supervisors, such matters tend to be rare. There is no consistent monitoring to determine if all calls that do not involve child welfare matters are actually recorded on the IM.



Once a call is concluded, CRU staff is required to complete the "wrap up". This term refers to the follow-up that must occur on each referral. This includes entering the demographic information into the IM database, checking historical involvement, and writing a brief assessment of the information and follow-up required. It is estimated that a "wrap-up" takes anywhere from 45 – 60 minutes to complete. If the referral requires immediate action, the information is forwarded to the team responsible for service delivery.

A team of six CRU workers is scheduled to provide the screening function at any given time. However, this number of workers does not consistently provide telephone coverage at any one time. This is due to workers who are still completing the processing of referrals, and completing the "wrap up" tasks. The telephone system allows CRU workers to either log / register to the telephone system, or "make busy", which indicates that they are not available to accept telephone calls at the time. A review of the telephone system showed that CRU workers were available to accept incoming calls an average of 34% of the time.

According to CRU workers, the screening function involves more than taking down information to use in distinguishing between appropriate and inappropriate referrals for child welfare services. Workers must be able to guide referral sources to share and disclose pertinent information. This may require time as relevant information is extracted. Many calls require no action, however, time is spent calming a concerned referral source or comforting a parent or family member. The workers report that a significant amount of time is spent on matters where there are no child protection issues.

The workers enter all calls into the IM database. Workers advised that information on cases where no child protection concerns exist is not always written up. The documentation that follows a telephone screening is time consuming. An average of 45 minutes is spent checking background information and documenting current information following an Intake. When documenting, CRU workers are unavailable to respond to telephone calls.

### ***Service Delivery***

Responding to emergency child welfare situations is the other primary function of the CRU. The CRU responds to immediate high risk situations and matters of low priority where a situation can be resolved at the CRU level with minimal agency intervention.

54% of all Intake referrals to the CRU during the time period reviewed required a field visit. It is a program requirement that all field visits are completed in 24 hours and written up immediately for closure or transfer to another ANCR program. According to supervisors, there are no cases held beyond 24 hours unless the CRU worker is waiting for additional information to complete the case for closure.

CRU workers confirmed that a number of cases remain open beyond the 24-hour limit as workers obtain information, make referrals, and conclude investigations. Fieldwork can be intensive and time consuming, and workers are not always able to complete the work in the 3-day time period designated





for service delivery responsibilities. At times, when workers return to telephone screening duties, they are still “wrapping up” work from the period of time they were assigned to service delivery.

The majority of the CRU staff expressed concern regarding the workload created by the two CRU functions and questioned the ability of CRU to complete both telephone screening and field work.

### ***Ancillary Functions***

Ancillary services fall into the service delivery category. The nature of the service requests are discussed separately, to distinguish whether these services require the time and skill of a professional social worker or can be addressed by a paraprofessional.

Ancillary services refer to requests for services of the CRU that require action, but do not always reflect a child protection concern. These requests require fieldwork that is necessary and time consuming. While some of these requests appear to be for ancillary services, an assessment may still be required to determine underlying child protection issues. Several ancillary services that are assigned to the CRU were reviewed.

*Figure 32: Ancillary Services*

<b>Ancillary Services</b>	
<b>Type of Request</b>	<b>Action Taken by CRU</b>
Requests for food vouchers	After an assessment of the validity of the request, the CRU worker faxes the food request to a local grocery store. The food is usually delivered to the family by a CRU worker on service delivery.
Service of court documents on behalf of other CFS agencies	CRU workers serve court notices at the request of other provincial CFS agencies and out of province agencies.
Notices of Maternity	All Notices of Maternity and Birth Alerts are opened on the IM at Screening and assigned to a CRU worker. These may be logged and closed or forwarded to Tier II Intake depending on the circumstances of the situation.
Repatriations of Children in Care	CRU workers are responsible for arrangements to repatriate children including performing such tasks as booking bus transportation, taking the child to the bus depot, waiting with the child, and arranging for someone to meet the child at their destination. This can be time consuming and often requires repeated efforts due to the child being unavailable or AWOL at the time arrangements for repatriation have been scheduled.
Requests for information	This is usually received in writing. The supervisor reviews the request and assigns to a CRU worker for completion.
Requests for home assessments	Requests for home assessments have to come in writing. The request is assigned to a CRU worker who opens the referral on the IM, generates information and forwards to the Tier II Intake Units for completion.
Reporting from Victim Services; Cyber tips; etc.	These requests are usually submitted in writing. The reports are assigned to CRU workers for brief assessment through the IM and CFSIS database to determine whether there are concerns or not. If there are concerns, the referral is forwarded to Tier II Intake or Abuse Investigation Unit, and if not, the referral is closed.
Supervising children brought into the office until arrangements for placement are finalized	CRU staff report they often have to supervise children brought into the ANCR office or, occasionally, in the home until placement arrangements are completed or a support worker or family member arrives at the home to care for the children.



At the time of the CRU interviews, the Unit did not have the assistance of case-aides. Having this resource may assist with a number of functions that do not require the involvement of a social worker and would enable CRU workers to direct more time toward screening and assessment services.

## **Meetings**

### ***CRU Managers and Staff***

During the review of the Crisis Response Unit, individual and team interviews were conducted with the following:

- The CRU/AHU Program Manager
- Two CRU Supervisors
- The CRU Administrative Assistant
- Three CRU Workers

A large number of the CRU staff and managers have considerable experience in CFS. Many worked with WCFS prior to the restructuring of the CFS system in Manitoba. One supervisor and the program manager were directly hired by ANCR. Several of the staff interviewed worked in the Joint Intake Response Unit (JIRU) from June/2005 to February/2007, and in the WCFS Intake program since its implementation in 1999 to June/2005.<sup>8</sup>

CRU workers and managers were asked to share their views on the current CRU Program Model. Several issues were identified<sup>9</sup>.

1. CRU staff report that CRU provides emergency response and field services on many cases already open to other CFS Agencies. According to CRU staff, this is largely due to the fact that case openings are not being entered into the CFSIS database as required. CFS Agencies are not consistently using CFSIS and/or are not consistently utilizing it as a case management tool. As a result, when an Intake referral is received, and there is no record on the database of it already being open to another CFS Agency, it is treated as a new referral.

Most often the worker learns that the case is open while speaking to a child or family member. Several hours of work may be spent on a case by CRU, when, had the information been on CFSIS, the case could have been immediately forwarded to the appropriate CFS agency.

<sup>8</sup> In 1999, the four geographic Child and Family Service Agencies in Winnipeg were amalgamated. Intake staff from each Agency moved to a centralized Intake Unit that provided Intake services in Winnipeg from 1999 to 2005. This unit became the joint intake unit (JIRU) as the AJL-CWI transfer of services began in Winnipeg in June/2005. JIRU became a separate agency known as ANCR when it received a mandate separate from WCFS.

<sup>9</sup> Feedback from staff and collaterals is helpful in identifying areas needing improvement. Some of the feedback received by the Review Team was supported by the findings and the analysis of data. Other feedback is based on personal experience and opinion of the individuals. It may point to areas requiring further review.



2. CRU staff report that they are asked to do child abuse investigations that come in close to the end of the work day. They reported that the AIU does not immediately accept abuse referrals that come in at the end of the workday. CRU workers must complete an initial investigation to determine child safety and write-up the referral for transfer to the AIU the next day.

The CRU workers do not feel adequately prepared or qualified to do an abuse investigation and believe these are the responsibility of the specialized abuse investigators. CRU workers believe that abuse investigators should be flexible enough to respond to abuse disclosures even if they are reported close to the end of the workday.

3. CRU staff report that callers are frustrated by the difficulty in getting their telephone calls through to a CRU worker. CRU staff is concerned that child protection reports may be lost in the process of getting a call through as callers become frustrated and hang up. CRU staff report that they have to deal with frustrated and angry callers because of the difficulty in getting through the telephone system to speak to a CRU worker.

CRU staff report that every day a number of messages regarding child welfare emergencies sit in a message box in the reception area of ANCR and that regularly, reception area staff walk over to the CRU unit reporting that they have an emergency call on hold that must be transferred to someone immediately. Because of the difficulty in getting telephone calls through to the CRU, telephone messages are taken by the receptionists and placed in a message box for CRU workers. The receptionists often screen calls and prioritize responses as they are the first point of contact for calls when a CRU worker is not available. Reception staff is not trained for this responsibility.

4. CRU staff reports that they perform some ancillary tasks that can be assigned to a paraprofessional such as a case aide or a support worker. Currently, there are no case aides assigned to assist the CRU team and workers perform tasks such as delivering groceries; looking after children in the waiting area until a placement can be located; scheduling repatriations; and delivering court notices.
5. CRU staff report that the current CRU model requires that workers alternate between spending three days on telephone screening and three days on service delivery. Service delivery can be intensive and time consuming and workers may not be able to complete the work in three days. They may still be wrapping up the work when they return to telephone screening duties. The existing CRU model features two teams of six social workers alternating between telephone screening and emergency response functions. CRU staff were concerned that the screening function was being lost, as workers have to respond to emergencies.

A model where workers are dedicated to telephone answering and screening was favoured. CRU workers recommended that the unit become a Screening Unit and that all Intakes requiring fieldwork are forwarded to specifically designated Intake teams. They supported a model that



includes paraprofessional staff to assist with service issues that do not require the skills of an Intake worker.

Staff and managers agreed that the emphasis on quality telephone Intake screening, consultations, and community referrals can be improved by restructuring the program model to support a team of qualified and experienced staff, knowledgeable in community resources, to focus on the Intake screening function.

6. CRU staff report that supervisors are responsible for concluding all service activity performed by AHU workers. CRU staff report that all Intakes processed by the AHU are forwarded to CRU supervisors each morning (except for weekends) for completion and disposition. This process involves a duplication of services, as all AHU files have to be re-read in order to determine which files should be closed, assigned to a CRU worker, forwarded to Tier II Intake or the AIU. CRU supervisors would like to see the AHU supervisors responsible for recommending the disposition of the AHU referrals.
7. CRU staff voiced concerns about strained working relationships that exist between different program areas in ANCR. CRU staff agreed that program areas within ANCR tend to operate as "silos" and communication between staff from different program areas could be improved. Complaints and concerns tend to be directed to Program Managers who take them up with other Program Managers. Supervisors and staff would rather resolve the concerns at their level. The current process does not encourage teamwork and further creates a barrier between different program areas.
8. In the intensive, fast-paced work environment of the CRU, supervision is usually incident-based and provided when required. The demand for this type of supervision is constant and supervisors have little time to schedule individual staff supervision sessions that can focus on longer term professional development and performance feedback. The demand for supervisory consultation and authorization is ongoing. Workers are regularly waiting in line to consult with a supervisor regarding situations related to Intake referrals. Supervisory presence is required in the CRU at all times.

Additionally, supervisors are responsible for reading, reviewing and finalizing all Intakes opened by the AHU every morning for assignment to the appropriate program. This involves updating demographic information, obtaining medical and police information on files where access to these services is not available during night time hours, recommending closings, assignment to CRU workers or transfers to other ANCR Programs. Supervisors have little time for formal staff supervision sessions and regular team meetings.

According to the supervisors, CRU team meetings occur once every two months and individual staff supervision is conducted every four to six weeks.



9. CRU staff report that a large amount of the CRU workload involves forwarding external telephone calls, written requests, and information requests to the appropriate CFS Agency. The CRU acts as a distribution centre for calls and information involving children and families already open to other CFS agencies in the province. A large number of out-of- province requests that could be going directly to the Provincial Coordinator come to the CRU and then have to be re-directed. In addition, callers unsure of which agency to contact call ANCR with service requests. These requests have to be redirected.
10. Occasionally, due to a lack of information on CFSIS, CRU workers complete an initial assessment before they find out the family already has an open file with another CFS Agency.
11. Child abuse investigation reports are not attached to CFSIS until they are completed. An abuse investigation may take several weeks or months to complete. In the meantime, as new protection concerns are reported to AHU or CRU, they may proceed with an investigation without being aware that a child abuse investigation is in progress.

### ***Meetings with staff from Tier II Intake***

Like staff from external CFS agencies, there are differing perceptions among internal staff about the role of the CRU. Interviews with Tier II Intake workers resulted in expressions of concern about redundancy in services with both the CRU and the Tier II Intake workers providing services to the same client.

Tier II Intake staff reported concerns that the brief interventions by CRU workers do not allow for adequate assessments and these have to be completed again by the Tier II Intake worker. As a result, Tier II workers questioned whether it was really necessary that CRU workers go out on field visits.

Tier II workers were concerned about the number of CFS workers that clients have to work with. They described situations where clients refused to provide further information to them because they had already done so in a meeting with a CRU worker. The concern is that too many child welfare workers are involved with clients, creating confusion and making it difficult to form trusting working relationships. Several Intake workers agreed that they would like to be involved at the onset of a new Intake, rather than have someone else would meet with a client for a brief visit and then transfer the file.

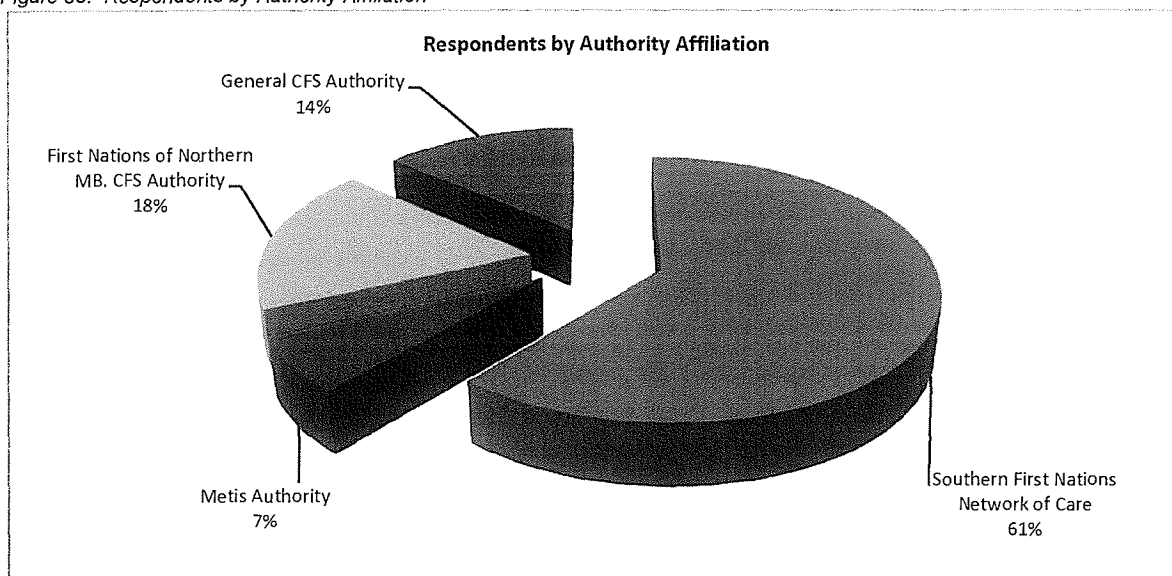
### ***Interviews with Staff from other CFS Agencies***

Staff and managers from other CFS agencies in the province were interviewed regarding their experience with the CRU. Respondents were asked ten questions about their experience working with the CRU. Forty-four (44) staff and managers from several CFS agencies responsible to the four CFS Authorities in the province participated in the interviews. The respondents had experience ranging from one and half to thirty years in the CFS system in Manitoba.



The following figure shows the respondents by Authority affiliation.

Figure 33: Respondents by Authority Affiliation



The input of staff from agencies that are key to the operations of the CFS system in the province is valuable. However, the actual interaction between CRU and other CFS agency staff is limited to situations where a referral is being made to the CRU or the few situations where there may be joint involvement with a child or family. This may be the reason why staff from other CFS agencies have little involvement with the CRU, and as a result, are not clear about the specific role of this Intake program. Interviews with staff from other CFS agencies confirm that the CRU is not regarded as distinct from the overall Intake function at ANCR.

#### Understanding of Roles and Functions

A number of respondents did not know the CRU existed. Only 24 respondents, or 54% of the sample group, had experience with the CRU. This would be expected, as the CRU primarily has contact on new referrals, and not files open to other CFS agencies.

Those that were aware of the program or had involvement with the CRU described it in different ways, revealing a lack of clarity about its role and function. The CRU was described as a filter for initial calls in assessing the need for Intake involvement and as the unit that provides initial stabilization services.

Other explanations included viewing the role of the CRU as receiving cases from Intake and following up on them prior to transferring to other CFS agencies. Some staff explained the role as being the first response for family matters of child protection, to assess immediate safety and determine the need for further response. CRU was identified as providing coverage on holidays, acting as a crisis response service, and as another response level within ANCR.



### Circumstances under which a referral or service request would be made

Workers seldom related to the CRU unless they were referral agents of a situation. This included requests for services on open cases, to reopen a closed case, or to work with a family where the CFS agency did not have an open file.

### Referral Process

In regards to referrals to the CRU, respondents indicated that workers would phone, fax or send letters outlining a service request. The CRU determines whether the family requires other ANCR services such as an abuse investigation or family enhancement services. The need for ANCR as well as CRU to refer cases for preventative services was emphasized.

### Experience in Receiving a Case Transfer from CRU

Respondents emphasized the importance of ensuring that children are seen and interviewed by the CRU staff, prior to the case being transferred. They commented on the need to streamline the services at ANCR, pointing out that families have sometimes been seen by multiple workers prior to the case transfer from CRU. Respondents spoke about the importance of ANCR staff working with agencies in a manner that encourages engagement, rather than from a directive approach.

### Strengths of Service Provided

Workers described the CRU as the "gate keepers" who perform the function of screening and doing consults. CRU was generally seen as an effective experienced work group with a good awareness of child welfare service delivery, and as having service responses well documented in case notes.

### Difficulties with Services at CRU

It was pointed out that it can be difficult to get through to the CRU on the telephone. The current telephone system is a contributing factor and should be reviewed. Several respondents indicated that it is easier for families if they can deal with a person, rather than with voice mail. The importance of good communication, appropriate assessments, culturally appropriate services, and knowledge of ANCR programs were identified as important elements of CRU services.

### Working Relationship and Communication

There were mixed responses in this area. Some respondents stated that they experienced a positive and reasonable working relationship with the CRU. Others found the working relationship more difficult.

### Overall Satisfaction

Ten out of the twenty-four staff who had experience with the CRU responded to this questions. Seven out of ten were very or mostly satisfied. Three were somewhat or generally unsatisfied.



### Suggestions for Improving Services at CRU

Suggestions made included:

- Improved communication between CRU and CFS agencies.
- Improved collaboration and partnering with other CFS agencies.
- The development of a "guideline" to assist others in understanding the role of the CRU.
- Review of the service model and the need for two levels of intake (CRU/Intake Tier II).
- The need for culturally proficient staff.
- Improvements to the telephone system to make it more responsive to families.

### **Report from CRU Planning Workshop - January/2008**

An external consultant was contracted by ANCR to conduct a planning workshop for the CRU in December/2007. CRU staff participated in group planning sessions to develop goals and expectations for the program. Four core goals for the program were identified to be in place by 2010:

- CRU will have a full complement of staff on a daily basis.
- All CRU staff will be trained to effectively and efficiently perform core functions.
- CRU will practice consistency within teams, and as a program, in service delivery, work expectations, documentation, assessment and response.
- CRU will have defined a risk assessment process and practise it consistently.

During the planning sessions CRU staff identified strengths in teamwork, strong relevant skills, empathy and compassion for client situations including understanding of client frustrations with systems, knowledge of community resources and strong work ethics. They cited lengthy CFS experience, education and training, and indicated that they provide excellent crisis intervention, assessments and delivery of preventive services. The Unit indicated that they cared about their work and the clients they serve, had a sense of humor, and an understanding and respect for each other.

CRU staff indicated that more communication with collaterals was needed to assist them with the information that is required when making a child protection referral. Follow up with sources of referrals informing them of outcomes could be improved. Greater consistency in service delivery was needed, within the program and between teams. Staff indicated that information from program meetings was not being provided to them and that more training opportunities were required. Other issues related to the lack of consistent staffing, program descriptions, manuals and written processes regarding the current program model.

Because the program was not fully staffed at the time, CRU staff reported that they were not handling the volume of calls or responding appropriately to service demands when providing service delivery under pressure. They reported that they did not do enough to advocate for themselves for adequate coverage, resources such as car seats, training opportunities and regular team meetings.





Staff shared their own lack of clarity about the program model. They noted that doing two different functions contributed to a lack of consistency in how the work was done. At the end of the planning session, the CRU came up with several strategic priorities, including having adequate staffing, ensuring training and orientation for new workers, setting regular team meetings and treating team members similarly regardless of their experience. The unit prioritized communication with collaterals and team members, and consistency in practice through the development of standards for service delivery, consistency in documentation and a risk assessment tool.

## **Summary of Findings**

1. The CRU operates as an intensive, fast-paced environment with constant telephone activity and workers coming in and out of the office.
2. CRU is tasked with responding to all initial requests for service and/or all child protection referrals. The referrals are accepted via the following mechanisms: phone, fax, e-mail, mail or walk-in. All referrals are screened to ensure appropriateness. Once it is confirmed that a child welfare response is required, the CRU worker will gather all needed information to determine the appropriate course of action.
3. Two CRU teams rotate on a three-day schedule. One team is responsible for all telephone screening. The second team is responsible to respond to all written referrals, walk-in clientele and emergency field visits. Once either team has determined that the family requires service by the CFS system, an intake case is opened and referred to the appropriate ANCR program for further assessment or service.
4. This rotation of staff at CRU does not appear to be effective.
5. There is a lack of clarity about the specific functions of the CRU (telephone screening and emergency service response) in relation to the other general intake functions provided by ANCR. This lack of clarity exists for ANCR staff as well as for the other CFS agencies and collateral organizations.
6. When a case is transferred to Tier II, the Intake worker often does the same thing that the CRU worker did (i.e. completion of family assessments). This is a duplication of services between the CRU and Tier II Intake. This duplication contributes to workload issues.
7. The current service model can result in a family being seen by multiple workers while still at ANCR, and then yet another worker once the file is transferred to a CFS agency for ongoing services.
8. There are two teams, each consisting of a supervisor and six social workers. A Program Manager, an administrative assistant, and two receptionists make up the rest of the unit staff.



9. The staff composition at the CRU has been relatively stable this past year. In February/2010, there was one vacancy in a social work position.
10. The majority of the staff at the CRU has considerable experience in the child welfare system. Of the thirteen filled social work positions (2 supervisors and 11 social workers), eight have their BSW, one has a BSW in progress, three have related post-secondary degrees, one has a CFS diploma, and one has no post secondary degree but 27 years CFS experience. Six of these staff have ten or more years experience. The Program Manager and both supervisors are well qualified.
11. Seven staff in the CRU are secondees.
12. The CRU does not have the assistance of a case aide. Having this resource may assist with a number of functions that do not require the involvement of a social worker. This would enable CRU workers to direct more time toward screening and assessment services.
13. The emergency nature of the CRU is evident in the worker/supervisor relationship. Unlike other program areas and other CFS agencies, supervision for workers is constantly available as needed. Formal supervision sessions are spaced four to six weeks apart, and team meetings occur once every two months. The style of supervision is crisis-oriented, there to provide authorizations and brief consultations and guidance to the worker when needed. While this is consistent with the nature of the work at the CRU, this type of supervision may deny workers the opportunity to obtain constructive performance feedback necessary to acquire knowledge and develop skills, identify training needs, and receive regular performance appraisals.
14. The CRU responds to an average of 442 Intakes each month. Approximately 275 Intakes are received during regular daytime hours. In addition, an average of 167 referrals are transferred monthly from the After Hours Unit (AHU) to the CRU for follow-up.
15. The highest number of referrals occur during the spring and early fall. The lowest number of referrals occurs during the summer months of July and August.
16. Community referrals account for 64% of the total number of referrals to the CRU. This category includes community organizations that are tasked with responsibility to provide educational, medical and justice services to children and youth. Most of the community referrals (30%) are received from schools. This is followed by medical professionals or hospitals, which account for 17% of the referrals. Community members not associated with a community organization account for 13% of all sources of referral to the CRU.
17. Self-referrals and referrals by family members make up 20% of all referrals to the CRU. Of this number, 58% are self-referrals while the remaining 42% are referrals made by a member of the family.



18. Other CFS agencies in Manitoba account for 7% of the referrals to the CRU, and placement resources for children in care, such as foster homes, shelters and residential treatment centers account for less than 1% of the referrals to the CRU.
19. 5% of all referrals to the CRU come from anonymous sources.
20. The majority of referrals to the CRU are made by telephone (80%). Referrals sent through the fax machine account for another 12% of the total referrals. Approximately 8% of referrals come through e-mail, regular mail, or walk-ins.
21. The majority of intakes to the CRU (92%) are new referrals. The remaining 8% of the referrals required services on cases that were already opened. Of these, 5% were in response to an incident on a case open to another in-province CFS agency, and 3% required service on an existing ANCR case.
22. A total of 54% of all referrals to the CRU required a field visit. Field visits were more likely to occur on a new referral and least likely to occur for an incident on a case open to another CFS agency.
23. Field visits were required in 56% of all new referrals. This was followed by 37% when the incident involved an existing ANCR case and 27% of the time when an incident involved the ongoing case of another CFS agency.
24. The issues most frequently reported in referrals during daytime hours include child protection concerns due to:
  - Parental substance abuse
  - Inappropriate parenting skills
  - Family violence
  - Other concerns about parental capacity to care for a child or children
25. In 47% of the referrals to the CRU, the service action that followed in response to the referral was not entered in the IM database. This section of the database is not being regularly completed. It is uncertain whether this is because the service actions are not the responsibility of the CRU worker or whether this section is too time-consuming, unclear or confusing. Further follow-up is required in this area.
26. Approximately 20% of Intake referrals to the CRU are received in written form through the mail, email or facsimile. One half of all written referrals to the CRU (50%) are from community agencies and organizations, followed by other provincial CFS agencies and Authorities (31%) and out-of-province CFS agencies (17%).



27. The majority of written requests from community members and collaterals are associated with concerns about child safety and parental capacity to provide care to a child. While reports of child protection concerns were the highest, at 69% of the total, written referrals from community members and organizations requesting assessments for parents and children accounted for 38% of the total written referrals. 45% of all written referrals reported minor expectant parents or notified the agency of a pregnancy in potentially high-risk situations.
28. Other provincial CFS agencies and CFS Authorities accounted for 31% of all written referrals to the CRU. Written service requests were received from 18 different CFS agencies in the province during the review period from September 1/2008 – March 31/2009, with each agency referring in writing from one to eight times.
29. The majority of the written service requests were on behalf of a child protection concern. A smaller number requested some assistance by the CRU on an existing CFS case such as requesting historical information on a family, requesting home studies, assessments, or the service of court documents.
30. Approximately 17% of written service requests were from out-of-province CFS agencies. One half of these were from CFS agencies located in Ontario. Out-of-province service requests were less likely to report a child protection concern. The majority of the service requests required assistance for case management purposes, such as access to historical information on a child or family, service of court documents, and home studies or guardian assessments.
31. The draft *CRU Program Manual* outlines a 24 hour time frame for updating and closing or transferring a file to another ANCR unit after the brief assessment and intervention are completed. This time frame appears to be unrealistic. Several days are often needed to obtain the information needed to conclude or transfer a file.
32. Approximately 68% of all telephone calls to the CRU result in an open Intake file.
33. In 25% of all referrals, no entry was made in the IM to indicate whether a field visit was required. Not all CRU workers are entering this information on the database.
34. Similarly, 42% of issues identified by the CRU indicate that they have been completed. 8% of the issues show the service status as 'Ongoing'. More than one-third of the ongoing issues were identified almost one year earlier and not completed on the IM at the time of this review. It appears that once a case has been transferred outside the CRU, the less likely it is that the Issue Management section of the database will be completed.
35. There is an absence of data in the Issue Management section of the IM. This lack of information impacts service delivery responses, particularly with electronic case transfers. It is not certain what accounts for the absence of data in this section. Further review is required.



36. Safety assessments were completed in 8% of all the identified issues. Almost all safety assessments occurred on new referrals.
37. The Safety Assessment form in the Intake Module (IM) is not being used to determine risk. Workers report that the form is not appropriate to many of the situations that they deal with. Some of the compulsory questions cannot be answered at the time of Intake and the process cannot be completed. Workers admit to often by-passing this section of the IM.
38. A review of Intakes during a specific time period in 2008-2009 suggests that 45% of Intakes do not require any further services. At the same time, 25% of Intakes were assigned to a CRU worker for a further assessment and intervention, and 30% of Intakes were forwarded to another CFS agency or ANCR Program.
39. 42% of the total intakes are transferred from the CRU to Tier II Intake on a monthly basis.
40. 39% of intakes processed by the AHU are assigned to the CRU for follow-up.
41. On a weekly basis, CRU workers respond to intake referrals and provide emergency services to children and families that are open to other CFS agencies because no documentation exists on the CFSIS database reporting that the family is active with another CFS agency. This leads to redundancy and duplication of services to families.
42. CRU workers perform a number of ancillary tasks, such as delivering food hampers, supervising children waiting for a placement resource, serving court documents, looking up historical family information for other agencies, arranging for children to be repatriated, and transporting children to and from placement resources that do not require the skills of an Intake workers. Many of these tasks can be performed by paraprofessional staff.
43. A large amount of the work performed by the staff involves the forwarding of external telephone calls, correspondence, and requests for information/service to the appropriate CFS agency, Authority, or Child Protection Branch by CRU staff. CRU has become a distribution centre for telephone calls and written material involving children and families already open to other CFS agencies in the province. Frequently, callers who are unsure of who to contact will call the CRU with service requests. Such calls are time consuming, as a CRU worker must listen to the concerns, and then redirect the caller to another agency. ANCR is intended to be the point of contact with the CFS system in Winnipeg, and these types of calls are to be expected.
44. A review of telephone responses showed that CRU workers were available to accept incoming Intake calls an average of one-third or 34% of the time. In eight of the twenty two workdays in March/2009, CRU workers were available less than 20% of the day to take Intake calls. The rotation system may be one cause for the low availability of workers for telephone screening.



45. The majority of respondents, who completed the section, rated being mostly satisfied with their experience with the CRU.

## ***The Tier II Intake Units***

New referrals opened by the After Hours Unit (AHU) or the Crisis Response Unit (CRU), that require further assessment and intervention, are forwarded to the Tier II Intake Units. According to the *Child and Family All Nations Coordinated Response Network Tier Two Intake Policy Manual*, dated October/2006, this level of Intake service is responsible for:

- Providing child protective services.
- Assessing the need for on-going service by a mandated child welfare agency under Part II or Part III of *The Child and Family Services Act*.
- Transferring services to the appropriate mandated CFS agency.

It is the role of the Tier II Intake program to ensure that families receive appropriate and timely services. This includes protective services related to the abuse and neglect of children and/or the timely transfer of cases requiring further service to a mandated CFS agency. The Policy Manual states that Intake workers are expected to establish good working relationships with all collateral service agencies and all other involved mandated CFS agencies.

This portion of the review focused on the role of the Tier II Intake Units in ANCR in accordance with the following terms of reference:

- Overview and analysis of service volume at the Tier II Intake program.
- Overview and analysis of current staff resources.
- Overview of the Tier II Program Model including workload and service responsibilities.
- Overview and analysis of the case transfer process.

Several sources of data were collected and analyzed during the process of conducting the review of the Tier II Intake program including:

- A review of data contained in the IM and in manual record-keeping methods by the program manager and supervisors.
- A review of the *Child and Family All Nations Coordinated Response Network Tier Two Intake Policy Manual* dated October/2006.
- A review of the *Supervision Policy* for the Tier II Intake Unit and AIU.
- A review of the *Tier II Client Contact Policy*.
- A file audit review of a sample of 33 cases opened to the Tier II Intake program from February/2009 to May/2009.
- Interviews with staff and managers working in the Tier II Intake Units.



- Attendance at two meetings with Tier II Intake Units.
- Interviews with staff from other CFS agencies.

## **Program Structure**

The Tier II Intake program became part of the Child and Family All Nations Coordinated Response Network (ANCR) in February/2007 when the Agency became the designated Intake service agency in Winnipeg. Prior to this, the program was part of the Joint Intake Response Unit (JIRU), operating under the direction of WCFS. Under JIRU, there were two Intake units: a North Winnipeg Intake Unit and a South Winnipeg Intake Unit, with two teams in each unit. Intakes were assigned to each Unit based upon the address of the Intake case reference. If the address of the case reference was not determined, the cases were assigned to the Units on a rotational basis.

In 2009, in an attempt to balance workload, the geographic boundaries were lifted. For the sake of distinguishing between the Units, they continue to be referred to as the North A Unit, the North B Unit, the South A Unit, and the South B Unit. Most of the Intakes assigned to the Tier II program are transferred from the Crisis Response Unit (CRU). These Intakes are assigned on a rotational basis, while taking into consideration staff availability to accept cases. It is the responsibility of the Intake supervisor to assign the intakes to the Intake workers on their teams.

According to the *Child and Family All Nations Coordinated Response Network Tier Two Intake Policy Manual*, dated October/2006, the objectives of the Tier II Intake program is to:

- Provide intervention and crisis stabilization services.
- Provide thorough assessments on all referrals.
- Provide referrals to other programs and services, internal and external to ANCR.
- Provide referrals to mandated on-going service provider agencies.
- Complete the Authority Determination Protocol (ADP).

Also listed in the Manual are a number of case management activities that should be provided by the Tier II Intake Units. These include the following:

- Assessment and investigation of neglect, including an assessment of the family/child's needs/issues, resources and strengths.
- Gathering of information from collateral agencies that are involved with the family/child.
- Completing referral to the ANCR Abuse Program if required.
- Providing emergency services to stabilize the family.
- Making referrals to alternative community programs.
- Making referrals to other external programs and services.
- Completing the ADP.
- Transferring to the appropriate mandated CFS agency.
- Completing all required documentation.



The primary role of the Tier II Intake Units can be summarized as follows: investigating child protection matters; completing assessments, including gathering information from collateral agencies; providing emergency services to stabilize the family; and making appropriate referrals to community programs and services. If ongoing CFS involvement is required, then an ADP form is signed and the case transferred to the appropriate CFS agency.

## **Staffing**

The *Child and Family All Nations Coordinated Response Network Tier Two Intake Policy Manual* dated October/2006, indicates that the Tier II Intake Program consists of 32 staff members, including:

- 1 Program Manager
- 4 Supervisors
- 24 Intake Workers
- 2 Administrative Assistants
- 1 Legal Clerk

Each supervisor manages a team of six Intake workers for a total of four Intake teams. Each administrative support worker provides support to two Intake teams. The supervisors report to the program manager, who in turn reports to the executive director.

## ***Employment Equity Hiring***

The goal is to staff positions according to employment equity position designations. As indicated in the figure that follows, 46% of the positions are designated 'General', and 54% 'Aboriginal'.<sup>10</sup> Of the current staff, 35% are Aboriginal. 75% of the filled positions are filled according to the position designation.

## ***Secondments***

Vacant positions will become direct hires. 66% of the positions at Tier II Intake are direct hires. 34% are filled by seconded Province of Manitoba employees.

Figure 34: Tier II Intake Staffing (February/2010)

Number of FTE Positions	
Supervisor	4
Front Line	24
Admin Support	3
Family Support / Case Aides	1.5

<sup>10</sup> The Program Manager is included in the Management /Corporate listing.





Staffing Data	
Direct Hires	66%
Seconded (Permanent)	25%
Seconded (Temporary)	9%
Positions designated 'Aboriginal'	54%
Positions designated 'General'	46%
Not designated	0
Positions filled according to designation	75%
Aboriginal Staff	35%
Vacancies	
5 Front Line worker positions	

### ***Experience in Child and Family Services***

Years of experience in the CFS system varied among the social service staff. The following figure shows the experience of Tier II staff.

Qualifications of Social Work Staff	
BSW/MSW	49%
Other related degree	13%
CFS Diploma	9%
Info. with WCFS	30%
10+ yrs of experience	17%
6-10 yrs experience	17%
3-5 yrs experience	13%
1-2 yrs experience	13%
Less than 1 yr experience	9%
Info. with WCFS	30%

49% of the social work staff (front line and supervisors) have a BSW/MSW; 13% have a related degree and experience; and 9% have a CFS Diploma. 30% of the staff have this information on personnel files at WCFS and this was not available to the reviewers.<sup>11</sup>

17% of the social work staff had ten or more years of experience in CFS; 17% had 6-10 years; 13% had 3-5 years of experience; 13% had 1-2 years of experience, and 9% had less than one year.

<sup>11</sup> These staff are seconded from WCFS and this information is kept on the file at WCFS, not ANCR.



## ***Supervision and Staff Development***

Supervision in the Tier II Intake Unit appears to be regularly scheduled and consistent with the *Joint Intake Response Unit, Tier II Intake and Abuse Supervision Policy*, Draft May/2006. This policy provides the framework for the role of supervision in the Tier II Intake Unit and the AIU. The policy states that:

*"...supervision is critical to the quality of service delivery and the experience of service users..."*

The policy is concise and provides guidance on the key components of providing supervision.

Supervision in the Tier II program appears to adhere to the policy. According to Tier II Intake staff, supervision in the program occurs as follows:

- A Program Meeting is held once a month for all Intake staff.
- Supervisors meet with the Program Manager once every two weeks.
- Intake workers meet with supervisors once every two weeks.
- In addition, the Program Manager and the supervisors are available to workers on an as needed basis.

Intake staff report participating in regular training sessions, including the Core Competency Training. New staff describes an orientation process which introduced them to the organization and prepared them for assuming Intake services.

## ***Vacancies***

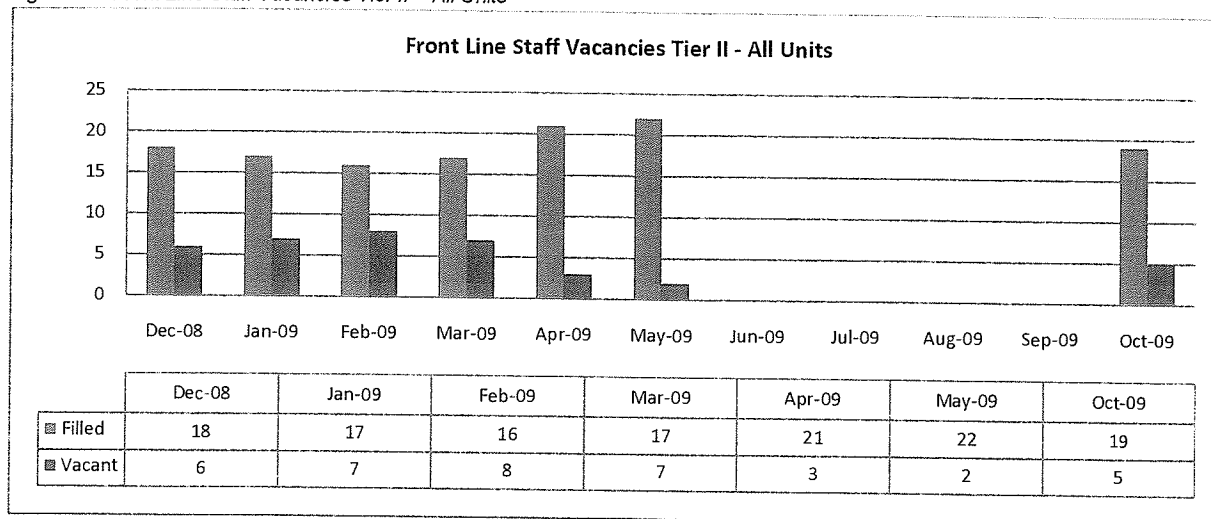
In October/2009, the Tier II Intake program had five vacancies within the social work positions. In February/2010, the vacancy rate was the same, also within the social work positions.

The Tier II Intake Units have experienced staffing changes in the past year. The number of vacant staff positions was reduced significantly in April and May of 2009, but increased again in October/2009. This was the result of a planned leave and the appointment of a front-line worker to a term supervisor position in the Tier II Intake Program in April/2009. The two vacant positions in the North B Unit were the result of the dismissal of a new employee and the appointment of a front line worker to a term supervisor position in the AIU. The vacant position in the North A Unit was the result of the appointment of a front line worker to a term supervisor position in the Tier II Intake Program.

The number of front line staff vacancies on each of the four Intake Teams was examined for the six-month period from December/2008 – May/2009, and again in October/2009.



Figure 35: Front Line Staff Vacancies Tier II – All Units



Vacant positions were not equally distributed between teams. The following charts show the vacancies by unit.

Figure 36: Front Line Staff Vacancies Tier II – Unit 1

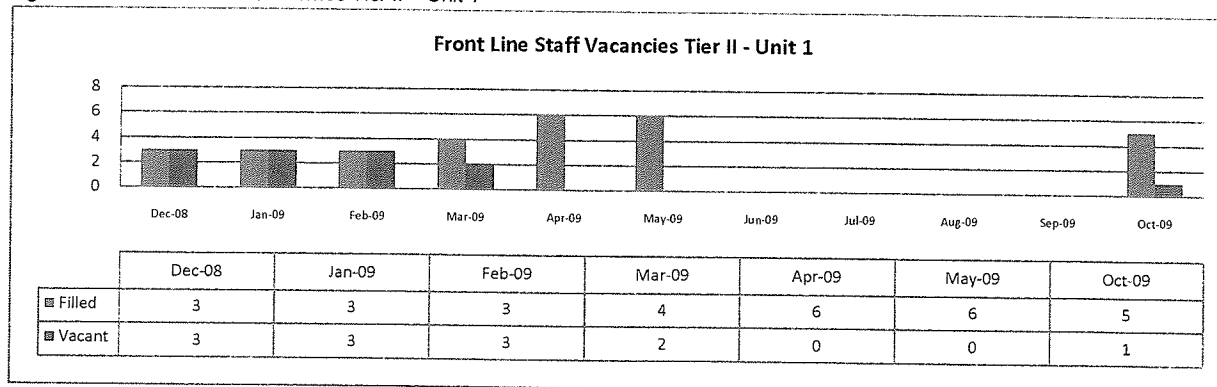


Figure 37: Front Line Staff Vacancies Tier II – Unit 2

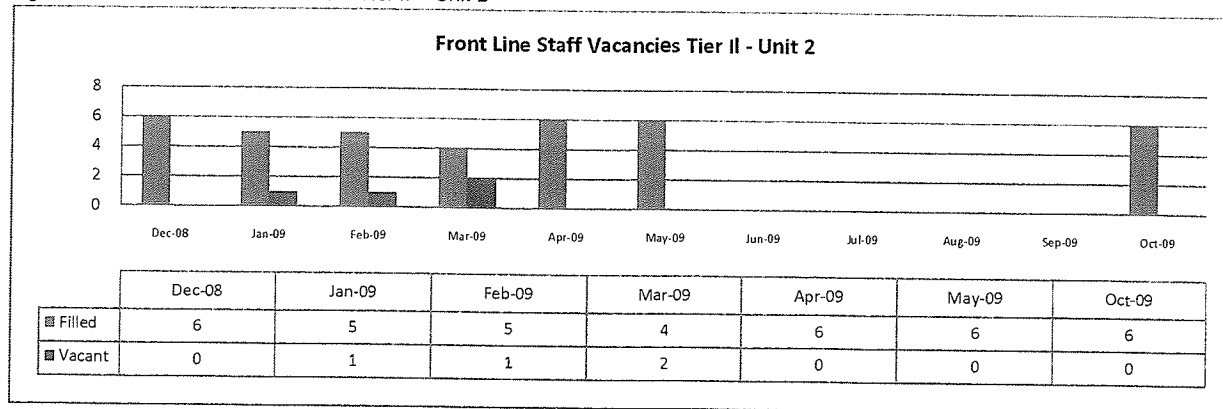




Figure 38: Front Line Staff Vacancies Tier II - Unit 3

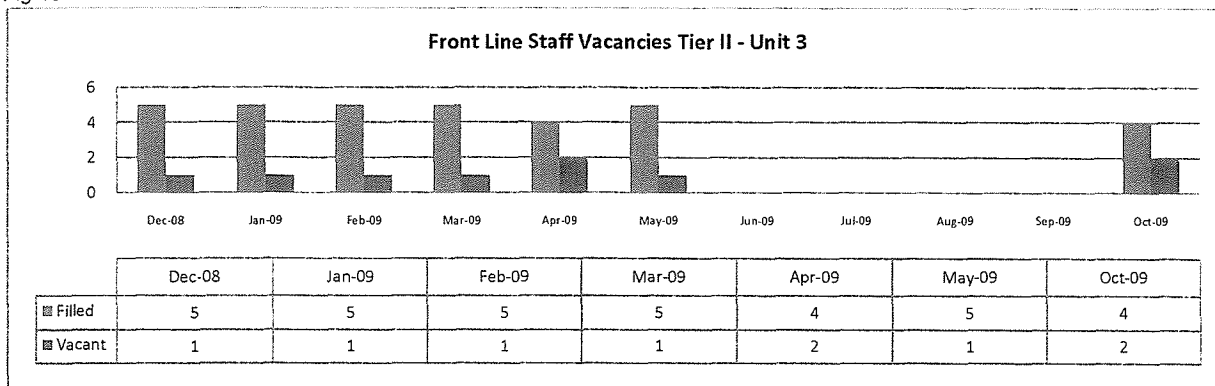
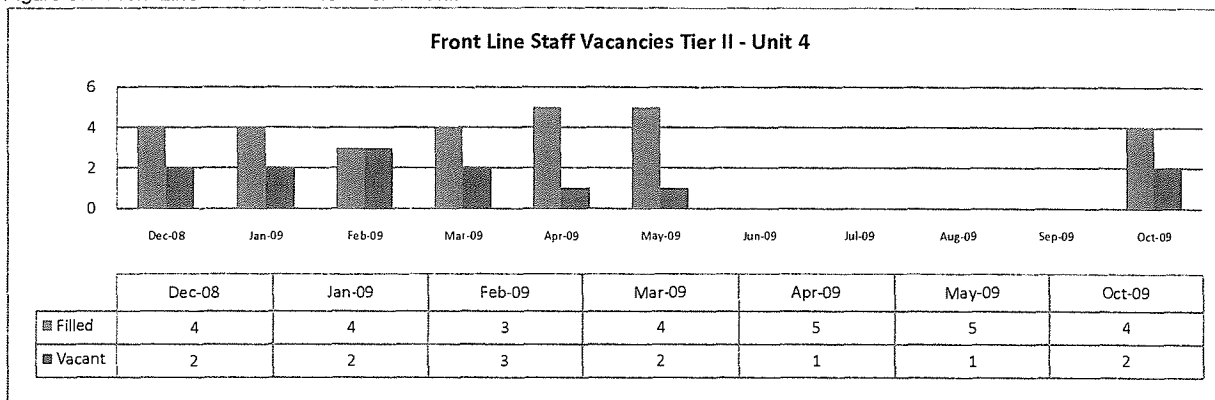


Figure 39: Front Line Staff Vacancies Tier II - Unit 4



Supervisor turnover has been high in the past year. A seconded employee with over 30 years of experience in CFS returned to WCFS in 2008. Another seconded employee with considerable supervisory experience left the position in 2008 when a supervisor was directly hired for the position. A third seconded employee with over 20 years of experience left the position to assume employment in another organization. As of February/2010 all four supervisory positions were filled, 2 with direct hires, one was a permanent seconded employee, and one a temporary seconded employee. All of the supervisors have seven or more years of CFS experience.

## Service Volume

Almost all Intakes assigned to the Tier II Intake Units come from the Crisis Response Unit (CRU) in accordance with a process that includes the following steps:

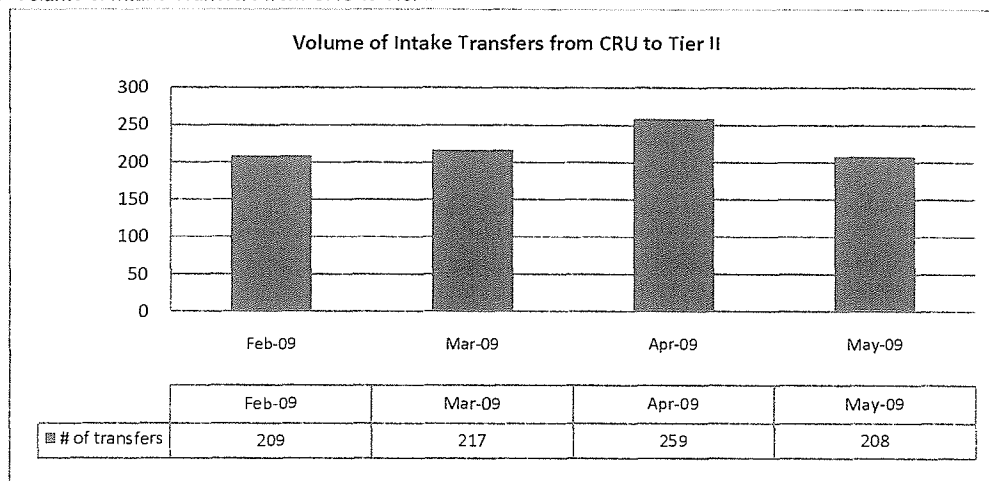
- Every Friday Tier II Unit supervisors advise the CRU which unit is able to accept new Intake referrals. This information is based on the supervisor's knowledge of the team workload and which Intake worker is able to accept new cases.
- Based on the information provided, the CRU administrative assistant forwards the cases to the appropriate supervisor who, then, assigns the cases to the Intake workers able to accept cases.



## Total Number of Intakes Transferred from CRU to Tier II Intake

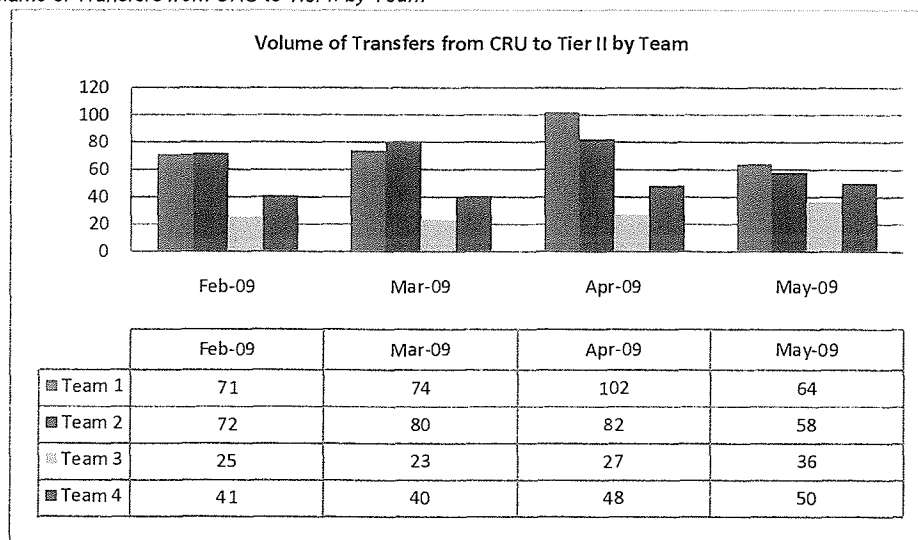
The Tier II Intake Program maintains manual records on all referrals transferred from the CRU. This includes Intake referrals received from after-hours shifts and new referrals screened and processed during day time hours. Intakes transferred from the CRU to the Tier II Intake teams during the months from February/2009 to May/2009 inclusive were reviewed. The following figure shows the volume of transfers by month.

Figure 40: Volume of Intake Transfers from CRU to Tier II



The transfers from CRU received by the Tier II Intake varied between teams. The figures below show the number of transfers from the CRU to Tier II, by team.

Figure 41: Volume of Transfers from CRU to Tier II by Team





In addition to cases transferred from the CRU, Intake workers are assigned cases under three other circumstances:

- An incident involving child protection concerns occurs on a case open to an Intake supervisor because an AIU worker is investigating an abuse complaint.
- A family referred to the Family Enhancement Program is no longer eligible for the services because of a crisis or serious child protection concern.
- A referral is received on a case closed by Intake less than 30 days.

Data was not available to draw conclusions on the number of additional cases that are assigned to Intake workers through these circumstances.

## **Case Assignment**

With the lifting of the geographic boundaries, Intake cases are assigned to Units on a rotational basis. Supervisors determine which Intake workers can accept new Intake cases. Two factors are considered. New cases are not assigned to Intake workers who are away for five days or more and supervisors may remove a worker from the rotation schedule temporarily if their workload is excessively high.

Without knowing how many workers may have been away or off rotation during the above time period, the number of Intakes transferred from the CRU was matched with the number of Intake workers on rotation schedules to determine how many new cases are assigned to each Intake worker in a month.

*Figure 42: Average Number of New Cases per Intake Worker (February/2009 to May/2009)*

Average Number of New Cases per Intake Worker (February/2009 to May/2009)			
Time Period	# of Intake workers	# of intakes from the CRU	Average # assigned to worker
Feb-09	16	209	13
Mar-09	18	217	12
Apr-09	21	259	12
May-09	22	208	9

Based on the above information, and assuming all Intake workers are regularly on rotation for case assignments, each worker would be assigned an average of 11.5 new cases in a month. If all 24 positions were filled, and all Intake workers able to accept new cases, the average number of cases



assigned to an Intake worker would be 9 in a month. The information reviewed indicates that there are usually any number of Intake workers who cannot accept cases at certain times.

Manual data is maintained on the number of staff on rotation. This information was used to review the average number of Intake workers on rotation, and able to accept case assignments, in the above time period. As the data is maintained by week, it was organized into four time periods.

Figure 43: Number of Intake Workers on Rotation over a 4 Week Period

Number of Intake Workers on Rotation Over a 4 Week Period								
	Week 1		Week 2		Week 3		Week 4	
Unit	Total Staff Number	On Rotation	Total Staff Number	On Rotation	Total Staff Number	On Rotation	Total Staff Number	On Rotation
South A	5	4	5	4	6	5	6	5
South B	5	4	5	4	4	4	5	5
North A	3	1	4	1	6	2	6	3
North B	3	2	4	2	5	2	5	3

There are differences between teams in the number of Intake workers on rotation and available to accept case assignments. On average over the four weeks, the % of staff available was as follows:

- In South A, 82% of the staff were available to accept new cases.
- In South B, 90% of the staff were available to accept new cases.
- In North A, 35% of the staff were available to accept new cases.
- In North B, 54% of the staff were available to accept new cases.

For all the teams, the % of staff available was as follows:

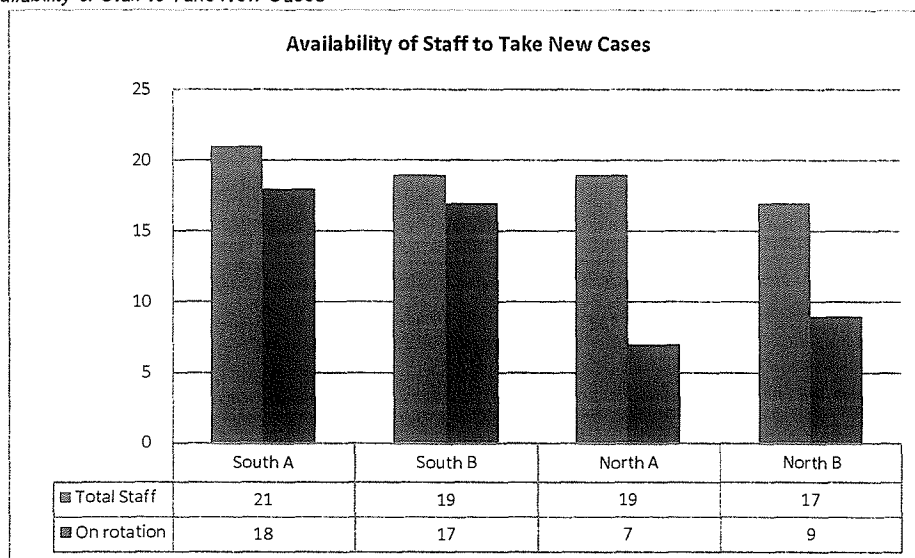
- Week 1: 65% of the staff were available to accept new cases.
- Week 2: 59% of the staff were available to accept new cases.
- Week 3: 64 % of the staff were available to accept new cases.
- Week 4: 73% of the staff were available to accept new cases.

On average over the 4 week period, 65% of the staff were available to accept new cases.

While most of the Intake workers in South A and South B were on rotation for case assignments consistently during the above four month time period, half or less of the Intake workers in North A and North B were on rotation for case assignments.



Figure 44: Availability of Staff to Take New Cases



The Tier II Intake program attempted to address this disparity by eliminating the geographic boundaries for each team and placing all teams on rotation equally. According to this data, the disparity still existed in the spring of 2009.

Tier II staff and supervisors speculate that this disparity could be the result of different casework styles between teams. They suggest a number of factors relating to casework style:

- Some workers may be providing more intensive services to families and therefore families would stay on their caseload for longer periods of time.
- Some workers may focus on transferring the case to the identified ongoing service agency as quickly as possible so that families receive services from their long term worker more quickly.

### **Service Inconsistencies Between Units in Tier II**

Reports from Intake workers, supervisors, and staff from other CFS agencies, as well as the examination of workload data and file information, suggests differences between units in Tier II in key variables such as:

- The length of time cases remain open at Intake.
- The amount of contact with families.
- The quality of the information obtained through family assessments.





This is to be expected due to the unique needs of children and families. However, different interpretations between teams on the amount of and type of services that should be provided at Intake appear to play a role.

Some Intake workers reported that their role was to provide crisis stabilization services to families to assist them to the point where the situation is stabilized and then either close or transfer the case. The length of time taken to achieve this is considered less important than meeting the goals of the case plan. As a result, many Intake cases are open for longer periods of time.

On the other hand, several Intake workers reported that they may have one or two contacts with a family and close or transfer the case. They viewed their role primarily as gathering the information needed to transfer a case. These workers reported that the majority of their cases are transferred, rather than closed.

Intake supervisors confirmed that workers are encouraged to process cases quickly, to avoid the backlog of closed cases that was evident in the early part of the year. This approach would aid in ensuring that families are quickly connected to the worker and the agency that will be carrying the case on a longer term basis.

Disparity in services at Intake was a concern heard during interviews with staff from other CFS agencies. Staff reported that some reports were complete and informative with appropriate case plans. Other reports were described as incomplete, at times inaccurate, and with repetitious information. Some case plans were described as unrealistic and "cookie cutter" in nature.

An audit of sample files confirmed some of the expressed concerns. This audit showed significant gaps in assessment information, missing data, frequent 'cut-and-paste' information from case notes, and ambiguous case plans. The audit reported that in half of the sample cases only one contact occurred with a family member.

According to the Tier II Intake Program Manager, the above concerns have been long standing and attempts have been made to regulate the type of contact that would be expected on an Intake. In October/2006, the *Client Contact by Tier II at JIRU* policy was introduced. The policy states that all Intakes require face to face contact by the Intake worker in the home of the client. Decisions resulting from telephone contact are not acceptable. The Tier II Intake Units have monthly program meetings where service expectations are discussed.

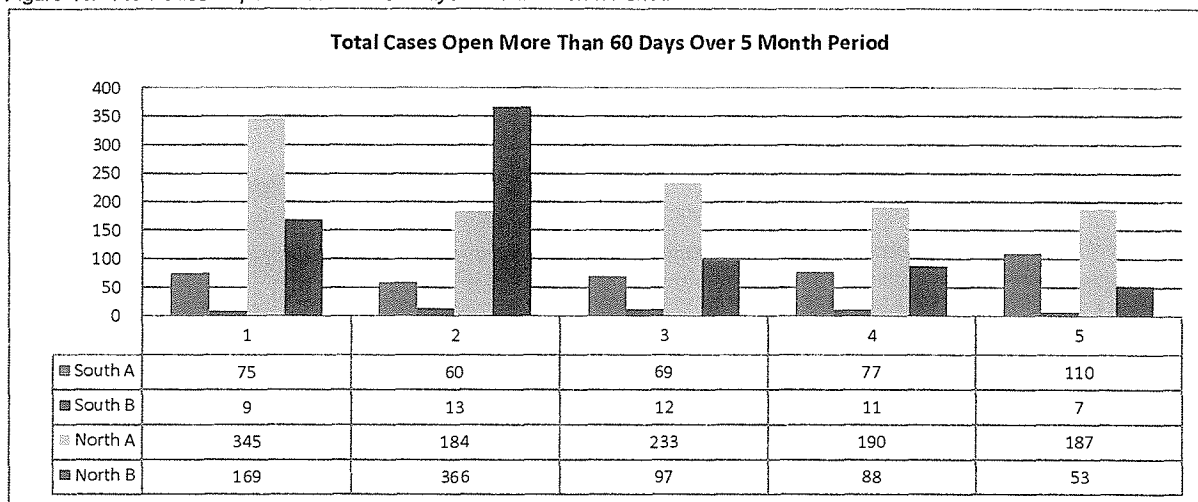
In November/2008, due to concerns about large caseloads, the Tier II Intake program began tracking cases that were open over 60 days in an attempt to reduce the length of time that Intake cases remained open. This process encouraged the closing of hundreds of cases that were not active but remained open because documentation had not been completed.



## Cases Open Longer than 60 Days

Cases assigned to an Intake worker should be processed within a reasonable length of time. Neither the *Tier II Program Manual* nor the *Manitoba CFS Standards Manual* indicate what this length of time should be. The Tier II Intake Program tracks cases open longer than 60 days to determine whether they are waiting closure or still active after 60 days. This data was reviewed by team for the period from February/2009 to June/2009 inclusive. The total number of cases opened longer than 60 days to each team is shown in the graph that follows.

Figure 45: Total Cases Open More Than 60 Days Over a 5 Month Period



This data reflects the cases that are open for more than 60 days. These totals include active cases where it is assumed services are being provided by the Intake worker, and cases that remain open only because the worker has not completed the documentation to close the case.

There are significant differences between teams, as shown in the figures below.

Figure 46: South A Team: Cases Open More Than 60 Days

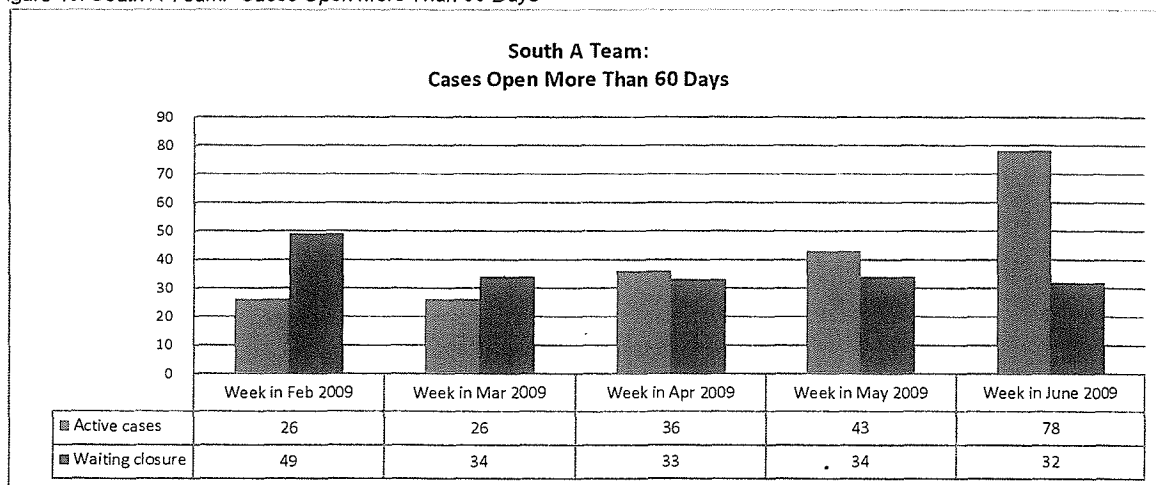




Figure 47: South B Team: Cases Open More Than 60 Days

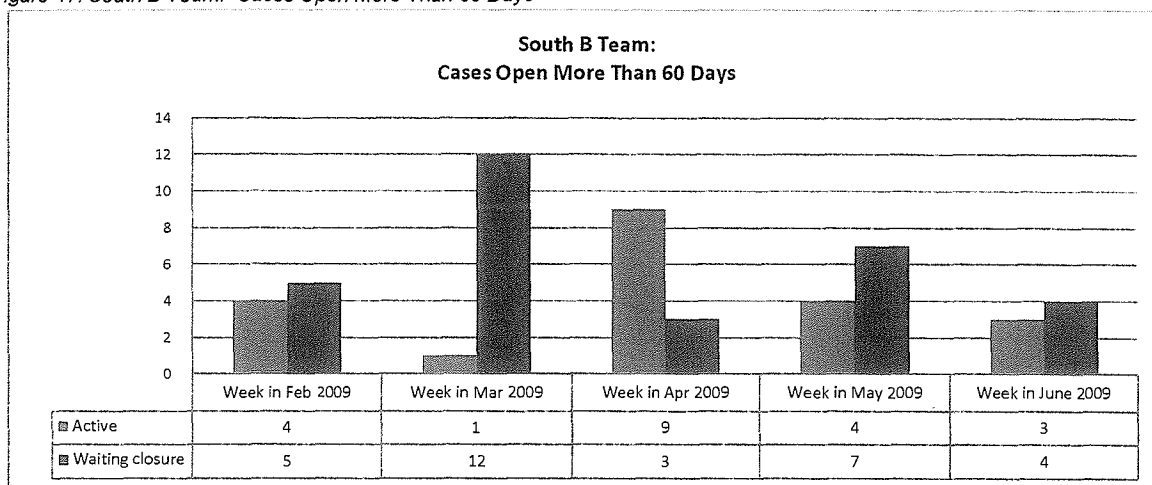


Figure 48: North A Team-Cases Open More Than 60 Days

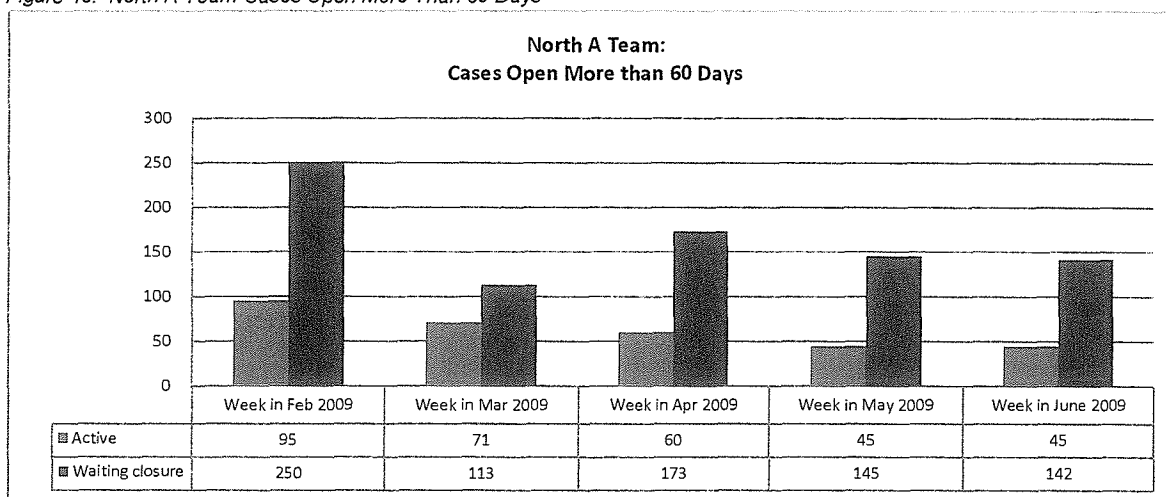
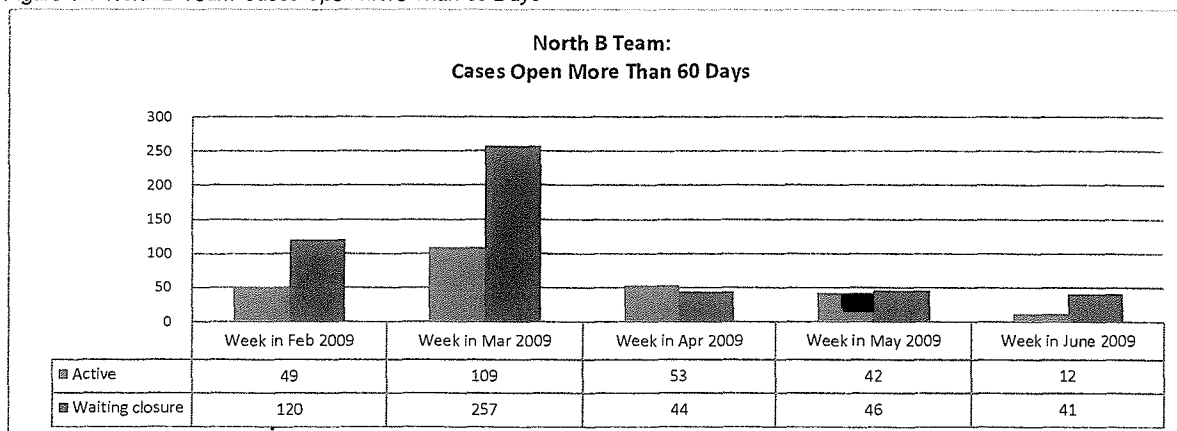


Figure 49: North B Team-Cases Open More Than 60 Days





The North A Team showed the largest number of open cases, followed by the North B Team. The South B Team consistently had the fewest cases opened longer than 60 days.

The high numbers of cases open longer than 60 days on caseloads in the North Teams impacts the ability of the workers on these teams to equally participate on the rotation schedule for new case assignments.

By Week 5 (June 1/2009), both the North A and North B Teams significantly reduced the number of cases open to their team for longer than 60 days. However, the North A Team continued to have more open cases than the other teams. The South A Team showed an increase in cases open longer than 60 days and the number for the South B Team remained low.

### ***Cases Open Longer than 60 Days but Waiting Closure***

A large number of cases in the Intake program remain open because the closing process has not been completed. Services to these cases have been completed and no further services are required at this time. Intake caseloads may not be accurately presented if there are a large number of cases that are waiting closure.

It is unfair to families to have open CFS cases when there are no longer any service needs. CFS Standards recommend the closure of cases no later than 30 days after services have been completed. The numbers of cases that were designated as "waiting closure" during the months from February/2009 to June/2009 can be seen compared by team in fig. 47 to fig. 50.

The data indicates that there was a reduction in the "waiting closure" cases in the North B Team between February/2009 and March/2009, while the North A Team continued to have a consistently high number of cases that are waiting closure. The South teams have a much smaller number of cases waiting to be closed.

### ***Active Cases Open Longer than 60 Days***

A relatively large number of Intake cases remain active longer than 60 days. These cases, compared by team, can be seen in fig. 47 to fig. 50.

The data indicated that the North A Team consistently had the largest number of active cases over 60 days. A steady decline in these numbers was evident over the five month time period from February/2009 to June/2009. The North B Team also reduced the number of active cases during this time period. Active Intake cases open longer than 60 days gradually, but consistently, kept increasing in the South A Team to the point where by June 1/2009, this team had the largest number of open active cases in the program. The South B Team consistently maintained a low number of cases open for more than 60 days.



## **Abuse Only Cases**

In the current ANCR program model, AIU Investigators provide a specialized investigative role. AIU investigators do not manage the case and do not provide other required services. This is done by other staff that are assigned as case managers.

All abuse referrals from Intake are assigned to an Intake worker if other child protection issues have been identified. If there are no other protection concerns, and Intake is waiting for the abuse investigation to be completed, the case is assigned to a supervisor.

In May/2009, there were 74 abuse cases assigned to Intake workers for direct services. There were 978 cases where no other active services for the client were required; these were assigned to supervisors. In these cases, the abuse investigation, either by ANCR and /or by the police, was in progress. Families would be involved primarily with the AIU worker.

The process of assigning these types of cases to a supervisor is an issue that needs to be reviewed. ANCR needs to develop a more appropriate system of tracking cases open for abuse investigations only, when there are no other child protection concerns.

## **Transfers and Closings**

The *Joint Intake and Emergency Services by Designated Agencies Regulation 186/2003*, registered November 10/2003, identifies the process for assessing the need for ongoing services 9(1), transferring to the appropriate agency 9(2) and confirmation of transfer 9(3). The Regulation states the following:

### *Assessing need for ongoing services*

- 9(1) *After providing Intake and emergency services to a person or family, a designated agency must determine if child and family services are required on an ongoing basis.*

### *Transfer to appropriate agency*

- 9(2) *If services are required on an ongoing basis, the designated agency must*
- a) determine the authority of service that is responsible for providing ongoing services to the person or family in accordance with the authority determination protocol established in Part 2 of the Child and Family Services Authorities Regulation*
  - b) arrange to transfer responsibility for the person or family to the appropriate agency (the "receiving agency") in accordance with the authority determination protocol*
  - c) forward the person's or family's service records to the receiving agency that will be providing ongoing services*



*Confirmation of transfer required*

- 9(3) *The designated agency must not transfer responsibility for the person or family to the receiving agency for ongoing services until it receives written confirmation from the receiving agency that it assumes responsibility for the person or family*

After an assessment and brief intervention by the Intake Unit, cases that cannot be closed at Intake are transferred to other CFS agencies in accordance with the family's choice of Authority of Service. This is determined through the Authority Determination Protocol (ADP).

During the four months from February/2009 to May/2009, a total of 393 cases were transferred from the Intake Unit to other CFS agencies. 267 (68%) were Family Service cases while 126 (32%) were Child in Care cases.

The majority of cases were transferred from the two South Teams. These cases represented 64% of the total transferred cases. The remaining 36% of cases were transferred by the other two Intake Teams. This information is consistent with an earlier finding that these same two Teams show the most active cases for a period longer than 60 days.

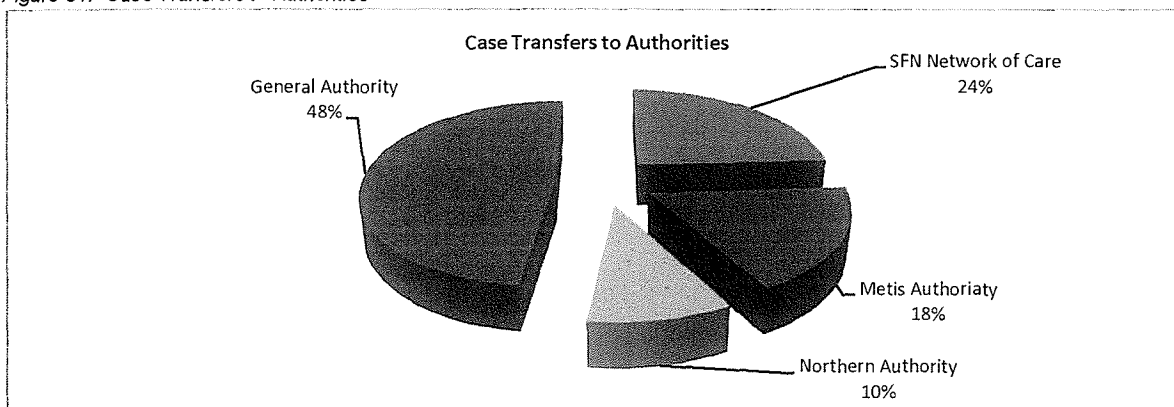
Figure 50: Cases Transferred From Tier II Intake

Cases Transferred from Tier II Intake											
Unit	Feb-09		Mar-09		Apr-09		May-09		Totals		
	Family	Child in care	Family	Child in care	Family	Child in care	Family	Child in care	Total	Total child in care	Total Family
South A	26	5	13	12	17	10	28	20	131	47	84
South B	22	3	23	7	12	15	32	8	122	33	89
North A	10	1	14	13	12	8	10	6	74	28	46
North B	11	1	10	8	5	5	22	4	66	18	48
	69	10	60	40	46	38	92	38	393	126	267

During the four month review period (February/2009 to May/2009) 48% of the cases were transferred to Winnipeg CFS, an agency responsible to the General CFS Authority. Transfers to agencies responsible to the Southern First Nations Network of Care, the Metis CFS Authority, and the First Nations of Northern Manitoba CFS Authority accounted for 52% of the cases transferred.



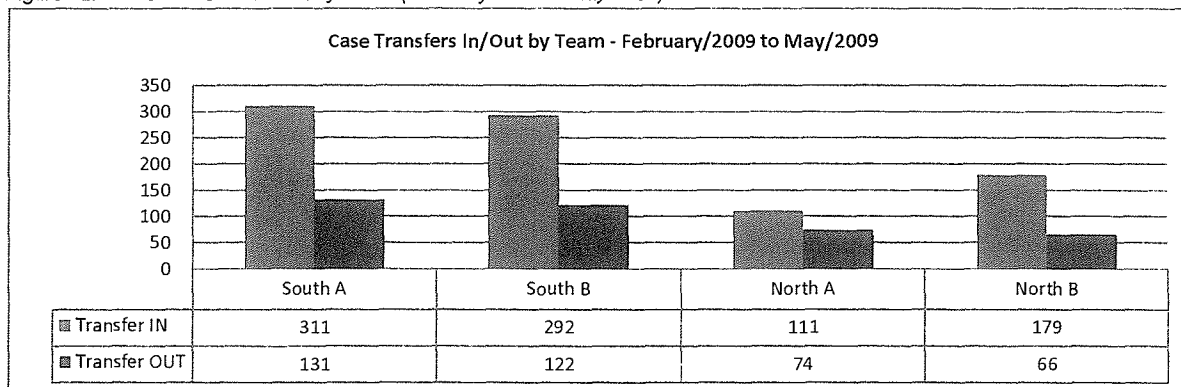
Figure 51: Case Transfers to Authorities



### Case Transfers In/Out

The overall number of cases transferred to the Intake Unit was compared with the number of cases transferred out of the Unit to other CFS agencies for the four month period from February/2009 to May/2009. The following figure compares the number of cases transferred in to each Intake Unit with the number of cases transferred out of the Unit.

Figure 52: Case Transfers In/Out by Team (February/2009 to May/2009)



The number of cases transferred to the Tier II Intake Units (893) more than double the number of cases (393) transferred out of the Units.

The South A Team received 311 cases during this four month time period and transferred out 131 cases. The South B Team received 292 cases and transferred out 122 cases; the North A Team received 111 cases and transferred out 74 cases; and the North B Team received 179 cases and transferred out 66 cases.

This data does not allow for variables such as the number of cases each Team had at the start of the review, the staff numbers, rotation schedules, and services needs.



## **File Audit**

A file audit was conducted in August/2009 on a sample of files open to the Tier II Intake Unit during the time period from February/2009 to May/2009. A sample of 33 files was randomly selected from the 127 files provided by the Tier II Intake Program Manager. This sample represented 26% of the files provided.

Files were examined for:

- Length of time between file opening and file closing.
- Documentation and Record keeping.
- Key variables such as standards compliance, police/collateral involvement, issue identification.
- Adherence to procedures and documentation standards for files.

### ***Openings, Closings, Last Recording***

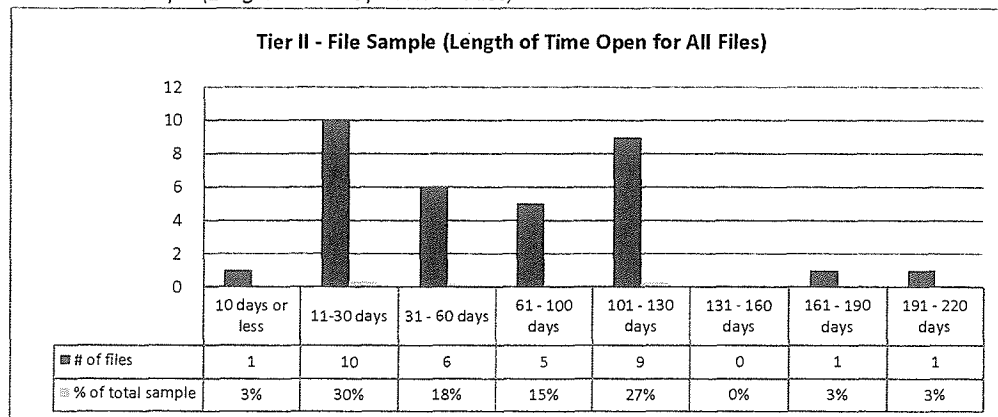
In the first step of the file audit, files were examined for dates of opening, dates of transfer, dates of closing, and date of last recording. Of the 33 files reviewed for opening and closing, only one file was opened longer than six months. The file recording identified the reason for this as a change of worker and reassignment.

The 'Open' date is almost always consistent with same day or following day of first contact with the 'Source of Referral' and therefore, there was no distinction between the date of first contact and date of opening on Intake. Only one file showed a three day difference between date of first contact and opening on Intake.

### ***File Sample - All Files***

The following figure shows the length of time that the files (both closed/transferred and those still open to Intake) were / have been open at Tier II.

Figure 53: Tier II - File Sample (Length of Time Open for All Files)







The **mean** (average) is 67 days (2.2 months). This is not the best way to analyze this data, as one or two extremes will skew the analysis, and this will not reflect the length of time that a file is commonly open at Tier II.

The **mode** is 109 days (3.6 months), meaning that in the set of files, that is the number of days open that occurs most frequently.

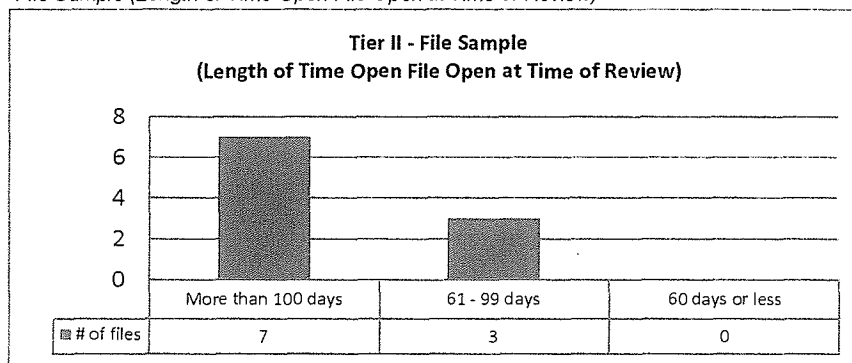
The **median** is 56 days (1.8 months), meaning that half of the files are open more than 56 days and half are open less than 56 days.

### ***File Sample - Cases Remaining Open***

There were 10 cases in the file sample remaining open to Tier II Intake at the time of the review. Of these files, the oldest opening was May 3/2009 and the most recent opening was May 21/2009.

The following chart shows the length of time the files have been open to date.

Figure 54: Tier II - File Sample (Length of Time Open File Open at Time of Review)



70% of the cases still open to Tier II Intake have been open for more than 100 days (3.3 months). The longest is 112 days (3.7 months) and the shortest is 74 days (2.4 months). The average is 102.3 days (3.4 months); the median is 106 days (3.5 months); and the mode is 108 days (3.6 months).

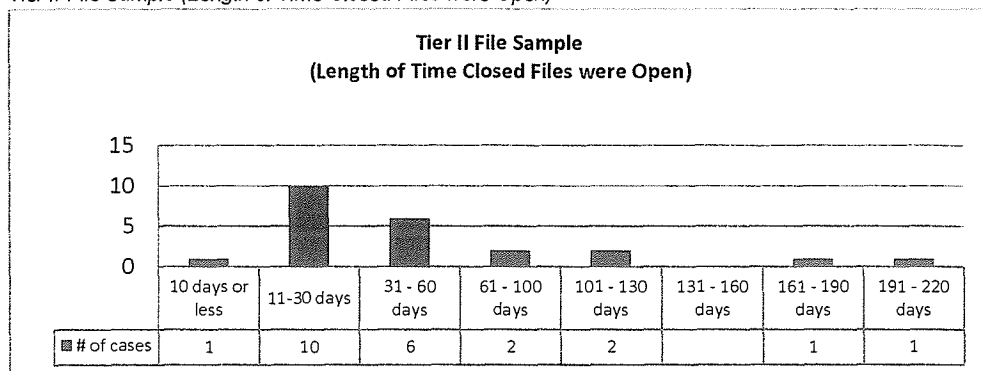
All of the cases that remained open had file recordings on the file. The oldest recording was May 5/2009 and the most recent was July 22/2009. Nine out of the ten files that were open were behind in the file recordings.

### ***File Sample - Cases Closed to Tier II Intake***

There were 23 files in the file sample that had been closed to Tier II Intake. These files were either closed at Tier II or transferred to another CFS agency for ongoing services. The following chart shows the length of time that those cases were open to Tier II Intake.



Figure 55: Tier II-File Sample (Length of Time Closed Files were Open)



The mean (average) is 51 days (1.7 months); the median is 31 days (1 month); and the mode is 11 days (2.5 weeks). The longest a file was open was 207 days (6.8 months); the shortest time was 7 days (1week).

All closed files had at least one recording on the file. The oldest recording was on February 27/09 for a file that closed /transferred on that date. The most recent recording was on August 14/2009.

The most recent opening was May 22/09 for a file that closed/transferred on July 3/2009. This file had a file recording date of June 16/2009 and did not have a closing/transfer file recording on file. Most files had a file recording very soon after the case closed/transferred; five files did not have a file recording on file following case closure/transfer.

### ***Documentation and Record Keeping***

Regulations for minimum documentation requirements do not go as far as outlining what content should be in case files and what documentation should look like. Section 19 of *The Child and Family Services Act*, and Sections 24 and 25 of *The Child and Family Services Authorities Act* speak only to establishing minimal requirements for recording. The expectation is to ensure that files are in compliance with legislation on confidentiality, security and storage of records. The Acts do not provide guidelines on the content of files.

*The CFS Standards Manual*, Chapter 1 (Case Management) and Chapter 7 (Service Administration) presents some guiding principles for file recording:

#### **1.1.1 Intake Policy**

*To gather/screen information to determine necessary and appropriate services.*  
*The CFS Standards Manual identifies several areas where information needs to be generated in the course of providing Intake services.*



### **1.1.2 Assessments**

*To gather and analyze information on strengths/needs/resources of a person or family including extended family and community resources to determine what the family needs in order to care for the child(ren).*

### **1.7.1 Recording Management Practice**

*According to the CFS Standards Manual, the standards for Records Management practices involve maintaining case records. The content of case records for Intake is to include:*

- *Personal and case information gathered on behalf of the family – including historical data*
- *Case notes by date related to referrals, client and collateral contact, assessments, and services provided as well as decisions made*
- *Level of risk*
- *Names of workers and Supervisors*

The IM has many built in features that allow workers to choose categories of case notes according to a drop-down menu on the program. The Safety Assessment/Safety Plan window helps workers to identify risk and to recognize immediacy and response time requirements. It identifies the worker and supervisor based on the security and passwords of those inputting information. The IM assures this information by default, therefore this was not included in the file audit.

## ***Quantity and Quality of File Information***

Files were reviewed to ascertain the quantity and quality of relevant information contained about a family. A discussion of the selected criteria used in the review follows.

### **Referral Source**

In 100% of the files reviewed, there was a clear statement of who was making the referral. Motivation for the referral was occasionally included when relevant.

### **Issue Identification**

The presenting issue was always clearly revealed within the first paragraph of the Intake recording. There were no files in which there was confusion of what the worker was dealing with. Frequently the issues were implied in the description rather than a clear statement of the issue (i.e. addictions is stated as "mother is drinking every day")

### **Prior Contact Check**

A history of previous involvement was included in every file reviewed. Unfortunately, some historical summaries were simply cut-and-paste from past Intake reports that included its own daily dictation,



summaries and recommendations. This resulted in confusion when reading and created challenges in establishing current assessments and needs.

### Field Visits Conducted

A potential issue identified in this review was the workers capacity to conduct field interviews to assess risk and carry out case planning. According to competency based training criteria, four meetings with the family are necessary to allow for a thorough assessment of the family functioning and appropriate case planning and referrals. Of the 33 files reviewed, only five files had recorded four or more fields conducted. One family, that had been open for more than a year, received six field calls. The most frequent case recording for fields was one field per family (11) while seven cases did not have any fields recorded by a worker.

Excluded in these findings was the interviews conducted in the office. There were a total of eight files that held in-office meetings. Two cases counted as 'no fields' conducted had either one or two meetings in the office. Three other cases conducted fields and augmented the contact with in-office interviews. If "in-office" visits were included in the number of fields conducted, there would be six files with four or more fields conducted, rather than the five represented.

### Case Notes

Case notes were consistent with CFS Standards in that they were recorded according to date. Other than date of recording, case notes varied widely in their content, flow, and relevance to provision of services to families. Case notes provided everything from assessments, issue identification, collateral contact information, and risk assessments to also include process and administrative notes such as supervisor consult for direction and discussions with other agencies on file transfer process.

Case notes were consistently detailed enough for readers to understand the family issues and to glean from the notes the necessary information to proceed. Case notes were never used to inform the reader of 'next-steps' or case planning.

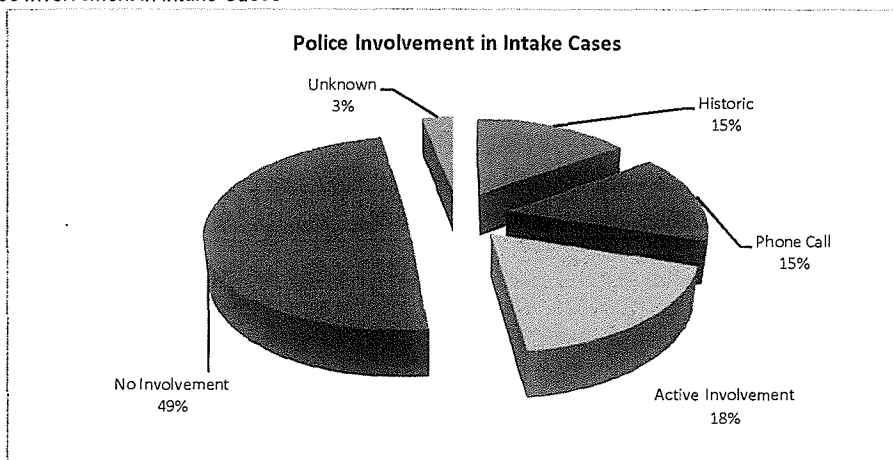
### Police Involvement

Police involvement was reviewed to determine if active investigations slowed the ability for workers to proceed with case planning. In the files reviewed, this was not the case.

File recording showed that the police were involved almost 50% of the time and frequently only as a collateral to inform the Intake worker of their involvement with the family. "Active involvement" with police indicates a referral to the police by the worker or an investigation being conducted on the family by the police. "Historic" and "Phone Call" categories refer to the worker mentioning in case notes that police were involved either historically or through a phone call. This added to the ability to assess and case plan. The figure below shows the level of police involvement in case planning at Intake.



Figure 56: Police Involvement in Intake Cases

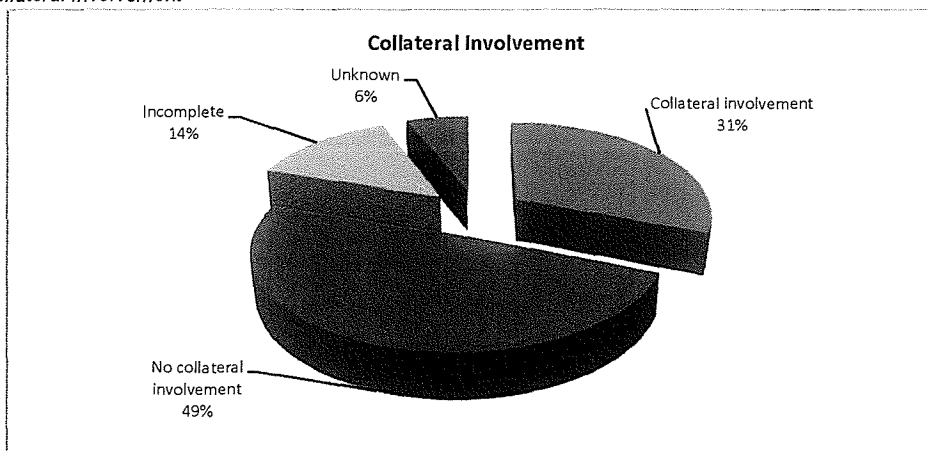


### Collateral Information

Collateral information was found in various locations throughout the Intake recording. The files being prepared for transfer or closing frequently had the heading of collateral information or "significant others" but was used differently by different workers.

The 'Collateral Information' category of case recording was used by some workers to include all pertinent collateral data such as the collateral name, agency, address, and contact information. Other workers identified collaterals by name only. Some workers identified one or no collaterals in the category whereas their case notes reflected several collateral contacts. Police involvement, incident numbers, or contact information regarding investigations were not included in any collateral information. In some cases, police contact information was identified in the case notes, or a reference to ongoing investigations was included in case notes with no contact information provided.

Figure 57: Collateral Involvement

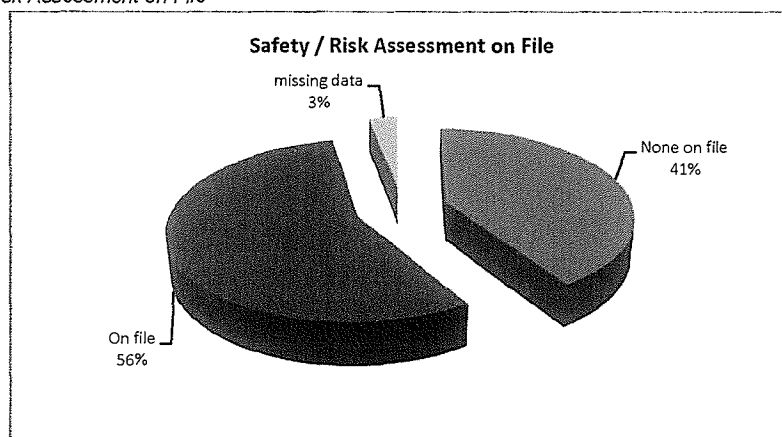




### Risk and Family Assessment

The completion of a Risk Assessment correlated with the completion of a Family Assessment. If workers included a family assessment category in their file recording, they also included a risk assessment category or a statement of risk. Fourteen of the file audits, or almost half of the cases reviewed, did not have an assessment of risk or a family assessment of any kind. Of the 19 case reviews where the file recording had a risk assessment, it also had an assessment notation and conclusion.

Figure 58: Safety / Risk Assessment on File



Included in the categories 'Assessment' and 'Conclusion and Recommendations' were the following: Family Composition; Significant Others Information; Child Welfare History; Issue Assessment; Environmental Stressors and Resources; Parents Psychosocial Functioning; Parenting Skills; Child Information; Family Strengths and Skills; Statement of Risk; and Assessment Conclusion. This was followed by a further 'Recommendations' category.

These case recording titles are consistent with the competency based training on assessing families and factors for assessing risk to a child. With these titles provided to workers, the categories were again inconsistently used. These categories often included a 'cut-and-paste' of information from case notes that already included partial or implied assessments of risk and functioning. Case note descriptions of situations were assumed to be documentation of 'issue identification' with very little notation on causality or resolutions.

### Competency Based Training Methods Used

Competency Based Training (CBT) tools are used as a guide by numerous workers in their recordings. The outline provided for assessing families is also found in the core training material. It is important to note that Case Note' categories/Case Note Type in the IM are identified but are inconsistently used in application of file recording. More than 90% of the files reviewed showed significant gaps on their assessments and they were not used according to the CBT definition provided in the training.



### Case Documentation

In general, the content in the Intake reports provided a fairly good preliminary view of the case situation. Reviewers were able to identify key issues and understand the rudimentary conditions surrounding the issues. Spelling and grammar mistakes were common but did not detract from the general information or the understanding of content and context. Flow of the information, such as sentences out of context with the body of the report, sometimes made it difficult to follow. In addition to the formatting of the IM in case note ordering and entry date, this can present as choppy and not fluid in context. Technological difficulties such as no cut and paste, spell check, or other software abilities in the IM make clean recording more difficult.

The language and tone used by some workers often gave value laden statements such as:

“...a withdrawn child who seems starved for affection...”

“It was apparent that she did not have appropriate role models when she was residing at home...”

“...should be held accountable for neglect...”

These statements were found in the file, but there was no context or supportive statements to validate the workers' opinions.

Case planning was often done prior to the field assessment. There was reliance on the Source of Referral (SOR) information to make case planning and process decisions. Information was reported as fact rather than as an allegation to be verified. At times, it appears that workers made decisions based on these reported “facts”.

Extraneous information not related to the investigation or necessary for case planning was at times entered as a separate entry. Entries included administrative tasks such as the completion of the ADP, cases marked 'open' on CFSIS which was supposedly closed and transferred to another agency, and several discussions around ownership of a file/case/family and other transfer process difficulties were recorded in case notes.

Some data was repeated in different case notes of the same report, while the assessment carried new information on the family. Some case workers provided documentation of advice given to clients that was faulty, and/or lacked the necessary information to provide to collaterals/caregivers for appropriate child care.

A number of files found some information missing and it was difficult to ascertain where the case worker determined the case planning to proceed. An example of this is found in a situation where the initial field reported the possible exploration of a familial place of safety (POS) and several days later the child was placed in a shelter with no information provided as to why the POS was not used.



Case notes that reflect a forum for expressing personal values, opinions, and/or judgmental comments is often not constructive in providing the next caseworker involved with the family with sufficient accurate information to proceed with the provision of services to that family. The lack of consistency in case note recording among the files reviewed may indicate a lack of knowledge or training on case recording methods and expectations.

The priority of the case note entries and significance of the entries for accountability purposes and process mapping needs to be defined. Documenting information should be with the view of who will be reading the information and what they need to know in order to provide the best planning for the family. Extraneous notes and entries that are not relevant to the provision of service to the family or relevant case planning may need to be documented for administrative and/or accountability purposes elsewhere.

### *Family Assessments*

In addition to the inconsistency in case note recording, family assessments were also full of discrepancies and irregularities in recording styles and methods. The following areas were examined:

#### *Family Composition*

Family composition was given as demographic information by some case workers while others provided a more descriptive narration on family and extended family. Both are useful. It may be consistently provided as demographics with a description of the relationships. This would also be relevant for the "significant others" category. Some Intake workers were unable to flush out family connections and support networks as part of their investigation.

#### *Significant Others Information*

Also used as collateral information, this section should include all information available (name, relationship, contact information) that would be helpful to ongoing assessments and case planning.

#### *Child Welfare History*

Previous child welfare history was used differently by workers. Some itemized the historical contacts while others simply made reference to other recordings. The description of previous contacts in some cases were very detailed and often detracted from the current Intake while others used this to augment and understand the current situation. This category requires a consistent format that provides a summary of important historical information that is not a "cut and paste" from previous recordings.

#### *Issue Assessment*

The 'Issue Assessment' category is provided to describe factors contributing to the problem or issue and to identify services to address the issue(s). It should include the identification of familial values, cultural aspects, knowledge of services, use of supports and potential barriers. In this file review, 'Issue Assessment' was used often to reiterate the same information on the current Intake, while some others provided new information not previously recorded in case notes. Neither contribution is useful. Caution is needed in labeling the "problem" as the "cause".





This section can be more effectively used to illustrate key issues that are creating child welfare concerns. For example:

Issue 1: Addictions

This family has historically resorted to the use of illicit drugs and alcohol as a coping mechanism. The father is aware of local programming for addictions and has attended two treatment programs in the last year to address his addiction. He has not been successful in completing either program and has attributed this to lack of supports in maintaining the gains he makes.

Issue 2: Domestic Violence

This family has identified that both families of origin as well as other close, personal relationships are riddled with violence as a method for solving relational problems. This couple has very poor communication skills and is emotionally and socially impaired due to their addictions.

*Environmental Stressors and Resources*

The 'Environmental Stressors' and 'Resources' categories were used differentially. Repeating the same information as reported in the case notes and referral is unnecessary. Few reports provided information on the clients' support networks, connectedness to the community, abilities, and/or factors hindering the family's ability to make transformations in their environment or functioning. Stressors such as poverty, inability to access resources, poor housing, and cultural factors were not included in any report reviewed.

*Parents Psychosocial Functioning*

Workers were unable to identify possible mental health concerns or articulate unusual behaviors, dysfunctional patterns, anti-social activities, or acute stress. They were lacking in the identification of clients' personal/interpersonal maturity, self-esteem, coping skills, or interpersonal connectedness with others. 'Parents psychosocial functioning' is a category that again was used to repeat facts.

*Parenting Skills*

Identification of basic child care skills (provision of food, clothing, and shelter), nurturing, type of attachment to child, discipline, and supervision was minimal.

*Child Information*

This category was used only if the child came into care. It consisted of contact information for the child only. This category can be used to describe the child's functioning within the home, temperament, developmental information, maturity, and any other pertinent information for workers to provide ongoing assessment and case planning.



### *Family Strengths and Skills*

This section should report on discussions with the family to assist them to identify what the family does well, what tools they have to problem solve on their own, how successful they have been in the past to solve their problems, and what goals they have.

### *Statement of Risk*

'Statement of Risk' was inconsistently used to describe either the risk to the child at present or if/when the child should remain in the home. No factors to determine risk as per the Safety Assessment/Safety Plan on the IM, the Manitoba Risk Estimation Scales (MRES), or the newest risk estimation scale currently being piloted, were used. Workers reported risk in terms of 'High', 'Medium', and 'Low' and often justified the classification as "based on the information". Statements of risk need to include type, degree, and frequency of harm/potential harm as well as child characteristics, parental characteristics and socio-economic factors that contribute to the increase or decrease of harm.

### *Assessment Conclusions*

There is a common understanding among workers that it takes time to build a relationship for a complete and thorough assessment. The focus of investigation and intervention is not always the same from one worker to another. Assessment for overall case planning purposes should hold elements of the various case note plans and information obtained from the family, with notes on what more information is required.

According to the CBT material, assessment conclusions require a summary of parental behavioral indicators, psychosocial functioning, strengths, skills, resources, and economic/social/cultural barriers as well as their attachment to the child. This section should be used to:

- Identify and propose an understanding of the key elements in the situation (environmental, social, and developmental).
- Understand the meaning of the problem from the client's perspective.
- Use professional skills to identify what needs to be altered to alleviate the situation based on best interest planning and what the system is able to offer.
- Plan on how these changes can be achieved.

The assessment conclusion was often a statement that the file needed to be closed/transferred to an agency for ongoing or further assessment.

### *Case Recommendations*

Recommendations were occasionally provided as directives for case planning with little reference to issues. It is useful to re-identify the issues and make recommendations that are directly related to the issues, and based on family functioning assessments. Recommendations are based on accountability or best interest planning and support. A directive from the Intake worker to the CFS agency without



knowledge of available resources, support systems, or ability to accommodate recommendations reduces its usefulness.

## **Meetings**

### ***Meetings with Staff and Managers***

During the review of the Tier II Intake Program, individual meetings were conducted with the following:

- The Tier II Intake Program Manager
- Three Tier II Intake Supervisors
- Eight Tier II Intake Workers
- One Administrative Assistant

In addition, members of the review team attended the North Intake Team meeting on May 22/2009.

The Program Manager, who has an MA (Sociology) and fourteen years CFS experience, including in several different program areas at ANCR, has been in the position since September/2005, when responsibility for Intake Services was with WCFS. This Program Manager was involved in the development and implementation of the ANCR Agency.<sup>12</sup>

Three supervisors participated in the meetings. The fourth supervisor position was temporarily occupied by an Intake worker in an acting capacity until the vacant position was filled. The most senior supervisor in the Tier II Intake Unit has been in the position for just over one year, since September/2008, but has over 15 years CFS experience, including supervisory experience at another CFS agency. The other two supervisors have been in the positions for approximately six months, since April/2009. One supervisor has been directly hired for the position on a permanent basis and the other supervisor is in the position temporarily. These supervisors were employed as front-line Intake workers in the program prior to assuming the positions.

Eight Intake workers participated in meetings. The workers were equally divided between directly-hired ANCR employees and Government of Manitoba (seconded) employees. Four worked in the North Intake Units and the other four worked in the South Intake Units. Three of the employees occupied 'Aboriginal' designated positions and five were in 'General' designated positions. The Administrative Assistant with the Intake Unit also participated in a meeting.

Reports of dissatisfaction with management practices, feeling distanced from operational matters and not being informed of developments within the Agency were some of their concerns. Employees reported feeling uninvolved and felt that their contributions were not appreciated.

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<sup>12</sup> In January/2010 this individual became the interim Executive Director at ANCR. An Acting Program Manager for Tier II was assigned at this time.



Seconded employees reported that they were reminded that their style of work was the WCFS model, and therefore, not acceptable to the way ANCR did the work, making them feel that their contribution was not valued. Some of these employees remain defensive, feeling that they are being told that the way they worked for years is no longer effective and, as a result, their suggestions, opinions and recommendations are not valuable at ANCR.

Some of the newer, directly hired staff felt that the seconded employees were inflexible to changes and appeared committed to maintaining the status quo. They expressed the view that they were made to feel less qualified or capable.

Overall, a prevailing workplace atmosphere of negativity, dissonance and low staff morale was described by the majority of staff and managers that participated in the meetings. On a positive note, employees identified constructive interactions and humorous experiences between team members and supervisors in the program. Supervisors were described as likable and hard workers who tried their best, but were limited by their ability to lead because of a lack of training and experience.

Staff and managers were asked to share their views on the current Tier II Intake program. Several issues were identified:

- The current Intake model, where the CRU is the first point of contact in all Intakes, was not favoured by many of the Tier II Intake staff. They reported that this model creates a duplication of services that is not understood by the client and is not a productive, cost effective service. Several staff recommended that the CRU be eliminated.
- Tier II Intake workers reported that they duplicate the brief assessments conducted by the CRU in order to obtain family information. The assessment process requires similar inquiries with the family. Not only is this a source of confusion for families, it creates duplication of the same services.
- Staff reported that many cases transferred to Tier II are closed immediately because the assessment of the Intake worker differs from that of the CRU worker.
- Cases from CRU are being transferred without sufficient concerns to warrant opening the case, according to Tier II staff. Their perception is that whenever the CRU is ambivalent about whether a case should be closed or not, they transfer it to Tier II, leaving this program with the responsibility to make the decision.
- There is no protocol that supports communication between the two Units. Once the case comes to Tier II Intake, it becomes their responsibility. Intake workers reported concerns about the quality of the transfers they receive from the CRU. These are often found to be brief, mostly based on telephone information, and missing information. Several Intake workers indicated that they have to



call the sources of referral back in order to get accurate and more detailed information, thereby repeating the work performed by the CRU worker.

- Cases requiring an abuse investigation are assigned to a Tier II Intake unit for case management services. In these cases, the Tier II Intake worker is the primary worker while the AIU worker focuses on issues specific to the abuse investigation. Clear protocols and delineation of responsibilities is required.
- Most Intake workers indicated that they are unlikely to refer cases to the AIU once the case is opened to them, unless the incident involves a recent disclosure.
- Intake workers reported that in the majority of cases assigned to them, some element of child abuse is present. Usually it is historical or has happened a while ago. Several Intake workers stated that they believe themselves qualified to address these abuse issues.
- Abuse workers are not assigned as case managers. Cases that do not require ongoing service, and/or where the assessments and investigation has been completed, are not transferred out of the AIU. Rather, they are assigned to the Intake supervisor to "hold" until medical and police involvement is completed. Should any activity arise on the case, the supervisor must follow up.
- In May/2009, there were 74 abuse cases assigned to Intake workers for direct services and 978 cases assigned to supervisors, with no active services being provided by the Intake Unit. Supervisors regularly have to respond to telephone calls about these cases. The outcomes of the telephone calls can include assigning the case to an Intake worker, providing consultation over the telephone and/or locating the appropriate contact and redirecting the call. Supervisors are concerned about the workload generated on cases that would otherwise be closed in the Intake program and about the consequences if a child protection concern occurred on one of these cases. It should be noted that these cases do have an AIU worker involved.
- In abuse cases, the IM contains only the name of the assigned Intake worker and supervisor. The AIU investigator is not listed on the 'Person Information' screen, but on the 'Issues Management' screen. Anybody looking at the information will not be aware that an AIU investigator is also involved with the client unless they open the 'Issues Management' screen.
- Intake workers would like to see the AIU Investigators listed in the IM so reports regarding abuse matters can be directed to them and not to the Intake worker or supervisor, who must then re-direct the call or forward the information to the AIU worker.



- A significant number of cases referred to the Family Enhancement Unit are returned to the Tier II Intake Unit. Intake staff would like to see the FE Program having the capacity to transfer the cases for ongoing services, rather than sending them back to Tier II to do the transfer.
- Intake workers are cautious about transferring cases to the FE Unit. They believe the program is too narrowly focused. Cases transferred to the FE Unit are often returned to Intake because the FE worker is unable to locate the family or is told by the family that they do not want the service. In addition, whenever a crisis develops on a family enhancement case, it is directed back to the Intake Unit.
- Tier II Intake staff do not receive cases solely from the CRU. Cases come from the AIU, the FE Unit, and "re-opens" when a referral is received on a case within 30 days after the case has been closed by Intake.
- Cases involving child abuse investigations by the AIU, and where there are no other child protection issues, are assigned to Intake supervisors while the abuse investigation progresses. If another child protection issue arises on these cases, they are sent to an Intake worker for follow up while the AIU worker continues with the investigation.
- Staff identified a number of issues that impact workload and service delivery at Tier II. These include the difficulties with the section 28 transfer process<sup>13</sup>; the time lines of transfers as a whole; and the lack of knowledge at other CFS agencies regarding the ADP and section 28 protocols.
- Discrepancies exist in caseload sizes and the services provided to clients by Intake workers. While some Intake workers report having caseloads of 30 or more families with whom they are actively working, others indicate that their caseload size ranges between five and eight families. Some Intake workers report weeks of service delivery and intervention plans, while others report an average of two contacts with a family before the case is closed or transferred. Some Intake workers believe that their role is to provide services to families until a crisis is resolved and the case can be closed or transferred. Others indicate that their role is to obtain enough information to complete the Authority Determination Protocol (ADP) and transfer the case.
- Staff reported that the expectations differed among units and were subject to the interpretation of the unit supervisor. New workers were more likely to report that their contact with a family involved one or two visits and a transfer to another CFS agency.

<sup>13</sup> These are transfers of apprehensions from one agency to another under section 28 of *The Child and Family Services Act*. ANCR does emergency apprehensions of children in need of protection. When these cases are transferred to another CFS agency for ongoing service, and the child is still under apprehension, a section 28 transfer is required to transfer the case.



- There appears to be a lack of clarity by Intake workers on the extent of their responsibilities. Workers report that different supervisors have different expectations of what Intake services should be provided to families. Some supervisors supported short-term casework with families, others promoted case closings and transfers. A unified view and direction to staff is needed. Some staff suggested the need for a statement that provides a philosophical value base on the work of the Intake Unit and principles that guide staff in making decisions.
- Some Intake staff was concerned with losing their skills if the Intake Unit provides less direct services to clients. These staff are concerned that Intake services are being redefined and Intake workers are becoming information processors rather than social workers. They felt that where Intake was once a program where short-term, crisis services were provided to families until their situation was stabilized and the case could be closed, it is now another layer where clients are asked to provide information and told that someone else will be contacting them. While the FE Unit program provides such short term services, this program only works with voluntary families and there are many more families that could benefit from short-term, crisis resolution work.
- Like staff from other program areas in ANCR, the Intake staff voiced concerns about the number of CFS workers that are involved with a client family. A family could meet with a CRU worker, get assigned to an Intake worker, receive services from a Family Enhancement worker, and possibly speak with an AIU worker, all within a period of three months before being transferred to another CFS agency.
- Intake workers recommend that case aides be available to the teams. Case aides can assist with such tasks as caring for children, delivering groceries, transporting children and supervising family visits. These tasks are currently carried out by Intake workers.
- Several staff indicated that additional administrative assistants were needed to process the large number of cases waiting to be closed.

### ***Other CFS Agencies Staff***

A number of staff and managers from other CFS agencies in the province were interviewed regarding their experience with the Tier II Intake Unit. Respondents were asked ten questions focusing on their experience working with the Intake Unit. Forty-four (44) staff and managers from several CFS agencies participated in the interviews.

#### **Understanding of Roles and Functions**

Most respondents appreciated the fact that an Intake unit existed. Intake was described as the Unit that responds to the family situation, undertakes an assessment, and works on a plan before sending the case to the appropriate agency. The Unit will try to defuse/stabilize the situation or take whatever



protective action is required. It was referred to as the first point of contact for children and families in the City of Winnipeg.

#### Staffing and Relationships between ANCR and other CFS Agencies

There are few opportunities for building relationships between staff from ANCR and staff at the CFS agencies. Staff from the agencies commented on their perception that staff at ANCR was inexperienced. They noted that it appeared to them that there had been no noticeable increase in cultural proficiency in the work of Intake staff. There was concern that the Intake units were understaffed and that there appeared to be a high degree of staff turnover.

Some respondents stated their perception that some ANCR staff appeared to be of the view that the agencies were not qualified to do the work of case management and that the views and opinion of agency staff were not respected.

#### Transfers from the Intake Unit

There were mixed remarks about the quality of the information received from the Intake Unit. Some respondents were positive. They reported that the information they received was complete and informative, summaries flowed well, and the presenting challenges, strengths, and 'next steps' were adequately explained to the families. Other respondents were not so positive. There were reports that assessments were not complete and, at times inaccurate, information was repetitious, and plans were often unrealistic and "cookie cutter" in nature.

#### Strengths of Services Provided

Most respondents indicated that there was some excellent work being done at the Intake Unit where information comes in a timely manner and the assessments are relatively good and come with reasonable plans. The turnover time was cited as a positive by some respondents and, in general, good documentation was identified as a strength.

#### Difficulties with Services Provided

Some respondents indicated that the quality of the assessments they received were poor, scanty and cursory in nature. Other examples of concern were the quality of the Transfer Summaries. Case plans were cited as superficial in nature, unrealistic and/or impractical. Respondents indicated that they did not always agree with the case decisions, yet there were no opportunities to discuss these before the case is transferred.

#### Working Relationship and Communication

Respondents cited that their relationships with Intake workers had been positive. Most respondents cited the working relationships with the Intake Unit as very professional and courteous. Several





respondents commented on the lack of opportunities for relationship building and face-to-face contacts between workers.

### Overall Satisfaction

Respondents were divided in their overall satisfaction with the Intake services. Seven of the respondents reported that they were satisfied with the services provided by the Tier II Intake Unit and six respondents reported being unsatisfied.

### Suggestions for Changing or Improving Services at the Intake Unit

Intake was seen as the crucial element in the organization. Suggestions by staff in the other CFS agencies included:

- The most experienced workers should be at the front-end.
- Training is imperative to ensure maximum quality services to families and children at the Intake level.
- Clear and consistent policies, risk assessment tools and standards of services with ongoing training were seen as important to the Intake function.
- More opportunities for dialogue and interaction between ANCR and the agencies would be helpful.
- Assessment should be more thorough and complete with genograms, cultural background, placement information, and information about the language spoken.
- Steps should be taken to minimize the possibility of unnecessary referrals.
- Steps should be taken to ensure that families are fully informed of the choices they have for service.

### Summary of Findings

1. The Authority Determination Protocol (ADP) is completed by Tier II Intake workers. There continue to be some difficulties and concerns associated with this process, both at ANCR and with the other CFS agencies.
2. There is an Orientation process for new staff which introduces them to the organization and prepares them for assuming the Intake function. Other training opportunities are available on a regular basis, including CFSIS and core training. Employees participate in such training.
3. Front line workers in the Tier II intake program were well qualified in terms of training and CFS experience. The Tier II Intake program has experienced a high rate of staff changes and on-going vacancies, particularly in front line Intake worker positions in the past year.



4. Supervisor turnover has been high. Staff reported the loss of four experienced supervisors in the past two years. Positions are now filled, and although the supervisors are all relatively new to the position, they have seven or more years of CFS experience. Supervision in the Tier II Intake program appears to be regularly scheduled and consistent with the *Joint Intake Response Unit, Tier II Intake and Abuse Supervision Policy*, Draft May/2006.
5. There are permanent and temporary secondees in Tier II. Secondees were restricted from applying for other positions within the provincial government as a result of the WFA strategy. In the past year, the WFA was ended, and these staff can now apply for positions within the civil service. While they are able to apply for a direct hire to ANCR, loss of benefits is a barrier to this. To many Intake workers this is not an option. This issue will have to be addressed at some point as it contributes to poor staff morale and impacts the effective operations of programs at ANCR.
6. Most of the intakes assigned to the Tier II Intake Units come from the CRU. An average of 223 Intakes from the CRU are assigned monthly. Cases are also assigned to Intake workers when an incident involving a child protection issue occurs on an 'Abuse only' case open to an Intake supervisor. In addition, Intake receives cases from the FE Unit. Cases that closed at Intake are returned directly to Intake if a child protection concern arises within 30 days of closure.
7. Intakes are assigned on a rotational basis. Supervisors determine which Intake workers can accept new Intake cases. Workers are not placed on rotation if they are away from work for five days or more, or if their workload is considered to be excessively high.
8. There is considerable disparity between Intake teams in the number of workers available to accept case assignments. This impacts staff morale and creates tension in the work environment.
9. Services provided by the Intake program lack consistency. While some services are intensive and directly address crisis and stabilize the family, others are brief and focus on gathering information for the purpose of transferring. Staff report feeling pressured to process cases quickly. Some staff believe this is a disservice to clients, while others are comfortable with the role.
10. In May/2009, 978 'abuse only' cases were assigned to Intake Supervisors because a case manager needed to be identified on the CFS Information System. The role of AIU staff is as specialized abuse investigators and AIU staff does not have other case management responsibilities. While 'abuse only' cases do not require other case management services, that can change on a case if other child protection concerns surface.



11. During the four months from February to May/2009, a total of 393 cases were transferred from the Intake Unit to other CFS Agencies. 68% were Family Service cases while 32% were Child in Care cases.
12. The South A Team received 311 cases during the four month time period and transferred 131 cases and the South B Team received 292 cases and transferred 122 cases. The North A Team received 111 cases and transferred 74 cases and the North B Team received 179 cases and transferred 66 cases. The majority of cases were transferred from the South A Team, followed by the South B Team. These cases represented 64% of the total transferred cases. The remaining 36% of cases were transferred by the North Intake teams.
13. According to information obtained from a file audit on a sample of Intake cases active in the four month time period from Feb to May/2009, the average length of time that a file is open on Intake is approximately 75 days. When calculating the mode or most frequently occurring amount of time a file is open, the audit showed an approximation of two-three weeks of file activity before transferring or closing of a file.
14. Of the 33 files reviewed, one field visit occurred in 11 of the files, no field visits occurred in 7 files, four or more visits occurred in 7 files and one family, that had been open for more than a year, received six field calls. In 8 files, meetings were held in the office. According to competency based training criteria, four meetings with the family are necessary to allow for a thorough assessment of the family functioning and appropriate case planning and referrals.
15. Case notes were consistent with CFS standards in that they were recorded according to date. Other than date of recording, case notes varied widely in their content, flow, and relevance to provision of services to families. Case notes provided everything from assessments, issue identification, collateral contact information, and risk assessments to also include process and administrative notes such as supervisor consult for direction and discussions with other agencies on file transfer process.
16. Case planning was often done prior to the assessment and workers often relied on the Source of Referral (SOR) information to make case planning and process decisions. Information was frequently reported as fact rather than as an allegation to be verified and workers made decisions based on these reported "facts".
17. Categories designated for assessment information were inconsistently used. These categories often included a 'cut-and-paste' of information from case notes that already included partial or implied assessments of risk and functioning. More than 90% of the files reviewed showed gaps in assessment information.



18. A number of reviewed files found some information was completely missing and it was difficult to ascertain where the case worker determined the case planning to proceed.
19. Employees in the Tier II Intake program reported dissatisfaction with management practices, and low staff morale. Statements of being unvalued, unheard, and disposable were heard. Some staff expressed feeling "locked in" to their position as a result of the WFA.
20. Most Tier II Intake staff suggested changing the current Intake model. The role of the CRU was not favoured, as the services provided by this program duplicated those of the Intake workers. Intake staff favoured an Intake screening component and another layer of staff to follow up on Intake referrals.
21. Intake workers and supervisors are concerned about the protocol in managing abuse cases. The Tier II Intake Worker is the primary worker while the abuse worker focuses on issues specific to the abuse investigation. The result can be an awkward arrangement, where two workers are involved with a family, creating confusion for both clients and collaterals and duplicating services.
22. A significant number of cases referred to the FE Unit are returned to the Tier II Intake Unit. Intake staff would like to see the FE Unit having the capacity to transfer the cases rather than sending them back to Tier II to do the transfer.
23. There are no case-aide positions currently designated to the Intake unit. Intake staff report that the program can benefit from paraprofessional staff to assume tasks such as child care, transportation, delivering groceries and supervising family visits.
24. The Tier II Intake staff report a divided work environment at the Agency, where programs operate as "silos" within the larger organization. As a result, there are few opportunities for interpersonal communication between staff from different program areas and limited opportunities to discuss cases and resolve issues.
25. In interviews with forty-four staff from other CFS Agencies in Manitoba, respondents voiced many concerns about their experience working with the Intake Unit. Several respondents commented on the lack of professional qualifications and management skills of the managers and some supervisors at ANCR. There was concern that the Intake units were understaffed and that a high degree of staff turnover had occurred. This was followed by concern that workers may be responding to "burnout" and low morale, affecting services to children and families.
26. There were mixed remarks about the quality of the information received from the Intake Unit. Some respondents were positive. They reported that the information they received was complete and informative, summaries flowed well and indicated the presenting challenges and



strengths and the next step was adequately explained to the families. Other respondents were not so positive. There were reports that assessments were not complete and, at times inaccurate, information was repetitious and plans were often unrealistic and "cookie cutter" in nature.

27. Respondents were asked to identify the strengths of the Intake unit. They reported that there was some excellent work being done at the Intake Unit where information comes in a timely manner and the assessments are "decent" with "reasonable plans". The turnover time was cited as positive by some respondents. Good documentation by experienced workers was regarded as a strength.
28. Respondents were asked to identify the difficulties in the Intake unit. Concern was expressed about the quality of the assessment and transfer summaries. Case plans were cited as superficial in nature, unrealistic and/or impractical. Some cases appear to be "dumped" unfinished. Respondents indicated that they did not always agree with the case decisions yet there were no opportunities to discuss these before the case was transferred.
29. Respondents were divided in their overall satisfaction with the Intake services. Of the thirteen respondents who completed this section, seven respondents reported that they were satisfied with the services provided by the Tier II Intake Unit and six respondents reported being unsatisfied.
30. Respondents were asked to make some suggestions for improvements to the Intake Unit. Suggestions included ensuring the most experienced workers are at the front-end of Intake; providing maximum training for Intake staff; having clear and consistent policies and risk assessment tools to work with. Several respondents indicated that staff relationships between the agencies needs to be nurtured with more dialogue and interaction. Others thought that more complete assessments are needed with genograms, cultural background, placement information, language spoken and funding clarification. A better overview of the First Nation communities would assist in minimizing cases going to the wrong agency. Jewish CFS cited that better cultural identification of Jewish families was needed.
31. The review of the Tier II Intake Unit suggests the need for stability in the program. The Intake Unit has been subjected to one change after another particularly with respect to staffing. The work environment for staff is difficult for staff. New staff is not impermeable to the negative influences in the work environment. It would benefit the Agency to address these issues as soon as possible.



## ***The After Hours Unit (AHU)***

A critical part of any intake service is the availability of a 24 hour response in matters regarding child protection. In accordance with the *Joint Intake and Emergency Services by Designated Agencies Regulation, 186/2003, Section 8(b)*, the ANCR Agency is mandated to assess all allegations involving child welfare concerns on open and new child and family service cases and referrals in its designated geographic area.

The After Hours Unit (AHU) operates after 4:30 p.m. Monday to Friday, on weekends, and during all statutory holidays. As indicated in the draft *AHU Program Manual*, dated December/2008, the responsibility of the AHU is to provide emergency responses to all afterhours child welfare referrals, to gather and screen information, to determine the validity of referrals, to assign priority level to referrals and to ensure further assessment or investigation occurs, if required.

They key functions include:

- Receive all after hours referrals on new, open and previously closed child welfare cases.
- Receive and respond to service requests from within ANCR and other child welfare agencies within the jurisdiction.
- Open all intakes on the Intake Module (IM).
- Gather and screen information to determine if a child welfare response is necessary.
- Assess referrals and response times based on IM criteria.
- Complete initial safety/risk assessment.
- Respond to all high risk child protection issues requiring an immediate response.
- Provide crisis intervention and stabilization services.
- Determine need for further Intake assessment and intervention.
- Refer to the appropriate agency, the next working day, if the case is open.
- Provide CFSIS information to other Designated Intake Agencies (DIA) as requested by those agencies.
- Complete all required documentation on the IM.
- Establish a strong working relationship with collateral child welfare agencies in the jurisdiction.
- Establish a joint working relationship with internal agency teams.
- Establish positive working relationships with key community collaterals (i.e. police, medical personnel, community agencies).

All service activity is documented using the IM and reports are generated and forwarded to the CRU at ANCR if it involves a new referral or to another CFS agency if the referral involves an open case.



The review of the AHU had the following terms of reference:

- Overview and analysis of the service volume at the AHU.
- Overview and analysis of current staffing and scheduling practices.
- Overview of the AHU program model.
- Overview and analysis of service requests to the AHU from other CFS agencies.
- Overview and analysis of services provided by the AHU.

Several sources of data were collected and analyzed in the process of conducting the review of the AHU. This included:

- Review of specific data obtained from the IM.
- Review of data contained in manual record-keeping processes in different program areas of the Agency.
- Review of a sample of Service Requests from other CFS agency workers.
- Review of services provided by the AHU.
- Review of the *Draft After-Hours Program Manual* December/2008.
- Review of notes from the January 11/2008 *AHU Planning Workshop*.
- Review of the telephone systems utilized in the delivery of services by the AHU.
- Interviews with managers and staff working in the AHU.
- Interviews with staff from other CFS agencies using the AHU services.

## **Program Structure**

The AHU is an integral part of the CFS system but, by virtue of its hours of operations, remains somewhat distinct from the larger CFS system. The AHU has been a part of several system changes. It has been operating out of the same Portage Avenue location since the 1990's without much change to its hours of operation, work schedules and program model.

According to the *Draft AHU Program Manual*, dated December/2008, the AHU is responsible for all afterhours referrals on new, open and previously closed child welfare cases. In addition, the AHU responds to service requests from within ANCR and other CFS agencies for services within ANCR's jurisdiction.

As part of its responsibilities, the AHU opens all Intakes on the IM. AHU workers gather and screen information, respond to all high risk child protection issues, provide crisis intervention and stabilization services, determine the need for further intake assessment and intervention, and refer the intakes to the CRU at the end of the shift.

In addition to responsibilities resulting from new referrals and calls on ongoing child welfare cases, the AHU is responsible for following up on services requested by workers from other CFS agencies. These requests are for a service response which is needed after regular work hours. This may include



completing apprehensions after regular work hours; making “spot checks” where concerns about the well-being of children has been reported; transporting children because of placement changes or following a reported absence; and delivering food hampers when an emergency food supply is needed.

All services provided by AHU workers must be completed by the end of each shift. This is particularly important as AHU staff schedules include a combination of full-time, part-time and casual workers working various shifts throughout the week. Although the work shifts are consistent, the scheduling process is complicated by the large number of staff who work part-time or are on a “four days on – four days off” rotation.

Casual staff supports the staffing complement of the AHU. Schedules are developed by supervisors each month, based on the written availability provided in advance by each staff person. A half-time administrative assistant with the AHU concentrates almost solely on duties related to scheduling and payroll functions.

The Review looked at service volume and the efficiency and effectiveness of the current AHU program model. This included a review of staffing, scheduling, shift configurations and service responses. Meetings were held with a number of staff and managers with the AHU and CFS agencies that use the services of ANCR.

## **Staffing**

According to the *Draft AHU Program Manual* (December/2008), the AHU consists of a total of 17.5 FTE staff positions, including: 2 supervisors, 15 FTE social workers (staffed with full and part time staff), and a .5 administrative support worker. In addition, there is a roster of casual front-line staff.

There are two teams within the AHU. Each team consists of 1 Supervisor and a combination of about 11 – 12 full and part time staff. Casual staff is utilized on an as needed basis. One administrative support position is designated to provide support to all AHU administrative and executive functions. The administrative duties are focused on scheduling and payroll. The supervisors report to the AHU Program Manager, who in turn reports to the ANCR Executive Director.

In February/2010 there were 19.75 full time equivalent (FTE) positions in the AHU, filled about 30 full and part time staff. There was a .25 supervisor position vacant, along with 1.61 after hour worker FTE, and a .5 case aide position.

*Figure 59: AHU Staffing (February/2010)*

Number of FTE positions	
Supervisor	2
Front Line	15.75
Admin Support	1
Family Support / Case Aides	1





Staffing Data (based on FTEs)	
Direct Hires	60%
Seconded (Permanent)	18%
Seconded (Temporary)	22%
Positions designated 'Aboriginal'	58%
Positions designated 'General'	42%
Not designated	0
Positions filled according to designation	45%
Aboriginal Staff	24%
Based on FTEs	
Vacancies	
.25 supervisor	
1.61 After Hours worker	
.5 Case Aide	

Qualifications of Social Work Staff	
BSW/MSW	75%
Other related degree	4%
CFS Diploma	4%
Other	11%
Info. with WCFS	7%
10+ yrs of experience	25%
6-10 yrs experience	7%
3-5 yrs experience	7%
1-2 yrs experience	7%
Less than 1 yr experience	4%
Info. with WCFS	50%

*Info based on # of staff, full and part time, and not FTEs*

The large number of part-time employees in the AHU resulted from the guaranteed employment offered to WCFS employees as part of the AJI-CWI. Guaranteed employment hours were established with the MGEU Bargaining Unit based on the actual work hours with the AHU prior to the AJI-CWI restructuring. Guaranteed hours of employment range from .75 EFT to .14 EFT. This results in a large staff roster of part-time employees and a complicated system of scheduling.

As guaranteed part-time positions were vacated by government employees, replacement staff was hired by ANCR. In February/2010, 60% of the staff were direct hires and 40% were temporary or permanent secondees. 45% of the positions (full and part time) were filled according to the position designation.

AHU employees primarily work ten hour shifts. Many of the part-time AHU employees have additional jobs, either in the CFS system or with other organizations.



75% of the full-time and part-time AHU social work employees have a BSW/MSW degree. 4% have a related degree, and 4% have a CFS diploma.

There are two supervisor positions in the AHU. In June/2009, one was occupied by a full-time ANCR employee and the other was staffed by two part-time government employees who shared the position. In July/2009, the two part-time Supervisors were replaced by a full time Supervisor hired by ANCR. By September/2009, the position was vacant and at the beginning of October/2009, supervisory coverage was being provided by four different ANCR employees with supervisory experience from other program areas. In February/2010, there was one full time supervisor, one .75 supervisor, and a .25 supervisor position vacant.

An administrative assistant almost completely focuses on the task of scheduling staff and completing payroll functions. Payroll forms for government employees are submitted to the provincial payroll department. In August/2009, the administrative assistant position, which was a .5 position, became vacant when the previous employee assumed a full-time position with another program at ANCR. In October/2009, the position was posted for hiring. In the meantime, it was temporarily occupied by an Administrative "Float" employee. In February/2010, this position was filled as a full time position.

A review of payroll schedules for the 12 pay periods between January 3/2009 and June 19/2009 revealed the following:

- Approximately 35% of the part-time staff worked additional hours in the AHU as casual employees.
- Four of the part-time AHU staff are also employed, on a full time basis, with other CFS agencies.
- One part time AHU staff is employed full time at another CFS agency and is guaranteed .25EFT with the AHU. This requires a minimum of 20 hours of work in each pay period. This staff worked an average of 28.4 hours a pay period during the review period.
- Another part-time AHU employee who is employed full time at another CFS agency and guaranteed .23EFT with the AHU worked an additional 14 hours beyond the guaranteed 16 hours a pay period.
- Another AHU part-time employee, working full time at another CFS agency, is guaranteed .5EFT with the AHU. This requires a minimum of 40 hours of work in each pay period. This staff worked an average of 43 hours a pay period in the AHU during the review period.
- Another part-time AHU employee working full time at another CFS agency and guaranteed .5EFT with the AHU, worked 4 additional hours beyond the minimum requirement of 40 hours of work in each pay period.
- Several other part-time AHU employees work full time or part time in other positions outside the CFS system.

AHU evening shifts go from 4:00 p.m. to 2:00 a.m. on weekdays. On occasion, an evening shift will end at 12:00 a.m. This requires AHU part-time employees to make arrangements with their other places of



employment to ensure that they are able to begin their AHU shift at 4:00 p.m. During interviews with casual and part-time employees regarding this issue, they reported that they are successful in making arrangements to leave their other employer earlier by using accumulated compensating time off. Being able to successfully manage both jobs was not reported as a concern by any of the front-line or management employees interviewed.

A roster of casual employees supports the AHU. In June/2009, there were 16 casual staff on the roster. In September/2008, there were 20. In February/2010, the roster had 29 names listed. Close to 40% of the casual staff on the current roster work in other program areas within ANCR. Most of the other staff on the roster were employees of other CFS agencies, retired from the CFS system, or working with other social service organizations. The AHU continues to actively recruit for the casual staff roster.

Casual employees cover positions due to vacation or other leave by full-time or part-time employees, or in the event of a vacancy, until the position is filled. The data in June/2009 showed that the 16 casual staff collectively worked enough hours to be equivalent to one or more full time staff positions.

According to the draft *AHU Program Manual*, full time staff and supervisors are scheduled on a “four days on four days off” rotational basis. The shift configurations for front-line staff are from Sunday through Wednesday and Thursday through Sunday. Most shifts are for a period of 10 hours. Shifts are scheduled as follows:

Figure 60: AHU Shift Schedule

AHU Shift Schedule	
Weekdays (Monday to Friday)	<ul style="list-style-type: none"><li>▪ 1-2 shifts - 4:00 p.m. - 12:00 a.m.</li><li>▪ 5-6 shifts - 4:00 p.m. - 2:00 p.m.</li><li>• A minimum of five, but most often six, shifts are scheduled each weekday.</li><li>• A review of the AHU shift schedule for the month of May/2009 showed that 17 out of 21 weekdays were comprised of six shifts while the other 4 days had five shifts.</li><li>• Five shifts are most likely to be scheduled on a Monday, Tuesday, or Wednesday.</li><li>• At least one, and sometimes two, shorter shifts are scheduled each weekday evening.</li></ul>
Supervisor shifts	<ul style="list-style-type: none"><li>▪ 3:00 p.m. to 1:00 a.m. on site and then on standby from 1:00 a.m. - 8:30 a.m.</li><li>• Rotational 4 days on / 4 days off schedule, with crossover being at the end of the day shift on Sunday</li><li>• Rotation occurs every two months: For example, supervisor A works the Sun to Wed schedule for 2 months, then crosses over into the Thurs to Sun schedule</li><li>• Every time a cross over occurs, the team working the Sun to Wed schedule works an additional shift to balance the overall number of shifts worker</li><li>•</li></ul>
Overnight shifts	<ul style="list-style-type: none"><li>▪ 10:00 p.m. to 8:00 a.m. and 10:30 p.m. to 8:30 a.m.</li><li>• Two overnight shifts every day of the week</li><li>• Two employees consistently work the night shift for part of the week</li><li>• The other part of the week is covered by part time and casual employees</li><li>• Night shifts are difficult to fill; usually the newest and least experienced staff works this shift.</li></ul>



Weekend and holiday shifts	<ul style="list-style-type: none"><li>There are 10 shifts scheduled for weekends and holidays</li></ul> <p>Saturday:</p> <ul style="list-style-type: none"><li>7:00 a.m. to 5:00 p.m. - 2 shifts</li><li>8:00 a.m. to 6:00 p.m. - 2 shifts</li><li>12:00 noon - 10:00 p.m. - 2 shifts</li><li>4:00 p.m. - 2:00 a.m. (Or 12:00 midnight) - 4 shifts</li><li>Two Saturday night shifts from 10:00 p.m. to 8:00 a.m.</li></ul> <p>Sunday:</p> <ul style="list-style-type: none"><li>8:00 a.m. to 6:00 p.m. - 5 shifts</li><li>4:00 p.m. to 2:00 a.m. (or 12:00 midnight) - 5 shifts</li><li>Two Sunday night shifts from 10:00 p.m. to 8:00 a.m.</li></ul>
Statutory Holidays	<ul style="list-style-type: none"><li>Shifts on statutory holidays resemble those on Sundays.</li></ul>

According to the draft *AHU Program Manual*, all vacant shifts are back filled with casual staff. When this cannot be realized, overtime costs are incurred as full time AHU or other ANCR staff fills the shifts.

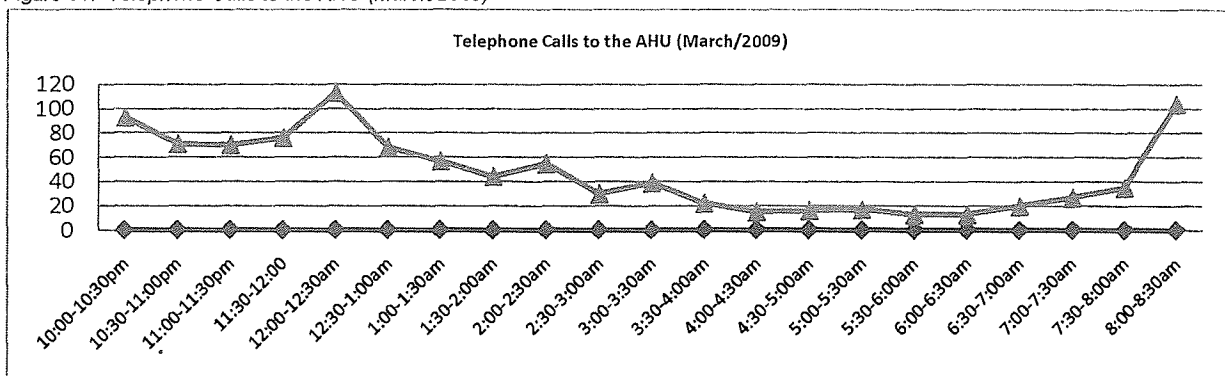
AHU shifts are configured to overlap between 10:00 p.m. and 2:00 a.m. During this period of time, seven to eight staff may be working. Both AHU staff and supervisors are satisfied with the current shift configurations. In response to questions about the necessity for seven to eight staff to be working between 10:00 p.m. and 2:00 a.m., staff and supervisors reported that this time was essential to complete reports and finish up tasks from their shift. It was reported that other shift configurations had been examined, and the current configuration was the most workable.

To examine the extent of the workload during the hours from 10:00 p.m. to 2:00 a.m., information was obtained on the number of incoming telephone calls to the AHU, the number of referrals, and the number of field visits required by the AHU during this time period.

### ***Incoming Telephone Call Volumes for Shift Times***

A review of incoming telephone calls to the AHU during the month of March/2009 shows a relatively high number of incoming calls between the hours from 10:00 p.m. to 2:00 a.m. The following figure illustrates the volume of calls for March/2009 between 10:00 p.m. and 8:30 a.m.

Figure 61: Telephone Calls to the AHU (March/2009)





Telephone calls between 10:00 p.m. and 2:00 a.m. made up 60% of the total number of calls to the AHU. 30% of calls were received between 2:00 a.m. and 8:00 a.m. and 10% of all calls were received in the half hour period from 8:00 a.m. to 8:30 a.m.

### ***Number of Referrals and Required Field Visits***

Information from the IM database indicates that 13% of intake referrals occur week nights between 10:00 p.m. and 2:00 a.m. 9% of all field visits are made during this time. This compares to 38% of intake referrals occur between 4:30 p.m. and 10:00 p.m. on weekday evenings, with 44% of these referrals requiring a field visit.

Based on this information, it appears that telephone activity is quite high during this time frame. This will impact the "wrap-up" process that is required on the workload generated between 4:00 p.m. and 10:00 p.m. The addition of two staff at 10:00 p.m. enables workers to complete activities and documentation.

### ***Memorandum of Understanding (MOU)***

Shift schedules were established during bargaining negotiations between the MGEU and the WCFS. An MOU provides the following guidelines regarding hours of employment and scheduling of shifts in the AHU.

- Non-supervisor AHU employees can work either 7.25 or 9.25 hour shifts exclusive of meal periods.
- Supervisors shall work 9.25 hour shifts exclusive of meal periods starting at 3:00 p.m. Monday to Sunday or at 8:00 a.m. Sunday.
- AHU employees must be willing and able to work all shifts.
- The Employer retains the exclusive right to determine the shifts and to schedule employees.
- Employee preference could be accommodated but must be guided by fairness, equity and availability in the allocation of work.
- The Employer should post shift schedules one month in advance.
- The Employer shall make every effort to fill midnight shifts on a regular and recurring basis.
- Full-time employees shall strive to maintain a Sunday - Wednesday and a Thursday - Sunday shift schedule.
- Once full-time employees of the AHU have been allocated shifts, the remaining shifts shall be allocated to part-time employees.

All activities related to staffing and scheduling appear to occur in accordance with these guidelines. Scheduling follows the process of assigning shifts to full time employees first, part-time employees second, and remaining vacant shifts to casual employees. Part-time employees are offered the option of working extra shifts when their guaranteed hours are filled and many do so.



## ***Availability Forms***

Shift schedules are developed on a monthly basis by AHU supervisors working from a master schedule. The schedule is adjusted as needed based on availability forms submitted by full-time, part-time, and casual employees at least one month in advance. The availability forms include a calendar where availability can be entered. There is a check list on the form where staff is asked to indicate preferences.

- Full-time staff are asked to indicate if they want to be scheduled for additional overtime and, if yes, how much overtime.
- Part-time staff are asked to indicate if they want to be scheduled for any additional shifts and, if yes, how many.
- Casual staff is asked to indicate how many shifts they would like to work in the month.
- All staff is asked to indicate if they want to be called for last minute replacement shifts in the month.

Not all AHU staff submits their availability forms as requested. According to the Administrative Assistant, this creates additional work, as follow up with staff must occur to determine their availability. Part time and casual staff interested in working AHU shifts will submit their availability forms consistently.

The review of the availability forms noted the flexibility that staff working in other CFS agencies or ANCR programs appear to have in being available to pick up the AHU shifts that start at 4:00 p.m.

## ***Scheduling System***

Each monthly schedule is posted in a central location. Once the schedule is completed by a supervisor, any changes become the responsibility of the Administrative Assistant. For example, if a scheduled worker calls in sick, the Administrative Assistant proceeds to find a replacement staff.

Schedules are handwritten using a one page calendar sheet for each month. As space is limited, initials are used to identify staff. Casual employees are differentiated by a circle around their initials and employees working the short shift are identified by an asterisk (\*) by their initials. Any changes to the schedule are made by striking out one set of initials and inserting the initials of the replacement employee.

Maintaining shift schedules and completing payroll functions for the large number of AHU employees with varied guaranteed hours or casual employment is a large task. Almost all of the time of the half time administrative assistant for the AHU is dedicated to scheduling and payroll functions.

The AHU scheduling system could easily be simplified and modernized, using available software. A more efficient way of managing this scheduling system could free up the administrative assistant to assist the AHU with other administrative tasks.

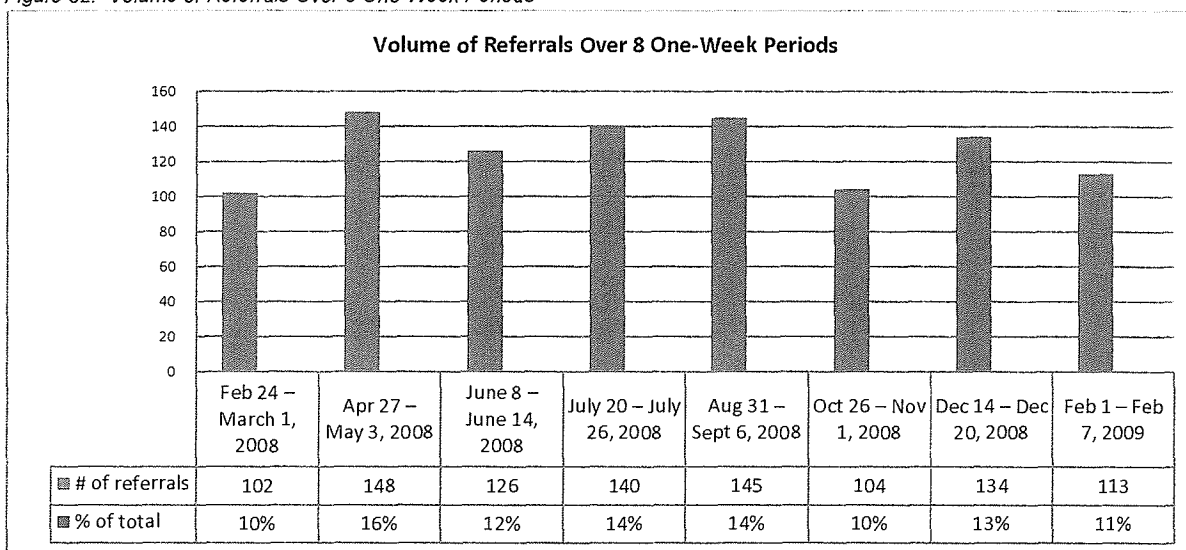


## Service Volume

A collection of specific data reflecting the volume and category of referrals and openings, sources of referral, time management and service demands, and the management of referrals to the point of closing or transfer was obtained and analyzed for the same eight, one-week time periods during the course of approximately twelve months. These one-week time periods were strategically selected to reflect service volume during winter months, summer months and at varying points within a month such as the beginning, mid- and end of a month. These periods were further divided into five time categories reflective of the shifts that comprise the work schedules within the AHU. For each time period, data was analyzed for variations in service volume.

The following figure shows the volume of referrals for the selected one week periods.

Figure 62: Volume of Referrals Over 8 One-Week Periods



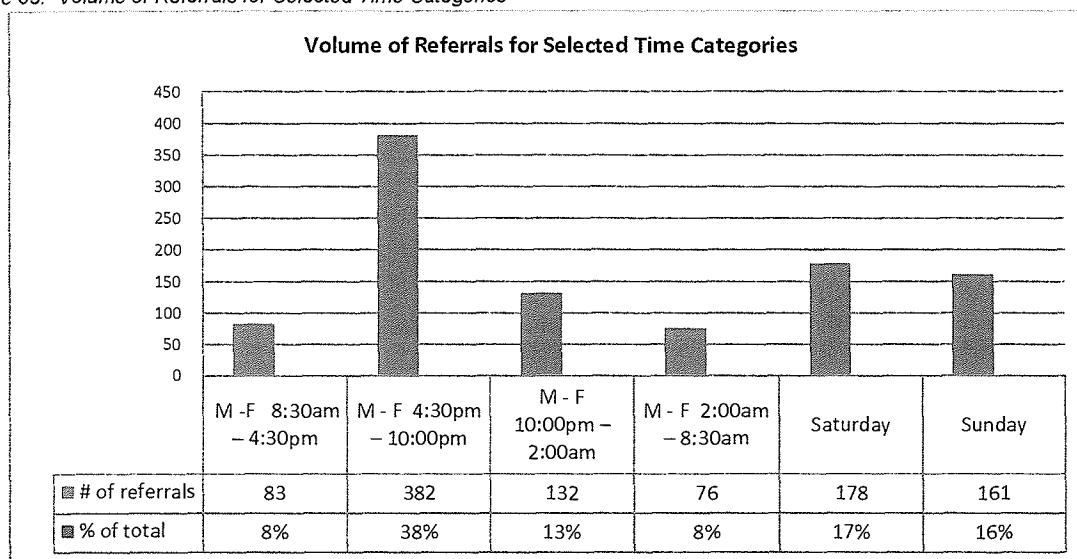
The AHU receives an average of 126.5 referrals weekly. 56% of all referrals were received during spring/summer months (April to September). This compares to the 44% of referrals received during the fall/winter months (October to March).

The IM data was analyzed for variations in service volume during specific time categories. The After Hours shift was divided into four weekday time categories and two weekend time categories to determine which category includes the greater service volume. As the afterhours shift begins at 4:00 p.m., the time category primarily covered by the CRU was included in the analysis if the service function was performed by an AHU worker. Approximately 8% of referrals to the AHU were received during the time category from 8:30 a.m. to 4:30 p.m.



The following figure shows the volume of referrals for the selected time categories.

Figure 63: Volume of Referrals for Selected Time Categories



38% of the referrals were received from 4:30 p.m. to 10:00 p.m. and 33% were received during the weekend. 21% of the referrals occurred between 10:00 p.m. to 8:30 a.m. The service volume during the weekday from 4:30 p.m. to 10:00 p.m. is the highest. There were more calls in this period than all of Saturday and Sunday calls combined.

## **Referrals**

### ***Sources of Referrals***

The IM database contains 29 categories under 'Source of Referral' ranging from self and family referrals to a list of specific community organizations and agencies. Data on referrals from other Manitoba CFS agencies was collected under a broad category that did not break down the referral source by specific child and family service agencies. Any referral from another CFS agency, CFS Authority, or Family Services and Housing (now called Family Services and Consumer Affairs) was entered under the broader category of 'Manitoba CFS agencies'.

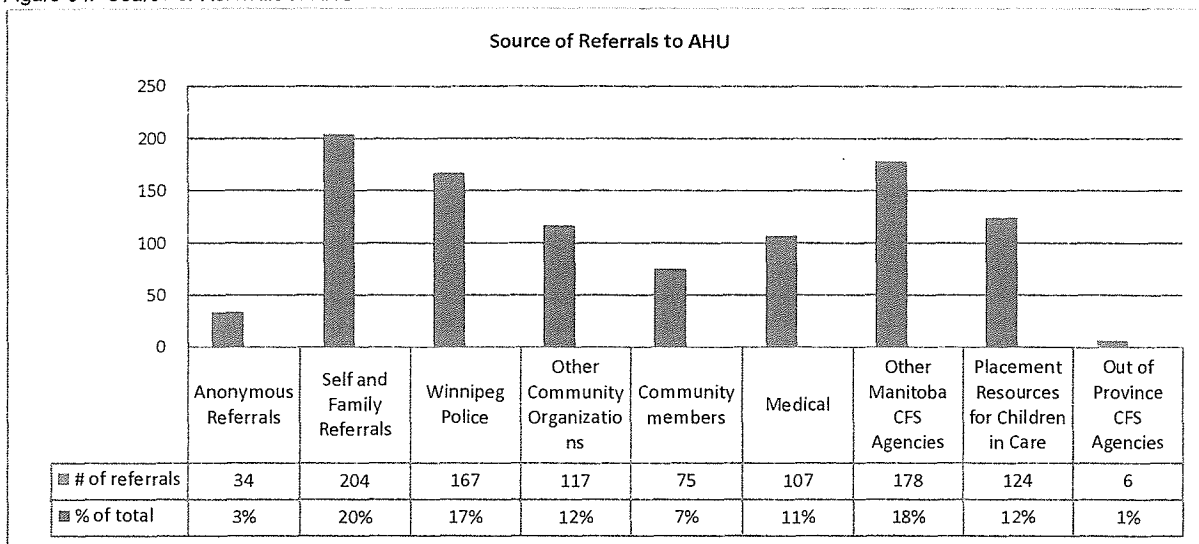
For purposes of analysis, the 29 categories were condensed into 9 broader categories. Referrals from collateral organizations (ex: schools, justice, mental health, treatment resources) are included under 'other community organizations'. 'Placement Resources for Children in Care' includes referrals from foster families, shelters, and residential care facilities. The nine broad categories provided the basis for analysis on the sources of referral to the AHU.





The following figure shows the number of referrals by these categories.

Figure 64: Source of Referrals to AHU



3% of referrals were made to the AHU through anonymous sources. Self-referrals and referrals by family members made up the largest single category at 20% of all referrals. Of these, 54% were self-referrals while the remaining 46% were referrals made by a family member. 17% of the referrals were from the Winnipeg Police Service (WPS). The majority of referrals between 10:00 p.m. and 2:00 a.m. and between 2:00 a.m. and 8:30 a.m. were from the Winnipeg Police Service.

12% of the referrals were from placement resources for children in care, such as foster homes, emergency shelters and residential care facilities. Of these referrals, 46% came from foster homes and 48% were from shelters for children in care. All these sources of referral would have involved children and youth already in the care of the CFS system.

18% of the referrals were from Manitoba CFS agencies. The majority of these referrals occurred between 4:30 p.m. and 10:00 p.m. All of these service requests involved children and families that were already open to a CFS agency.

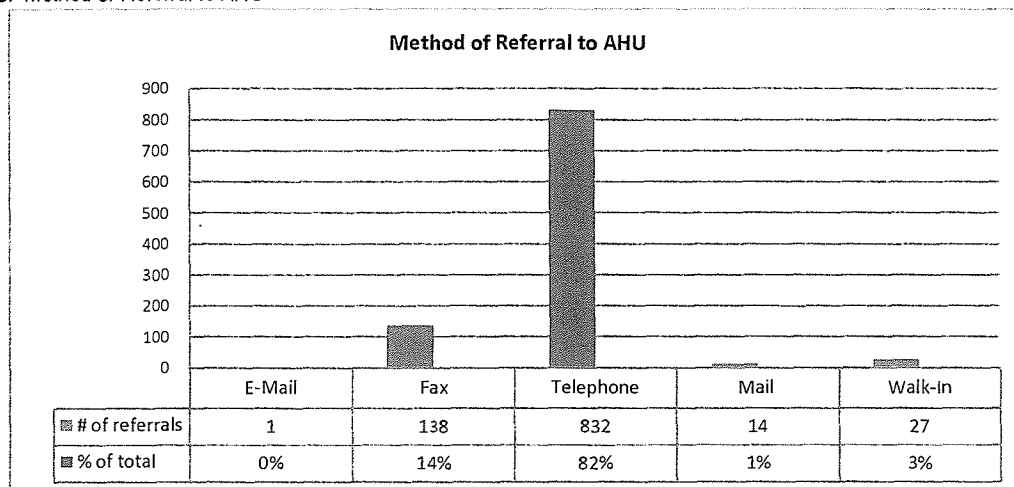
Because the IM database does not allow for specific listings of the CFS agencies that are making referrals to the AHU, a review of a sample of manual service requests provided further insight into this. The information can be found later in the report.

### ***Method of Referral***

82% of the referrals are received over the telephone. 15% are written referrals through mail, email and fax. 3% of referrals are walk-ins. The following figure shows the methods of referrals to AHU.



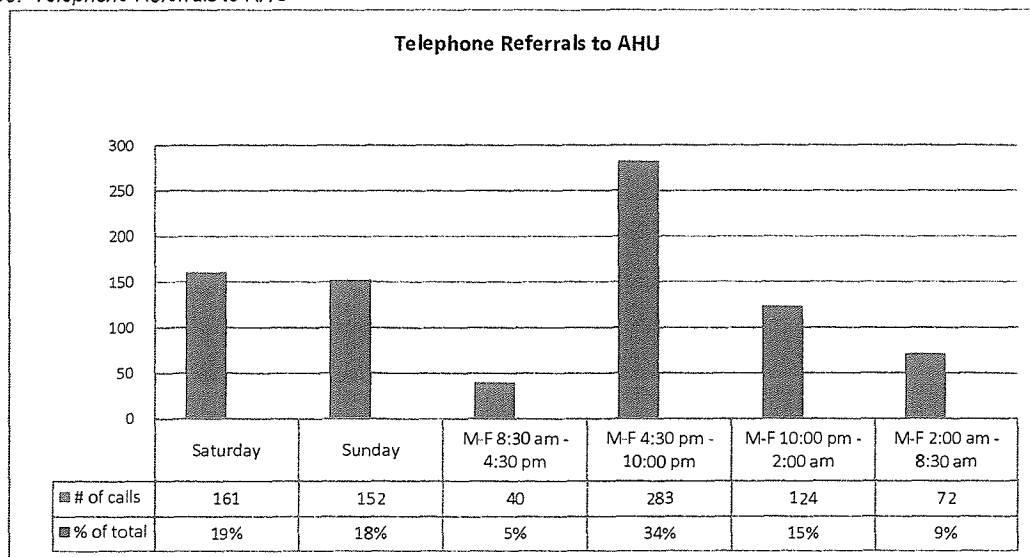
Figure 65: Method of Referral to AHU



14% of the referrals are by facsimile and are received mainly between 4:30 p.m. and 10:00 p.m. Only three percent of the referrals involve a walk-in. Walk-ins are more likely on a Saturday, Sunday, or between the hours of 4:30 p.m. and 10:00 p.m. during weekdays.

Telephone referrals are more likely to be made between 4:30 p.m. – 10:00 p.m. The following figure provides a breakdown of the telephone referrals.

Figure 66: Telephone Referrals to AHU





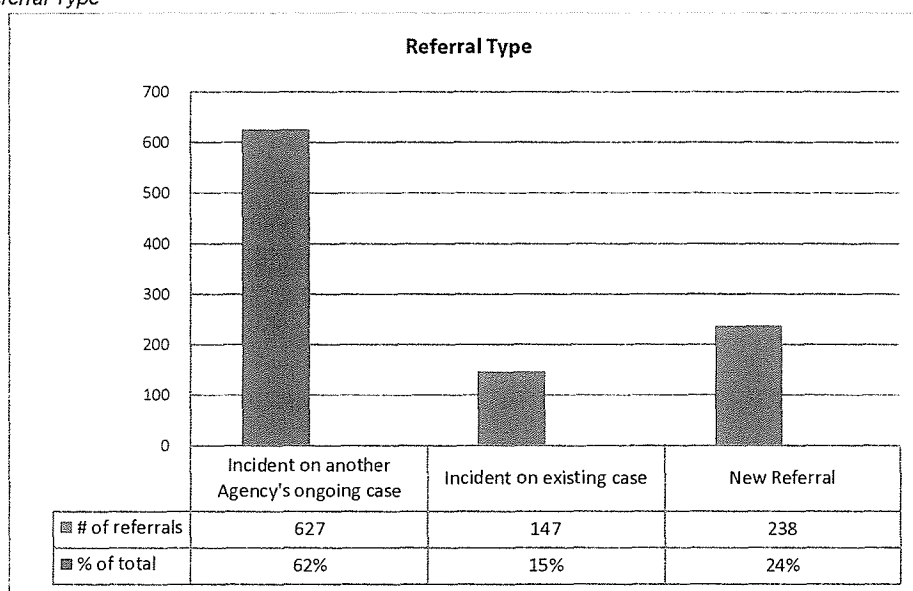
## Types of Referrals

The Intake Module (IM) requires that an Intake type be selected whenever a new referral is entered into the system. Three referral/intake types are available for selection in the IM. These include:

- Incident on another agency's ongoing case
- Incident on existing case
- New referral

The following figure provides a breakdown by referral type.

Figure 67: Referral Type



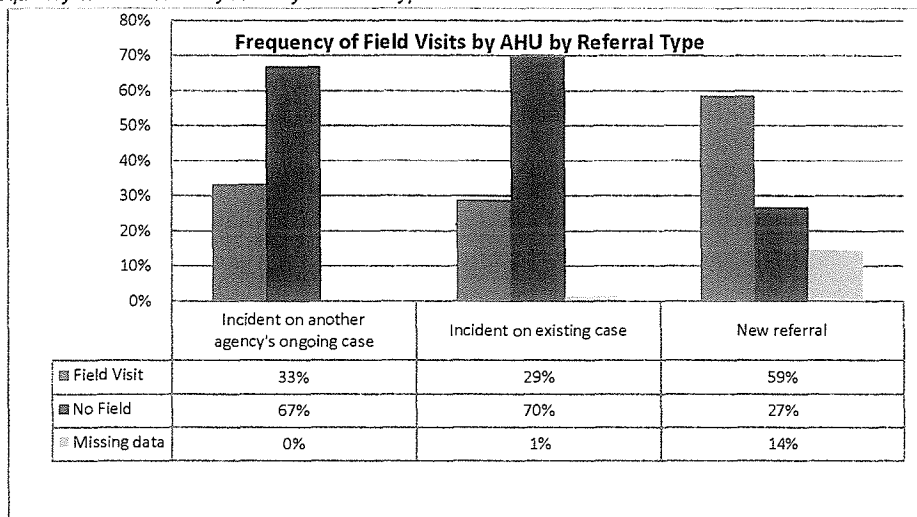
62% of the referrals involved an incident on another agency's ongoing case. 24% were new referrals and 14% involved an incident on an existing ANCR case. From this data, it appears that a considerable amount of work by the AHU involves the delivery of services to clients already open to another CFS agency. Less than one-quarter of the referrals to the AHU are new referrals to the CFS system.

## Field Visits

Depending on the circumstances and urgency of a referral, AHU workers determine whether a field visit is necessary. There were 1012 referrals received in the selected time periods. These were reviewed for the number of field visits that occurred by referral type. 39% of these referrals resulted in a field visit, 57% did not. No response was entered for the remaining 4% of referrals. The following figure shows the status of field visits by Intake type.



Figure 68: Frequency of Field Visits by AHU by Referral Type

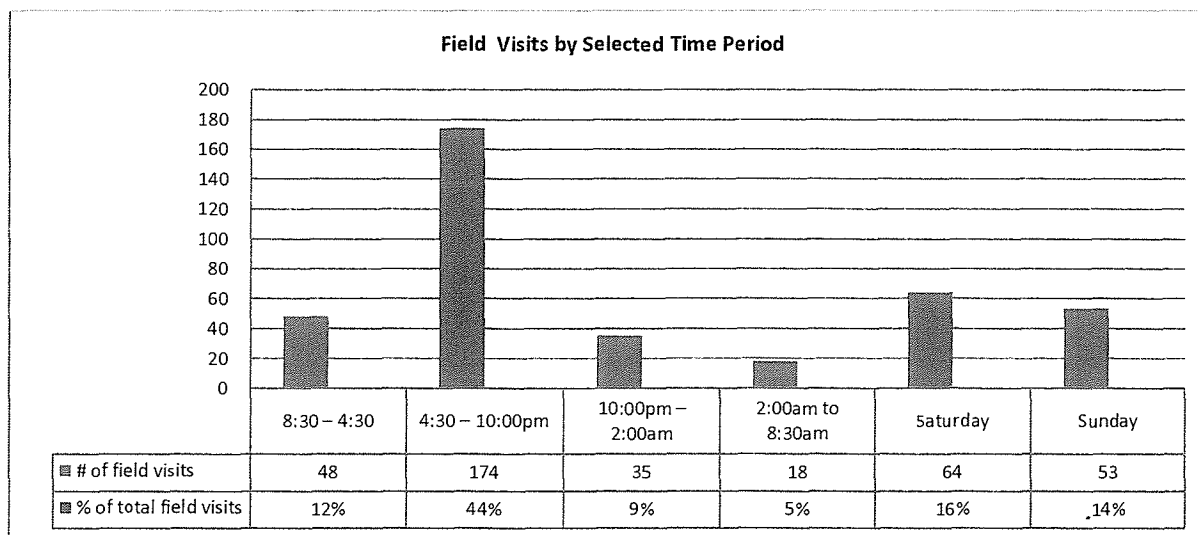


39% of all referrals to the AHU required a field visit. Field visits were more likely to occur when a new referral was received and least likely to occur on an incident involving an existing ANCR case. Field visits were required in 33% of all referrals involving an incident on another agency's ongoing case, while an incident on an existing ANCR case resulted in a field visit 29% of the time. New referrals resulted in a field visit 59% of the time.

More significant findings can be associated with the time category that field visits were likely to occur. Six time categories were examined for the eight one-week time periods reviewed. Time categories were compared with the type of referral when a field visit was required. As field visits were required in 39% of all the referrals, 392 referrals requiring field visits were reviewed.

The following figure shows the number of field visits by selected time periods.

Figure 69: Field Visits by Selected Time Period





The time category from 8:30 a.m. – 4:30 p.m. was included in the analysis when data was entered by the AHU only. CRU workers enter most intake data on the IM during this time category. The data indicates that 8% of referrals were entered into the IM database by AHU workers during the daytime hours from 8:30 a.m. – 4:30 p.m. This is due to the fact that AHU shifts begin at 4:00 p.m. 12% of all field visits were made by AHU in this time period; this would be after 4:00 p.m. Most of these field visits were made in response to incidents on another agency's ongoing case.

44% of all field visits by AHU workers were made between 4:30 p.m. and 10:00 p.m.

Field visits that occur during the night time hours from 10:00 p.m. to 2:00 a.m. or from 2:00 a.m. to 8:30 a.m. are more likely to be due to a new referral. 14% of all field visits took place in this time period. 30% of all field visits occurred during the weekend.

The following three figures show the time periods of field visits by Intake type.

Figure 70: AHU Field Visits - Cases Open to Other CFS Agencies

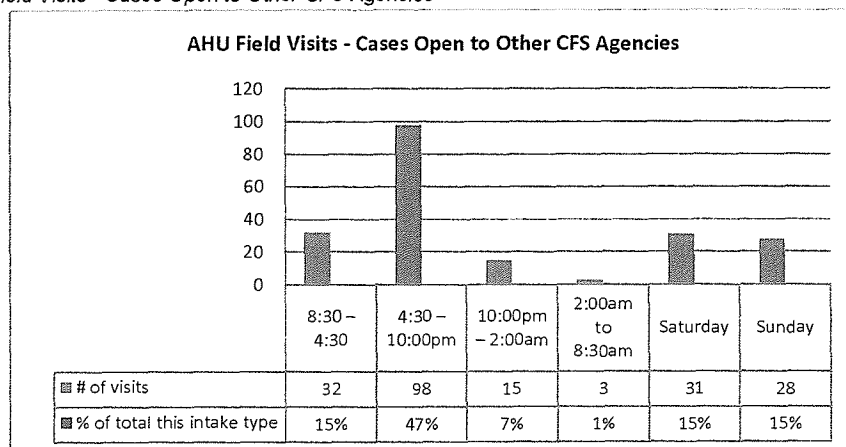


Figure 71: AHU Field Visits - Cases Open to ANCR

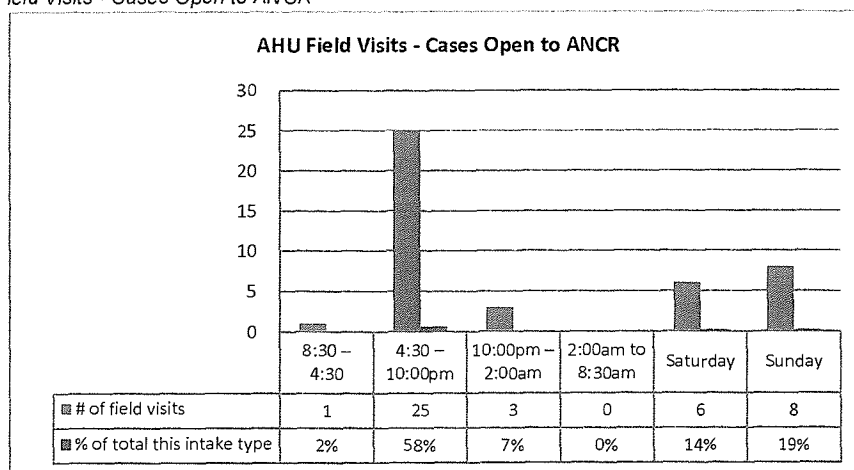
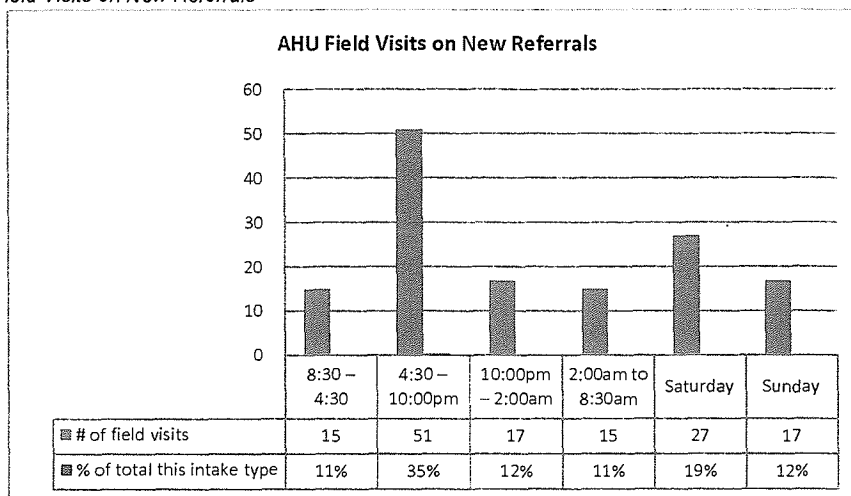




Figure 72: AHU Field Visits on New Referrals

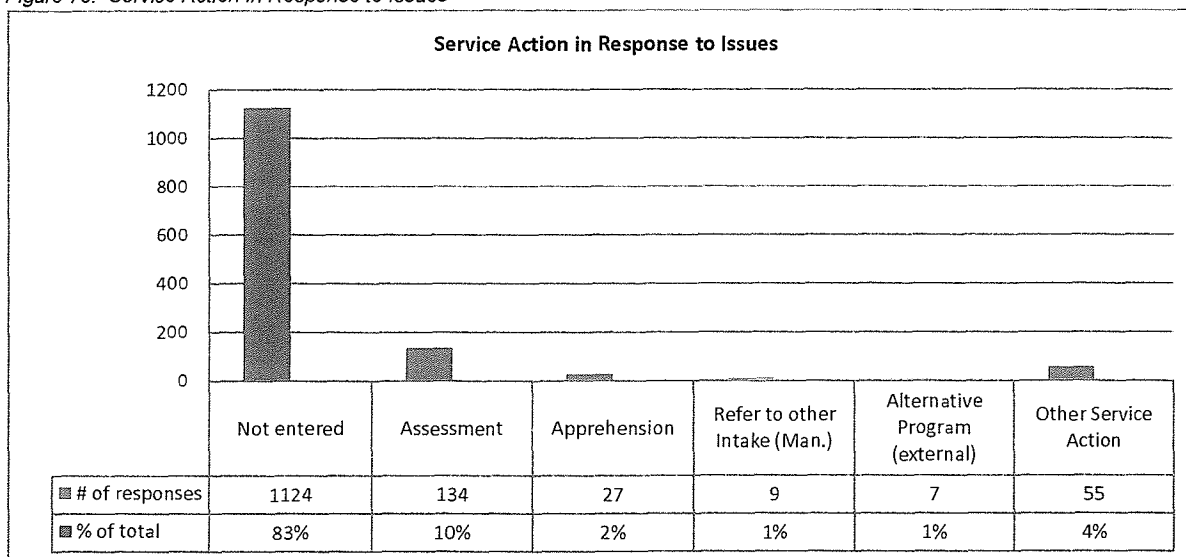


For all intake types, most of the field visits took place between 4:30 p.m. and 10:00 p.m. and about one third of all field visits were made on Saturday and Sunday.

### Service Actions in Response to Issues

The IM contains approximately 248 categories identifying service actions that can be taken in response to service issues. Out of a total of 1356 responses, the top five categories most frequently identified as a response to an issue by the AHU are shown in the following figure:

Figure 73: Service Action in Response to Issues



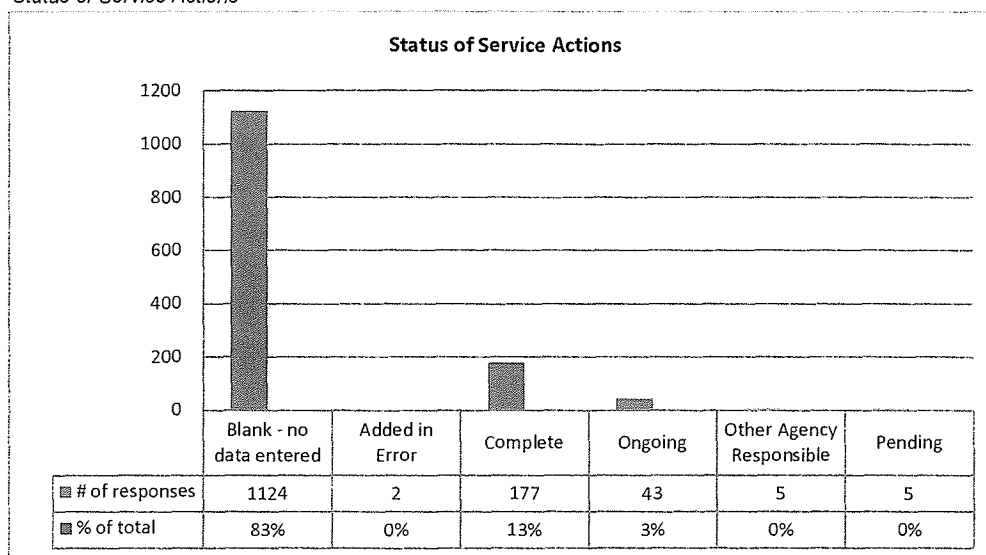
In the majority of the referrals, the service action that was taken is not entered on the IM. The status of 83% of the issues identified at referral has not been entered in the IM.



## Status of Service Actions

The status of the service actions is tracked by six categories: blank, added in error, complete, ongoing, other agency responsibility and pending. It is expected that once work on the issues has been completed, this would be entered into the IM as 'Complete'. A review of the action status of the issues identified for the selected time periods shows that a significant number of referrals in this category were missing 'Issue Management' data.

Figure 74: Status of Service Actions



Of the 1356 issues identified in this review period, service actions for 83% were not indicated. Only 13% of all issues identified by the AHU show that they have been completed. 3% indicate a service status of 'Ongoing'.

The absence of data does not allow for any meaningful analysis in this area. It is not clear why this section is not being completed. This should be reviewed further so that reporting on this item is improved.

## Safety Assessments

As per *The Child and Family Standards Manual*, the AHU is responsible for assessing identified issues to determine the level of response that is required. If an issue requires a response immediately and within 24 hours, the AHU worker completes a Safety Assessment. This is done within 24 hours from the time the referral is received. Based on a review of the circumstances of the case, a supervisor may approve an extension.

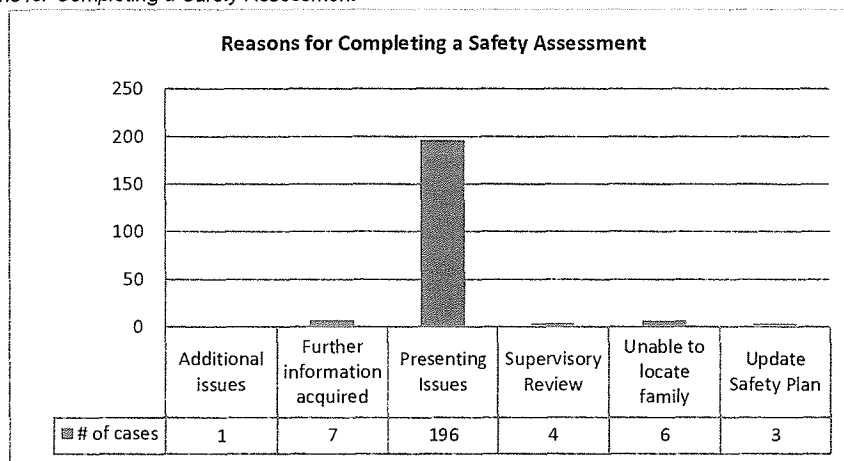
When the recommended response time is more than 24 hours, the afterhours worker may complete a safety assessment if there are concerns about the safety of a child. Based on the issues that were



identified for this review period, safety assessments were completed in 21% of the total number of referrals reviewed.

98% of the safety assessments were completed on new referrals while the remaining 2% were completed as a result of additional information that was obtained on a case. The reasons for completing a safety assessment were listed as follows:

Figure 75: Reasons for Completing a Safety Assessment



Almost all safety assessments were completed when the issues presented on a new referral. Extensions or overrides occurred in the six cases in the category 'Unable to locate family'.

### ***Intake Management***

According to the *After Hours Program Manual* (Draft 1, December/2008), the AHU opens an Intake file in the IM upon a request for service. Based on an initial assessment, the AHU either responds to the request or forwards the information to the CRU the next working day. If the request requires services on behalf of another CFS agency, the information is forwarded to the ongoing agency. At completion of this service, the IM file is concluded.

According to the data obtained for the review, the status of the 1012 referrals to the AHU showed that 96% of the Intakes were concluded. Less than 4% of the intakes were shown as being 'Open' at the time of this review. The AHU is effective in concluding almost all intakes by the end of their work day.

### **Transfers and Closings**

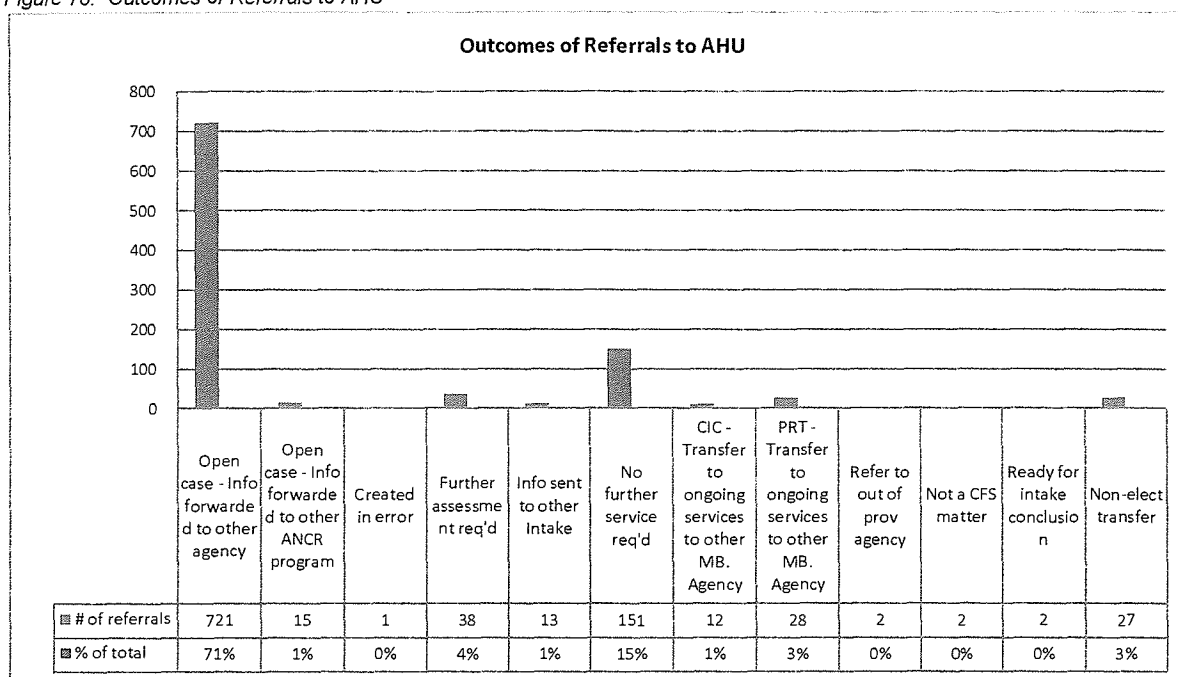
The 1012 referrals to the AHU were reviewed for outcome. In 15% of the intakes, no further service was required. In the remaining 85% of intakes, services provided or information taken on new referrals or existing cases was forwarded to the appropriate sources.





The following figure shows the outcome of referrals to the AHU.

Figure 76: Outcomes of Referrals to AHU



71% of the referrals to the AHU were on cases open to another CFS agency. These were forwarded to that agency. 4% of the referrals required further assessment. 3% were transferred non-electronically.

### ***Intakes Transferred from the AHU to Other ANCR Programs***

As stipulated in the *After Hours Program Manual* (Draft 1, December 2008), upon completing an intake report, the AHU worker notifies the supervisor with a recommendation to either open the case for further assessment and/or service by ANCR or close the intake. If an Intake requires further assessment and intervention, it is submitted to the CRU at the end of each working day and following the weekend. At that point, the intake is assigned to the appropriate ANCR program. Manual data is maintained on the number of referrals that are transferred from the AHU to the dayside Intake services. This data was examined for the time period from Jan 1 to April 17/2009.

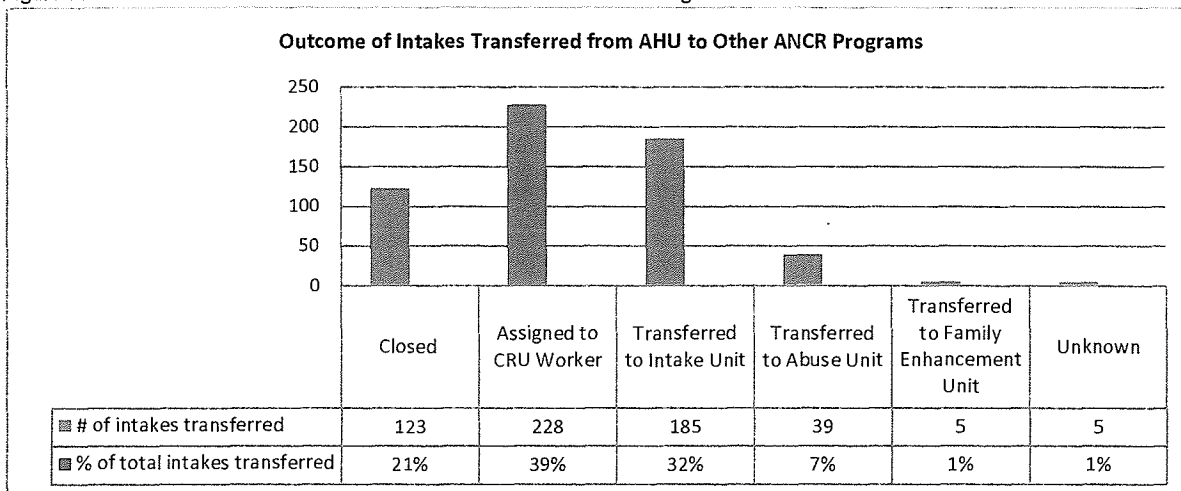
### ***Outcomes of Intakes Transferred from the AHU to Other ANCR programs***

During this time period, 585 Intakes were forwarded from the AHU to other program areas at ANCR.

The following figure shows the outcome of the intakes transferred from the AHU:



Figure 77: Outcomes of Intakes Transferred from AHU to Other ANCR Programs



21% of the intakes were closed in the AHU because service was no longer required or the information was forwarded to another CFS agency. 39% of the intakes were assigned to a CRU worker for follow-up. 32% of the intakes were transferred to the Intake Unit (Tier II), 7% were transferred to the Abuse Unit and 1% was transferred to the Family Enhancement Program.

## **Range of Services**

The *After-Hours Program Manual* (Draft #1, December/2008) provides a range of situations where a service response by the AHU is appropriate. The AHU will:

- Respond to any situation where a child may be at acute risk of abuse or neglect.
- Apprehend children in need of protection and place in places of safety as required.
- Respond to afterhours requests for information from closed protection files from designated intake agencies throughout the province.
- Complete initial safety assessments on all issues that have been identified as immediate responses.
- Respond to crisis via assessing and intervening in situations where a child may be at acute child protection risk, as defined under the CFS Act.
- Make the necessary contact(s) with the child/ren and any significant others in cases that are assessed by the AHU to be an immediate, within 24 hours response.
- Complete the Safety Assessment and manage the crisis prior to referring the case to CRU or the open CFS agency.
- Provide service to walk in clientele, which would include information gathering, assessment, and referral to other community resources, and ANCR CRU.
- Provide court document service to other CFS agencies, possibly in collaboration with the CRU and Legal Department staff.



The AHU provides services after regular work hours to new referrals and on existing child and family service cases on behalf of other CFS agencies in the province. According to the IM database, 24% of referrals to the AHU are new referrals while 76% involve services provided on already opened CFS cases.

## **Service Requests**

By completing a specific Service Request Form, CFS workers from other agencies or ANCR programs can request the assistance of the AHU to provide follow-up services on existing cases after regular work hours. This form must be completed by the caseworker requesting the service and signed by a supervisor. It is then faxed to the AHU.

Most service requests are faxed between 4:00 p.m. and 4:30 p.m. as CFS workers prepare to end their work day. Fax machine activity in the AHU is almost non-stop during this time period. In May/2009, the fax machine in the AHU broke down and, as a result, the fax number was programmed to another fax machine in the building. This fax machine had difficulty managing the workload and service requests literally jammed up the machine. At some periods of time it was unknown whether a faxed request actually got through the machine. During the 4-6 weeks that the review focused on the AHU, the fax machine was not repaired.

Approximately 14% of all referrals to the AHU come through faxes on the internal *After Hours Service Request Form*. These requests come from CFS workers with other CFS agencies in the province or other programs at ANCR. On occasion these requests are called in to the AHU. The AHU maintains these request forms for a period of time before disposing of them. This Review examined the service requests faxed to the AHU on the designated Service Request form for the sources of the service requests, the nature of the requests, and whether the service request was determined to constitute a child welfare emergency.

## ***Source of Service Requests***

445 Service Requests, faxed to the AHU from other CFS Agencies and ANCR Programs, were reviewed for the six-month period from November/2008 to April/2009. Service requests for April 19<sup>th</sup> and 20<sup>th</sup> were not available and were not included in the review.

Attached to all the Service Requests was a copy of the AHU response. When services are provided in response to a service request on behalf of an existing open case, the information is entered as a case note on the IM. The information is written up and sent to the worker through the fax system. The copies of the written responses are attached to the initial *After Hours Service Request* form. These responses are more detailed about the nature of the service that was provided than that recorded in the case note in the IM.

By reviewing service requests from CFS workers and the services provided by the AHU, it was expected that the information would provide insight into which requested services could be considered



emergencies where a child may be at imminent risk of harm, and which services were considered an extension or augmentation of the respective referring agency's case management responsibility.

To establish the context for true emergencies, the *Manitoba Child and Family Service Standards for Case Management* was used as a reference point. These set out the minimum required standards for the delivery of mandated child and family services in the Province of Manitoba. Levels of risk to children are key determinants of the response time and client contact that needs to follow. The Standards<sup>14</sup> identify risk as follows:

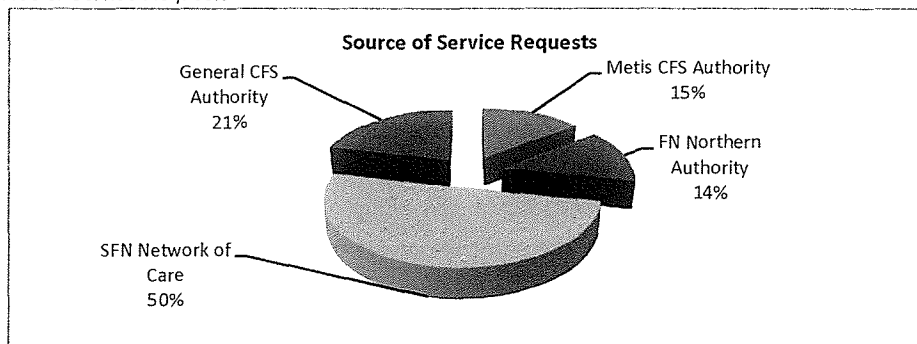
<i>High Risk</i>	<i>A child is likely to be seriously harmed or injured, subjected to immediate and ongoing sexual abuse, or permanently disabled or dies if left in his or her present circumstances without protective intervention</i>
<i>Medium Risk</i>	<i>A child is likely to suffer some degree of harm if he or she remains in the home. Intervention is warranted. However, there is no evidence that the child is at risk of imminent serious injury or death.</i>
<i>Low Risk</i>	<i>The home is safe for children. However, there are concerns about the potential for a child to be at risk if services are not provided to prevent the need for protective intervention</i>
<i>No Risk</i>	<i>The home is safe for children and there are no indications of potential risk to a child.</i>

The definition of risk to a child is an essential component in determining whether an emergency response is required. Any situation where there is a high risk of child maltreatment requires an immediate response and may be considered an emergency.

### ***After Hours Service Requests by Other Manitoba CFS Agency***

Seventeen Manitoba CFS agencies submitted service requests to the AHU during the six-month review period from November/2008 to April/2009. These agencies vary in size, structure, and geographic areas. All are agencies mandated to provide a full range of CFS services. The following figure shows the source of service requests to the AHU by CFS Authority.

Figure 78: Source of Service Requests



<sup>14</sup> Manitoba Child and Family Services Standards Manual, 2005



CFS Authorities, and their agencies, vary in size. Of the total child welfare cases open as of March 31/2009, 8% were with the Metis CFS Authority; 24% with the First Nations of Northern Manitoba CFS Authority; 40% with the SFN Network of Care; and 28% with the General CFS Authority. The frequency of the use of AHU services by CFS agencies can be compared to the percentage of total cases by CFS Authority.

There were 198 workers who requested services of the AHU during the review period. 41 of these did so more than three times in the six month review period. One worker requested services more than seven times.

### ***Nature of Services Being Requested***

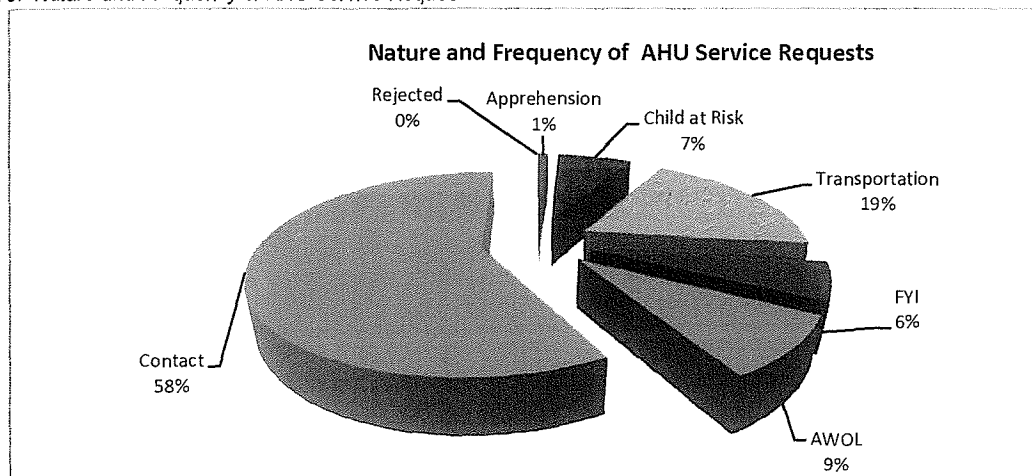
Service requests were divided into seven categories. These include:

Apprehension	This category was specific to a request for the AHU to apprehend a child, such as following a birth of a child in hospital.
AWOL	This category reflected those requests for AHU workers to attend particular addresses to retrieve an adolescent whom is absent from a placement. Infrequently (2x), AHU staff would make a field visit to locations even when it was not specifically requested.
Contact	This category was assigned to those requests requiring an AHU worker to attend at an address to view the family or situation and determine if the child is or is not in danger. This category also included requests from family service workers to provide a family with food, to arrange hotel placements, issue purchase orders, authorize taxi's etc. Some of these requests may arguably be viewed as emergencies and requiring immediate attention whereas others were not. Some service requests provided instructions on future dates and times for the field visits to occur and instructed on what service to provide. Some of the requests stated if certain persons or conditions were present that the child(ren) should be apprehended while others requested an assessment of the situation. While the circumstances varied, service requests in this category called on the AHU to conduct assessments and provide services, on behalf of other CFS workers after working hours on active, on-going child and family service cases.
Child at Risk	This category included those cases where a child was in imminent risk and a response was required. This also included cases where the family service worker was otherwise engaged with one aspect of the emergency and was requiring night duty assistance to support their efforts.
FYI	This category reflects information provided to the AHU staff to be aware of in the event that there may be action necessary for the identified family. The majority of these cases included children on the run or in anticipation of circumstances or conditions that may occur.
Transportation	This category included service requests for transporting children to and from placements as well as seeking placements for children on existing cases. Family Services workers appear to face a lack of resources for the placement of children and often relied on AHU staff to authorize hotel placements. AHU staff spend considerable time transporting, arranging for transportation, and placing children on existing cases.
Rejected	A few requests were rejected by the AHU because they were considered not appropriate for the services provided by the AHU.



The following figure shows the nature and frequency of service requests in each of these categories.

Figure 79: Nature and Frequency of AHU Service Requests



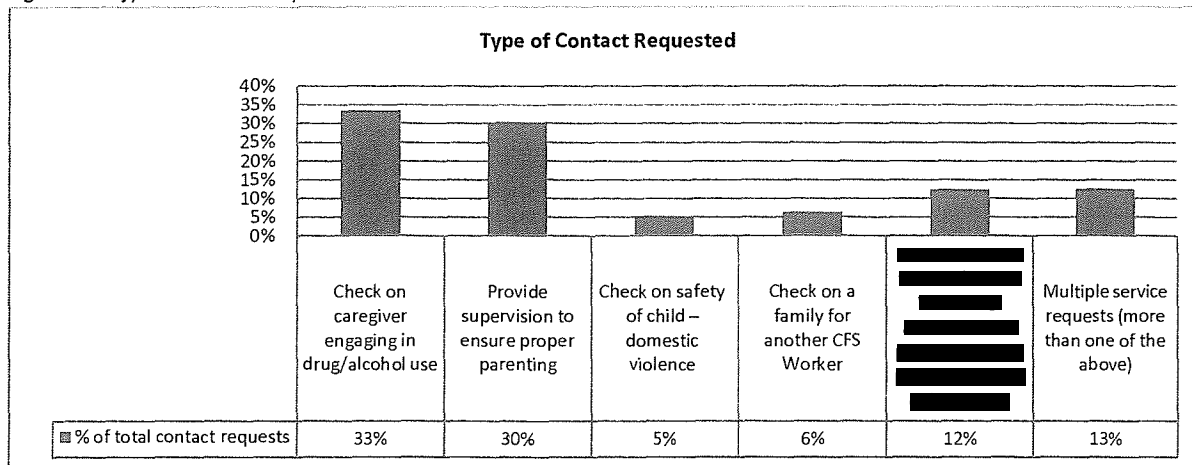
The 'Child at Risk' and 'Apprehension' categories make up 8% of the service requests. These two categories are considered emergency situations requiring a high level of response.

Service requests for the transportation of children/families made up 19% of the total. Data under this category was collected whenever an AHU worker actually transported a child/family or arranged for transportation on behalf of a child/family.

9% of the service requests involved searching for children in care when their whereabouts were unknown. 6% of the service requests contained information on a child or family that might be of assistance when/if the AHU becomes involved. Less than 1% of the service requests were rejected because the request was considered not appropriate for the services the AHU provides.

58% of the service requests were contained in the category referred to as 'Contact'. This category was broken down into the types of contact requested. The following figure provides this information:

Figure 80: Type of Contact Requested





68% of the 'contact' requests were due to concerns about parental capacity and behavior, such as parental drug/alcohol use, parenting ability, and domestic violence. 12% of the requests were multiple service requests which could also include parental behaviors. Concerns about parental capacity would include checking for the presence of offenders in the home.

A few service requests were rejected by AHU supervisors because they were considered inappropriate and sent back to the agency. In these instances, the AHU supervisor spoke to the agency supervisor and explained why the request was being rejected. Less than 1% of service requests were rejected.

The Service Request form contains a section that allows the referring caseworker to advise the AHU of a risk of violence. 11% of the requests indicated a potential for violence, 41% indicated there was no potential for violence and 47% had no information entered.

In 75% of the service requests, the AHU conducted field visits.

According to provincial CFS Standards, a situation is considered an emergency where the possibility of imminent risk of harm to a child is high. 92% of the total requests for service were identified as non-emergent.

There is considerable subjectivity in determining what constitutes an emergency situation. While the *CFS Standards Manual* points to the level of risk to a child as a determinant of urgency, there is very little information available regarding what constitutes a child welfare emergency. As a result, the AHU is required to use their own best judgment based on the information that is available to them in a Service Request Form.

Often a caseworker will note on the service request that a child may be at risk. When such a notation is made, a sense of urgency is generated. In some of the cases reviewed, the requested services were not consistent with an emergent level of need.

In some cases, the service requests arrived in the AHU between 4:15 p.m. and 4:30 p.m. This could suggest that the caseworker chose to make a service request of the AHU rather than following up on the matter close to the end of the work day.

AHU workers also reported attending to a home in response to a service request and hearing that the family had been unable to get a hold of their worker or had not seen their worker for a period of time.

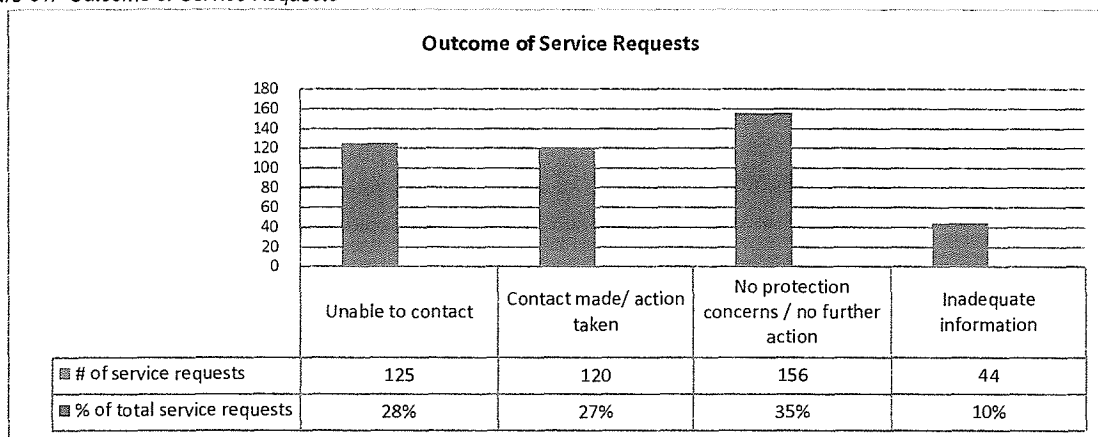
### ***Outcome of Service Requests***

Service requests were reviewed to determine whether any service actions occurred and, if so, what intervention followed. The following figure shows the outcome of the service requests:

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Figure 81: Outcome of Service Requests



In 28% of the service requests, the AHU was not successful in establishing contact with the child or family and no service action followed. In 27% of the responses, some form of action was taken by the AHU. A "caution and warn" from the AHU worker to the family did not constitute an action in this review.

In 35% of the service requests, AHU workers attended at the home of the family to find no protection concerns and further intervention was not required. 10% of the requests did not have adequate or accurate information to enable follow-up to occur. Many lacked sufficient information or the information that was provided was in conflict with information on the family in the Child and Family Services Information System (CFSIS).

Copies of written responses from AHU workers or supervisors are attached to copies of service requests and maintained in files at the AHU, with the original written responses faxed to the caseworker. The quality and quantity of the information in the service requests was often lacking. This left AHU workers unclear about the situation they were being asked to address. The frequency with which the "potential for danger" category was not included in the report is of concern.

### **Services Provided by the AHU on Open Cases**

A random sample of 500 written responses involving cases open to CFS agencies were examined from the 1338 available copies stored in the AHU. This represents approximately 37% of all service responses from January/2009 to April/2009. Examination of this sample included looking at:

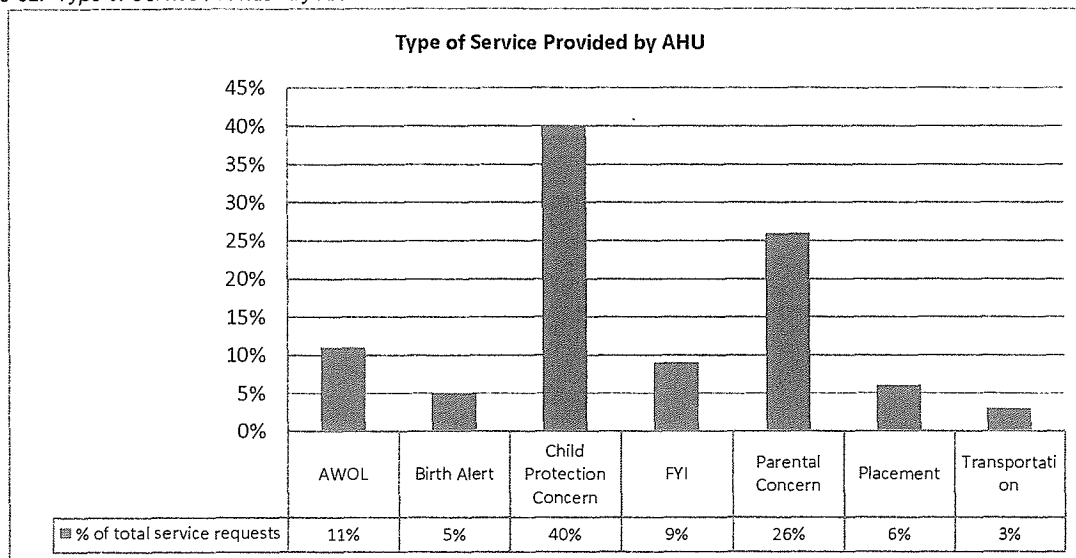
- Service type and nature of the contact
- Service request urgency
- Level of risk
- Level of AHU involvement
- Result of the service responses
- Types of Services Provided





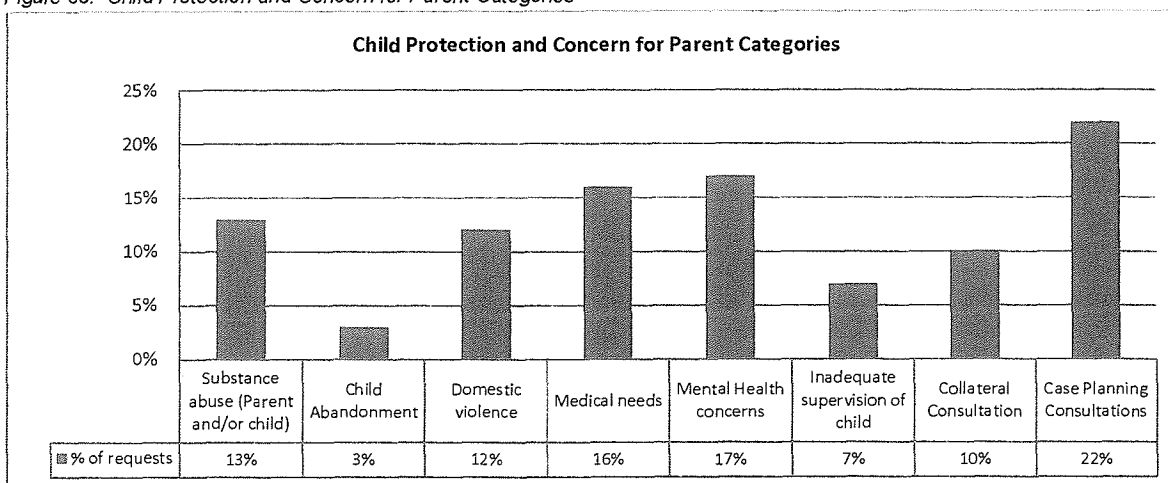
The types of service were broken down into seven categories. The following figure shows the frequency of the type of service by one of these categories.

Figure 82: Type of Service Provided by AHU



The categories 'child protection concern' and 'concern for parent' accounted for a total of 330 referrals, or 66% of the total referrals. The two categories were broken down into more specific issues. These are identified in the figure below:

Figure 83: Child Protection and Concern for Parent Categories





## Level of Urgency and Response

Urgency is discussed in *The CFS Standards Manual* in terms of how quickly a response is required. The level of urgency is based on the level of risk that may exist for a child. The CFS Standards outline response times as follows:

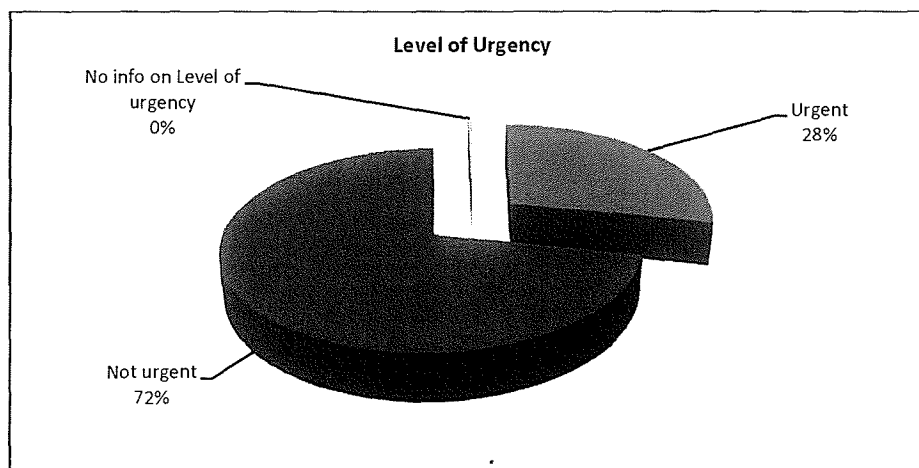
- Immediately and within 24 hours when a child may be at high risk of being in need of protection.
- Within 48 hours when a child may be at medium risk of being in need of protection or a notice of maternity is received.
- Within five working days when a child appears to be at low risk of being in need of protection or when a child under 12 years of age is involved in criminal activity.
- Within 10 working days when there are no apparent child protection concerns, but services are needed to strengthen and support a family, or when services under *The Adoption Act* are requested.

These procedures are outlined in the IM. Response times must be selected whenever a child protection concern has been identified.

Response times were identified in IM reports attached to the manual copies of the service responses provided to other CFS agency workers. This criterion was applied to determine the levels of urgency given to the sample of service responses. It was assumed that an immediate response was an indication that the matter was urgent.

Some situations that required an immediate response were dealt with by the Winnipeg Police Service (WPS) and information supplied to the AHU. From the 500 service responses in the sample, 28% were considered urgent and 72% were not urgent. Two requests did not contain any information on the level of urgency.

Figure 84: Level of Service Requests Received by AHU





### ***Services Requiring a Field Visit***

Several variables appeared to influence when and if a field visit was made. Determining the need for a field visit was often dependant on the number of service requests coming in, the level of information provided to the AHU, and the indication on the IM on the level of risk to a child.

A field visit was the result in 18% of the service requests. No field visit was made in 81% of the service responses and no information was available on three service requests.

### ***Police Involvement***

The service responses were reviewed for the number of times that the AHU worker requested police involvement during a field visit. Requesting police involvement suggests that a level of danger existed at the time of the field visit. Police involvement was requested in 31% of the service requests that required a field visit. Of these, the worker was accompanied by the police in 61% of the field visits. In 39%, the field visit was attended to solely by the police.

### ***Service Outcomes***

The primary service response was the documentation of information on open, ongoing cases. The source of this information may have been the result of telephone contacts, personal meetings, or information received from other sources. Of the total service responses (500), this category accounted for 61% (301) of the responses. Most of the service needs included processing information on children in care who were AWOL from their placements and documenting information received on active CFS cases.

AHU workers provided tangible services in 116 service responses, or 23% of the total service responses. Tangible services included such tasks as arranging for taxi services (25%); providing transportation for child placements (34%); completing purchase orders (13%); arranging for support workers (13%); delivering food, formula, medications (6%); and authorizing medical treatment (11%).

Collateral services, such as the Winnipeg Police Service (WPS), the Mobile Crisis Team, and an array of foster parents assisted and supported the AHU in the provision of tasks and services to children and families.

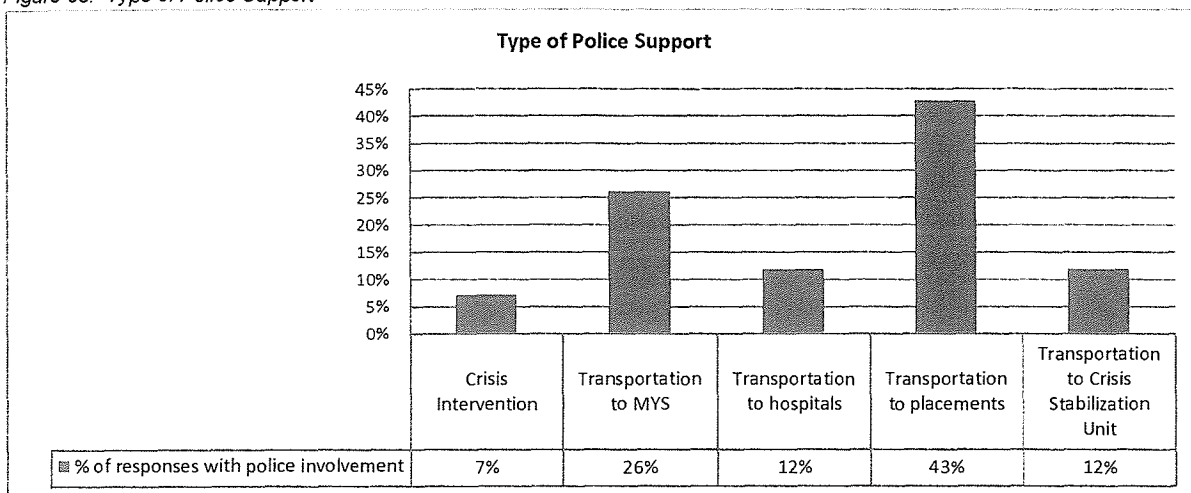
WPS provided support services on 42 service requests, or 8% of the service requests reviewed.

The type and level of police support is shown in the following figure:





Figure 85: Type of Police Support

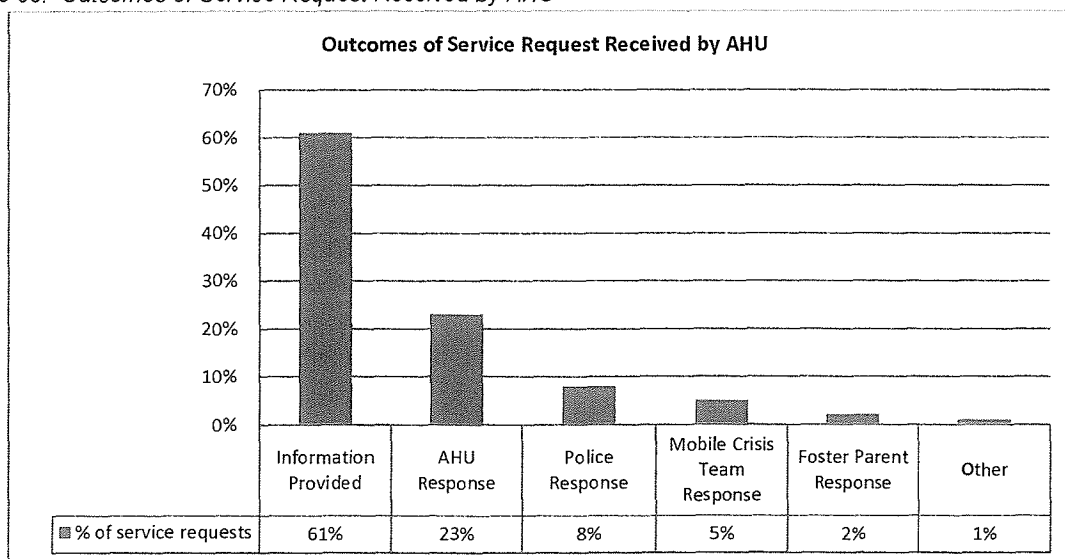


In 5% of the service requests, the Mobile Crisis Team (MCT) assisted in crisis situations involving families receiving services from CFS. Provision of transportation was a key activity.

Foster families, Emergency Placement Resource (EPR) shelter staff, and families assisted with transportation requests. Foster families provided transportation of children to Youth Addictions Stabilization Unit (YASU), Hospitals, or Adolescent Psychiatric Services (PY1) in 2% of the service requests.

84% of the service requests were addressed directly by the AHU. The following figure illustrates the outcomes of service requests:

Figure 86: Outcomes of Service Request Received by AHU





## ***Absence of Information on the CFSIS Database***

A review of service response information to CFS caseworkers showed references to the lack of information available on the CFSIS database. Such information would assist the AHU workers to determine an appropriate plan of action for a child or family. It was noted that some AHU workers reported that a lack of information would lead to a decision not to go on a field visit, while other workers stated that a lack of information would prompt them to go on a field visit.

Conflicts between work practices of some CFS agencies and the AHU were noted. Different work policies and styles have the potential to create conflict. One example of this was a case where a foster parent called the AHU to have a child removed from the home. The CFS agency involved did not feel this was a true emergency and refused to respond to the family. This left the AHU worker with a level of confusion and frustration trying to deal with the foster home.

## **Child Apprehensions**

In the period from January/2009 to April/2009, the AHU conducted 151 child apprehensions. Some days in the month of April did not have the apprehensions recorded on file. A review of the information indicates that an average of 38 apprehensions occurred monthly by AHU staff. The number of apprehensions may be higher than recorded in this review due to the missing data.

## **Interviews**

### ***Interviews with AHU Staff and Managers***

In addition to the review team members attending an AHU team meeting, individual meetings were held with the following AHU employees:

- The CRU/AHU Program Manager
- Two AHU Supervisors
- Nine AHU Employees – 4 full time; 3 part time, and 2 casual
- The AHU Administrative Assistant

The Program Manager assumed the position in March/2009 and was still in the process of getting familiar with the programs. Previous knowledge and experience, together with a warm style of interaction generated respect in the AHU. This was seen as a welcome addition to ANCR.

Interviews were held with full-time, part-time, and casual ANCR employees, and with seconded and directly hired staff. Staff who was interviewed had from one to 27 years of CFS experience.

Staff in the AHU work outside of regular daytime hours and have monthly team meetings on Sundays. There are few opportunities for AHU staff to interact personally with other ANCR employees outside of



occasional case-related discussions. Due to the hours of work, the AHU is rather isolated from other CFS systems including other program areas at ANCR.

Observations of the AHU showed a positive, self-reliant workforce composed of a group of tightly-knit individuals who work well in the challenging, fast-paced environment that characterizes the afterhours services. Staff admits to a sense of camaraderie between team members who share a common interest in working in a demanding and fast paced work environment. The staff interviewed reported a high level of job satisfaction, good working relationships, supportive supervisors and a sense of belonging to a team. Several staff cited the close working relationships with their peers and the teamwork in the AHU as the primary reasons for their job satisfaction. Staff reported adequate training opportunities and good supervision available as needed. Scheduled supervision is infrequent, according to some staff. Casual staff do not get regular supervision but access to a supervisor for consultations is always available.

Staff and managers were asked to share their views on the current AHU program model. Several issues were identified:

- No regulations regarding incoming telephone coverage.
- The ineffectiveness of the current telephone system as an emergency response system.
- Lack of regulating and monitoring of incoming telephone calls.
- Inconsistent 'logging in' to the telephone system by workers, resulting in calls going to the answering services.
- Too much discretion left with staff whether to log into the telephone system or not.
- Lack of regulating and monitoring of "smoke breaks".
- Concern about the use of the answering service, with clients reporting confidential information to telephone operators only to be told that calls will be transferred.
- Service requests from other CFS agencies or ANCR program areas lacked critical information such as an accurate description of the service need, basic updated family information, and descriptive data.
- The increase in CFS agencies and new workers in the system without an awareness of the role of the AHU has resulted in more service requests coming in that are lacking critical information, inappropriate, or unrealistic.
- Lack of updated information available to the AHU through CFSIS can result in a child being left in a risky situation and has workers spending additional time searching for information.
- The AHU began a process to update the Service Request form with more information categories to address some of these concerns.
- AHU workers are concerned that some CFS workers view their role as an extension of the case management function. Requests come in at 4:00 asking AHU to check on a family because a report just came in about a safety concern. Workers question why the CFS worker could not have completed that function.
- Additional concerns were reported about the follow-up responsibilities of other CFS workers following AHU involvement. Recommendations made by the AHU are not being followed up and the



same requests keep coming back to the AHU. Supervisors screen all service requests and attempt to clarify information prior to assigning the request to the AHU.

- The AHU is dependent on the information available in CFSIS and the IM when they receive a referral on an open child or family case. When there is no information, their ability to respond appropriately to the situation is compromised.
- AHU workers report that CFSIS information on children and families is not being updated. Examples were provided where there was no information showing that a child was in care, no accurate child placement updates and no medical number for a child in care. When such things as address changes and additions to families are not updated, AHU workers have to spend extra time searching for information before they can respond to the situation.
- Maintaining updated child and family information on the CFSIS database is critical when a call comes in after hours or on weekends and AHU workers have to determine a course of action. Attempts are being made to bring attention to files where the CFSIS information is not available and alert the appropriate CFS Agency to this concern.
- Placement resources and in-home support services are difficult to access after regular work hours. Often the only child placement resources available to the AHU are the emergency shelters or foster homes managed by the emergency placement resource program at ANCR. Getting a child into other facilities is difficult. There are rigid admission criteria requiring information about the child that AHU workers may not have a chance to collect in the short-time that they are involved. The workload on weekend shifts is the highest and locating placements during the weekend is especially difficult.
- It is equally difficult to obtain family support workers after regular working hours to care for children in their own home. The only option is to use a private organization that provides individuals for respite to the CFS system through a contractual arrangement. Numerous concerns were raised regarding the ability of contracted support staff to address the multiple issues of some children and youth. Access to this service is not available during the night shift. AHU workers indicate that they need access to dependable placement and family support resources when these are needed.
- AHU workers are increasingly concerned about safety risks as violence in the City of Winnipeg continues to escalate. Only two staff work the night shift. This is a source of concern for AHU workers who already take safety precautions by going out only in pairs and utilizing the Winnipeg Police Services (WPS) when needed.
- The night shift staff reported that the WPS often drop youth off at the ANCR office during the night. When this occurs a worker has to remain in the office. This leaves one worker to deal with any emergencies that may occur during the remainder of the night shift. Furthermore, some of the youth that are dropped off appear to be high on drugs and have had weapons confiscated by the police. Night shift staff is concerned about their own safety in the presence of some of the youth. The night shift staff would like to see a case aide assigned to the shift so that a third person is available when two workers are out of the office.
- AHU workers perform ancillary tasks such as caring for children waiting in the office for placements, supervising children in hospital emergency rooms while they are waiting for treatment, transporting



children to and from visits and placement resources, and delivering food hampers. These functions can be assigned to paraprofessional staff such as a case aide.

- Several staff reported that they required supplies such as flashlights to locate house numbers in the dark, cell phones, rubber gloves and a supply of blankets that could be kept in the vans. Currently AHU workers sign out cell phones when they leave the office. There are three or four cell phones in the office available to them. It is unclear why there are no flashlights, rubber gloves or blankets available to the workers.
- The majority of the AHU workers reported that their workload was manageable; however, scheduling could be more diligent to ensure that more staff are available during predictably busy times.
- Most AHU workers reported that there was no consistency to their workload. Each shift was different and varied from a quiet evening of answering telephone calls to several field visits in an evening. Weekends were predictably busier than week days and certain times of the month, when income assisted families received cheques, were always busy.
- Casual employees wanted to be included in team meetings and have an opportunity to participate in staff development events.
- Supervision in the AHU is incident-based and available as needed. While this is critical in an emergency response program, workers have limited opportunities for individual staff supervision where performance issues, training needs and staff development is addressed. Some AHU staff reported having supervision approximately twice in a year. Supervisors are cognizant of the limited opportunities for formal supervision in the program. Both supervisors indicated that they are currently attempting to complete staff performance appraisals.

### ***Interviews with Staff from other Child and Family Service Agencies***

As part of this review, a number of staff and managers from other CFS agencies in the province were interviewed regarding their experience with the AHU. Respondents were asked ten questions that focused on their experience working with the AHU.

Forty-four (44) staff and managers from several CFS agencies participated in the interviews. The respondents had experience ranging from one and a half to 30 years in CFS in Manitoba.

### **Understanding Roles and Functions**

The AHU was seen as the unit that provides crisis and emergency response to any child protection matter after 4:30 and on holidays. Respondents stated that the AHU monitors or manages high risk cases after hours and on weekends. Others provided examples where the AHU would be involved such as a child being released from the Manitoba Youth Center after 4:30 p.m. and checking for offenders in a home on an active file. Respondents acknowledged the factor of "time permits" in these activities. Some described the AHU as an emergency-only service while others spoke of performing duties not completed by day service.





### Circumstances Under Which a Referral or Service Request Would Be Made

The AHU was reported as a key resource for CFS workers. Some examples provided by CFS workers of situations when they would request services by the AHU included:

- Follow up/monitoring of high risk cases
- Repatriations
- Release of offenders
- Agency unable to contact during day time hours
- Unannounced evening visits to families
- Placement required after hours

Others reported that they would request the AHU to provide services in emergency situations, or when a family is in crisis and a check on the children is needed after regular work hours, or to follow-up on a birth alert.

### Referral Process

The referral process was described as filling out the After Hours Service Request Form; these are reviewed and/or signed by a supervisor and faxed to the AHU. Some workers indicated that if the situation was complex or high risk, they would call to provide more details. Others stated that they may follow up the faxed request with a telephone call to ensure that it was received. As some northern sub-offices do not have access to fax machines or the IM, request forms are completed on their behalf by staff from Winnipeg sub-offices.

### Strengths of Services Provided

Respondents viewed the fact that the AHU exists as a strength. The response time and next day reporting was seen as invaluable. The respondents indicated that there were some very seasoned workers at the AHU and had praise for their expertise and dedication. They were seen as skilled in the quality of their interventions especially surrounding de-escalations and assessments. AHU feedback was seen as quick, efficient and complete.

The fact that ANCR was providing this service was viewed very positively. Respondents reported favorable reactions from clients about AHU involvement. Some respondents noted improved working relationships between AHU and CFS agency staff. Respondents noted that from time to time, AHU has contacted them for information after hours. They cited that such requests have been appropriate and reasonable.

### Difficulties with Services at AHU

There were comments about some of the workers being inexperienced with this manifesting itself in the poor quality of the reports or interventions. Most cited difficulty in the volume of work that can



determine the kind and speed of responses. The response at times is just the "bare bones" when more time could offset a future crisis.

There are some unique circumstances for some agencies. The concern was voiced that ANCR is not always aware of these. This can impact on the interaction between the agency and ANCR, and on the service response provided by ANCR.

#### Working Relationship and Communication

Most of the respondents were positive about their relationships with staff in the AHU. Several other respondents indicated that their relationship with the AHU is solely through faxed communication.

#### Overall Satisfaction

Fourteen staff responded to this question. 10 of these were very or mostly satisfied, and 4 were somewhat unsatisfied.

Relationships and quality of communication were cited as a source of satisfaction. A need for more cultural awareness and respect for diversity was identified by the respondents.

#### Suggestions for Changing or Improving Services at AHU

More face-to-face exchanges between workers were viewed as important. Several respondents stated that communication should be improved. Training for new AHU workers was seen as very important. Suggestions provided were pairing with seasoned workers, shadowing workers and risk and assessment workshops with emphasis on safety planning. Cultural awareness sessions and overviews of agencies and their communities were seen as important. It was suggested that a plan for ongoing communication and get-togethers with ANCR and all agencies would be helpful.

The Steering Committee was seen as a valuable mechanism but respondents stated that there was a need to transform the committee back to the original intent, which is a two-way communication on front-line work. The Steering Committee was seen as valuable in identifying the "go-to" people in each agency to make contact easier.

One agency - Jewish Child and Family Services - cited the need for better identification of Jewish families at the front-end and a better way to let these families know about the services that Jewish Child and Family Services can provide.

The majority of respondents saw the role of the AHU positively and appreciated the fact that the After Hours program is available to them and to the community. While many respondents had praise for the skill and experience of many AHU workers, several stated that better training was needed for new AHU workers.



Respondents had several recommendations to change or improve the AHU, including improving communication by increasing opportunities for face-to-face exchanges, increasing training for new AHU workers, and organizing cultural and agency awareness sessions so the AHU would be more aware of specific issues such as impacting CFS agencies. It was suggested that the Steering Committee could have a role in fostering better communication and working relationships between ANCR and other CFS agencies.

### **Report from the AHU Planning Workshop - January/2008**

The AHU participated in a planning meeting on January 11/2008 where staff identified what was working well and what was not working well in the program. In notes from the meeting, staff reported that positive changes included regular program meetings and increased supervision. On the less positive side, they reported the following:

- New workers and supervisors from collateral agencies are inexperienced and often afraid.
- Increased negative perception of CFS, including from clients.
- Challenges for other CFS agencies as they adjust to providing services in an urban environment.
- Varying compliance with standards and varying service practice.
- Varying skills and experience in risk assessment.
- Increased number of service requests.
- After hours viewed as unit to which to divert work.
- Increased amount of case work.
- Lack of appropriate training for AHU staff.
- Influx of new staff (decrease from 8 vacancies to 1.6).
- Less use of skilled and experienced casual staff.
- Mandatory police domestic violence reporting protocol.
- Work is more dangerous, weapons more available.
- Lack of information on service requests.

The AHU identified several priorities for the program. The first priority was to improve the level of information that is reported on service requests. This included ensuring the all relevant information was presented and that the service requests were appropriate. Prior to the meeting, some work had begun to revise the Service Request Form to include more categories and some guidelines for required information. When the revised Service Request was completed, the AHU planned to hold meetings with other CFS agencies to review the new form.

The second priority was to improve communication and working relationships with other CFS agencies. The plan was to complete the *After Hours Program Manual* and arrange meetings with other CFS agencies where information about the role of the AHU could be presented and regular updates of information on CFSIS could be discussed. This would also provide an opportunity to obtain phone



numbers of on-call Agency staff to update the AHU roster. In addition, the AHU suggested that a protocol be established where workers from other CFS agencies can shadow the AHU workers to gain a better understanding of their role.

The third priority was to ensure that all AHU staff are able to participate in regular training events. Process steps were identified including developing a needs assessment for specific AHU training, developing a realistic training plan including onsite training, flexible scheduling to allow AHU workers to participate in training events, scheduling Team Days where the focus will be on specific training and identifying flexible training options such as an on-site mentor for new AHU workers.

Several other suggestions noted on the priority list but without an implementation plan included improving efficiency and technology within the unit, updating birth alerts, having better access to emergency placement resources, improving staff safety and developing specific resources to address specific issues such as dealing with violent youth with mental health issues.

At the time of this review, a revised Service Request was completed but not implemented. Without an opportunity to meet with other CFS agencies, there has been little progress on the second priority. AHU staff continues to be concerned about the lack of information on service requests and the often unrealistic requests of the AHU. They report not having an updated staff list with on-call emergency numbers for caseworkers from other CFS agencies.

AHU staff participated in several training events this past year including Tactical Training, ASSIST Training, Non-Violent Crisis Intervention, CFSIS/IM Training and Competency-Based Training. According to the supervisors, an orientation and training package is in the process of being developed. New staff is trained primarily by shadowing more experienced AHU workers.

## **Summary of Findings**

1. Approximately 14% of the AHU workload consists of interventions and service actions in response to Service Requests from other CFS Agencies.
2. The AHU has been consistently operating out of the same Portage Avenue location since the 1990's without much change to its hours of operation, work schedules and program model over the years.
3. The AHU is staffed by a combination of full and part time staff. Casual staff are used on an as needed basis, mainly due to vacancies or medical or vacation leave of other employees. In June/2009, the AHU had a roster of 16 casual staff who collectively worked an average of 268.5 hours each pay period during the six month review period from Jan 3 – June 19, 2009. Considering a full time position is based on 72.5 hours of work bi-weekly, this is equivalent to an additional 3.7 full-time staff positions each pay period.



4. In February/2010, 12 staff in the AHU were direct hires and 15 were permanent or temporary secondments. AHU employees primarily work 10 hour shifts. Most of the part-time AHU employees have additional jobs either in the CFS system or with other organizations.
5. A large number of AHU employees have guaranteed employment hours of less than 1 full time equivalency. Guaranteed hours of employment range from .75 EFT to 14 EFT. This is a system that was brought over from WCFS. As part-time positions are vacated, they continue to be filled in their partial capacity.
6. Four part-time AHU employees with guaranteed hours of employment ranging from .23 to .5 EFT also have full time positions in other CFS agencies. A review of payroll schedules for the 12 pay periods between Jan 3 – June 19/2009 indicated that each worked more hours than the guaranteed hours of work. As all AHU evening shifts are from 4:00 p.m. to 2:00 a.m. on weekdays, although occasionally an evening shift will end at 12:00 a.m., this requires arrangements with their other places of employment to ensure that they are able to begin their AHU shift at 4:00 p.m. Part-time employees reported being successful in making arrangements to leave their other employer earlier by using accumulated compensating time off. Being able to successfully manage both jobs was not reported as a concern by any of the front-line or management employees.
7. The AHU workforce is highly qualified.
8. Night shifts are difficult to fill. The newest and least experienced staff are usually the ones working the night shifts.
9. AHU teams work on a rotational “4 days on - 4 days off” schedule with the end of the day shift on Sunday being the cross over point. A rotation occurs every two months. Every time there is a crossover the team working the Sunday to Wednesday schedule would work an additional shift to balance the overall number of shifts worked.
10. Supervisor shifts are from 3:00 p.m. to 1:00 a.m. on site and then on stand-by from 1:00 a.m. to 8:30 a.m. for a total of 17.5 hours where they have to be awake and available for consultation if required.
11. AHU shifts overlap between 10:00 p.m. and 2:00 a.m. Evening shifts end at 12:00 a.m. or, most commonly at 2:00 a.m., while the night shift begins at 10:00pm. Both AHU staff and managers report that this overlap is required to complete “wrap up” work on the workload generated during the earlier part of the evening shift. Information from the Intake Module (IM) database indicates that 13% of Intake referrals occur between 10:00 p.m. and 2:00 a.m. during week nights and 9% of all field visits are made during this time frame. This compares to 38% of referrals between 4:30 and 10:00 p.m. on weekday evenings with 44% of these referrals



requiring a field visit. Based on this information and the fact that telephone activity is quite high during this time, the addition of two staff at 10:00 p.m. enables workers to complete activities and documentation from the busy earlier part of their shift.

12. The types of services that the AHU responds to can be categorized as follows:

- 40% of service responses involved concerns about a child or children.
- 26% of service responses involved concerns about a parent's ability to care for children.
- 11% of service responses involved children in care who were AWOL.
- 9% of service responses provided information on a child or family to the assigned caseworker.
- 6% of service responses involved child placements.
- 5% of service responses involved birth alerts.
- 3% of service responses involved transportation of children.

13. Approximately 28% of the service responses involved a sense of urgency due to a high risk of a child, and police involvement was required in 31% of these cases.

14. Approximately 28 children are apprehended by the AHU each month.

15. The primary service response was the documentation of information on open, ongoing cases. This may have been the result of telephone contacts, personal meetings or information received from other sources. This category accounted for responses to 61% of the total service requests in this review period. In addition, the following services were provided:

- Arranged for taxi services in 26 service requests.
- Provided transportation to placements in 40 service requests.
- Completed purchase orders (for hotels, food, other transportation) in 15 service requests.
- Arranged for Support workers (for visits, to stay in hospitals, respite etc) in 15 service requests.
- Delivered food, formula, medications in 7 service requests.
- Authorized medical treatment in 13 service requests.

16. According to the data available from the Intake Module, the AHU responds to approximately 127 referrals each week or approximately 506 a month. Slightly more referrals were received during the spring/summer months, with 56% of all referrals received during spring/summer months (April, May, June, July, August, Sept), compared to 44% of referrals received during fall/winter months (Oct, Nov, Dec, Jan, Feb, Mar). Of the sample of referrals to the AHU during the review period, 38% occurred between 4:30 p.m. and 10:00 p.m. on week days, 13% occurred on week nights between 10:00 p.m. and 2:00 a.m., 8% occurred on week nights between 2:00



and 8:30 a.m., 17% occurred on Saturdays and 16% occurred on Sundays. Another 8% of referrals occurred between 4:00 and 4:30 p.m. on week days.

17. Self-referrals and referrals by family members made up 20% of all referrals to the AHU. Of this number, 54% were self-referrals while the remaining 46% were referrals made by a family member.
18. Referrals from community members and organizations accounted for 46% of the total number of referrals to the AHU. Most community referrals (36%) came from the Winnipeg Police Service. This was followed by medical professionals and hospitals (23%). Members of the community, not associated with a community organization, made up 16% of the community sources of referral to the AHU. The majority of referrals between the time categories from 10:00 p.m. and 2:00 a.m. and between 2:00 a.m. and 8:30 a.m. were from the police.
19. Placement resources for children in care, such as foster homes, emergency shelters and residential care facilities accounted for 12% of all referrals to the AHU. Of these referrals, 46% came from foster homes and 48% were from shelters for children in care. These sources of referral would have involved children and youth already in the care of the CFS system. Less than 1% of referrals to Intake during day time hours come from placement resources.
20. Other CFS Agencies in Manitoba accounted for 18% of all referrals to the AHU. Most of these referrals were by way of Service Requests and involved services to children and families already open to the CFS system. Only 7% of referrals to Intake during the day time hours come from other CFS Agencies.
21. AHU staff indicated concerns about the quantity and quality of the service requests that they have been receiving from other CFS agencies. Staff provided numerous examples of inadequate, inaccurate and missing information on the request forms, questionable requests, limited contextual information and unrealistic expectations of the services that the AHU can provide. The AHU drafted a more specific Service Request form that would ensure more detailed information is provided. At the time of this review the new form has not been implemented.
22. Only 3% of all referrals to the AHU come from anonymous sources.
23. The majority of referrals to the AHU (82%) occur by telephone. While referrals by facsimile make up 14% of the total referrals, they are generally confined to the time period between 4:30 and 10:00 p.m. with the exception of those that arrive for the AHU prior to 4:30 p.m. Only 3% of referrals involve walk-in clients and another 1% is received in writing by mail or email. A walk-in referral is most likely to occur on a Saturday.



24. A considerable amount of work by the AHU involves the delivery of services to clients open to another CFS agency in response to service requests. Of the total number of referrals to the AHU during the time period reviewed, 24% were new referrals. 62% of the referrals involved an incident on another CFS agency's ongoing case and 14% involved an incident on an open ANCR case. During day time hours, 92% of Intake referrals involve new cases while 8% of the referrals require services on already opened cases.
25. The quality and quantity of the information in the service requests was often lacking which left AHU workers unclear about the situation they were being asked to address. Also concerning was the frequency that the "potential for danger" category was not included in the report.
26. Service requests were divided into seven categories:
- 19% required transportation of children.
  - 7% identified a child at risk.
  - 1% requested an apprehension of a child.
  - 9% reported the AWOL of a child.
  - 6% provided information that would assist the AHU if/when they had to provide services.
  - 58% involved some form of contact with a family after regular hours, such as "spot checks" on families or searches for offenders.
  - Less than 1% were rejected because of insufficient information.
27. From the information on the nature of service requests, it was not possible to determine which requests constituted an emergency and which did not. Service requests identifying a child at risk and requesting an apprehension of a child can be determined to involve a level of high risk to a child, therefore, these referrals may fit into the range of an emergency. Therefore, only 8% of the requests could be considered as emergency requests. However, it has to be noted that emergencies can occur on cases in any of the above categories. There is no system of tracking which service requests represented an emergency situation. Less than 1% of service requests were rejected.
28. Thirty-nine (39%) of all referrals to the AHU required a field visit. Field visits were more likely to occur in response to a new referral and least likely to occur on an incident involving an existing ANCR case. Field visits were required in approximately 33% of all referrals involving an incident on another agency's ongoing case, 29% of all referrals involving an incident on an existing ANCR case and in 59% of new referrals. During day time hours, 54% of all referrals to the CRU required a field visit. The AHU performed field visits in response to 75% of the service requests in this period of time.





29. A frequently represented situation was that AHU workers attended at the home of the family to find no protection concerns and further intervention was not required. This occurred in 35% of the service requests.
30. The majority of field visits by AHU workers occur between 4:30 p.m. and 10:00 p.m. 44% of all referrals during this time category required a field visit. Field visits during the night time hours from 10:00 p.m. to 2:00 a.m. or from 2:00 a.m. to 8:30a.m. were more likely to be due to a new referral. 30% of all field visits occurred during the weekend. This suggests that field visits between 4:30 and 10:00 p.m. week days and during weekend days are most likely due to follow-up services arising from service requests by other CFS workers.
31. The range of responses in the IM, to the issues most frequently reported at referral, were so broad that a percentage could not be established. Most AHU workers entered that information was gathered on behalf of assigned worker or that case assistance/follow-up was provided. These categories do not reflect the nature of the issues at referral.
32. Similar to the findings in the review of the CRU, a significant amount of data in the 'Issues Management' section of the IM was unavailable. The status of 83% of the issues identified at referral has not been entered in the IM. Only 13% of all issues identified by the AHU show that they have been completed. 3% indicate a service status of 'Ongoing' and the remainder are left blank. The intent of the IM is that data entry occurs as casework progresses. If a referral is transferred to another CFS agency or department, the sections of the IM that address service issues are meant to be completed by the assigned worker as interventions occur to address the issues. It is evident that this is not happening.
33. Safety assessments were completed in 16% of the identified issues. Almost all safety assessments occurred on new referrals.
34. An average of 167 Intakes are forwarded by the AHU to other ANCR programs each month. A review of these Intakes for the time period from January 1/2009 to April 17/2009 revealed that twenty-one percent (21%) of the intakes were closed because service was no longer required or the information was forwarded to another CFS agency. 39% of the intakes were assigned to a CRU worker for follow-up. 32% of the intakes were immediately transferred to an Intake Unit, 6% were transferred to an Abuse Unit and 1% was transferred to the Family Enhancement Program.
35. By virtue of its hours of operations, the AHU functions outside of the basic day to day operations of ANCR and is somewhat removed from the prevailing organizational culture of ANCR.



36. Observations of the AHU showed a positive, self-reliant workforce composed of a group of tightly-knit individuals who work well in the challenging, fast-paced environment that characterizes the afterhours services. Staff admits to a sense of camaraderie between team members who share a common interest in working in a demanding and often adrenaline-driven work environment. The staff interviewed reported a high level of job satisfaction, good working relationships, supportive supervisors and a sense of belonging to a team. Several staff cited the close working relationships with their peers and the teamwork in the AHU as the primary reasons for their job satisfaction.
37. There are two main concerns about the effectiveness of the telephone system at ANCR. The first issue involved the length of time a caller waits before gaining access to an AHU worker. The second issue was in reference to the lack of regulating and monitoring telephone activity. Telephones are not always covered due to workers having to provide service functions. A large number of incoming telephone calls are directed to the answering service.
38. The lack of updated information on children and families available on the CFSIS database is a high priority concern. AHU workers depend significantly on this information for child protection decisions, and it is highly concerning when information is inaccurate or missing.
39. Access to placement resources and family support services is minimal during the evening shifts and non-existent after mid-night. AHU workers report that children and youth spend hours in the office waiting for a placement in the morning. Because there are no support workers, AHU workers must remain in the office with the children. If a child welfare emergency occurs during this time, the only option is to ask the Winnipeg Police Services to respond, who are reluctant to do so because of their own workload.
40. AHU workers perform a number of ancillary tasks such as caring for children waiting in the office for placements, supervising children waiting for treatment in hospital emergency rooms, transporting children to and from visits and placement resources and delivering food hampers. These tasks could be performed by a paraprofessional staff such as case aides. Although the AHU has two case aides, they are scheduled for evening shifts and are not always available to address situations such as calls to wait with children in hospital emergency rooms. Staff indicate that access to case aides is needed for all the shifts. If not scheduled, they should be on-call.
41. Most AHU workers do not participate in formal supervision sessions. The large number of AHU employees and the emergency nature of the program limit opportunities for staff to engage in formal supervision session. For the most part, supervision occurs in the form of consultations, suggestions, directions and approvals as needed. Although this form of supervision is critical to an emergency response service, it denies workers the opportunity to obtain constructive



performance feedback necessary to acquire knowledge and develop skills, identify training needs, and receive regular performance appraisals.

42. Many AHU workers reported that their workload was manageable, however, thought that scheduling could be more diligent to ensure that additional staff was available during predictably busy times. Having more "bodies" in the AHU office during the night shift was supported by all the staff interviewed. As reported earlier, children and youth are often brought to the AHU office by the police during the night and must be supervised by the night shift workers. Some of the youth are in drug induced states and many others have gang affiliations. AHU staff reported feeling unsafe in the presence of some of the youth. Having more staff in the office would alleviate some of the safety concerns. Most staff reported that their concerns about safety are escalating as the presence of gang violence and use of weapons increases.



## ***Recommendations for Crisis Response Unit, After Hours Unit, and Tier II Intake***

### **Sec. 1:1**

It is recommended that ANCR reconfigure the service functions of the Crisis Response Unit (CRU) and the Tier II Intake Units, as well as some elements of the After Hours Unit (AHU), into a revised model that will streamline services more effectively, have a higher level of standardized practice responses, and include standardized criteria for decision making. This will include modifying the way in which the screening services, initial assessment and investigation services, brief family services, and support services are organized.

The revised model will have three units:

1. A 24 hour /7 day per week Intake Screening and Assessment Unit (replaces the CRU and some of the function of the AHU)
2. A Investigation and Stabilization Unit (replaces Tier II Intake)
3. A After Hours Unit (reconfigured)

### **Intake Screening and Assessment Unit**

#### **Sec.1:2**

It is recommended that the Intake Screening and Assessment Unit assume responsibility for the screening and assessment of all incoming child and family service reports and information. The duties and responsibilities of the Screening and Assessment Unit will include, but not be limited to, the following:

- Receive, assess, document and direct all incoming child protection reports
- Provide information/consultation to public and other professionals
- Receive, process and forward requests for other services, such as adoption or foster care applicants, and general inquiries
- Receive calls regarding children in care and forward for investigation, if abuse or neglect, or for follow-up to the child's worker
- Process and forward all out-of-jurisdiction requests for support or service
- Receive and document all calls regarding cases currently receiving service and forward documentation to the appropriate workers.
- Make the decision re. the service path (Protection / Family Enhancement) under a Differential Response Service Delivery Model



### **Sec.1:3**

It is recommended that the Screening and Assessment Unit be fully operational 24 hours a day, 7 days a week with a reduced "skeleton" overnight service as determined by an analysis of actual service volume.

*Although an answering service should be maintained as back up, the goal should be to significantly reduce the number of incoming telephone calls routed to the answering service.*

*Currently, employees in the AHU provide both intake screening/assessment AND service delivery functions. As they respond to incoming telephone calls in rotation, service actions from these calls become their responsibility necessitating that they log out of the telephone system to provide the required services. As a result, there is no assurance that an AHU worker will be available to answer incoming calls at any given time. This, combined with field work on service requests from other CFS agencies, results in 30% of all telephone calls to the AHU routed directly to the answering services. Concerns about losing Intake calls because some callers are anxious about leaving messages with an answering service or abandoning calls when the wait time is too long, is too high a risk when the issue may involve a child in need of protection.*

### **Sec.1:4**

It is recommended that the Screening and Assessment Unit be comprised of the most highly qualified and experienced child and family service employees. The minimum qualification standards should require at least five years of child welfare experience.

### **Sec.1:5**

It is recommended that MGEU and ANCR explore the feasibility of reclassifying these staff accordingly, to reflect the higher level of skill and expertise that is required.

### **Sec.1:6**

It is recommended that detailed criteria for service eligibility be developed such as decision-making trees that guide Intake screeners through the decision-making process with respect to which cases require Intake or abuse investigations vs. those that do not meet the standard threshold for intervention.

### **Sec. 1:7**

It is recommended that minimum training requirements be established for all employees in the Screening and Assessment Unit, including training in using clinical assessment and decision-making tools.



## **Investigation and Stabilization Unit**

### **Sec.1:8**

It is recommended that the Investigation and Stabilization Unit have comprehensive responsibility for:

- Investigations and assessments, including High Risk (within 24 hour) investigations, Medium Risk (within 48 hour) investigations, and Low Risk crisis stabilization services
- Family/Child Assessments
- Case monitoring
- Supervision services
- Brief family services
- Home Assessments
- Food delivery
- Repatriation services
- Completion of ADP

### **Sec.1:9**

It is recommended that services provided by the Investigation and Stabilization Unit be limited to thirty (30) days for an investigation and assessment, with the case either closed or transferred for ongoing services following this time period, and a maximum of ninety (90) days if crisis stabilization services are provided, with the case either closed or transferred for on-going services following this time period.

### **Sec.1:10**

It is recommended that all investigations include the completion of a risk assessment and all decisions to close or transfer the case be made in accordance with a specific criteria established to guide decision-making in this area.

### **Sec.1:11**

It is recommended that a protocol and procedures be established for the transfer of cases to another ANCR program or for ongoing services, and that these procedures are consistently applied.

### **Sec.1:12**

It is recommended that transfers occur within the standardized time frame to ensure that children and families do not experience a gap or break in service during the case transfer process.

### **Sec.1:13**

It is recommended that ANCR establish a committee to review service volume and develop practice standards, service guidelines, criteria for decision-making and workload management standards to ensure service time frames are met, and gaps or breaks in service do not occur because of workload issues.



## **After Hours Unit**

### **Sec.1:14**

It is recommended that the AHU be dedicated to service delivery functions required after hours, including investigations, assessments, and crisis stabilization.

*The 24/7 Screening and Assessment team will be responsible for all incoming calls and intakes. This team will be dedicated to the screening / assessment functions; any field visits and services past screening will be done by the AHU. The AHU will work closely with the Investigation and Stabilization Unit, and will hand off all cases to the ISU immediately after their shift.*

### **Sec.1.15**

It is recommended that a working committee be developed to address the human resource issues in the AHU, including the part-time staff equivalency and reliance on casual staff and move toward the goal of promoting and sustaining full-time employees in all shifts. It is recommended that this committee review the issue of possible conflict of interest for AHU staff who are also employed with other CFS agencies or the Child Protection Branch.

*The staffing configuration in the AHU includes full time employees, part time employees with guaranteed hours ranging from .14 to .75 and a roster of casual employees made up primarily of workers employed by other ANCR programs and CFS Agencies. There is a significant reliance on existing staff within other parts of the CFS system to fill after hours shifts as casual employees. A review of payroll records for a six-month time period from Jan to June 2009, found that casual staff collectively worked an average of 268.5 hours each pay period or an equivalent to 3.7 full time positions. More stability can be achieved through consistent, designated, full time staff to ensure high quality services are available at night as they are during the day.*

### **Sec.1:16**

It is recommended that a stronger criteria and framework be developed for the Service Request Forms. These forms should include, but not be limited to the following information:

- Information on the case plan for the child or family
- Date of last contact and face-to-face meeting
- Risk assessment
- Clear and accurate up to date information on the services requested

Once the criteria for Service Requests are completed, a plan for training all CFS workers in the criteria should follow.



#### **Sec.1:17**

It is recommended that the role of the AHU be re-evaluated and a decision made whether providing case management services after hours to cases open to other CFS Agencies should continue and whether ANCR is adequately resourced to provide this service.

*Approximately 18% of the work of the AHU is following up on service requests from other CFS Agencies on already open cases. Reports from AHU workers and an examination of service requests shows considerable inconsistencies in the types of services being requested of the AHU, the amount of information provided on the Service Request form, the accuracy in completing the forms, etc. In addition to this, interviews with staff from other CFS Agencies raised concerns about the expectations that other CFS workers had of the AHU. This issue has been a source of concern in the AHU and a revised Service Request Form has been drafted, but not yet circulated.*

*It is evident that the AHU does a considerable amount of work on existing cases of other CFS Agencies. It may be time to re-evaluate whether ANCR is resourced to manage this function in addition to emergency crisis situations as the designated Intake agency for Winnipeg and surrounding areas. If this model is supported, the criteria need to be redefined and the AHU needs to be resourced accordingly. The question remains whether CFS Agencies should consider their own case management functions after hours leaving ANCR to deal with emergencies and crisis only situations.*

#### **Sec.1:18**

It is recommended that a communication strategy for the effective communication and sharing of information between program areas at ANCR and other child and family service agencies be developed. The strategy should include an information package on the AHU along with referral criteria and program guidelines.

#### **Sec.1:19**

It is recommended that case aides be contracted for all AHU shifts including the night shift.

*There are any number of ancillary services required after hours: caring for children waiting in the office for a placement; supervising children waiting for treatment in hospital emergency rooms; transporting children to placements, hospitals; delivery emergency food and supplies. These tasks can be performed by case aides.*





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**Sec.1:20**

It is recommended that a working committee with ANCR staff and representatives from other CFS Agencies be established to develop guidelines for effective communication, shared information, and access to specific information and case plans after regular work hours.

**Sec.1:21**

It is recommended that the AHU shift scheduling system be modernized using available software.



## Section II: The Abuse Investigation Unit (AIU)

### *Abuse Investigation Unit (AIU) Overview*

The Abuse Investigations Unit (AIU) at the All Nations Coordinated Response (ANCR) Network in Winnipeg assesses and evaluates all requests for abuse investigation services in accordance with the following provisions of *The Child and Family Services Act*:

Section 18.4 (1) of *the Act* states that:

*"Where an agency receives information that causes the agency to suspect that a child is in need of protection, the agency shall immediately investigate the matter and where, upon investigation, the agency concludes that the child is in need of protection, the agency shall take such further steps as are required by this Act or are prescribed by regulation or as the agency considers necessary for protection of the child."*

Section 17 (2) (c) states that:

*"...a child is in need of protection where the child is abused or is in danger of being abused..."*

There is reason to believe that the investigation of alleged child abuse is one of the most challenging tasks in the field of child welfare as the outcomes of abuse can result in serious implications for a child. As a result, an investigation of alleged abuse must not be compromised by the investigator having any other responsibility to provide service to a family in which the alleged abuse has occurred. For those reasons, a separate unit has been created in ANCR, and its sole function is to investigate whether a child has been subjected to abuse.

According to the *Abuse Investigation Services Program Manual*, January/2007, the Abuse Investigation Unit (AIU) investigates and assesses allegations of child abuse within the jurisdictional responsibility of ANCR. The role includes abuse investigations involving interfamilial, third party, position of trust (including day care and school division settings) and foster home allegations. The AIU does not investigate allegations against CFS agency staff or allegations against residential child care facility staff. These investigations are done by provincial investigators located at the Child Protection Branch.

The AIU is responsible for the coordination of four Child Abuse Committees (CACs) that represent the four CFS Authorities. In addition, the AIU acts as a resource to agencies by providing specialized services in the area of abuse investigation. It is the role of the abuse investigators to establish joint working relationships with the case manager while the allegation is under investigation. They are not expected to carry out regular case management activities, with the exception of the immediate removal of a child when necessary to ensure the safety of the child.



In accordance with the *Joint Intake and Emergency Services by Designated Agencies Regulation, 186/2003*, Section 8(b), the AIU investigates and assesses all allegations of child abuse on behalf of all CFS agencies within the city of Winnipeg.

If there is an incident of alleged abuse that occurred outside of ANCR's jurisdiction, but one of the involved parties resides in Winnipeg, the AIU can be approached to provide courtesy service to the investigating agency such as conducting interviews of those parties, arranging for medical exams and/or arranging for police interviews. ANCR will also assess the involved parties' need for on-going services.

This portion of the review focused on the role of the AIU in accordance with the following terms of reference:

- Overview and analysis of service volume at the AIU.
- Overview and analysis of current staff resources.
- Overview of the AIU Model including workload and service responsibilities.

Several sources of data were collected and analyzed in the process of conducting the review of the AIU including:

- A review of data collected from the IM for the six month period from September/2008-March/2009 on closed files. Of 833 cases, 83 were sampled for review. Reviewers examined files for evidence of a coordinated investigation as well as for timeliness in conducting the investigations. Information sought from these files was:
  - Response times and compliance with response times.
  - Victim interview times.
  - Medical intervention required.
  - Police intervention required.
  - Time for an abuse investigation report to be generated.
  - File closing dates.
- Data related to the time elapsed between the initial referral of a case to the AIU and it being ready for conclusion was collected and reviewed on all abuse cases on CFSIS from March/2007 to March/2009, inclusive. This review also provided information on the number of cases AIU received in that period of time.
- A file audit involving twenty cases reviewed for quality of the investigation.
- A review of the *Child and Family All Nations Coordinated Response Network Abuse Investigation Services Program Manual* dated January/2007.



- A review of internal data collected and maintained by the AIU on abuse investigation referrals and conclusions.
- Meetings, discussion and consultation with seventeen staff and managers working in the AIU. Eleven were abuse investigators, two were supervisors and four were administrative support staff.
- Interviews with staff from other CFS agencies and external agencies, who make referrals to the AIU.

## **Program Structure**

Located at the ANCR Agency, the AIU is a centralized program providing consistent, standardized, and specialized investigations and assessments of all allegations of child abuse. The AIU responds to new referrals and requests on behalf of other CFS agencies providing services in Winnipeg and surrounding communities. The AIU is divided into three teams. One team represents the First Nations of Northern Manitoba CFS Authority and the Southern First Nations Network of Care. The second team represents the General CFS Authority and the Metis CFS Authority. The third team is newly formed. At the time of the review, the responsibility of the third team was not fully articulated. Two of the investigators on this team are dedicated to investigations involving sexually exploited youth.

The AIU receives referrals externally (from CFS agencies) as well as internally from ANCR programs. External referrals are assigned to the teams based upon the referring agency's mandating Authority. Internal referrals are assigned to a team based upon the case reference's culturally appropriate Authority. If this is not known or able to be determined, the case is assigned to one of the two teams on a rotational basis. The program manager also has the ability, when necessary, to assign cases to balance workload.

The AIU coordinates the four Child Abuse Committees (CAC) in the city of Winnipeg. Coordination of the CACs includes providing orientation and training to committee members, preparing cases for presentation, chairing meetings, maintaining minutes of meetings, and ensuring completion of follow up. This responsibility now falls to the two supervisors and the administrative support person. The AIU remains involved with a case until the investigation is complete, including situations where the case has been transferred to an on-going service provider.

## **Staffing**

The *Child and Family All Nations Coordinated Response Network Abuse Investigation Services Program Manual*, January/2007 indicates that staffing in the AIU consists of two supervisors, sixteen abuse investigators, two administrative support staff, and an administrative support staff dedicated to provide support to the CACs.



According to information provided by the HR Department at ANCR, a third abuse team was added in November/2008, bringing the staff configuration in the AIU to 33 FTEs: three supervisors, twenty-four investigators, three administrative support staff, one administrative support for the CACs, and 2 clerk typists.

As of February/2010, two supervisory positions were filled, with the third supervisory position being recruited. Twenty-one of the twenty-four abuse investigator positions were filled. The two existing supervisors are covering the supervision responsibilities.

The position of Child Abuse Committee Coordinator no longer existed. One administrative support person is responsible for administrative duties for the CACs.

In February/2010, the staffing information for the AIU was as follows:

Figure 87: AIU Staffing (February 2010)

Number of FTE positions	
Supervisor	3
Front Line	24
Admin Support	6
Family Support / Case Aides	1

Staffing Data	
Direct Hires	97%
Seconded (Permanent)	3%
Seconded (Temporary)	0
Positions designated 'Aboriginal'	53%
Positions designated 'General'	47%
Not designated	0
Positions filled according to designation	77%
Aboriginal Staff	30%
Vacancies	
1 Supervisor	
3 Abuse Investigators	

At the time of the transfer from WCFS, in June/2005, the abuse teams at were staffed almost entirely with temporary secondees. Out of the 16 original abuse investigator positions, 14 were temporary secondees. RJOs were made to the temporary secondees based on seniority. The steady recall of these employees, coupled with turnover, attrition, and leaves, resulted in many of the staff within the abuse teams leaving ANCR in a relatively short period of time, and impacted on the consistency and stability of the AIU. The lag time between a staff person leaving and a new hire being completed resulted in backlogs and increased workloads. Together with the creation of a new third abuse team, it has left ANCR with abuse investigators that, although having CFS experience, are relatively inexperienced in abuse investigations.



As of February/2010, 97% of the positions at the AIU were direct hires and 3% were permanent secondees. 53% of the positions were designated as 'Aboriginal' under the employment equity strategy. 30% of the staff in the AIU was Aboriginal. 77% of the positions were filled according to their designation.

The following chart illustrates the years of experience of the social work staff in the AIU:

Figure 88: Qualifications of AIU Social Work Staff

Qualifications of Social Work Staff	
BSW/MSW	70%
Other related degree	30%
10+ yrs of experience	22%
6-10 yrs experience	17%
3-5 yrs experience	39%
1-2 yrs experience	17%
Less than 1 yr experience	4%

70% of the social work staff in the AIU has their BSW and/or MSW. The other 30% have a related post-secondary degree.

22% of the AIU social work staff have 10 or more years experience. 17% have 6-10 years experience, 39% have 3-5 years, 17% have 1-2 years, and 4% have less than 1 year of experience.

Both the current supervisors have more than ten years of child welfare experience in a variety of roles, and have conducted abuse investigations in those roles. Neither had worked exclusively in an abuse investigation unit until they were hired in their current positions.

Specialized training is provided by ANCR. This training is coordinated with the Winnipeg Police Service, on a fee for service basis. As of November/2009, 11 of the abuse investigators had completed this training. Most employees commented favorably on the value of this training.

For a period of time, ANCR had the benefit of an experienced CFS staff person who provided training to staff in the AIU. Staff involved in that initiative commented on the benefit they received from this training when they first started working in the AIU.

Staff work from 8:30 a.m. to 4:30 p.m., Monday to Friday, on a regular basis, with the understanding that, as is required by all child welfare professionals, additional time may be required and will be compensated as per the collective agreement.

## **Referral Process**

The AIU receives abuse investigation referrals through two processes: internally from ANCR and externally from all other CFS agencies.



## ***Internal Referrals***

When a referral is internal, the AIU program manual states that the CRU and the AHU "...respond to all abuse allegation intakes which require an immediate response time by ensuring that the intake meets the criteria for a referral to the Abuse Investigation Unit and contacts AIU to request immediate involvement of an Abuse investigator".

Once it is determined that a referral to the AIU is required, information is completed on the IM and then forwarded from the CRU, the Tier Two Intake Unit, or the FE Unit, to the appropriate AIU supervisor. The AIU supervisor will screen the referral to ensure that it meets the program criteria and then assign the referral to an AIU investigator. The AIU investigator will coordinate their work with the unit making the referral.

## ***External Referrals***

Referrals from all CFS agencies are submitted directly to the AIU supervisor using the IM or if necessary the prescribed referral form via e-mail or fax. The AIU supervisor screens the referral to ensure that it meets the program criteria. The supervisor then assigns the investigation to an abuse investigator who contacts the assigned case manager to discuss and coordinate follow-up.

## ***Emergency Referrals***

There are abuse allegations that require immediate follow-up to ensure the safety of children. Although the safety assessment is generally a case management function, when an allegation of abuse requires immediate investigation and action to ensure the safety of children, the case manager may request that an abuse investigator immediately attend to interview the child. Case management activities, such as the safety assessment and removal of the child from an unsafe environment, would be conducted by the case manager, while the interview would be conducted by an abuse investigator. The only exception to the abuse investigator taking on case management activities is when immediate removal of the child is required and the abuse investigator is the only one present.

## ***Previously Closed Cases***

Cases that have been closed for less than 30 days are treated as open cases by ANCR. If an abuse allegation is made, CRU or AHU immediately advises the agency that most recently closed the case. That agency completes the abuse referral forms. Cases that have been closed for more than 30 days are treated as new cases.



## **Role of Abuse Investigator**

The role of an abuse investigator is limited to the investigative function and does not include case management responsibilities. This enables the abuse investigators to develop the specialized knowledge and skill required to investigate abuse allegations.

The *Child and Family All Nations Coordinated Response Abuse Investigation Services Program Manual* sets out the roles and responsibilities of workers managing the family service aspects of the case and the abuse investigator. It states that the AIU works jointly and collaboratively with the case manager at the agency level. It is an expectation that the AIU investigator communicates directly with the case manager after the completion of each step of the abuse investigation and immediately informs them of any information received as part of the investigation process.

One of the advantages of the abuse teams being CFS Authority specific is that the team members will be able to build relationships with the agency staff and gain knowledge about how each agency operates. The AIU supervisors can build close working relationships with the CFS agency supervisory staff to ensure professional and timely completion of the abuse investigation. AIU workers are required to remain involved with the case until all aspects of the investigation are completed. This includes situations when the case has been transferred from an ANCR Intake program to another CFS agency. Although the AIU may have concluded the primary investigation, responsibility will remain with the AIU until it is concluded by the appropriate CAC. This may take several months.

The specialized investigative function of the AIU has not been clearly articulated and understood within ANCR. It is important that the division of responsibilities is understood, so that staff are clear with respect to their role in a case. Abuse investigators are concerned about the absence of referral criteria that places some parameters around the types of abuse referrals that are being made to them.

The *Abuse Investigation Services Program Manual* contains clear referral criteria. It was reported to reviewers that any case in which abuse was suspected would be referred to the AIU. This leads to the AIU having to do complete investigations and reports in many instances which would not be investigated if more stringent criteria were applied.

## ***Abuse Investigation Records***

The AIU creates an abuse investigation client file that remains within the program until the investigation is complete, including the work of the police services and the CAC. Once the investigation is complete, the file remains with ANCR, but any or all parts may be photocopied for the case managing CFS agency.

The AIU file should contain:

- AIU Referral Form or a copy of the Intake that identifies abuse as an issue.
- Correspondence to the case manager informing them of the assigned abuse investigator.
- Case notes regarding all client, collateral and agency contact.





- Collateral information from the police.
- Any medical reports or information pertaining to the victim.
- Abuse investigation report.
- All required information regarding the referral to, and outcome of, the CAC.

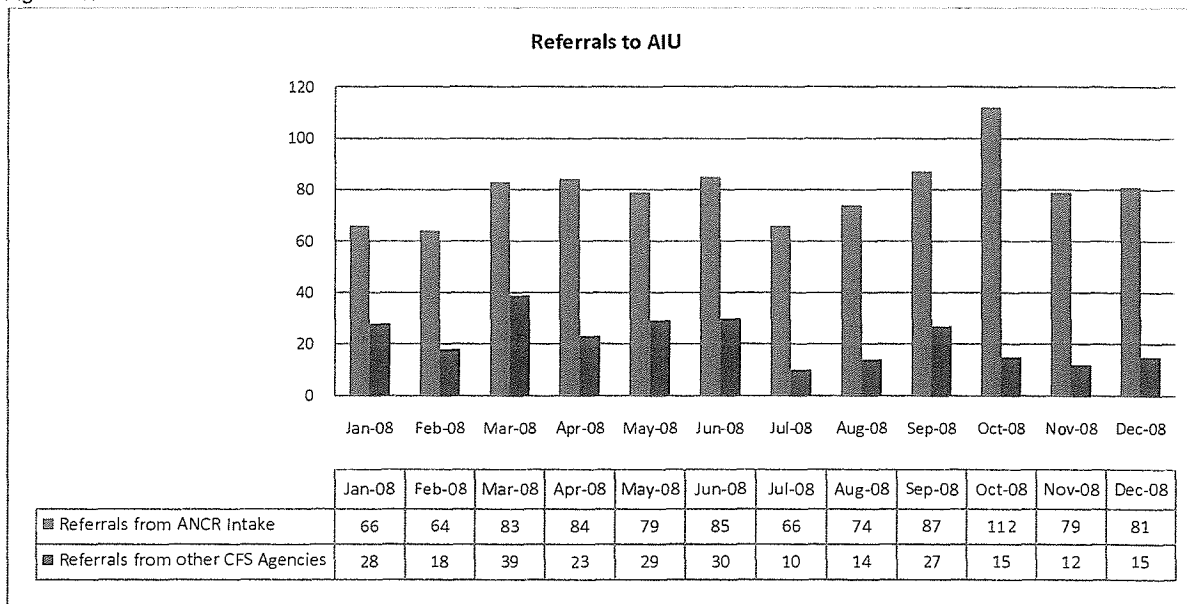
The AIU remains involved with a case until the investigation is complete, including situations where the case has been transferred to an on-going service provider with another CFS agency. AIU investigators reported concerns about the lack of information on children and family on the CFSIS. The absence of up to date information impacts the ability of the AIU investigator to provide an accurate assessment of risk due to the family situation and affects follow-up once the file has been transferred for ongoing services.

## Service Volume

The AIU assesses, evaluates and accepts referrals based on alleged physical and sexual abuse in accordance with the abuse investigation criteria in the *Abuse Investigation Services Program Manual*.

According to data obtained from records in the AIU for the year 2008, a total of 1220 abuse cases were referred for an abuse investigation. Referrals generally occur in one of two ways - directly from an Intake program at ANCR, or directly from another CFS agency. A total of 960 cases, or 78% of the referrals came from the Intake programs at ANCR while the remaining 260 cases, or 22%, were referred from another CFS agency. The following figures show the distribution of the cases by month:

Figure 89: Referrals to AIU

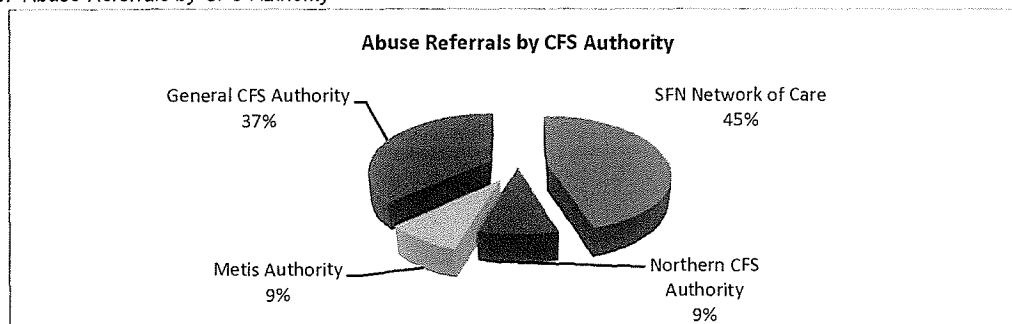




## Referrals to AIU from CFS Agencies

The number of referrals from external agencies, either opened or closed, were reviewed from records maintained by the AIU for the year 2008. The following chart shows the source of referrals by CFS Authority. All of the CFS agencies operating in the City of Winnipeg come under one of the CFS Authorities.

Figure 90: Abuse Referrals by CFS Authority



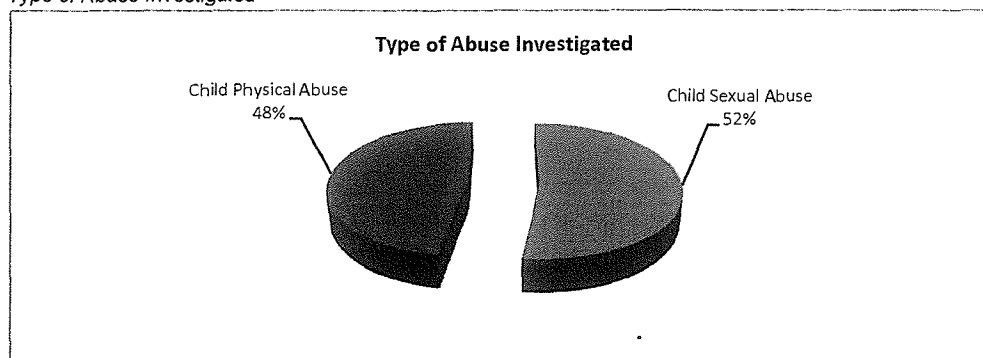
45% of referrals to the AIU came from agencies responsible to the SFN Network of Care. This was followed by agencies responsible to the General Authority which accounted for 37% of the referrals. Agencies responsible to the Northern Authority and the Metis Authority had an equal number of referrals accounting for 9% each of the total referrals.

There are differences in the size of CFS agencies and CFS Authorities. Larger agencies would be expected to refer more cases for investigations. When taken as a percentage of all cases open to each CFS Authority as of March 31/2009, the General Authority and the SFN Network of Care each referred 2% of their total cases for abuse investigations by AIU. The Metis CFS Authority and the First Nations of Northern Manitoba CFS Authority each referred 1% of their total cases.

## Investigation Conclusions

Of the 1220 referrals for an abuse investigation, 638 involved sexual abuse and 582 involved physical abuse.

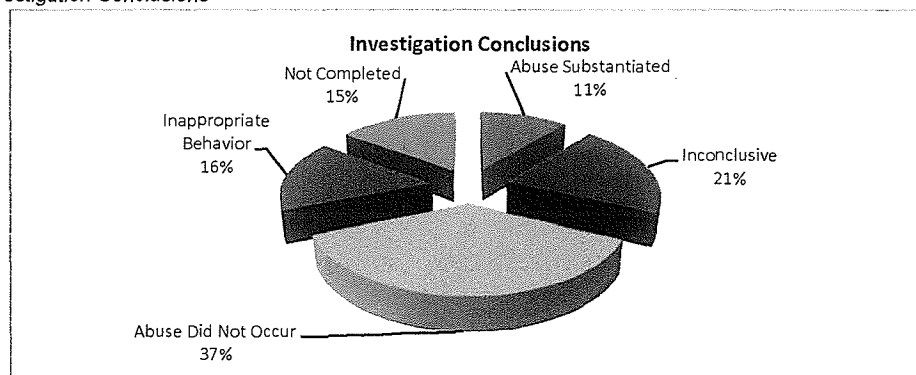
Figure 91: Type of Abuse Investigated





The AIU maintains data reporting whether an abuse investigation resulted in a substantiated finding of abuse or not. This section contains five categories: 'Abuse Substantiated', 'Inconclusive', 'Abuse did not occur', 'Inappropriate Behavior', and 'Incomplete'. This information was examined for the year 2008. The following chart illustrates the investigation conclusions.

Figure 92: Investigation Conclusions



In 15% of the referrals, the investigation was not yet completed. According to the data, abuse did not occur in 37% of the referrals. In 21% of the referrals, the investigation was inconclusive and a finding could not be made. Inappropriate behavior was determined in 16% of the referrals.

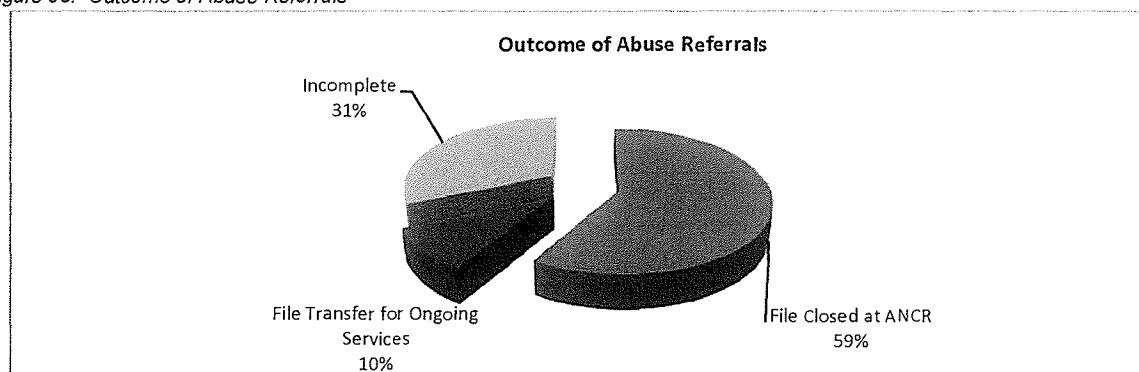
Abuse was substantiated in 11% of the referrals. Of these substantiated abuse cases, 63% involved physical abuse while 37% involved sexual abuse.

## Transfers and Closings

Abuse files that require no further action once the investigation is completed are closed at ANCR. Files that require ongoing service are transferred to a CFS agency. The investigations in these cases may be in progress or may be completed. The AIU remains involved in the abuse investigation until it is completed, even if the file is transferred for ongoing services to a CFS agency.

Figure 94 shows the outcomes of the 1220 abuse referrals received by ANCR in 2008.

Figure 93: Outcome of Abuse Referrals

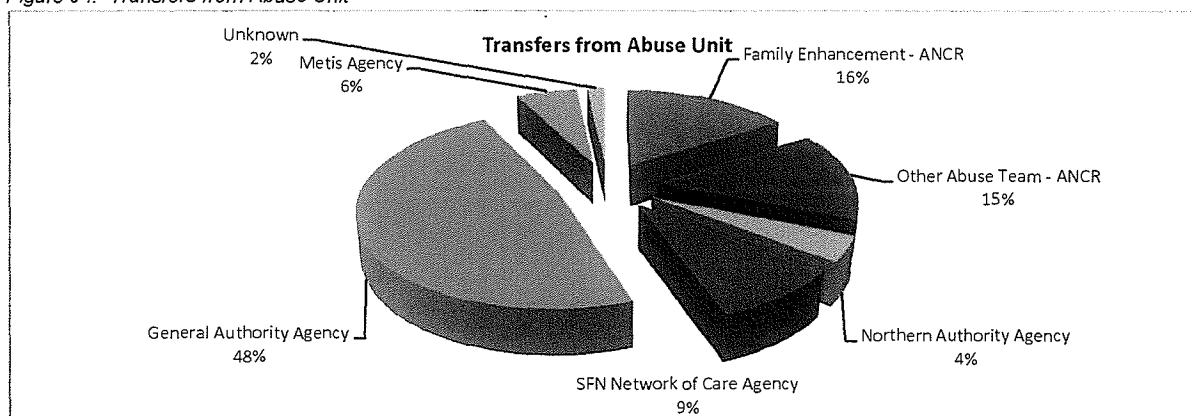




In 31% of the abuse referrals, the work of the AIU was not completed in 2008. Another 10% were transferred to CFS agencies for ongoing services, and 59% were completed and closed at ANCR.

The 119 transfers were made to either another CFS agency or an ANCR program area for further follow up. Transfers went to the following in 2008:

Figure 94: Transfers from Abuse Unit



31% of the referrals were transferred to other programs at ANCR – either another AIU Team or the FE Unit. 48% were cases transferred to agencies under the General Authority, 9% to agencies under the SFN Network of Care, 6% to the Metis CFS Agency, and 4% to agencies under the First Nations of Northern Manitoba CFS Authority.

## **Abuse Investigation File Audit**

File data was collected from the IM on recorded abuse files. These files were sorted according to program and date from the total number of abuse files entered or open on the IM within a six month time frame from September/2008 to March/2009. This involved 1575 cases.

In October/2009, 742 of these files remained opened and 833 were closed. 83 closed files (10%) were randomly selected for file review.

According to the referral process, all referrals must be completed, including the Safety Assessment/Safety Plan, and assigned to one of two teams for follow-up. The Reviewers examined files for evidence of a coordinated investigation, as well as timelines for conducting the investigations. Information looked at included:

- Compliance with response times standards.
- Response time to interview victims.
- Medical intervention requirements and time lines.
- Police intervention requirements and time lines.
- Completion of abuse investigation reports/summaries.
- File Closing dates.



## Response Times

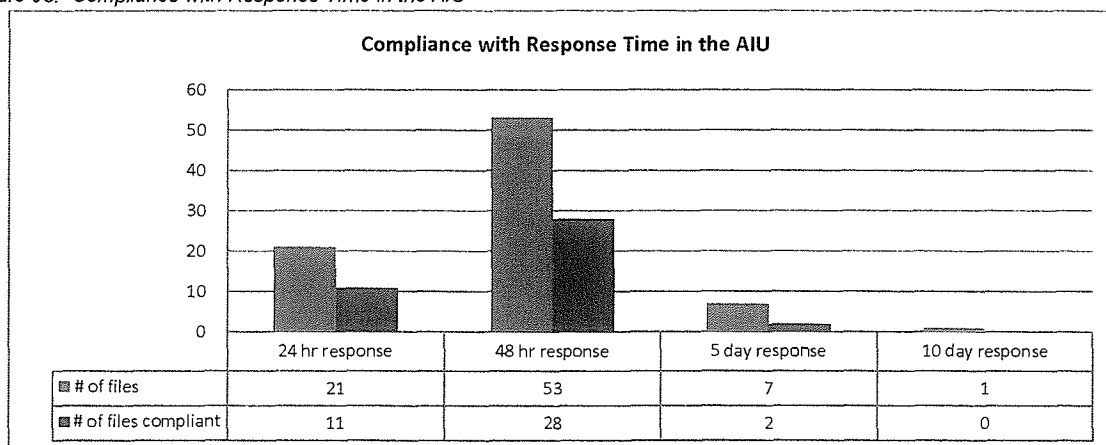
Workers enter the presenting issues in a case on the IM. The automated system will generate the required response time for that particular issue. The following copy of a screen from CFSIS illustrates how each issue has a required response time.

There were several cases where there was more than one incident on the IM file. In this situation, the reviewers used the first incident reported. It should be noted that the following response times are not limited to the AIU response but are more likely a response by the CRU or the AHU at the first point of contact with ANCR. The IM data base does not distinguish between programs. It simply reflects the data that is being entered. First point of contact is usually by the CRU during regular work hours or the AHU after regular hours.

## Compliance with Response Times

The following figure shows the number of files associated with each response time category and the number of cases in which there was compliance with the suggested response time. In many of the cases where there was no compliance, there appeared to be appropriate reasons.

Figure 95: Compliance with Response Time in the AIU





21 files had issues that required an immediate to 24 hour response. There was compliance with the response time in 11 of these files. The files where there was no compliance were reviewed and it was clear from the nature of the referral that the child/victim was safe and not in immediate danger.

53 files had issues that required a 48 hour response time. In 28 cases the worker responded in the required time or less. Of the 25 files where there was no compliance with the recommended response time, previous contact with the family contained information that influenced the workers response time.

7 files had issues that required a 5 day response time. Two situations received a response in six days and five were responded to only after a second call to ANCR.

1 file had a 10 day response attached which was responded to in approximately one month.

### ***Difficulties with the Response Time Compliance Reviews***

Some referrals were entered into the IM on the day that the AIU accepted the referral (i.e. there was no initial CRU data entry). This means that it is difficult to ascertain the amount of time (if any) between the initial call to ANCR and the time that the AIU Investigator received the file. It is assumed in these cases that the referrals came directly to the AIU and did not go through CRU.

There are 118 issues for workers to select from to identify the presenting concerns. There are 21 listed categories of issues to select from in the IM. Within each of these categories there are anywhere from one to twenty sub-selections of issues, all with suggested response times attached. Reviewers looked at the *first incident reported* as the response time review.

The compliance time reviews were taken from the IM's feature for date of transfer times. When this feature was not available or there were questions about its validity, the reviewers took the response time from caseworkers' notes. There were numerous examples when response time compliance was impossible or unnecessary according to information found in the caseworker notes. This information was not entered in the IM "reason for response time change" window. These exceptions were not taken into account when reviewing compliance.

None of the files reviewed included a Safety Assessment/Safety Plan as generated by the IM. As a result, there was 100% non-compliance with completing the necessary Safety Assessment/Safety Plan.

### ***Victim Interview Response Time***

Files were reviewed to determine if and/or when the victim was interviewed. This second level of assessment provided an indication of when workers begin their investigations following receipt of the file.



There were eight files where the victim was not interviewed. Reasons provided included the age of the child; child victim's willingness to comply; or no victim identified. These files were adjusted to dates of other interviews, such as those with caregivers.

When the 24 hour response time classification was examined, it was found that workers are most often responding within the required time frame. Workers most often responded to families on the same day the file was received.

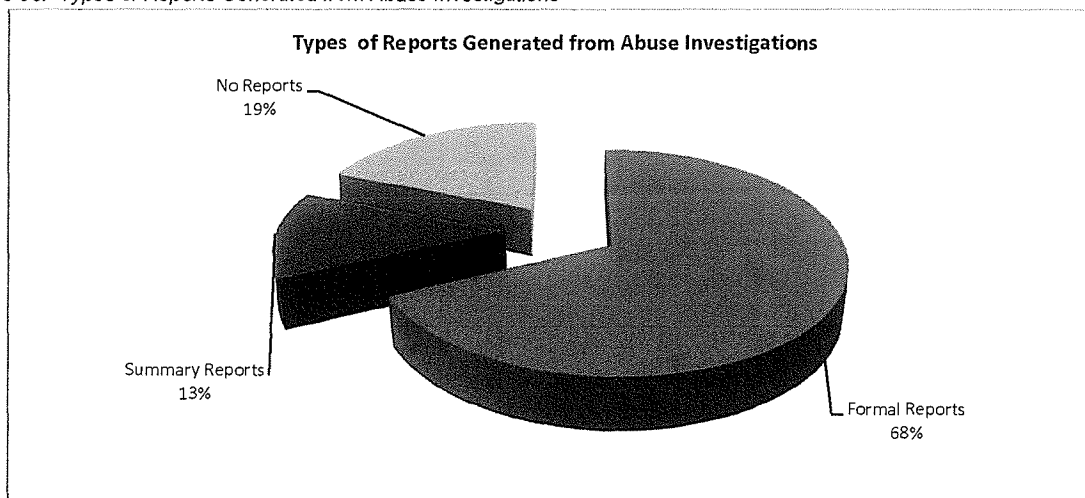
Where the response time classification was 48 hours, the file review revealed that the average response time to families was one month. As with all the response times for workers, including the five and ten day classifications, response times are determinate on knowing if the child is safe and not in any potentially imminent danger. When that information is present, workers determine priority relevant to other issues such as case management and workload.

The actual response time for files requiring a 5 day response (7 files in total) showed 2 files receiving a response within 1 day, and the remaining files receiving a response in 6, 10, and 14 days, while two files waited 56 days for a response.

### ***Reports Generated from AIU Investigations***

Following an abuse investigation, abuse investigators are required to generate a report of their investigation. Formal policies and procedures do not indicate what form this report is required to take. Formal abuse investigation reports were generated for 56 of the 83 reviewed investigations. The quality of these reports was thorough and well organized. A further 11 files held reports in the form of transfer summaries and/or closing summaries that also contained documentation of the investigations. The identification of "no reports" was on recordings in the IM that had no form of closure. This type of data entry consisted of the presenting referral and case notes on interventions but no concluding data.

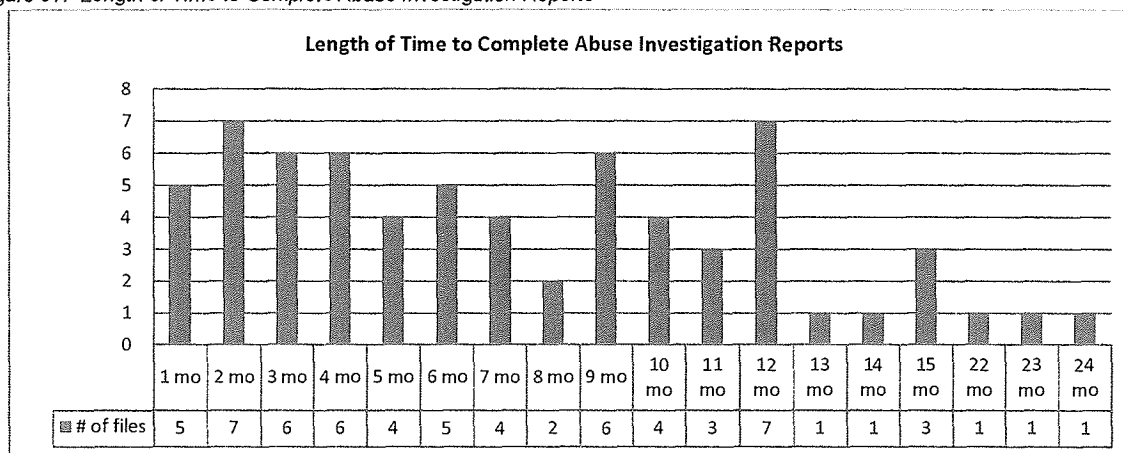
Figure 96: *Types of Reports Generated from Abuse Investigations*





Sixty-seven files were reviewed to determine how long it took from the time of referral until the abuse investigation report was completed. Frequently, these were generated in a timely fashion. In other instances reports were not generated for several months following the conclusion of the investigation. The figure below illustrates the length of time that it took to complete the abuse investigation report.

Figure 97: Length of Time to Complete Abuse Investigation Reports

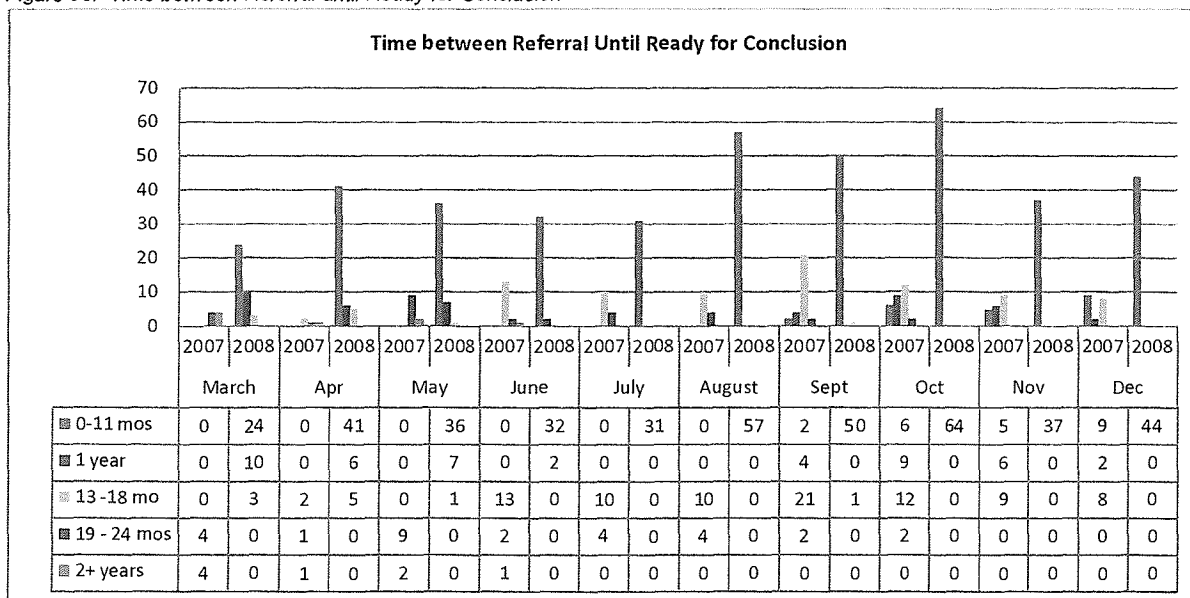


The average length of time to complete a report was 8 months. 50% of the files had the reports completed within 6 months or less.

### Time Between Case Referral and Ready for Conclusion

The results for the same time period for each of two years – 2007 and 2008 - are shown by the following figure.

Figure 98: Time between Referral until Ready for Conclusion







In March/2007, four of the cases that were opened took 19-23 months to be ready for conclusion and another four took more than 2 years. In March /2008, 24 cases were completed in the first 1-11 months 10 were completed within the year, and none took more than 18 months.

In September/2007, 21 of the cases which were referred took 13-18 months. In September/2008, 50 files were completed in the first 1-11 months, 1 within 13-18 months, and none longer than this.

In December/2007, 9 files were done in 1-11 months, 2 took up to a year, and 8 took 13 – 18 months. In December/2008, 44 files were completed in the first 1-11 months and no files took longer than this.

In March to June/2007, there were 8 files that took two or more years. As ANCR was mandated as a separate agency in February/2007, these files were transferred to ANCR from WCFS. For the balance of 2007 and for all of 2008, this did not re-occur.

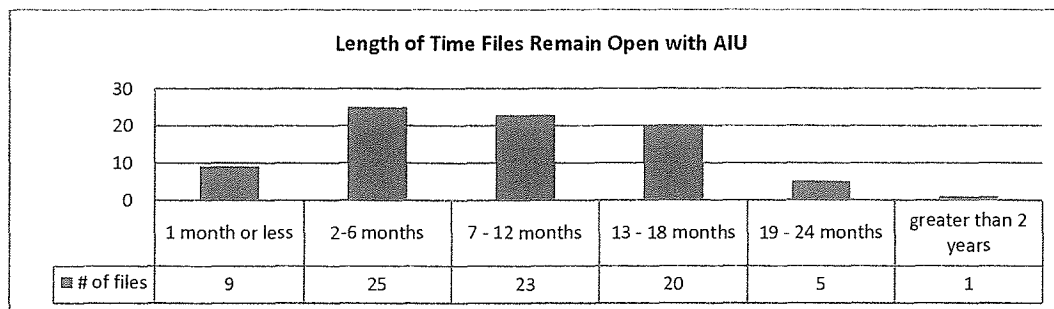
The decrease in response times in 2008 was in spite of a marked increase in the number of referrals to the AIU. With the exception of 2 files, response times remained less than a year from June/2008 to December/2008. A further analysis of the data for December/2008 shows that all but one of the cases were ready for intake conclusion less than 4 months from the date of referral; thirteen of these were ready within 6 weeks or less. Further analysis of the severity of suspected abuse would be informative in an effort to determine how this was accomplished.

The trend to faster response times continued through 2009. Of 41 cases in January/2009, only one took as long as 6 months. Of the 32 referrals in February/2009, all were ready to conclude in less than 3 months. This was also true of 26 of the 28 referred cases in March/2009. The remaining two were concluded in a further week or two. Data therefore shows that response times greatly improved and remained improved as late as March/2009.

### ***File Closings***

Cases ready for conclusion are not always closed immediately. The file review showed that cases remained open for significant periods of time after they were ready to be concluded. The following figure shows the length of time the 83 cases reviewed remained open with AIU.

*Figure 99: Length of Time Files Remain Open with AIU*





Of the 83 files reviewed, the average length of time for a file to be open to the AIU was 9 months. 50% of the files were open for 8 months or less; 50% were open for more than 8 months. These times suggest, when considering the amount of time for workers to respond to the victim, files are either concluded relatively quickly, or they remain open for lengthy periods of time.

The sample files were broken down further to separate abuse files into categories of earlier opening dates (prior to September/2008) to closing within the time frame of this Review. The more recent files showed a significant reduction in the length of time the file remained open. As a result, earlier files were open much longer than more recent files. It appears that as time went on, the file recording opening and closings became progressively timelier. This is a significant finding, and affords the possibility of a more detailed examination on a comparison of older files and more recent files on worker response and reporting times.

Another significant finding is that files are being closed on the IM while information continues to be added, modified, or otherwise appended. This became apparent in the more recent files. This may be important when workers are awaiting CAC reports, police reports/findings or other documentation that adds to the investigation but does not impair outcomes or conclusions. Faster abuse investigation file closings, particularly on new intakes, means that the CFS agencies receiving files transferred for ongoing services are able to better plan for children and families. However, the ongoing service worker would be missing the additional information for a period of time.

It is important to note that many of the investigations reviewed had significant lags between the conclusion of the interviews and investigation, and the conclusion of the reports. Regardless of the response time indicators, most investigators were able to conduct interviews within one month of the file being opened. As already noted, file recordings are averaging eight months to be completed and nine months for a file closure.

## ***Collateral Involvement***

### **Medical Intervention**

Files were reviewed to determine whether there was medical intervention. 13% of the files indicated that there had been some form of medical intervention, including consultation. It did not appear that response times or investigations were hampered in any way as a result of working relationships or investigation coordination with medical staff.

### **Police Intervention**

29 of 83 files, or 35% of the reviewed files, had police involvement. This included police:

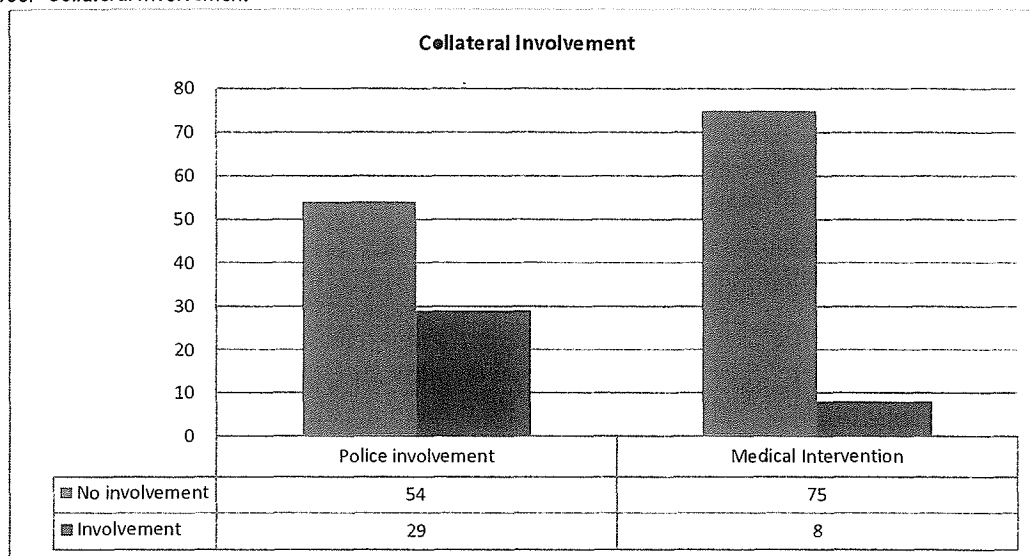
- Being engaged at the outset of the investigation.
- Being the source of referral and/or being consulted.
- Being reported to at the end of the investigation.



- Providing a report at the end of the investigation.

The following figure shows the level of involvement by medical and law enforcement collaterals.

Figure 100: Collateral Involvement



Police involvement had some bearing on the length of time that a case remained open in a small number of investigations. Information that a worker was waiting for police collaboration, coordination, or results of police investigations was sometimes noted in case recordings. Files were examined to see if there was any correlation between police involvement and lengthy reporting/closing/transfer times. There appeared to be no pattern of consistency related to police involvement and length of time for reporting or for file closing. Some files with police involvement had very quick opening/closing times while others had extensive waiting periods between the last interview by the case worker and the date a report was generated.

### ***File Audit for Content***

The content of the abuse files was generally very good and suggested that a thorough investigation occurred. The reports were well organized and included all significant persons and a risk assessment. Workers were able to coordinate their efforts with collaterals such as hospital and police personnel.

Paper files generally included a copy of the IM recording, all third party correspondence (including e-mail correspondence), agency correspondence, signed documents such as signed release of confidentiality, the ADP, worker daily case notes, and non-textual information such as pictures. Depending on the nature of the work with the families, this information can be quite extensive or minimal.



The file review resulted in some additional findings based on the information available in the files. Some findings were general in nature:

- Workers cut and paste process notes, email conversations, and interview transcripts.
- Some files include non-relevant information.
- Workers use “see addendum/case notes/attachment” rather than including a summary of these in the report. In some transfers, the notes referred to were not included and the receiving worker would not be able to see the referenced information.
- There was information missing in some files.
- Changes of workers prior to and during investigations created a lag in investigations.
- There were discrepancies noted in some of the workers’ reports.
- Some files had different file opening and file referral dates.

Some findings were specific to one case. These findings were noted for follow up. They are also relevant to identifying training needs. They included:

- In one instance, a file was opened under another family name, with no conclusion on the existing file.
- In one case, the investigation took one month, yet the referral agency did not get a letter of conclusion for fifteen months.
- In one case, additional disclosures made during an interview did not have documentation of follow-up.
- In one case, the offender did not appear to have been interviewed.
- In one case where the allegation was that the father administered inappropriate discipline, only the mother was interviewed by the worker.
- In one case involving an allegation that an offender had access to the children, only the children were interviewed.
- In one case, the initial referral was not followed up, but the worker responded to a second referral.
- In one case there was an allegation that an offender continued to have access to the children. There was no documentation on file, in summary and concluding reports, to show otherwise.
- In one referral, a school principal hit a child but there was no CAC report completed.

### ***The Child Protection Centre (CPC)***

The AIU, more so than other programs in ANCR, relies heavily on a reciprocal working relationship with the community and collateral agencies for resources, supports, and augmentation of the services they provide. The AIU works closely with the CPC at the Children’s Hospital.

In addition to providing medical information, evidence, and medical advice on child abuse, the role of the CPC is vital in investigations to determine whether abuse occurred. As a member of the interdisciplinary team, the CPC also provides consultations, support, and recommendations to the AIU.



The police, hospital, and CFS work from different program protocols, mandates, and regulations, and so there are often situations that require some type of dispute resolution. Issues sometimes arise out of staffing changes and differences in professional styles. Continuity of relationships is important for good working relationships with different systems. A working group, including representatives from the CPC, the Winnipeg Police Services and CFS, meet twice a year to discuss processes, issues, and case specific situations.

Interviews were held with members of the CPC to obtain their perception of the services performed by the AIU. The CPC is an assessment and early intervention unit for children subjected to abuse, and their families. The CPC offers medical and developmental assessment and intervention services, as well as consultation and educational services to other community professionals, such as the police and ANCR. The CPC personnel work closely with staff from the AIU and are on a first name basis with some of the abuse investigators. The Director of the CPC is a medical doctor who has been there for over thirty years. Likewise the Assistant Director is a medical doctor who has been there for some time. The Social Worker that manages the social work program has also been there for many years.

AIU workers can access the CPC for emergency services to sexual assault victims and serious physical assault situations, as well as for developmental assessments due to suspected neglect/deprivation. Physical and sexual abuse medical assessments include play preparation prior to medical examination and, if necessary, a brief social work assessment of the family situation. A medical assessment is followed by a documentation of the findings.

The CPC is a source of information and explanations on medical issues concerning abuse and neglect of children. On occasion, the CPC will make referrals to the AIU. In addition, the CPC, through its Child Development program, provides psycho-social assessments on parent-child relationships, abused children, parenting capacity, as well as education, consultation and treatment recommendations on child abuse cases.

Professionals at the CPC stated that generally they have a positive working relationship with several workers and respect the difficult job that social workers in the AIU have. The working group has been instrumental in resolving many issues. Currently there is a proposal for a social worker liaison position to work between the systems in resolving process and procedural issues that arise on a regular basis.

CPC staff reported concerns about unclear and inconsistent communication between CFS agencies and the AIU that interfere with investigative processes between the two systems. The need for the AIU and the CPC to share all information and coordinate services was stressed. Additionally, AIU and CPC staff needed to be clear about the roles and responsibilities of each program.

The *Child and Family All Nations Coordinated Response Network Abuse Investigation Services Program Manual*, clearly states that, "...the AIU works jointly and collaboratively with the Case Managers at the agency level. It is an expectation that the AIU investigator communicates directly with the case manager after the completion of each step of the abuse investigation and immediately informs them of any information received as part of the investigation process".



The CPC staff was concerned that some AIU investigators were not clear on their ability to share information while conducting abuse investigations. In particular, there is a need to clarify the protocols around the sharing of information between the AIU investigators and the CPC staff. The CPC is subject to the same confidentiality laws as CFS. There should be open communication between the two systems when conducting an investigation. Workers are often not forthcoming with information they feel is "confidential" and may impede CPC staff in the services they are providing.

### ***Child Abuse Committees (CACs)***

As part of the CFS Act (section 19), CACs are established by CFS agencies to "...review cases of suspected abuse of a child and to advise the agency concerning what actions, if any, may, in its opinion be required to protect the child or other children". It is the CAC's job to form an opinion about whether a child has been abused, and if the abuser is to be entered on the Child Abuse Registry (section 19.3), and to report on this opinion.

Previously, under WCFS, there were four CACs in the city of Winnipeg which were geographically based. Since the AJI-CWI restructuring, the four CACs are now Authority based. One committee represents and hears abuse cases related to the CFS agencies under the SFN Network of Care; one represents the CFS agencies under the First Nations Northern Manitoba CFS Authority; one committee is for the CFS agencies under the General CFS Authority; and one is for the Métis CFS Agency cases.

In accordance with the legislation, each CAC has a representative from health (CPC), police, education, a child abuse coordinator and two representatives from CFS. Where possible, other members of the community (for example, day care personnel, and community elders) are represented on the CAC. All four CACs have some overlapping representation.

An orientation and training package was developed for committee representatives to understand and familiarize themselves with their mandate and responsibilities. This orientation clearly outlines the criteria for abuse investigations, including definitions of physical abuse and sexual abuse. It outlines abuse investigation procedures and the factors workers use to determine their conclusion decisions and outcomes. Committee members are informed about the confidentiality requirements, the referral process, and committee roles and requirements.

### **Meetings**

#### ***ANCR Staff Employed in the AIU***

During the review of the AIU, individual interviews were conducted with the following ANCR staff:

- The Abuse Intake Unit Program Manager
- Two Abuse Intake Unit Supervisors
- Eleven Abuse Intake Unit Investigators
- Four Administrative Assistants



In addition, members of the review team attended meetings of the AIU. Information obtained in response to standardized questions during interviews was condensed under a series of headings that reflect common themes relevant to staff in the AIU.

### Caseloads

AIU workers were asked about their caseloads. All were able to provide estimates, but not exact numbers, of their active cases or the extent of their paper backlog (cases in which the investigations were finished, but reports were not completed).

Information from the workers indicated that while there are a high number of cases open to some workers, many of these are cases where the work has been concluded, and the file is ready to be closed pending completion of the paperwork. For example, one worker had 100 cases but on 90 of these, needed only to complete the paperwork in order to close the file. At the time of the interview, this worker had been withdrawn from the regular rotational assignment of new cases in order to complete this paperwork. Another worker estimated the caseload to be 100 cases, with at least 40 of those ready to be closed once the paperwork was done. A third worker had a caseload of 95, with 60 of those cases ready to be closed pending the paperwork being completed.

The number of cases where the investigation is completed, but the case is waiting for paperwork to be completed in order to be closed, ranges from 0 to 93 for workers. Half of the respondents had more than 20 cases in this category. This can suggest that once an investigation is complete, paper work can be put aside in order to attend to more urgent business. This is especially likely to occur when the teams are short staffed.

Overall, the number of active cases ranged from seven to sixty, with the higher number of cases generally being carried by the most experienced workers. Not all cases have the same complexity. Newer workers were generally assigned the less complex cases.

### Elements of a High Quality Abuse Investigation

Staff was asked to identify what they thought were the important elements of a high quality child abuse investigation. Responses were categorized according to the program structure which supports investigations; the knowledge and skill of the investigators; and the attitudes which are necessary precursors to effective work.

#### *Structural Supports*

Excellent supervision by people with experience in all aspects of child abuse was important to producing high quality child abuse investigations. Excellent supervision meant that supervisors are available either in person or by phone and have the time to offer consistent, supportive, challenging and regular supervision, together with 'as needed' consultation. Consistency in the supervisor and program manager positions was identified as important.



'On the job' training was identified as essential, particularly when staff have limited experience in conducting child abuse investigations, or are new to the field of child welfare. The presence of a trainer in the AIU was seen as having contributed significantly to the capacity of staff to complete good investigations. Ongoing training relieves existing staff of the need to 'supervise' new workers, and is helpful for experienced staff as well. The training sponsored by the Winnipeg Police Services was specifically mentioned as very helpful.

A thorough orientation for new staff, to ANCR, and the AIU specifically, was identified as important to ensuring high quality abuse investigations.

The ability to hire and retain experienced staff was noted as an important element in achieving high quality abuse investigations.

Another structural element identified was manageable caseloads, with 30-40 cases regarded as being a reasonable number. To achieve this, it is important to have a consistently full staff complement of experienced staff. Having the ability to match worker experience with case complexity contributes to the quality of the investigation.

The ability to work effectively with collaterals in other systems such as the police, schools, and health care was seen as contributing to a high quality of investigations. Developing working relationships with collateral professionals and having some continuity in these relationships increased the likelihood of high quality investigations.

It is important for management to express support for staff in the potentially high risk decisions they are making on a day to day basis. Feeling supported by management, along with the need to have a workplace where staff feels emotionally and psychologically safe, was considered important.

The ability to conduct a high quality investigation is enhanced when decision making processes are transparent and clearly understood, and all staff are expected to be part of that process.

Other structural elements noted as important to producing high quality abuse investigations included staff working effectively with other teams to address the issues that the children and families are facing. This included follow through on case transfers by family service workers on issues identified in the investigation. The potential value for families to have access to a "one stop shop" rather than having to deal with multiple workers was noted.

The importance of having a culturally diverse staff was identified. Abuse investigations are enhanced when workers have knowledge and understanding of the culture of the families that are involved, and can apply this knowledge in the investigative process.

#### *Worker Skill and Knowledge*

Comments in this category related to planning the work, interviewing, consulting with collaterals, assessment, and report writing.





When planning how to approach an investigation, it is helpful to have all the necessary information regarding demographics, collaterals and contacts, as well as a detailed history. It is important to have the details of the disclosure, a clear statement of the presenting problem and information about whether there are charges. In addition, the worker should be familiar with legislation, standards, and the purpose of their job. It is imperative to ensure the safety of the victim.

People who should be interviewed as part of the investigation are the victim, siblings, parents, offender, collaterals, and others who know the family. The skill of the interviewer is a factor in determining the quality of the investigation.

Developing and building working relationships with the key collaterals is vital. It is important that workers and collaterals understand the policies and procedures of their counterparts, particularly as it relates to the sharing of information.

A quality investigation includes a risk assessment and reasons for the risk rating. Investigations should be focused on maltreatment, completed within the required timelines, and include consultation with the case manager. It is important to assess how each person presented.

The following items related to report writing were noted as important to quality investigations:

- Reports should be done in a timely manner.
- Items which should be recorded include interviews; contacts with collaterals; statements about the relationships in the family; notes about whether there are charges and what is happening related to those charges; whether there was a medical and the results of that medical; conclusions and the reasons for them; future plans, recommendations and a transfer summary.
- The finding of the CAC should be noted if the case was sent to the CAC.
- If there are steps which are expected but were not completed, it is important that the reasons for those omissions be documented.
- Referrals, assessments and abuse investigation reports should follow a standard format.

#### *Attitudes Which Facilitate a Quality Investigation*

Positive worker attitudes were identified as contributing to the likelihood of having a high quality investigation. This includes job satisfaction of workers; having the right personality to do the work (e.g. assertiveness); being able to maintain hope that things can change; having belief in the work being done as important for children; supporting and actively practicing collaboration and cooperation with others involved, including the family; and the ability to develop and maintain good working relationships with colleagues.

#### *Barriers to Conducting a High Quality Investigation*

When asked to identify the barriers to completing a high quality investigation, workers responses included:



- High caseloads.
- Vacancies and staff turnover.
- Supervision is not available as needed.
- Direction is inconsistent.
- Supervisors lack experience in abuse.
- High ratio of workers to supervisor.
- Lack of training and orientation for new staff, including training in report writing.
- Lack of a procedures manual.
- Lack of confidence of staff in their abilities.
- The paper backlog that occurs from waiting for various things (i.e. police investigation).
- The requirement that full reports be written although investigations may be unsubstantiated or have a finding of inappropriate discipline.
- The redundant nature of the required recording.
- Lack of administrative support staff to assist in the completion of required paperwork.
- Lack of cooperation between collaterals.
- Inappropriate referrals by workers who do not know the screening protocols.
- Referrals that do not contain adequate information.
- The requirement to do a standard abuse investigation report on all referrals.
- Not being asked to be involved in providing important, firsthand experience and information as part of the decision making process.
- Lack of cohesion or sense of being a team and a "they" versus "us" attitude.
- Referrals coming through CRU rather than directly to the AIU.
- Lack of respect for the history, knowledge and experience of long term staff.
- Length of time for the court process to be completed.
- Lack of cultural proficiency of staff in relation to the families they are working with.

#### *Working Relationships with Other ANCR Units*

Generally, people interviewed reported that the working relationship with the other units was effective. Relationships become strained when there is confusion about the roles and responsibilities of the various units. This could be improved by a good orientation for all staff.



The AIU interacts most frequently with the Tier II Intake Unit, followed by the AHU and the CRU. There is little contact with Family Enhancement. It was noted that personally knowing the workers in other units facilitates effectiveness.

#### *Working Relationships with Other CFS Agencies*

Half the workers stated that the working relationships with other CFS agencies were seen as positive.

Some difficulties that were identified included:

- Lack of consistent use of CFSIS and the IM by the CFS agencies.
- Missing information in the referrals.
- Difficulty in contacting workers from the CFS agencies.
- Keeping track of staff changes at the CFS agencies.

#### *Using CFSIS and the Intake Module as Tools in Conducting Investigations*

The shortcomings of CFSIS were voiced as a concern of the staff. As with any data information system, it is only as good as the information that is put in. The information available on CFSIS is at times incomplete, inaccurate or out of date. This results in difficulty when gathering information for abuse investigations.

Regular training, including immediate training for new staff, is required. Administrative support staff play a large role in providing information on how to use the systems. They act as 'in house' trainers.

Transcribed interviews are completed in MS Word, and then placed in a folder for the worker. The worker attaches the transcription to the file electronically. Hard copies are faxed to all relevant CFS agencies.

Systemic problems were identified. The IM is problem based and does not look at family strengths or relationships. The time frames create an 'assembly line approach' to investigations. Frequently information is blocked because of a 'confidential case'. Workers do not know when to use the IM and when to use CFSIS. The consensus appeared to be that the systems were cumbersome and added unnecessarily to the time spent in documenting the work done by the AIU.

#### *Experience with the Child Abuse Committees*

The time spent preparing cases for the CACs increases the work load of the supervisors, as well as the duties of the administrative support person for the committees. The General Authority committee has cases now which are scheduled for review in 8 months, while the other CACs generally see a case within a month. In some cases, the CAC has been cancelled when there were no cases to review. There was uncertainty about whether the cases could be transferred from one committee to another in order to relieve a backlog. Protocols and procedures for cases to go before an alternate CAC should be put in place.



When the CAC requests follow up work, a case may sit for considerable time before that work is completed. This does not affect the completion of the investigation by the AIU, but the file remains open during that time.

There are more than 100 cases waiting for court decisions or letters from the police. In these cases, the investigations are completed and service response either completed or underway, but the abuse file is not closed until documentation is received.

The possible reinstatement of the CAC Coordinator position should be examined. This might be helpful for improved coordination of the work of the committees.

#### *Appropriateness of referrals to the Abuse Investigation Unit*

AIU staff reported that there has been a substantial increase in cases carried by the AIU from 2007 and 2008. Respondents stated that there are a number of cases which could be handled by the Intake Unit or, if open to a family service worker, by that worker. Many said this would be better for families, as it would reduce the number of people involved during a time of crisis. AIU Investigators reported several examples which could be served by the case manager. This included:

- Third party assault, unknown offender.
- Inappropriate discipline (child over 2 and under 12, no injury).
- Parent teen conflict (child restrained or not injured).
- Custody disputes.

#### *Interviews with Staff from other CFS Agencies*

A number of staff and managers from other CFS agencies in the province were interviewed regarding their experience with the AIU. Respondents were asked ten questions that focused on their experience working with the AIU. Forty-four staff and managers from several CFS agencies responsible to the four CFS Authorities in the province participated in the interviews.

#### Understanding Roles and Functions

There was some variation in knowledge by staff from other CFS Agencies about the specifics of the AIU and how it works, what standards to expect from them, and what services they can be expected to deliver. There were mixed opinions about the merits of a centralized service, although it was generally favored. For the most part, the AIU was described as responsible for all child abuse investigations in Winnipeg, for putting the matter before the CAC, and for providing a report with recommendations for follow-up.

#### Work Circumstances with AIU

Most of the respondents indicated that allegations of sexual or physical abuse on existing agency caseloads are referred to the AIU. Workers are involved with the unit while the investigation is



underway. In some situations, other CFS agency workers reported that they will assist the AIU in the investigation (e.g. interview child or family member). Besides receiving cases, the case manager would be involved in such things as following up on treatment and therapy recommendations.

#### Comments on Staffing and Relationships Between the AIU and Agencies

Staff from other CFS agencies commented on the high rate of staff turnover and the number of new and inexperienced staff providing a very specialized service. Other workers spoke of the partnering and joint work that takes place on some investigations. The agency social worker can be viewed as supportive rather than adversarial, since the abuse investigation is not under the purview of the agency. The agency and the AIU complementing their respective roles were seen as important.

#### Referral Process and Time for Completion

The actual referral process is quick. Agencies use the ANCR form and fax it to ANCR. There was a recommendation that the form be included in CFSIS.

Time was a factor when it came to the length of time required to complete the investigation and CFS agencies receiving a completed report back from the AIU. This was articulated as a significant issue for agency staff.

There were three points in the interview process where the time factor was a concern:

- The time from the referral to the first interview.
- The time from the first interview to the conclusion of the investigation and the receipt of a verbal report.
- The time from the conclusion of the investigation to the receipt of the final report.

The experience of agencies varied, but it appeared that this issue was consistently problematic. The time varied between six months and two years. Some agencies were of the opinion that the problem of lengthy delays had gotten worse in the past two years. Some agencies stated that they were doing some of their own investigations because it took the AIU too long.

There are service implications in these delays. Workers may change during the process; families are left in limbo; children who could be returned, particularly when allegations are not substantiated, or when the issues within a family can be addressed, are left in care for a longer period of time; children forget; children do not feel listened to or valued.

Agency workers stated that it was difficult to plan or move forward with families, when all decisions are pending the outcome of the investigation. It limited the agency intervention options when the case was active with the AIU.



### Experience in Receiving a Case or Service Transfer from the AIU

Agency experiences in receiving service transfer reports were positive. The reports were described as "thorough", "getting better" and "excellent". The staff were seen as competent.

Agencies spoke of the frustrations experienced by the family and the workers when there is an "inconclusive" outcome. This is particularly difficult when there has been a long wait for the conclusion.

### Strengths of Services Provided

Agency staff reported very thorough work by the AIU. Reports were described as comprehensive and with full attention to collateral input. AIU staff was viewed as specialized workers with expert knowledge. Thorough reports, comprehensive and detailed, were cited as the main strengths by the majority of the agencies' staff. Agencies appeared appreciative that an "outside" agency responded and performed the abuse investigation function.

### Difficulties with Services Provided

The AIU is seen as having the potential to be a helpful resource to the agencies. Areas for improvement were identified. One suggestion was that better integration with the police and the CPC would serve to improve the services. The need for the AIU to be more cognizant of, and competent in, culturally appropriate services, would be helpful.

The timeliness of investigations was cited as a concern. Families, and agencies, can wait for months to get information on the outcome of an investigation. Sometimes this outcome is inconclusive. This makes it difficult for families and agencies to plan.

The process for the CAC, waiting for the decision of the CACs, and inconsistent feedback from the CAC were raised as areas needing improvement.

Staffing emerged as an issue. There is a perception that there is high staff turnover and that staff carry high caseloads. Both of these can affect the quality of the work and it is important to establish stability and consistency in the AIU.

### Working Relationship and Communication

Agency staff described the working relationship with the AIU as professional. The volume of casework for the workers and the administrative procedures of the CAC were cited as main factors in slowing things down. Agencies stated that while recommendations were not always universally and mutually supported, the relationship between the AIU and CFS agency staff was positive.

It was suggested that a commonly understood and carefully detailed partnership between the AIU and the other CFS agencies was needed. This should include a process to clarify roles and responsibilities,



and a mechanism for accountability. The process should include agencies receiving regular updates from the AIU regarding case progress, timelines, and reporting.

### Overall Satisfaction

Of the sixteen staff that responded to this question, seven were very or mostly satisfied with the services provided by the AIU, nine were somewhat or generally unsatisfied.

### Suggestions for Changing or Improving Services at the AIU

Staff at the CFS agencies offered the following suggestions for the AIU.

- The need for more contact between the AIU and other CFS agencies was the suggestion heard most often. CFS agency staff stated that this should include face to face meetings as well as "real" voice phone contact. This would assist in obtaining initial information, clarifying responsibilities and expectations, providing updates on case progress, considering recommendations, and sharing the outcome of investigations.
- Written materials that outline the AIU mandate and processes, together with staff names, phone and fax numbers should be available. Opportunities for workers to gain experience in each other's workplaces should be explored.
- Formal orientation for new workers was suggested.
- Attitudinal issues need to be addressed to change the perception that the AIU believe that some agency workers are less skilled.
- Two suggestions regarding changes to the structure were offered; either having an AIU worker housed within a specific agency or having a particular worker work with designated agencies. Others suggested that the agencies should take on the abuse investigations function, or at least those situations which are low risk, low severity, and low urgency.
- Staff should be increased, to reduce the length of time for completing reports.
- AIU needs to partner with, or at least involve, the CFS agency during an investigation.



## **Summary of Findings**

1. There are two teams within the AIU. Currently, the General Authority/Metis Authority Unit consists of 1 supervisor, 9 front line workers, 1 administrative support, and a case aide who works 20 hours a week. The First Nations North/South Unit is similarly configured. According to HR records, when the third unit is functioning, each team will have one supervisor, one administrative assistant and eight AIU investigators.
2. The role of the AIU investigator is limited to the investigative function and does not include case management functions. All cases that are referred to the AIU are also assigned to a case manager. Case managers can be Intake workers at ANCR, Intake supervisors at ANCR, or workers with other CFS agencies. As a result, the AIU investigator role is specific to investigating abuse allegations and following up on these in accordance with provincial abuse regulations. This division in case responsibilities has been a source of contention for some case managers who have difficulty separating the two responsibilities.
3. The division of case responsibilities (due to the involvement of both an AIU investigator and a case manager in a case) associated with the current AIU model is not without some complications. The biggest complication appears to involve communication and reporting between the work being done by the AIU investigator and the case management decisions and actions completed by the case manager. Case managers need ongoing information on the abuse investigations and implications from the investigation, and AIU investigators need up to date information on any other actions or changes occurring with the child or family.

Although the *Abuse Investigation Services Program Manual* outlines the responsibilities of the AIU investigators for sharing information, it is unknown what guidelines are available for case managers. However, whether guidelines exist or not, communication is, at times, subject to human error. Concerns have been voiced by multidisciplinary team collaterals about errors in case management resulting in potential risk to a child due to the lack of or inconsistent, communication between AIU investigators and case managers. The CPC staff provided an example of a child sent on a home visit where access to the offender was possible. This was due to the fact that information was not being forwarded by the AIU investigator to the case manager.

4. When an abuse allegation is being investigated, client families must work with two different workers. If their respective roles are not clearly understood by the workers, this can be a source of confusion to families.
5. AIU investigators are expected to work closely with a multidisciplinary team including police and medical professionals and present the findings to the appropriate CAC. This may take several





months to complete. In many cases, there are no child protection concerns, and no further child and family services required by the family.

6. Cases that are waiting for the CAC and/or medical and/or police reports must be kept open. As no other services are required, and since open cases must have a worker assigned, ANCR has a practice of assigning these cases to the Intake supervisors. This is intended to have a "placeholder" function only, until the reports are received and the file closed.

Cases that are "Abuse Only" are also assigned to Intake supervisors. These are cases where an abuse investigation is in progress, but where no other child protection concerns exist and no other CFS services are required. An example of such a case is that of a third party assault against a child, where parent(s) are able to provide the appropriate care and support to the child. In such cases, there are no case services provided. The family is aware of the open file because the abuse investigation is underway. The main contact for the child and the family would be with the AIU investigator.

In May/2009, 978 such cases were assigned to Intake supervisors. Some of these cases have been open for months. The more immediate and concerning issue here is that little communication between the AIU and the Intake supervisors occurs around most of these cases. Intake supervisors report that they are sometimes not sure if investigations are still in progress on some cases or if they have been completed.

7. The *Child and Family All Nations Coordinated Response Network Abuse Investigation Services Program Manual, January/2007* indicates that staffing in the AIU consists of two supervisors, sixteen abuse investigators, two administrative support staff, and a staff dedicated to provide administrative support to the CACs.
8. As of November 30/ 2009 the AIU reorganized into three abuse investigation teams consisting of a total of 24 AIU social workers (8 investigators plus 1 supervisor per team). In addition, there are three administrative support staff (one for each team), the administrative support to the CACs, and 1.5 clerk typist positions. As of February/2010, four positions remain vacant, including the third supervisor position and 3 abuse investigators. All other positions were filled.
9. While the exact responsibility of the third unit is not yet fully articulated, it is expected to provide services to particular groups of children. Two workers will be dedicated to abuse investigations involving sexually exploited youth. These investigators will not be utilized for other abuse investigations or to deal with any back logs that may occur on other abuse investigations.
10. Most of the employees in the AIU are relatively new to this position. There has been high turnover of staff in the AIU. This was due to a recall of secondees, as well as staff resignations. Turnover has occurred in the supervisor positions.



11. Staff in the CFS agencies had some positive comments about the AIU. Generally, the feeling was that the AIU could make some improvements to live up to its full potential.
12. The burden of responsibility on AIU supervisors is heavy at this time. While a third supervisor is being recruited, there are 2 supervisors for 21 investigators, along with 5.5 administrative support staff and two contracted case aides. The level of supervision required is high, given the relative inexperience of the abuse investigators. This requires considerable attention to training, supervision, guidance and consultation. In addition, AIU Supervisors coordinate the CACs.
13. There are concerns that supervision is not available as needed and that direction provided is inconsistent.
14. The time spent preparing cases for the CACs increases the work load of the supervisors, as well as the duties of the administrative support for the CACs. It was reported that when the CAC requests follow up work, it increases the time that the file remains open. AIU staff estimated that there are more than 100 cases waiting for court decisions or letters from the police. It is noted that these cases do not require further CFS services.
15. An AIU Trainer position was contracted for a term. Staff reported this to be a valuable resource. This is not a funded position and the contract was not renewed.
16. Most AIU Investigators reported receiving training which introduced them to the organization and helped prepare them for assuming abuse investigation functions. Training opportunities have been available to AIU employees. Staff reported favourably on the benefits from this training.
17. The AIU receives referrals for abuse investigations through two processes: internally from other ANCR programs and externally from other CFS agencies. In 2008, a total of 1220 referrals for abuse investigations were made to the AIU. 960 of the referrals, or 73% of the total referrals, were directly from the ANCR Intake programs and 260, or 27% of the referrals, were from other CFS agencies.
18. Of the referrals from other CFS agencies, 45% came from agencies responsible to the SFN Network of Care, 37% from agencies responsible to the General CFS Authority and 9% each from agencies responsible to the First Nations of Northern Manitoba CFS Authority and the Metis CFS Authority.
19. From the 1220 referrals, 638 involved sexual abuse allegations and 582 involved physical abuse allegations.
20. Abuse was substantiated in only 11% of the referrals. It was found that abuse did not occur in the 37% of the referrals. In 21% of the referrals, the abuse investigation found that the allegation was



inconclusive and a finding could not be made, although in 16% of the referrals inappropriate behaviour was determined.

21. Not all of the referrals received by the AIU require a full abuse investigation. This is confirmed by the number of referrals where the finding is that no abuse occurred. There are referrals which could, and perhaps should, be handled by the Intake unit, or, if open to a family service worker, by that case manager.
22. Being unable to access accurate and up to date information on children and families on CFSIS has implications on the ability to conduct investigations and is a source of frustration for AIU workers when immediate information is required.
23. Individuals performing search functions through 'Prior Contact Checks' are unable to see that an abuse investigation is in progress on a case. Client information in the 'Person Profile' on the IM only shows the name of the case manager and does not indicate that an AIU worker is involved with a family. This additional information is available when a further search is made and the 'Issue Management' window is accessed. This is not routinely done when a case search is required, resulting in the potential to miss this important piece of information when checking a case on the IM.
24. In substantiated abuse cases, 63% involved a physical abuse and 37% involved a sexual abuse.
25. In 2008, a total of 717 abuse investigation referrals were closed and 119 transferred out to other CFS agencies. While 69% of the abuse investigation referrals were either closed or transferred in 2008, 31% remained to be completed.
26. A file audit reviewing compliance with response times identified at the point of entry to the Intake system, found that only one half of the Intakes requiring a 24 hour response actually received a response within that time frame. Of 21 files where a 24 hour response was determined, only 11 were responded to within this time frame. Similarly, in 53 files calling for a 48 hour response, only 28 files received a response within that time frame.
27. Information available in the IM database presented difficulties in determining the time between an initial referral to the Intake system and the actual time that an AIU worker received the investigation referral.
28. Safety Assessments were not completed on any of the files audited.
29. Findings on worker compliance with response time identified on the IM suggests that worker response is more determinant on knowing if a child is safe than on the response time frame identified in the IM.



30. Only 56 of the 83 files reviewed contained a formal abuse investigation report. In 11 files, the report was in the form of a transfer or closing summary and no report was available in 16 of the files. Where an abuse investigation report was available, it was very thorough and well organized.
31. Sixty-seven (67) files were reviewed for the length of time it took from referral until an abuse investigation report was completed. Findings showed an average length of time of 7.5 months to complete the report following a referral.
32. A comparison of the length of time between case referrals and case conclusions showed a gradual decrease in the time it took to conclude cases from 2007 to 2009. In 2007, cases were taking over one year to conclude; in 2008 this decreased to 4 months, and in 2009 this further decreased to three months.
33. Files are not always closed immediately following conclusion. In 2009, the average length of time that files were open to the AIU was 9 months.
34. Although cases are closed on the IM, it was found that information continued to be added, modified or otherwise amended. This became more apparent in recent files where the cases were closed sooner.
35. In the audited files, 13% required medical involvement and 35% had police involvement. The remaining 52% of abuse investigations were completed without the involvement of these collaterals.
36. The ability to utilize the CFSIS database with any degree of success was frequently mentioned. Most of the criticisms reflected incomplete, inaccurate and out of date information that was not useful or helpful. Staff were equally frustrated with the IM system.
37. Several AIU investigators reported having caseloads between 95 to more than 100. In many of these cases, the investigations have been completed. The files only require completing the paperwork to close them. One half of the employees interviewed had a least 20 such cases to close. One reported having 93 cases to close.
38. The number of active cases ranged from 7 – 60, with the higher number of cases being carried by the most experienced workers.
39. AIU investigators identified that their most urgent needs were consistent supervision, available when needed; opportunities to take essential training; and manageable caseloads.



40. Generally AIU staff reported that the working relationships with other CFS agencies were positive. Some difficulties were noted: referrals were highly variable, often lacking information and a case plan; difficulties in contacting the other CFS worker; limited, if any, information on CFSIS to assist them in an investigation.
41. The timeliness of investigations and the decisions of the CAC were cited as problem areas. Agencies, as well as families, await the outcome, sometimes for months. This is stressful for the family and hinders ongoing case planning. Inconsistent feedback from the CAC was also identified as a problem area.
42. There was a need identified for more contact between the AIU and other CFS agencies. This contact should include face to face meetings as well as "real" voice to "real" voice contact in order to obtain initial information, clarify responsibilities and expectations, provide updates on case progress, consider recommendations, and share the outcome of investigations.
43. Written materials outlining the AIU mandate and processes, together with staff names, phone and fax numbers should be available.
44. Attitudinal issues of some staff need to be addressed. Aboriginal agencies noted that some AIU staff convey an attitude and unspoken message that they believe that Aboriginal agency workers are less skilled.



## ***Recommendations for the AIU***

### **Sec.2:1**

It is recommended that a streamlined and strengthened abuse referral criteria be developed for all referrals of cases for abuse investigations by the AIU.

*Reports from AIU workers and an examination of data maintained by the AIU show a clear disconnect between referrals and abuse conclusions raising questions about the appropriateness of the existing criteria for abuse referrals. Large numbers of abuse referrals result in findings that abuse did not occur. As a result, there is reason to be concerned that the referrals were not suitable for an abuse investigation, and could have been investigated by an Intake worker. The criteria for referring a case for an abuse investigation needs to be examined, probably narrowed and strengthened in keeping with similar expectations for decision-making by the Intake Screening and Assessment Unit.*

### **Sec.2:2**

It is recommended that criteria such as decision-making trees be used to guide Intake screeners through the decision-making process with respect to which cases require Intake or which require abuse investigations.

### **Sec.2:3**

It is recommended that a committee be established to review the 978 abuse only cases assigned to Intake Supervisors with the task of closing all inactive cases and acquiring up to date information on the status of the cases still active with the AIU.

*AIU workers are limited to a specific investigation function in abuse cases. They are not case managers. If a new case is referred to the AIU, it is also assigned to an Intake worker. When there are no other child protection issues, the practice has been to assign the case to an Intake supervisor to reduce the workload of Intake workers. In May/2009, there were 74 abuse cases assigned to Intake workers and 978 cases assigned to Intake supervisors. No active services are provided when a case is assigned to an Intake supervisor. Some Intake supervisors have had no contact around these assigned cases for months. This is a concerning practice as the potential for negative implications is high and needs to be re-examined for other feasible alternatives.*

### **Sec.2:4**

It is recommended that this committee make recommendations on feasible alternatives for case management in circumstances where there are no other child protection concerns, but an abuse investigation is in progress.

### **Sec.2:5**

It is recommended that this committee develop policies and practice standards for service responsibilities, information sharing and record management when a case is referred for an abuse investigation.



#### **Sec.2:6**

It is recommended that ANCR complete a thorough analysis of referral data, abuse investigation findings and closings/transfers to determine the appropriateness of referrals to the AIU. Further expansion of the AIU abuse investigator positions should be put on hold until this analysis is completed. AIU staffing levels should be finalized based on this analysis.

*Increasing the number of staff in the AIU should stop immediately and a thorough analysis of the data on referrals, abuse investigation findings and closing/transfer information should begin as soon as possible. The data available to reviewers suggests that referrals may be inappropriately coming to the AIU. Given the volume of inappropriate referrals and the recommended narrowing of the referral criteria, it may be necessary to rethink the current movement in expanding the AIU.*

*The AIU is already staffed with many new AIU investigators. Twenty one AIU investigators, most with less than 18 months of experience in abuse, are supervised by two supervisors who are also responsible for tasks associated with the CACs. This limits the amount of training and supervision that can be provided to new employees.*

*Adding new employees will delay the stabilization of the AIU team and the confidence-building relationships that need to be re-established with other collaterals and CFS agencies.*

*More precise decisions around staffing, guidelines and criteria will require further analysis of service volume and additional research and examination of various Intake and abuse investigation guidelines and decision-making criteria.*

*Following a further analysis of abuse investigation referrals after narrowing the abuse referral criteria, the staff resources in the AIU will need to be reviewed. If the staff resources invested in the AIU are not supported given the findings, a reduction process may be necessary.*

#### **Sec.2:7**

It is recommended that ANCR take immediate action to relieve the workload of the supervisors in the AIU. Supervisor to worker ratio should be reduced from 1:8 to 1:7, and supervisors should be freed from the responsibility of coordination of the Child Abuse Committees (CACs).

*Supervisors should be free from the other responsibilities in order to focus on providing guidance, support and performance feedback to the AIU investigators and the other employees within the AIU. This is important to creating a strong and respected abuse investigation team. Supervising 8-9 AIU investigators is too large a workload for supervisors.*

#### **Sec.2:8**

It is recommended that an in-house AIU trainer/staff mentor position be established.



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**Sec.2:9**

It is recommended that a Child Abuse Coordinator position be established, with responsibility to coordinate all functions associated with the CACs and the related tasks of liaising with interdisciplinary members of the child abuse team.

**Sec.2:10**

It is recommended that ANCR develop protocols and procedures for moving abuse cases between Child Abuse Committees if a backlog occurs at one of the committees. This is necessary to ensure that cases can be closed in a timely manner. ANCR should develop these protocols in conjunction with the CFS Standing Committee.

**Sec.2:11**

It is recommended that ANCR create case aide positions for the AIU that can perform the ancillary tasks currently being done by the AIU investigators.

**Sec.2:12**

It is recommended that ANCR consider implementing the "third report rule" which requires that any case (household not child) which has been reported three times within a 12 month period is transferred for investigation on the third occasion.

**Sec.2:13**

It is recommended that ANCR develop a strategy for consistent and continuous communication with the CFS agencies on whose behalf ANCR is providing abuse investigative services. This should include written protocols and procedures for partnering on services to families and children.

**Sec.2:14**

It is recommended that written protocols for abuse case transfers, clearly delineating the role of the case manager and the abuse investigator, should be developed. This should include a clarification of roles and responsibilities and a mechanism for accountability.





## Section III: The Family Enhancement Unit

### Overview

The Family Enhancement Unit (FEU) was not included in the scope of the program model review.

There was a community program unit at WCFS, and resources for this were transferred to ANCR. Initially, this program operated at ANCR under the name of "Community Programs Unit". This unit is undergoing substantive change as part of a province wide initiative to implement a differential response service delivery model for CFS.

To provide a full overview of ANCR, and to provide context to the pieces in this report that refer to the FEU, this section is intended to give a brief overview of the Unit, its staff, and the services provided at this time. A brief overview of a differential response service delivery system is provided.

### A Differential Response Service Delivery System

Trocme et.al. provides the following definition:

*"Differential response models, sometimes referred to as alternative response models or multi-track systems, include a range of potential response options customized to meet the diverse needs of families reported to child welfare. Differential response systems typically use multiple "tracks" "or streams" of service delivery, with at least one investigative track for high risk cases and an alternative "assessment" or "community" track for less urgent cases, where the focus of intervention is on brokering and coordinating other community services to address the short- and long term needs of children and families."*<sup>15</sup>

The current CFS service model uses a "one size fits all" approach, dealing with all families using a protection / adversarial approach. Families are assessed for service based on the degree of risk of the protection concerns. A family that does not meet the threshold or criteria for 'protection' - even though they are in need of supports - does not get services from CFS. Families who meet the criteria for "protection" all get the same approach, regardless of the degree of the risk.

Differential response is NOT a program or a project - it is a description of a process to respond to families at risk.

<sup>15</sup> Trocme, et.al Community collaboration and differential response: Canadian and international research and emerging models of practice CECW 2003



Having a "differential response service delivery system" means that the CFS system will use different ways of responding to the needs of families and children at risk – providing different services to different families, depending on the needs of the family and the level of risk as assessed by the agency.

Implementing a differential response service system will give CFS agencies a new capacity to provide support services where a child protection investigation is not warranted, but where families are struggling with challenges that, if left unaddressed, will likely result in children being in need of protective services in the future. It may add to the target group of families / children that get services from CFS.

Differential response service models are prevention focused in that the primary intent is to intervene early in a supportive manner so that the more intrusive and adversarial child protection response may not be required. The focus is on the full array of family needs, not just the immediate child maltreatment threat.

A differential response service delivery system includes prevention and early intervention activities as well as child protection activities. It will be supported by legislation, and will use a strength based approach to providing services to families, including family and community engagement strategies. It does not reduce or remove the responsibility of the mandated CFS agency to assess risk and to provide child protection / investigative services as required.

The decision to determine which type of response will be provided to a family is based on structured decision making, using a risk assessment tool, with an accompanying strength based family assessment tool.

### **Family Enhancement Services at ANCR**

The FEU will be the "prevention stream" of services offered to families at ANCR.

ANCR contracted with an external consultant to provide a review of the former Community Programs Unit and to identify where services and programs required changes or additions to better fit a differential response service model.

Given that such a transition of the service model is currently underway at ANCR, it was determined that this Review would not include the FEU. A review of this unit will be undertaken separately once the revised model is established and implemented.

### **Current Program Structure**

ANCR has some capacity to deliver preventive programs. There are two family resource centers in operation which do prevention work with families. Two Family Service Teams provide case services. These preventive services are currently available to families.



ANCR has started the work of revising the program model. In addition to the name change from Community Programs Unit to Family Enhancement Unit, ANCR has developed a draft procedures manual and completed some staff training in the use of the structured decision making process.

## **Staffing**

There are 37.6 full time equivalent positions in the FE Unit: 4 supervisors, 23.3 social work positions, 6.8 other professionals, 3 administrative support, and a .5 case aide position.

73% of the positions are direct hires, and 27% are seconded. 63% of the positions are designated as 'Aboriginal' and 37% as 'General'. 98% of the filled positions are staffed according to the position designation. 58% of the current staff is Aboriginal.

The following figure provides a information on the staffing of the FEU as of February/2010.

*Figure 101: Family Enhancement Unit Staffing*

Number of FTE positions	
Supervisor	4
Front Line	23.3
Admin Support	3
Other Professional	6.8
Family Support / Case Aides	0.5

Staffing Data	
Direct Hires	73%
Seconded (Permanent)	24%
Seconded (Temporary)	3%
Positions designated 'Aboriginal'	63%
Positions designated 'General'	37%
Not designated	
Positions filled according to designation	98%
Aboriginal Staff	58%
Vacancies	
1 Elders helper	
2 Family Service Team Worker	
1.5 Resource Center Worker	



Qualifications of Social Work Staff	
BSW/MSW	54%
Other related degree	13%
Info with WCFS	21%
Other	13%
10+ yrs of experience	29%
6-10 yrs experience	17%
3-5 yrs experience	21%
1-2 yrs experience	4%
Less than 1 yr experience	4%
Info with WCFS	21%
Missing data	4%

54% of the social work staff has a BSW/MSW degree. 13% have a related degree, and 21% have this information with WCFS. In 13%, the data was missing.

29% of the social work staff has 10 or more years of experience. 17% have 6-10 years of experience, 21% have 3-5 years of experience, 4% have 1-2 years, and 4% have less than one year of experience. For 21% of the staff the data was with WCFS.

To have an effective family enhancement program at ANCR, the Agency will need to address the following key areas:

- ANCR needs to develop an agency wide and agency specific service practice for differential response.
- ANCR needs to integrate a differential response approach throughout its entire intake process.
- All front line ANCR workers need to be provided with training on the ANCR differential response model and accompanying service practise.
- Case management and family enhancement services are integral to a differential response service model but need to be supported by comprehensive and immediate assessments of a family's strengths and their willingness and capacity to engage at the initial intake level.
- A strength based assessment needs to be integrated into the initial agency contact with families to secure immediate engagement of families.
- Systems and standards that support consistent assessments and case documentation need to be in place and well communicated to all staff.



- A risk assessment and structured decision making process (SDM) needs to be incorporated into the process and needs to be well understood by all staff.
- The array of prevention services available through ANCR, other CFS Agencies, and the community need to be clearly defined and well coordinated through protocols, referrals, service purchase agreements, and other service partnerships.
- Referral and transfer processes need to be strengthened and streamlined.
- ANCR needs to set up a process to clearly communicate to all of the CFS agencies in Winnipeg on whose behalf they deliver intake services how the differential response model, and the family enhancement program in particular, will be delivered at ANCR.

## ***Recommendations for Family Enhancement Unit***

### **Sec.3:1**

It is recommended that a quality assurance review of the FEU be undertaken by the SFN Network of Care no later than 2013/2014.



## Section IV: The Telephone System

### *Overview*

During the course of the service model review, issues about the telephone system were identified. This included concerns about the difficulty in calls getting through to the CRU, the lengthy wait times before calls were answered, and the use of a telephone answering service to take calls when workers were not available. As a result, and in conjunction with the service model review, the telephone services were examined in accordance with the following terms of reference:

- Volume of telephone calls
- Efficiency of the telephone systems
- Wait time before calls are answered
- Tracking of telephone activity
- Tiger Tel Communications answering service

The review of the telephone system involved several methods of data collection:

- Service reports provided by the Manitoba Telephone System (MTS) on the three telephone systems in use at ANCR - Interactive Voice Recognition (IVR), Universal Call Distribution (UCD) and Automatic Call Distribution (ACD) - were collected and reviewed.
- Review of correspondence in ANCR with regards to telephone services.
- Communication with Receptionists responsible for the UCD telephone system.
- Communication with all levels of staff using the telephone systems.
- Interview with the Customer Service Representative at the Tiger Tel Communication Inc.
- Consultation with a Communication Coordinator with MTS.

### **The Interactive Voice Recognition (IVR) System**

The IVR is a telephone system that allows a computer application to handle calls, and to interact with the caller via voice commands and key activation features during the call. The IVR system can respond to pre-recorded generated audio to further direct callers on how to proceed. For example, callers looking for access to a worker or the telephone number of another CFS agency can access this information through the IVR without having to speak with a receptionist.

During regular working hours all calls made to the two main published telephone numbers at ANCR are filtered through the IVR system. Callers have the option of directly accessing a staff person or another CFS agency through voice recognition and key activation features. If a caller is reporting a child



protection concern or wants to speak directly to an operator, the calls are directed to the front reception desk where two receptionists are available. Based on the nature of the call, the receptionists transfer calls to the appropriate sources or take messages. Callers are also able to find out ANCR's hours of operation by accessing one of the key activation options.

### ***The Voice Recognition Component***

The voice recognition component has been set up to reduce the number of calls involving personal assistance by featuring a voice recognition component that enables callers to directly access the staff person they want to speak to. The caller is prompted to state the first and last name of the person they want to speak to. Once the name is recognized by the system, the call is transferred to the appropriate extension.

Reviewers found that updating the directory does not occur on a regular basis and many staff currently employed at ANCR was not listed in the directory. At the time of this review (July/2009), the staff directory had not been updated since October 27/2008.

### ***IVR Usage during Regular Business Hours***

The majority of calls through the IVR system go directly to the receptionists. MTS set up an automated process for the IVR to automatically generate weekly reports on usage. Using the data available from the automated system, incoming calls to the IVR were reviewed for the months of March/2009 and April/2009.

The two receptionists staffing the reception desk at ANCR manage a significant number of telephone calls. According to the data on incoming telephone calls to the IVR system in the months of March and April/2009, 7197 calls were handled by the IVR system at ANCR during regular work hours. Out of the total calls, 6506 calls or 90% required direct personal contact by a receptionist. This averages out to 108 telephone calls a day during that period of time.

10% of callers used the voice recognition feature to access the direct line of the person they wanted to speak to, or used the feature to access the number to another CFS agency or to find out the hours of operation for ANCR.

Due to the volume of telephone calls that come through the IVR telephone system on an ongoing basis, a period of one week was selected for a more detailed review. Telephone calls to the IVR telephone system were collected from March 23 - March 29/2009. This seven-day period was reviewed for the volume of calls, call distribution details, and the number of calls that were abandoned.

A total of 1093 telephone calls were made to the IVR system during regular working hours from March 23-27/2009.

- 19% of the callers used the voice activation process to connect with a worker



- 4% used the activation key to connect with another CFS agency
- 77% of the calls required direct contact with a receptionist
- 11% of the calls were abandoned or terminated after contact with the IVR

The detailed review shows a slightly higher use of the voice activation component during the week of March 23 – 29/2009 compared with the data collected in March and April/2009. 19% of callers used the voice activation feature to obtain a staff telephone number during this week compared to the 9% reported in the IVR data reports for the months of March and April/2009.

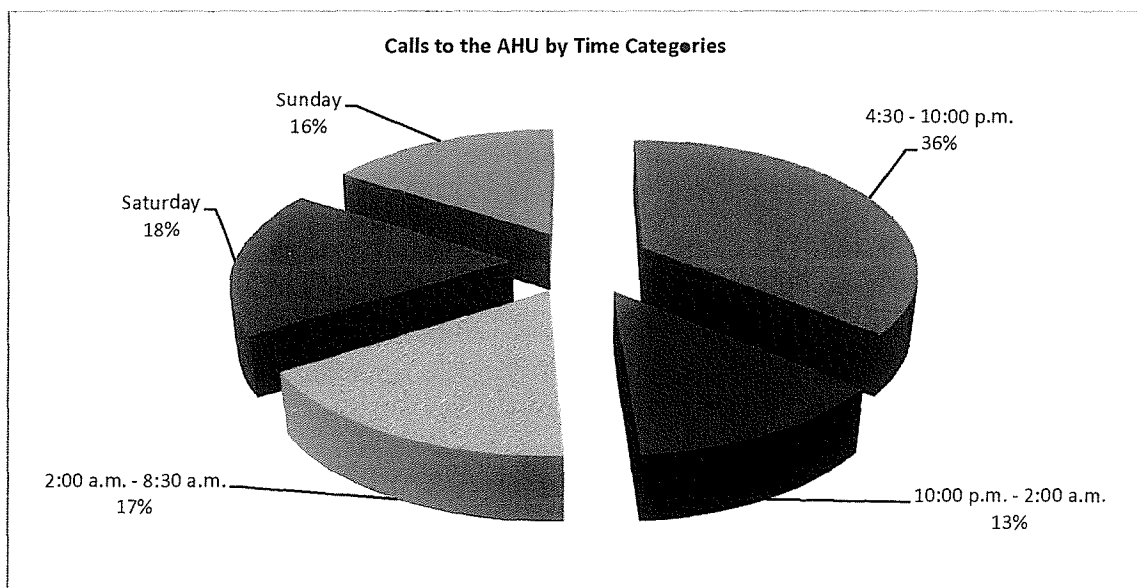
### ***IVR Telephone System Usage after Regular Working Hours***

At 4:30 p.m. until 8:30 a.m. on weekdays, and on Saturdays and Sundays and statutory holidays, the IVR telephone system changes to accommodate the After Hours Unit (AHU). Compared with regular working hours, callers do not have the same options to choose from. Calls made to AHU are generally either rerouted to the queue or to Tiger Tel, a telephone answering service, or they are terminated by the caller before being responded to.

Callers to the IVR telephone system after regular working hours receive an opening message and then are asked to stay on the line for assistance. Calls to the AHU are then automatically distributed to the AHU queue. Calls that are not able to get into the AHU queue or have exceeded the maximum wait time are automatically forwarded to Tiger Tel, where an operator takes a message.

IVR data on calls after regular working hours was collected for the time period from March 23 – 29/2009 to review the number of calls made to ANCR after hours, the times that calls were made, and the number of calls that were abandoned.

Figure 102: Calls to the AHU by Time Categories







During the time period reviewed, 907 telephone calls were made to the IVR telephone system between 4:30 p.m. and 8:30 a.m. on weekdays, and during the day on Saturday and Sunday.

- 36% of all calls were made during 4:30 p.m. – 10:00 p.m. on weekdays
- 17% of calls were made between 2:00 a.m. and 8:30 a.m.
- 13% of calls were made between 10:00 p.m. and 2:00 a.m.
- 18% of calls were on Saturday and 16% on Sunday
- 16% of calls were abandoned or terminated by the caller

### **The Universal Call Distribution (UCD) Telephone System**

All telephone calls to ANCR during regular work hours can be directed to the reception desk. The reception desk is staffed by two receptionists/operators who transfer calls, take messages or re-direct calls as required using a UCD telephone system.

This system includes two telephones for queuing, distributing and routing calls. The UCD queue can hold up to twenty calls. When the maximum number of calls is exceeded or a caller waits in queue for over ten minutes, the queue shuts down and the call goes to the threshold route, which is a busy signal.

The front reception telephone system includes two rotary lines that are outside the UCD system and are also used for outgoing calls. Calls waiting for more than four minutes to get into the CRU queue are routed to the rotary lines.

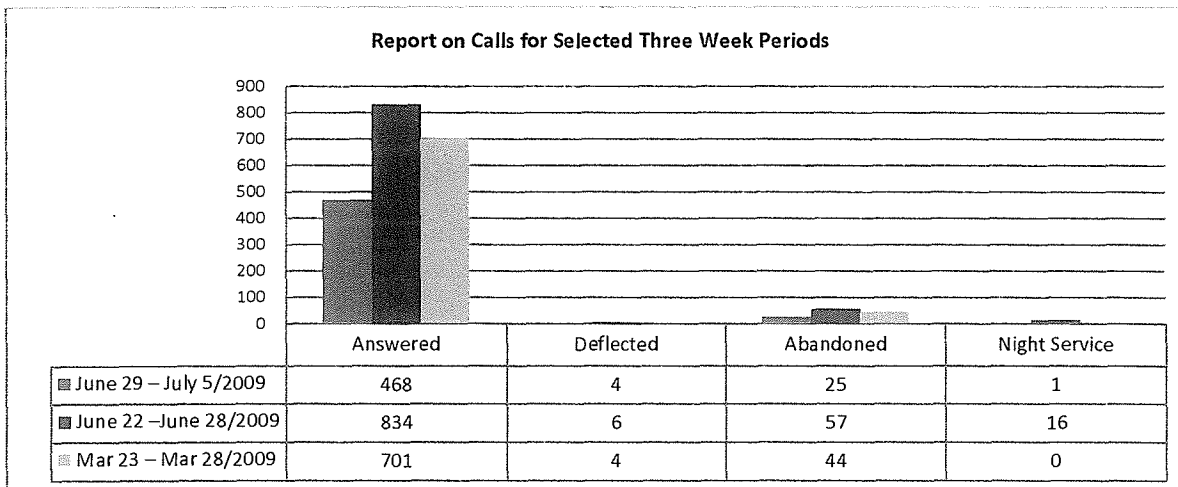
In the event that both reception switchboards are logged off, calls go to a specific telephone in the AHU. If the telephone is forwarded to Tiger Tel, the call is sent to the answering service. This can occur during the working hours when the receptionist has to leave the desk to search for a supervisor or program manager to answer an urgent call.

MTS can provide monthly reports on the operation of the UCD system at ANCR. Reviewers obtained reports for three-one week time periods: June 29 – July 5/2009, June 22 – 28/2009 and March 23 – 29/2009. Information obtained in the reports was used to determine the number of telephone calls to the UCD system, the number of calls answered within the maximum wait time and the number of calls deflected<sup>16</sup>, abandoned or directed to Night Service.

<sup>16</sup> Calls are deflected when the maximum capacity of calls in queue or the maximum wait time has been reached. Deflected calls go to the threshold rule, where a busy signal is heard, and are eventually sent to the Reception desk.



Figure 103: Report on Calls for Selected Three Week Periods



During the weeks examined, 93% of the total numbers of calls to the UCD telephone system were answered within the maximum time capacity. Less than 1% of the calls were deflected.

Abandoned calls occurred in 6% of the total number of calls to the UCD. 19% of the abandoned calls occurred between the time periods from 8:00 – 9:00 a.m. and 4:00 – 5:00 p.m. These periods of time reflect changes between the AHU and the CRU. Callers may be terminating calls when they learn that services have reverted from dayside to after hours or the other way around.

Less than 1% of calls went to the AHU. From the seventeen calls that went to the AHU during daytime hours, thirteen occurred on one specific day during a half hour time period. It is uncertain why this happened. It is more likely that calls go to the AHU during changes from dayside to after hours. This occurred in the remaining four calls.

Many calls to ANCR are requests to speak to a caseworker. When the caller does not know the name of the caseworker, a CFSIS check is done and the call is forwarded to the appropriate caseworker either at ANCR or at another CFS agency. If there is no assigned caseworker, the call is forwarded to the CRU. The caller waits in rotation until a CRU worker is available to take the call or the maximum holding time of 180 seconds is exceeded. If the call is not answered within the allocated time, it is returned to the switchboard and a message is taken.

The volume of telephone calls to ANCR is significant. Receptionists at the ANCR front desk report a steady stream of telephone calls for the duration of a regular workday. During the two month time period where call volume was reviewed, it was found that receptionists handled about 171 calls per day.

A concern reported was the lack of consistent availability of CRU workers to take telephone calls, especially if there was urgency in a child welfare matter. In those instances, the receptionists are placed in a position where they have to screen telephone calls for child protection urgency. For the most part,



messages are manually taken and placed in a distinct box for CRU workers to pick up and respond to. If a call was determined to be urgent then a supervisor or program manager would have to be located.

After 4:30 p.m., Tiger Tel operators are placed in the same position. Answering service operators, who are untrained in child welfare, are faced with judgment calls on the urgency of child protection matters when deciding if an AHU worker should be contacted or if a message should be taken.

## **The Automatic Call Distribution (ACD) Telephone System**

For the past three years the CRU has been using an automatic call distribution (ACD) telephone system – also known as the Perimeter Telephone System - to connect callers to an Intake worker. During regular business hours, receptionists directly forward all calls for Intake services to the CRU Perimeter Telephone System.

The Perimeter System features the ability to queue incoming calls to a pool of agents. If no agents are available at that time they may hear a recorded message and the call is kept in a holding queue until the next agent is available.

Three calls can be held in queue while they wait for an available CRU worker. The maximum wait time is 180 seconds or three minutes. Calls on hold when the maximum wait time is reached can be deflected back to the receptionist or routed into the time delay threshold route. When the maximum threshold is reached, callers hear a busy signal. Callers that are still in queue at 240 seconds or four minutes are routed to a two-line rotary telephone at the front reception desk.

The Perimeter system features monitoring tools, automated messages that can be changed as required at any time and a comprehensive data reporting capacity. The Perimeter telephone system features a comprehensive data reporting application and monitoring function that allows for calls to be monitored at all times. This allows the program manager and supervisors of the CRU to view the number of staff that is logged on at any time, track the number of calls in the queue, and generate a wide range of standard and custom reports. Along with the telephone system, a server has been installed in the office of the Program Manager so that reports can be locally produced using data generated from the daily use of the telephone system. Reviewers found that the capacity of this system and its actual utilization is quite different. Management acknowledges that the Perimeter system is not being used to its fullest capacity. They report that this is, to a large extent, due to time and workload constraints and a lack of knowledge and training. Another barrier is that training from MTS is very costly.

The Perimeter telephone system is a highly complex system that requires a great deal of time to input, update and review reports if it is to be used to its full potential. The system was installed approximately three years ago under the direction of a former IT Coordinator.

The new IT Coordinator has not become familiar with the capacity or maintenance needs of the Perimeter system. The CRU Program Manager is also new and is learning about the system. At the time



of the review, it was found that there was no designated person responsible for the telephone systems and a number of issues needed to be addressed including:

- Updating the list of CFS agencies in the IVR system; this list appears to have not been updated since November/2008.
- Updating the Staff Directory; this was last updated in late October/2008.
- Training for the CRU Program Manager and the IT Coordinator on how to generate statistical reports from the Perimeter server.
- Training for supervisors in CRU on how to use the supervisor add-on module to monitor log ins/outs and calls waiting in queue.
- Consistent logging in and out of the system by workers.
- Determining an accessible location for the server.

## **Review of Telephone System Usage**

The Perimeter telephone system has the capacity to generate a variety of reports on its effectiveness and efficiency. With the assistance of a MTS Communication Consultant, a number of service reports were collected and analyzed for this review.

The telephone system usage in the month of March / 2009 was reviewed for:

- CRU availability for incoming calls.
- Incoming calls to the CRU Perimeter system.
- Level of service compared to industry standards.<sup>17</sup>
- Outgoing telephone calls by CRU workers.

### ***CRU Availability for Incoming Calls***

The Perimeter system maintains detailed information on the agents, or in this situation, the CRU workers, that respond to calls via this system on a daily basis. By monitoring the time that CRU workers log in and out of the telephone system, reports can be generated to reflect a wide-range of telephone activity.

The basic premise is that CRU workers log into the telephone system when available to take Intake calls and log out of the telephone system when no longer available to take calls. In between, workers can touch the “make busy” key, which indicates that while they are logged into the system, they are involved in other activities and are unable to respond to calls.

<sup>17</sup> The level or grade of service refers to the number of calls answered in accordance with industry standards, which dictates that all calls should be answered within 25 seconds. The industry standard is used by the MTS and refers to the acceptable length of time for a telephone call to be answered in a basic call centre environment. A basic call centre environment is not an accurate descriptor of the current system at ANCR, however, the grade of services provides a comparative benchmark, or baseline.



According to the data reports, an average of six CRU workers was available to take calls daily. This number is accurate in accordance with the CRU program model. However, the accuracy of this data is contingent on a consistent pattern of logging into the Perimeter telephone system when available to take calls and logging off when the worker is unavailable.

There are inconsistencies with regard to the pattern of logging in and logging out. A number of CRU workers do not log out at the end of the day and are reported as being logged in even after work hours.

An examination of "Agent Detail Reports" for twelve CRU workers during the week from March 23 – 29/2009 showed that ten workers did not log out of the system at the end of their workday and were shown to be available to take calls on a 24-hour basis. Nine workers did not log out at all during this week, while one worker only occasionally logged out. Two CRU workers used the system appropriately showing daily log in and log out activities. As a result, it is not possible to confirm that all six CRU workers, scheduled to take telephone calls, were actually available and taking telephone calls during this week.

The 'All Positions Busy' report tracks the amount of time that CRU workers are not able to accept calls from the queue by the amount of time that they are either responding to a caller, logged out of the telephone system or unavailable because they have executed the "make busy" function. Data from this report was examined for the 22 working days in the month of March/2009 during the daytime hours from 8:30 a.m. to 4:30 p.m. The following chart indicates the percentage of time during each day that CRU workers were unable or unavailable to accept a call from the Perimeter telephone system queue.

Figure 104: Percentage of Time Each Day CRU Workers Unavailable to Accept Calls (March/2009)

Percentage of Time Each Day CRU Workers Unavailable to Accept Calls (March/2009)										
02	03	04	05	06	09	10	11	12	13	16
78.0%	21.2%	66.8%	87.7%	88.4%	95.7%	88.2%	100%	96.1%	33.6%	22.2%
17	18	19	20	23	24	25	26	27	30	31
33.9%	81.9%	56.2%	77%	65.8%	75.2%	64.4%	83.1%	71.4%	49.8%	24.7%

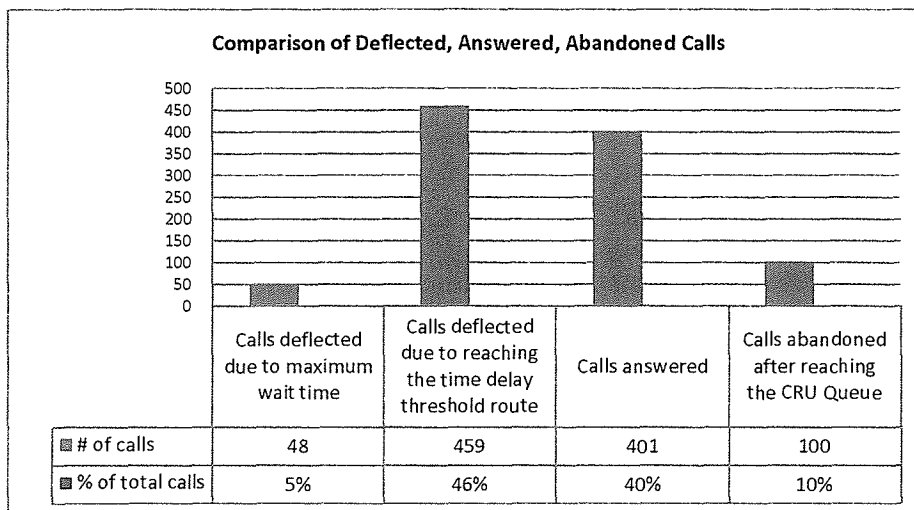
During regular daytime work hours, CRU workers were unable or unavailable to accept intake calls through the Perimeter telephone system an average of 66% of the time, leaving the receptionists to respond to calls and take messages or locate an available supervisor or program manager if calls were urgent.



## ***Incoming calls to the CRU Perimeter system***

Incoming call termination reports track the path of incoming calls routed through the Perimeter system. Data is available on calls prior to their reaching the CRU queue and following their position in the queue. The number of calls that were deflected or terminated before reaching the CRU queue in the month of March/2009 were examined in comparison with the number of telephone calls that were either answered or abandoned after reaching the CRU queue.

*Figure 105: Comparison of Deflected or Terminated Calls with the Number of Calls Answered or Abandoned in CRU Queue*



A total of 1008 telephone calls were routed to the CRU queue during regular daytime hours in March/2009.

Calls deflected, either due to maximum wait time or after reaching the time delay threshold, accounted for 51% of the calls, meaning they did not get through to the CRU and were transferred to the receptionists.

40% (401) of the total calls were answered by a CRU worker.

10% (100) of the total calls were abandoned after waiting in one of the three positions in the CRU queue.

During that same time period, worker availability data suggests that workers were available to respond to calls 34% of the time available during regular working hours.

## ***Level of Service Compared to Industry Standards***

Perimeter telephone system data is maintained on a daily basis. By examining daily telephone records, the fluctuations in daily telephone responses can be observed. As a result, daily telephone reports were



selected for nine days in March/2009; the Monday and Friday of each week were selected and examined for:

- The number of calls answered.
- The percentage of calls abandoned.
- The *Grade of Service*<sup>18</sup>.
- The number of outgoing calls that CRU workers made on the same day.
- Average wait times for callers.

Figure 106: CRU Telephone Calls Grade of Service

Date	Percentage of Abandoned Calls	Grade of Service	Number of Answered Calls	Number of outgoing calls
Mon March 2/2009	35%	39%	20	129
Fri March 6/2009	57%	7%	6	100
Mon March 9/2009	55%	18%	5	106
Fri March 13/2009	0%	88%	32	93
Mon Mar 16/2009	11%	72%	42	67
Fri March 20/2009	0%	68%	19	114
Mon Mar 23/2009	21%	52%	26	100
Fri March 27/2009	10%	48%	19	99
Mon Mar 30/2009	14%	72%	25	67

The data suggests that although there are daily fluctuations in the numbers of calls that are abandoned, the average percentage of calls abandoned is 23%.

The CRU is consistently below the industry standard of answering calls within 25 seconds. The average grade of service falls at 51.5%. A favorable grade would be in the 90% level according to MTS service representatives. The grade scores examined during this time period, suggests that callers are waiting well over the 25-second acceptable time limit before their calls are answered.

The number of telephone calls answered by CRU workers is disproportionate to the number of telephone calls they made daily. An average of 22 calls was answered every day, while an average of 97 outgoing telephone calls was made every day. With six staff positions responsible for Intakes to the CRU

<sup>18</sup> This category assigns a percentage score based on the number of calls that were answered according to industry standards; that is, answered within 25 seconds. A higher % is interpreted as greater compliance with answering calls within the 25-second time limit.



each day, this number averaged out to four incoming calls answered and sixteen outgoing telephone calls by each staff person each day.

### ***Average Wait Times for Callers***

The same nine days used to show the number of calls answered and abandoned, were used to illustrate the average speed of answering a telephone call and the average wait before a call was abandoned. This data refers to the telephone calls that were already waiting in queue. Maximum wait periods are included to illustrate the maximum length of wait time that occurred before a call was answered and again before a call was terminated.

*Figure 107: CRU Wait Times for Calls in Queue*

<b>Date</b>	<b>Average Speed of Answering Call</b>	<b>Maximum Wait to Answer Call</b>	<b>Average Wait to Abandon Call</b>	<b>Maximum Wait to Abandon Call</b>
Mon March 2/2009	50 sec	3.8 min	3.4 min	4.8 min
Fri March 6/2009	1.9 min	3.6 min	2 min	3.8 min
Mon March 9/2009	47 sec	1.8 min	2.4 min	3.7 min
Fri March 13/2009	19 sec	3.7 min	0	0
Mon Mar 16/2009	27 sec	3.8 min	1.7 min	3.8 min
Fri March 20/2009	47 sec	3.9 min	0	0
Mon Mar 23/2009	46 sec	3.6 min	2.8 min	5.3 min
Fri March 27/2009	1.2 min	3.6 min	2.2 min	3.9 min
Mon Mar 30/2009	23 sec	3.9 min	1.3 min	2.4 min

The majority of incoming telephone calls are answered within 60 seconds. Although this is somewhat higher than recommended, it is not unreasonable.

On a daily basis some callers wait for more than 3 minutes before their call is answered. The average wait before a call is terminated ranges from 2 – 3 minutes with maximum wait times extending up to 5 minutes before termination.

The maximum wait time with the Perimeter telephone system is 180 seconds or three minutes. When the maximum wait time has been reached, calls are either deflected to the receptionist or sent to the threshold route, which is a busy signal. If callers continue to wait, at 240 seconds (four minutes) the call will be forwarded to the reception desk rotary line and answered by a receptionist.





## ***CRU Staff and the Perimeter Telephone System***

Several staff working at the Reception and CRU levels were given opportunity to discuss the efficiency and efficacy of the telephone system as an emergency response tool. Reception staff voiced their concerns about difficulties in getting calls through to the CRU because of inconsistent availability of workers to accept calls and urgent calls are not able to get through to the CRU. They find themselves in a position where they are screening calls with regard to urgency and at times having to leave the desk to go find a Supervisor who can take the call. The concerns of reception staff were not as much with the telephone system as with the availability in staffing to ensure telephone calls to the CRU are getting responses.

Staff was not knowledgeable of, or that interested in, the information generating capacity of this system. They were only slightly aware of the monitoring function and did not think any monitoring was really occurring. Staff was satisfied with the telephone answering function and perceived this telephone system to be as good as any other. There were no specific concerns regarding the telephone system.

Concerns were broader and more reflective of workload and service issues. Staff reported that their workload, as a result of the division of responsibilities in the program model, does not allow them to dedicate time specifically to telephone work. The six staff scheduled to respond to telephone calls at any one time are often still catching up on work from the previous period of service delivery. The dual functions of telephone screening and service delivery often result in telephone screening time being used to transfer and/or complete reports.

## **The Perimeter Telephone System After Regular Work Hours**

The Perimeter telephone system was installed in the AHU in the fall of 2007 in nine telephone sets. It was reported that the process was not smooth and several initial technical concerns were reported with the system, including redirected calls and improper telephone numbers entered into the system. In February/2008, the AHU recommended the removal of the Perimeter system and return to the previous telephone system. MTS responded to the concerns and corrected the technical issues.

The difficulty getting through to speak with an AHU worker was a concern raised by both collaterals and AHU workers. AHU workers working in the field were having difficulty getting through to the office. To resolve this, a separate telephone line exclusively for the use of AHU staff was installed.

After regular work hours the main switchboard at ANCR closes down and calls to the IVR telephone system are automatically routed to the AHU telephone number. This number directs callers into the AHU queue. Similar to that during daytime hours, the AHU queue can hold up to three calls until answered, in rotation, by an AHU worker. If the maximum wait time in queue is exceeded or no workers are available to take calls from the queue, calls are automatically forwarded to the Tiger Tel answering service through a separate telephone system with three direct lines to the answering service.



The role of the answering service after regular work hours becomes much like that of the receptionists during regular work hours. By responding to all calls that are not answered by an AHU worker, it becomes necessary to screen calls for urgency and, on occasion, deal with emergency situations. To address the matter of call urgency, the Tiger Tel answering service has cell phone numbers for AHU workers and uses these whenever they determine there is a need to speak to an AHU worker.

Most staff is not aware of the detailed configuration of the Perimeter telephone system and is only using the call distribution part. More specifically, staff is using the log in, "make busy", and log out functions.

The AHU includes a large number of part-time and casual staff who work only a few shifts with considerable time between shifts; failing to log out at the end of the shift has implications for the way calls are managed in the Perimeter system. The effectiveness of the Perimeter telephone system is contingent on the consistent use of the log in and out feature. This Reviewer along with the MTS Communications Coordinator made a random check of telephone sets in the AHU on July 9/2009 and found that five out of the nine telephone sets showed that the last AHU worker had not logged out of the system.

A random scan of the Demand and Resource Report for the AHU group for the number of AHU workers still logged into the Perimeter telephone system after 8:30 a.m. on weekdays provided the following information:

Date	No. of Staff Logged In
Wed. March 4/2009	2 AHU staff logged in
Wed. March 18/2009	0 AHU staff logged in
Wed. March 11/2009	1 AHU staff logged in
Wed. March 25/2009	1 AHU staff logged in

### ***Review of telephone system usage***

The telephone system usage in the month of March/2009 was reviewed for:

- AHU availability for incoming Calls.
- Incoming calls to the AHU Perimeter system.
- Level of service compared to industry standards.<sup>19</sup>
- Outgoing telephone calls by AHU workers.

<sup>19</sup> The level or grade of service refers to the number of calls answered in accordance with industry standards, which dictates that all calls should be answered within 25 seconds. The industry standard is used by the Manitoba Telephone System and refers to the acceptable length of time for a telephone call to be answered in a basic call centre environment. A basic call centre environment is not an accurate descriptor of the current system at ANCR, however, the grade of services provides a comparative benchmark, or baseline.



## AHU Availability for Incoming Calls

Unlike the consistent staff composition of the CRU, the AHU staff composition includes permanent full time employees, permanent part time employees and casual shift employees. Because of varied work schedules, AHU workers are more likely to log in and out of the telephone system. 32 staff logged in and out of the AHU telephone system during the week of March 23 –29/2009. 29 staff did so consistently over the one-week time period, two staff only occasionally logged out and one staff did not log out at all. The majority of the staff only worked two to three shifts during this time period. This data was used to track the amount of time that AHU workers were not able to accept calls from the queue because they were either responding to a caller, logged out of the telephone system during their shift or unavailable because they executed the “make busy” function. This data was examined for all telephone activity outside of regular work hours in the month of March/2009.

The following figure indicates the percentage of time during each day that AHU workers were unable or unavailable to accept a call from the Perimeter telephone system queue.

Figure 108: Percentage of Time Each Day CRU Workers Unavailable to Accept Calls (March/2009)

Percentage of Time Each Day AHU Workers Unavailable to Accept Calls (March/2009)												
01	02	03	04	05	06	07	08	09	10	11	12	13
5.9%	6.3%	3.3%	2.6%	6.9%	5.0%	3.2%	12%	2.4%	27.9%	7.5%	4.5%	7.2%
14	15	16	17	18	19	20	21	22	23	24	25	26
15.9%	2.4%	2.3%	5.4%	2.8%	3.2%	6.3%	33.3%	9.6%	4.7%	4%	3.4%	5.1%
27	28	29	30	31								
2.3%	2.1%	13.5%	6.6%	3.5%								

AHU workers were available to accept incoming calls 93.1% of the time and unable or unavailable to accept intake calls through the Perimeter system an average of 6.9% of the time. This availability is significantly higher than that of CRU workers during regular work hours. The latter group showed an availability of 34% during the same month.



## ***Incoming Calls to the AHU Perimeter System***

Telephone calls are routed from the IVR telephone system somewhat differently after regular work hours than during daytime hours. The route is less complex. Calls are either routed to the AHU queue or, if unable to get into queue, to the Tiger Tel answering service. Three telephone lines are available for calls to route to the answering service. The Incoming Call Termination Report for the month of March/2009 shows the number of telephone calls offered to the AHU queue but deflected to Tiger Tel prior to reaching the AHU queue, the number of calls answered, and the number of calls abandoned after reaching the AHU queue.

*Figure 109: Telephone Calls Deflected, Answered or Abandoned After Reaching AHU Queue (March/2009)*

Calls deflected prior to reaching AHU queue	Calls answered	Calls abandoned after reaching AHU queue
1022	2200	100
30%	66%	4%

During the month of March/2009, a total of 3322 telephone calls were routed to the AHU Perimeter telephone system after regular work hours.

66% of calls are being answered by AHU. 30% of calls are not getting through to AHU workers resulting in the calls being deflected to the telephone answering service. 4% of calls are abandoned.

## ***Level of Service Compared to Industry Standards***

As with the CRU, Perimeter telephone system data for the AHU was reviewed for the number of calls answered, the percentage of calls abandoned, the *Grade of Service* and the number of outgoing calls made by workers. The daily telephone reports were selected for the same nine days in March/2009 that was used for the CRU and examined for:

- The number of calls answered.
- The percentage of calls abandoned.
- The *Grade of Service*.<sup>20</sup>
- The number of outgoing calls that CRU workers made on the same day.
- Average wait times for callers.

<sup>20</sup> This category assigns a percentage score based on the number of calls that were answered according to industry standards; that is, answered within 25 seconds. A higher % is interpreted as greater compliance with answering calls within the 25-second time limit.



Figure 110: AHU Telephone Calls Grade of Service

Date	Percentage of Abandoned Calls	Grade of Service	Number of Answered Calls	Number of outgoing calls
Mon March 2/2009	3%	94%	60	143
Fri March 6/2009	10%	81%	82	91
Mon March 9/2009	4%	95%	96	70
Fri March 13/2009	4%	91%	53	83
Mon March 16/2009	6%	92%	49	88
Fri March 20/2009	8%	85%	55	67
Mon March 23/2009	4%	93%	117	76
Fri March 27/2009	2%	93%	58	70
Mon March 30/2009	6%	93%	85	69

The data suggests that although there are some daily fluctuations in the numbers of calls that were abandoned, the overall percentages of calls abandoned is 5%.

The AHU unit is within the industry standard of answering calls within 25 seconds. The average grade of service during this time period was 91%. A favorable grade would be in the 90% level, according to MTS service representatives, and the AHU exceeds that level most days.

In addition to responding to an average of 73 calls each night, AHU workers made an average of 84 outgoing telephone calls each night. With approximately eight AHU workers on staff at different times each night, this averages out to nine calls answered by each worker and eleven outgoing calls made by each worker.

### ***Average Wait Times for Callers***

The same nine days used to show the number of calls answered and abandoned, were used to illustrate the average speed of answering a telephone call and the average wait before a call was abandoned. This data refers to the telephone calls that were already waiting in the AHU queue. Maximum wait periods are included to illustrate the length of wait time that occurred before a call was answered and again before a call was terminated.



Figure 111: AHU Wait Time for Calls in Queue

Date	Average Speed of Answering Call	Maximum Wait to Answer Call	Average Wait to Abandon Call	Maximum Wait to Abandon Call
Mon March 2/2009	7 sec	26 sec	10 sec	21 sec
Fri March 6/2009	14 sec	2.5 min	34 sec	1.8 min
Mon March 9/2009	8 sec	1.25 min	21 sec	35 sec
Fri March 13/2009	9 sec	36 sec	4 sec	5 sec
Mon March 16/2009	7 sec	55 sec	12 sec	31 sec
Fri March 20/2009	11 sec	2.6 min	36 sec	1.1 min
Mon March 23/2009	7 sec	1.1 min	53 sec	1.3 min
Fri March 27/2009	12 sec	3 min	41 sec	41 sec
Mon March 30/2009	8 sec	2 min	24 sec	1.15 min

The majority of incoming telephone calls to the AHU were answered within fifteen seconds.

The maximum wait time ranged from half a minute up to three minutes.

5% of telephone calls were abandoned after reaching the AHU queue.

The average wait to abandon a call ranged from 4- 53 seconds with the maximum wait time being just less than two minutes.

This information does not suggest that callers were abandoning calls because they were waiting too long in the queue.

### ***AHU Staff and the Perimeter Telephone System***

As indicated earlier, technical problems with the Perimeter telephone system following installation resulted in AHU staff recommending the removal of this system in favor of the previous system. Once the technical issues were corrected, AHU staff began adapting to the system.

Most staff reported concerns with the difficulty getting a call through to the AHU and the number of calls being answered by the answering service. Several staff provided examples of callers telling them that they already provided information and become resistant when they were asked to do so again. As the call was transferred from the answering service, the person the information was provided to was a telephone service operator. Other callers complained about the difficulty getting through and the long wait as the call was routed several times.



Most AHU staff are not that aware of the capacity of the Perimeter telephone system. They are only concerned with the functions related to answering incoming calls and making outgoing calls.

Most staff shown how to log in, use the "make busy" feature, and log out and follow this process every time they work a shift. Specific to these features, staff are mostly satisfied with the Perimeter telephone system. As a positive feature, they like the fact that calls are distributed in rotation. Some staff were concerned that the system does not reduce misuse and that activating the "make busy" key for lengthy periods of time to complete other work was a practice. For the most part, workers reported that the telephone system was working for them.

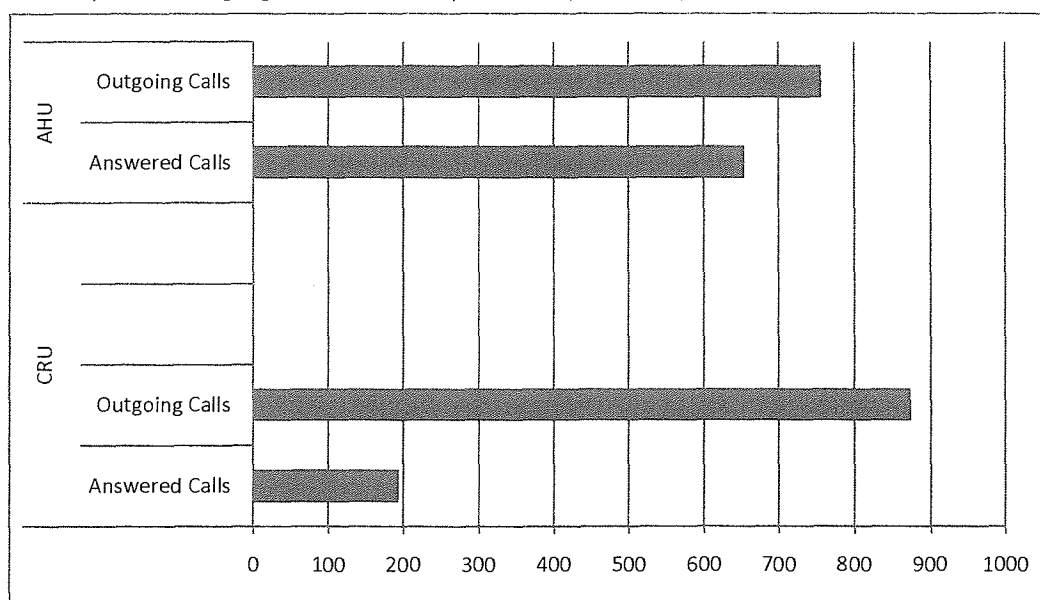
No add-in modules for AHU supervisor telephones leave them unable to monitor call activity. As a result, they cannot utilize the monitoring feature that this telephone system promotes nor can they access reports on telephone activity.

## **Comparing AHU to CRU**

### *Outgoing and answered calls*

The number of outgoing and answered telephone calls by the AHU and the CRU for the same nine days in March/2009 was compared.

Figure 112: Comparison of Outgoing and Answered Telephone Calls (March/2009)





CRU had more outgoing calls and answered considerably less calls than the AHU. The AHU was more evenly balanced between the two.

#### *Incoming answered / abandoned calls*

Figure 113: AHU Percentage of Incoming Calls Answered/Abandoned

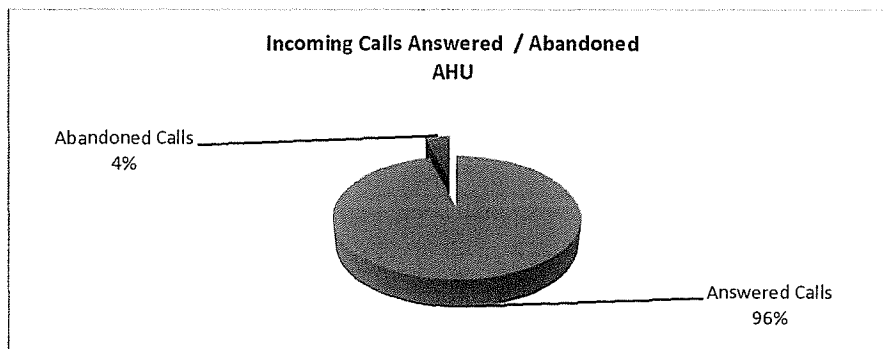
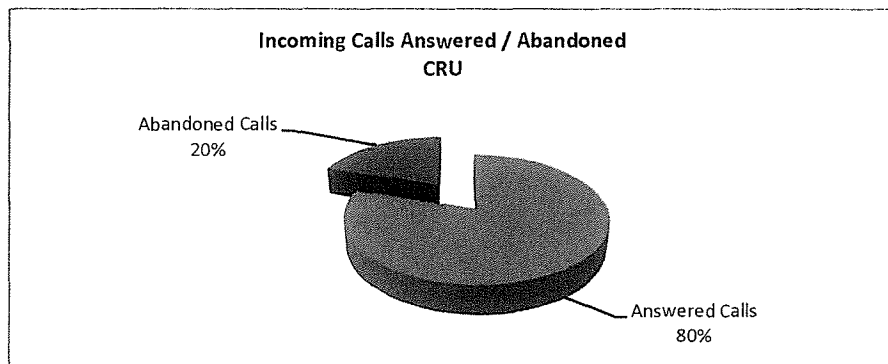


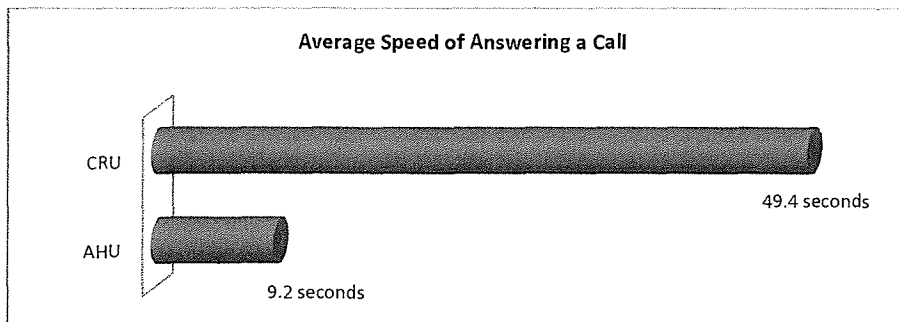
Figure 114: CRU Percentage of Incoming Calls Answered/Abandoned



Calls are less likely to be abandoned when they reach the AHU queue, compared to the risk of abandonment while in the CRU queue. 4% of the incoming calls in the AHU queue are abandoned. 20% of the incoming calls in the CRU queue are abandoned.

#### *Speed of answering a call / Wait times*

Figure 115: Comparison of CRU and AHU Average Speed of Answering a Call







The CRU program answered calls within an average speed of 49.4 seconds while the AHU responded to calls within an average speed of 9.2 seconds.

Callers in the CRU queue waited an average maximum of 3 minutes before abandoning the call. This is in contrast to callers who call the AHU and will wait an average maximum of about 48 seconds before abandoning the call.

The amount of time that calls wait in queue before being answered is also different for the two programs. While the average maximum wait time in the AHU queue is 1.6 minutes before being answered, the average maximum wait time before calls were answered in the CRU was 4 minutes.

### **Tiger Tel Communications Inc.**

Tiger Tel Communications Inc. has been providing telephone answering services to the After Hours Unit of WCFS since March 27/1986. The initial contract for this service was established with the Central Area of WCFS, and continued through the re-structuring of the CFS system in Winnipeg. Neither the Tiger Tel Communications Inc. nor ANCR has been able to locate a contract or agreement that establishes the working relationship between the two services. In February/2007, the Tiger Tel Communication Inc. submitted a proposal to ANCR with a quotation for service costs. There is no indication that a response was provided by ANCR. Management reports that communication with Tiger Tel has now been initiated to begin the process of securing a contract.

Forwarding of telephone calls to Tiger Tel can occur in three ways:

- Automatically at 4:30 p.m. when the main daytime switchboard closes.
- Automatically after 4:30 if all AHU telephone lines are in use.
- Manually by After Hours workers when they leave the office.

### ***Time Usage Reports***

Tiger Tel collects and maintains data by time usage; specifically the number of minutes that answering services are provided on each account. This data is collected in monthly usage summaries and used for billing purposes. More detailed reports include data on the number of minutes used for incoming calls, the number of minutes used for dialing out to a customer, the number of minutes used for patching calls from one caller to another and the number of minutes used to submit messages by fax machine. The reports do not contain information on the time that calls were received or made.

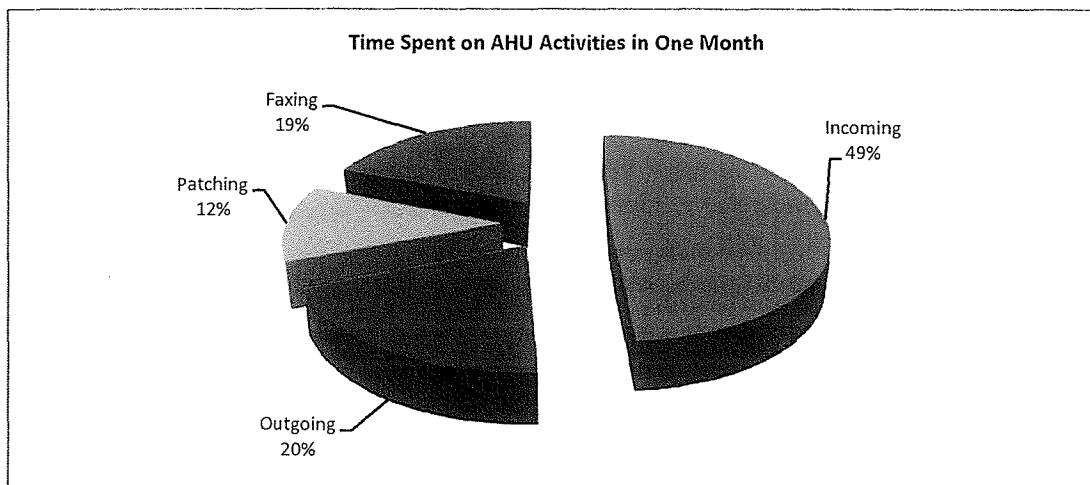
A monthly usage summary was acquired for the one-year time period from June/2008 – May/2009. Tiger Tel Communications Inc. provided a total of 33,802 minutes of telephone answering services to AHU during the one-year time period examined. This averages 2817 minutes, or almost 47 hours, of telephone answering services to the AHU on a monthly basis or approximately 1.5 hours of telephone answering services daily.



## Time Spent on Service Activities

The answering service maintains detailed monthly summary reports with the amount of time spent on specific activities. These activities include the time spent in answering incoming calls, making outgoing calls, patching calls from one person to another and faxing messages to the AHU. This information was condensed into the average number of hours that Tiger Tel spends on the following service activities for the AHU.

Figure 116: Tiger Tel - Percentage of Time Spent on AHU Service Activities



Approximately 49% of the time is spent on answering incoming telephone calls. Another 19% of the time is spent on outgoing telephone calls, most often to AHU workers. 12% of the time is spent in patching calls from one caller to another. Although requests for patching calls may not be frequent, patching activities are more time consuming than other activities. And 19% of the time is spent faxing messages to the AHU.

## Current Service Package

Tiger Tel Communications Inc. reported that they bill ANCR for telephone answering services in accordance with a base package that includes the following monthly cost breakdown:

Telephone answering fee	\$194.95
Holiday fee	\$15.00
Fax service fee	\$20.00
Account Maintenance	\$15.00

The package includes 100 free usage minutes and a cost of .90 for each additional minute. Regular cost increases occur on an annual basis on the first day of January every year. The Tiger Tel Sales



Representative advised that this package was very basic and that there were other, cost efficient service packages available.

### ***Cost of Service***

The cost of Tiger Tel services was reviewed for the months of December/2008, January/2009, and February/2009.

*Figure 117: Cost of Tiger Tel Services*

Month	# of min.	Amount
December/2008	2378	\$2 258.05
January/2009	2329	\$1 441.75
February/2009	1422	\$1 970.05

### ***Shift Configurations***

Tiger Tel Communications Inc. provides telephone answering services to the AHU between 4:30 p.m. and 8:30 a.m. Their customer service representatives work regularly scheduled shifts. There are four service representatives working the evening shift from 3:00 – 11:30 p.m. Only one service representative works during the midnight shift from 11:30 p.m. - 8:30 a.m.

All customer service representatives have access to an on-call Supervisor at all hour. The Supervisor is able to connect to the telephone system from a home computer. In the event that there is a system breakdown, emergency back-up coverage is provided by the Tiger Tel Communications office in London, Ontario.

### ***Training and Supervision***

Tiger Tel has a grading system to determine the level of complexity involved in telephone answering for specific organizations and services and matches the level of complexity to the most experienced employee. ANCR is considered to have complex service needs and is placed in the highest level where only senior experienced employees are matched to work with this agency.

### ***Child and Family Service Knowledge***

Although Tiger Tel requires that all customer service representatives go through a rigid training process, this does not include familiarity with services provided by the organizations purchasing telephone answering services from them. As a result, operators are not provided with information about the mandate of CFS and the nature of the emergency decision-making that may be required when a child is at risk of harm. As an answering service for an agency mandated to provide an emergency response, operators can be faced with circumstances that require urgent, informed decision-making.



While Tiger Tel currently has experienced operators taking calls on behalf of AHU, they have little information to support their actions in the event of a child protection emergency. The operator can only call an AHU worker or patch the caller to a cell phone number provided by the AHU. If the cell phone is in use, there may be no one to call.

Tiger Tel operators do not receive any training specific to CFS. They are not made aware of the *Child and Family Services Act* and the mandatory responsibilities associated with child protection. All Tiger Tel operators utilize an on line message pad that provides information on what may constitute an urgent call. This includes "all abuse, presence of violence, unattended kids, caller is a child". If such a call is received, the operators are instructed to call the AHU worker themselves or dispatch the call to an AHU worker.

It should be noted that Tiger Tel Communications Inc. provides telephone answering services for several other CFS agencies in the province of Manitoba.

### ***Confidentiality***

Tiger Tel requires that all their employees sign an *Employee Confidentiality Agreement* confirming their understanding of their responsibility in maintaining all information encountered during their employment with the Company confidential.

### **Summary of Findings**

1. The numbers of calls to ANCR using the central Interactive Voice Recognition (IVR) telephone system were reviewed for a period of one week from March 23 – 29/2009. A total of 1093 calls were received during regular working hours and 907 calls were received after regular working hours.
2. The majority of calls after regular working hours occur between 4:30 and 10:00 p.m. This accounts for 36% of all telephone calls after regular working hours.
3. Calls on Saturdays and Sundays account for 35% of all calls to ANCR after regular working hours.
4. The caller abandons approximately 11% of all calls during regular working hours and 16% of all calls after hours to ANCR. It is likely that callers who abandon calls will call back, as data indicates some level of frustration expressed by people when they do get through. It is also possible that some abandoned calls could represent risk to a child.
5. Assuming that the week of March 23-29/2009 is relatively representative of calls received at ANCR, the following table provides some projections for volume in a year:



Figure 118: Projections of Volume based on March 23-29/2009 Data

Projections of Volume based on March 23-29/2009 data			
	Day time	After hours	Total
Total calls (March 23-29/2009)	1,092	907	1,999
Calls per day	218	130	348
Calls per month	4,586	3,939	8,525
Calls per year	55,037	47,268	102,304
Calls abandoned in the week	120	145	265
Abandoned in year	6,246	7,546	13,792

6. There were 1256 new intakes created on CFSIS by ANCR in March/2009. Based on 80% of the referrals to ANCR coming by phone, it was projected that 1005 of these new intakes was a result of telephone calls. From this, one can project that for every 8 phone calls, one new intake is created.
7. In spite of automated voice recognition and key activation features, approximately 91% of all callers during daytime hours require personal assistance from the Receptionists.
8. There appears to be no dedicated staff person to ensure that the Staff and Agency directories in the IVR system are updated on a regular basis as staff changes occur.
9. The Universal Call Distribution (UCD) telephone system is used by Receptionists at ANCR to transfer or direct calls. This system has a queue capacity for 20 calls at a time and wait period of 10 minutes before callers hear a busy signal.
10. The UCD telephone system appears to be effectively queuing, distributing and responding to calls coming into to ANCR. A review on the operations of this system for a one month period showed that 93% of all calls that required personal assistance received a response. Only 1% of these calls were deflected and 6% abandoned by the caller. There were no concerns presented by the receptionists who use this system.
11. According to the receptionists, the larger concern to their work is the unavailability of CRU workers to accept Intake calls.
12. A review of worker availability in the month of March/2009 showed that CRU workers were available to accept incoming Intake calls on average 34% of the time. In eight of the 22 work days in March/2009, workers were available less than 20% of the day to take Intake calls.
13. During the time period reviewed, only 49% of all calls to the CRU actually get to the queue. The remaining 51% are deflected back to the Receptionists or are terminated by the caller.



14. The wait time for callers before they even enter the CRU queue can be lengthy. A caller can wait up to 10 minutes in the UCD system for a Receptionist to forward the call to the CRU queue; then wait from 3-4 minutes to enter the CRU queue. If still waiting at 3-4 minutes, the call can be deflected back to the UCD system and the caller waits for a receptionist to take a message or forward the call to the CRU queue again.
15. Once the call enters the CRU queue there is a wait for a CRU worker to answer. A review of wait times in the month of March showed that calls in queue were answered in an average time of 45 seconds. In some instances each day callers waited for up to 3 – 4 minutes before their calls were answered.
16. 9% of the total calls received during the time reviewed were abandoned before being answered by a CRU worker. Calls are reported as abandoned when the caller terminates the call.
17. Abandoned calls waited in queue for an average of 3.95 minutes before the call was terminated.
18. The grade of service is a percentage score that reflects the number of calls answered in accordance with industry standards, which is, answered within 25 seconds. A high percentage is interpreted as greater compliance with answering calls within the 25-second time limit. The grade of service reached by the CRU for the review period was 51.5%. According to MTS representatives, an acceptable grade of service should be in the 90% range. This information indicates that calls are answered within the 25-second time limit in just 51.5% of the time.
19. The number of calls answered by the CRU is disproportionate to the number of calls made by CRU workers. Nine randomly selected days in March were reviewed. During this time period, the CRU answered 194 incoming calls and made 875 outgoing calls. This averages out to 16 outgoing calls by each CRU worker every workday.
20. CRU workers are either not using or only inconsistently using the Perimeter telephone system functions as recommended. Nine out of 12 workers did not log out of the system at all, while 1 logged off occasionally. Only two workers followed the log in and log out procedure. Failing to log in and out affects data accuracy. Agent (worker) data reports were not useful in this review because the data on agency availability reflected 24-hour days and not the actual 8:30 – 4:30 p.m. day.
21. Neither the CRU worker nor supervisors are using this telephone system to its full capacity. There is little monitoring of CRU log ins, calls in queue, or worker availability.
22. At the time of this review, neither the Program Manager nor the IT Coordinator knew how to generate reports from the Perimeter database.



23. The Perimeter automatic call distribution telephone system was installed in the AHU in the fall of 2007, approximately 1 ½ years after it was installed in the CRU. The primary difference in the operations of this telephone system during afterhours is that all calls to the AHU that are unable to get through to an AHU worker are routed to the answering service.
24. The Tiger Tel answering service is able to access AHU workers through the Perimeter telephone system, the staff telephone, or a cell phone if a call requires immediate attention or to consult on an urgent call.
25. AHU staff were concerned about the long wait for callers to get through the system, as they experienced difficulty in getting through to the AHU when out in the field. As a result, a separate telephone was installed in the AHU exclusively for the use of staff trying to call the office.
26. Like CRU staff, many AHU staff are unaware of the detailed operations of the Perimeter telephone system. Most staff only use the log in, "make busy" and log out functions.
27. AHU Supervisors do not have the add-on modules to monitor worker availability, calls in queue, etc. According to the MTS representative, the unique composition of the AHU staffing configurations does not allow for the monitoring capacity.
28. Most AHU workers are logging in and out of the Perimeter telephone system as required.
29. A review of the availability to accept calls in the month of March/2009 showed that AHU workers were available to accept incoming calls 93% of the time. This compares to 34% availability by CRU workers during the same month.
30. A total of 3322 calls were made to ANCR after regular work hours in March 2009. 30% of the calls did not reach the AHU but were routed to the answering service. This compares with 51% of calls to the CRU during regular work hours routed directly to the Receptionists.
31. The remaining 70% of calls to ANCR after regular work hours went to the AHU queue. 66% of the calls were answered while 4% of the calls were abandoned in the queue. This compares with 49% of calls to the CRU that go into the queue. 40% of these calls are answered by a CRU worker and 9% are abandoned in queue.
32. The AHU showed a 91% level of compliance with the industry standard of answering calls within a 25 second time limit. In fact, the average speed of responding to a call was 9.2 seconds. The level of compliance for the CRU was 51.5% and the average speed of responding to a call was 45.4 seconds. According to MTS representatives, a compliance of 90% or more is considered a suitable level of service.



33. Tiger Tel Communications Inc. has been providing telephone answering services to the After Hours Unit of WCFS since March 27/1986. There is no formal contract, terms of reference, or service agreement in place.
34. An average 2817 minutes, or almost 47 hours, of telephone answering services is provided to ANCR monthly.
35. Approximately 49% of the time is spent on answering incoming telephone calls to ANCR. Another 19% of the time is spent on outgoing telephone calls, most often to AHU workers. 12% of the time is spent on patching calls from one caller to another and 19% of the time is spent on faxing messages to the AHU.
36. The cost of purchasing telephone answering services for the ANCR After Hours Unit averages \$1889.95 a month.





## ***Recommendations for the Telephone System***

### **Sec.4:1**

It is recommended that responsibility for the telephone system be assigned to an appropriate staff person to ensure the proper management of the system. This includes the development of operational procedures and regular updating of directories; provision of ongoing training and support for staff and management in the use of the system; and generating appropriate Perimeter system data for the purpose of reviewing and monitoring telephone activity and reporting progress.

*The telephone system at ANCR is a modern one, with multiple functions which can support the work of the Agency. The system permits the user to change the threshold and reporting levels, allowing ANCR to fine tune the capacity of the system to support quality assurance monitoring.*

*Based on the findings of the Review - directories not updated; senior managers not able to operate the reporting modules; staff not complying with log out feature; staff overusing the 'make busy' feature - it would appear that the concern is the way in which staff interacts with the telephone system, and not the system itself.*

### **Sec.4:2**

It is recommended that staff and management - in particular the program manager, supervisors, and IT coordinator - are fully trained in the capabilities of the phone system, and that the phone system is fully utilized.

*While the Perimeter Telephone System features top of the line technical innovations ideal for a productive work site, its capacity is not being fully utilized at ANCR. All levels of staff involved with this system are not committed to it. This is partly due to limited knowledge about the system and a lack of recognition of any value that this system may have outside of basic telephone services.*

### **Sec.4:3**

It is recommended that to support quality assurance, the Perimeter system be programmed to alert the CRU supervisor when a CRU worker has activated the make busy option for either 60 minutes continuously or 60 minutes cumulatively during a shift.

### **Sec.4:4**

It is recommended that staff who are assigned to telephone screening maintain a service availability to accept phone referrals at a minimum level of 80% each day.

*The Review found that CRU availability was, on average, 34%. A minimum service availability of 80% could be considered a reasonable client centered target for good practice.*



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**Sec.4:5**

It is recommended that directories in the phone system be updated every 30 days at a minimum.

**Sec.4:6**

It is recommended that ANCR enter into a service agreement with Tiger Tel Communications for the purpose of establishing a suitable, cost effective fee for service arrangement with respect to answering services provided after regular work hours.



## Section V: General Recommendations

A number of recommendations resulting from the Review are applicable across the program units at ANCR. They are grouped under specific themes.

### **Information Systems Management**

#### **Sec.5:1**

It is recommended that the Province and the 4 CFS Authorities make it a priority to ensure that all CFS agencies in the Province are fully utilizing the CFS Applications (CFSIS / IM) as a case management tool and that the Province immediately address the outstanding connectivity issues to provide all agencies with the capacity to do this.

#### **Sec.5:2**

It is recommended that the Province, jointly with the CFS Standing Committee, review the IM, and in particular those areas identified in this review where there is a lack of reporting. This review should look to determine the reasons for the non-reporting, and provide options for addressing these. One example is the 'Issues Management' information section.

### **Working Relationships with CFS Agencies, Collaterals, and Community**

#### **Sec.5:3**

It is recommended that a strategy for the effective communication and sharing of information between program areas at ANCR and other child and family service agencies be developed. The strategy should include an information package on the ANCR programs, program guidelines, and referral criteria. The strategy should include a plan for ongoing and consistent communication. This strategy should be jointly developed by ANCR and the four CFS Authorities.

#### **Sec.5:4**

It is recommended that a review of the terms of reference of the agency steering committee be jointly completed by ANCR and representatives from the steering committee, and that this committee have a meaningful and effective role in addressing service issues that arise.

#### **Sec.5:5**

It is recommended that service recipients be given the opportunity to provide input into the change process through a 'consumer' survey. This survey should be done under the auspices of the CFS Standing Committee.



## **Case Management Issues**

### **Sec.5:6**

It is recommended that a quality assurance file audit of the ADP process be completed, to determine compliance, identify related service issues, and offer recommendations for improvement. This file audit should be conducted jointly by the SFN Network of Care and the Child Protection Branch.

### **Sec.5:7**

It is recommended that a committee be established to examine the process for section 28 transfers and make recommendations for improvements. This working group should include representatives from ANCR, the Province, the CFS Authorities, the judiciary, and CFS agencies. Agency legal counsel representatives should be included as part of this committee.

## **Training**

### **Sec.5:8**

It is recommended that the CFS Standing Committee, through the Joint Training Team, develop and implement training for CFS workers in:

- Case recording and documentation
- Authority Determination Protocol
- Section 28 transfer process

This training should occur on a regular and consistent basis.

## **Management**

### **Sec.5:9**

It is recommended that ANCR create a position of Director of Services, with responsibility for the management and oversight of programs and services. Responsibilities could include but are not limited to:

- Planning and coordination of the services of the Screening and Assessment Unit, the Investigation and Stabilization Unit, the After Hours Unit, the Abuse investigations Unit, and Family Enhancement Unit
- Supervision and mentoring of the Program Managers of these service units
- Ensuring the successful reconfiguration of the CRU, Tier II, AHU, and AIU
- Implementing internal quality assurance measures for service delivery
- Ensuring continuity and least disruption in services to children and families and CFS agencies during the transition / change process at ANCR
- Overseeing the development and consistent use of decision-making instruments for the Intake Screening and Assessment Unit



- Overseeing the development of policies, standards, guidelines and criteria for decision-making to support the delivery of quality services
- Ensuring adaptability of the reconfigured system to the larger child and family services system
- Oversight and evaluation of the new program model

## **Human Resources**

### **Sec.5:10**

It is recommended that ANCR, jointly with the Province and the MGEU, work towards establishing its own work force through a planned, orderly, and agreed upon process.

## **Transition and Change Management**

### **Sec.5:11**

It is recommended that an implementation process and structure be established to oversee the change management / transition work that will be required over the next three years, and that this process be resourced.



# Community Perspective

## *Overview*

Obtaining a sense of how ANCR was viewed by the service community was an important component of the review.<sup>21</sup> Interviews were scheduled and conducted with 19 representatives from key collateral organizations that had regular contact with programs at ANCR and 44 representatives from other CFS agencies in the province. Respondents were asked to report their experiences working with ANCR, including comments on the strengths and challenges experienced; overall satisfaction with the experience; and recommendations for improving ANCR services.

Community organizations included victim services programs, medical facilities, mobile crisis program, police services, children's advocacy services and several schools. Representatives from these organizations ranged in experience from two to ten years, and each had some previous contact with ANCR programs. Some were previous ANCR employees. All were familiar with the responsibilities of ANCR as the entry point for new referrals and abuse investigations.

Community perspective is important and assists in identifying those issues of interest to the community. Respondents' statements must be placed in context, particularly where it is unlikely that respondents would have direct knowledge of the matter.

## *Experiences in Working with ANCR*

Representatives from other CFS agencies in the province reported that they viewed the mandate of ANCR as providing central Intake services in Winnipeg to families concerning child welfare matters. Most agreed that ANCR completes the initial assessment to determine if service is required, provides brief services including assessment, apprehension and referral to community organizations, placements and independent living. If the situation requires longer term work, ANCR transfers the case to the appropriate CFS Agency.

While the services provided by ANCR were seen as valuable to other CFS agencies, representatives indicated that ANCR required a full staff and management complement composed of highly skilled, experienced and stable staff. There was a perception that there was low staff morale at ANCR. Generally, respondents favored a centralized intake service, but there was recognition that this was not without its challenges.

Intake workers were described as 'gatekeepers' for other CFS agencies. The Intake workers were seen as providing support to families to ensure child safety, prevent placement, and investigate child protection

<sup>21</sup> As with staff comments, feedback from the community that engages with ANCR is important in identifying areas needing improvement and getting information about the community's perception of the services provided. As with the staff comments, these comments reflect individual experiences and/or opinions. Some of the feedback is supported by the data reviewed.



concerns. Most respondents indicated that they call ANCR to obtain information, to consult on child welfare concerns, or to report abuse and neglect, drug/alcohol misuse, parenting concerns and domestic violence. Some contact involves the sharing of information for the protection of children.

When respondents were asked to report on the quality of the professional working relationship with ANCR employees, many reported favorable working relationships. These were qualified with words such as "respectful", "excellent", and "they are lucky to have the staff they do".

The biggest concern to a working relationship was the amount of staff turnover. This resulted in inconsistencies in work relationships. Some respondents reported that their calls were not being returned. Most respondents were aware of strained staff-management work relationships at ANCR.

## **Strengths**

Respondents were asked to report on the strengths they observed in the ANCR. Many reported that the source of strength in the Agency is the experienced, skilled workers who provide the services at ANCR. However, respondents were concerned that skilled workers were leaving and new, inexperienced workers taking their place. In general, respondents reported good follow-up, responsive and collaborative working relationships, and good knowledge of resources by some workers.

## **Challenges**

Respondents were asked to identify the difficulties and challenges they faced in working with ANCR. Most frequently noted were the difficulties getting through on the telephone system, along with long periods of wait time before they were able to speak to a CRU worker. Some respondents stated that they fax non-emergency Intakes because of the difficulty accessing services through the telephone system. Other respondents reported that receptionists were screening and making referral decisions because Intake workers were not available.

There were concerns voiced that CRU workers did most of their work over the telephone and were not attending family homes to do an assessment. Some respondents suggested that police services were contacted to do investigations that the CRU should have been doing.

Several respondents stated that it appeared to them that staff at ANCR carried high workloads and had experienced high staff turnover. It was stated that Intake required skilled and experienced staff at all levels, and that services and follow-up needed to be consistent.

The present service model can result in a family having to deal with numerous workers. Respondents pointed out the importance of agencies being kept up to date on the progress of referrals, and the need for consistently respectful and effective service delivery. The potential for breaches of confidentiality exist and these need to be dealt with promptly and appropriately.



## **Overall Satisfaction with the Services**

More than half of the respondents were satisfied with the services that they experienced with ANCR. When asked how the services could be improved, respondents had several suggestions. These included:

- Increasing staff in the Intake Units.
- Reducing staff turnover.
- Supporting the number of skilled, experienced staff by introducing strategies for staff retention.
- Putting initiatives in place to improve staff morale.
- Training for new workers.
- Improving the automated telephone system.
- Information sessions for community organizations and members to improve awareness of ANCR services.
- Improve communications between CFS agencies and ANCR.
- Implementing workload management strategies, including ensuring that supervisors do not carry any cases.
- Implementing the use of a standardized risk assessment tool.
- Completing investigations and assessments in a timely and consistent manner.
- Training for staff and agencies on the ADP process.
- ANCR should focus on the primary mandate first by developing a “robust” Intake program.
- Establishing good working relationships with child care facilities

## ***Recommendations to Improve Services***

Several recommendations to improve services at ANCR were shared. These included:

- Ensuring that ANCR is adequately and fully staffed.
- Managing caseload size.
- Ensuring that leadership was skilled, experienced and professionally qualified.
- Greater transparency in the staff selection process.
- Providing training in abuse investigations and cultural proficiency.
- Improving communications and opportunities for contact between ANCR staff and CFS agency staff.





# Summary of Recommendations

## *Section I: CRU, AHU, Tier II Intake Recommendations*

### Sec.1:1

It is recommended that ANCR reconfigure the service functions of the Crisis Response Unit (CRU) and the Tier II Intake Units, as well as some elements of the After Hours Unit (AHU), into a revised model that will streamline services more effectively, have a higher level of standardized practice responses, and include standardized criteria for decision making. This will include modifying the way in which the screening services, initial assessment and investigation services, brief family services, and support services are organized.

The revised model will have three units:

- A 24 hour /7 day per week Intake Screening and Assessment Unit (replaces the CRU and some of the function of the AHU)
- A Investigation and Stabilization Unit (replaces Tier II Intake)
- An After Hours Unit (reconfigured)

### Intake Screening and Assessment Unit

#### Sec.1:2

It is recommended that the Intake Screening and Assessment Unit assume responsibility for the screening and assessment of all incoming child and family service reports and information. The duties and responsibilities of the Screening and Assessment Unit will include, but not be limited to, the following:

- Receive, assess, document and direct all incoming child protection reports
- Provide information/consultation to public and other professionals
- Receive, process and forward requests for other services, such as adoption or foster care applicants, and general inquiries
- Receive calls regarding children in care and forward for investigation, if abuse or neglect, or for follow-up to the child's worker
- Process and forward all out-of-jurisdiction requests for support or service
- Receive and document all calls regarding cases currently receiving service and forward documentation to the appropriate workers.
- Make the decision re. the service path (Protection / Family Enhancement) under a Differential Response Service Delivery Model



#### **Sec.1:3**

It is recommended that the Screening and Assessment Unit be fully operational 24 hours a day, 7 days a week with a reduced "skeleton" overnight service as determined by an analysis of actual service volume.

#### **Sec.1:4**

It is recommended that the Screening and Assessment Unit be comprised of the most highly qualified and experienced child and family service employees. The minimum qualification standards should require at least five years of child welfare experience.

#### **Sec.1:5**

It is recommended that MGEU and ANCR explore the feasibility of reclassifying these staff accordingly, to reflect the higher level of skill and expertise that is required.

#### **Sec.1:6**

It is recommended that detailed criteria for service eligibility be developed such as decision-making trees that guide Intake screeners through the decision-making process with respect to which cases require Intake or abuse investigations vs. those that do not meet the standard threshold for intervention.

#### **Sec.1:7**

It is recommended that minimum training requirements be established for all employees in the Screening and Assessment Unit, including training in using clinical assessment and decision-making tools.

### **Investigation and Stabilization Unit**

#### **Sec.1:8**

It is recommended that the Investigation and Stabilization Unit have comprehensive responsibility for:

- Investigations and assessments, including High Risk (within 24 hour) investigations , Medium Risk (within 48 hour) investigations, and Low Risk crisis stabilization services
- Family/Child Assessments
- Case monitoring
- Supervision services
- Brief family services
- Home Assessments
- Food delivery
- Repatriation services
- Completion of ADP



#### **Sec.1:9**

It is recommended that services provided by the Investigation and Stabilization Unit be limited to thirty (30) days for an investigation and assessment, with the case either closed or transferred for ongoing services following this time period, and a maximum of ninety (90) days if crisis stabilization services are provided, with the case either closed or transferred for on-going services following this time period.

#### **Sec.1:10**

It is recommended that all investigations include the completion of a risk assessment and all decisions to close or transfer the case be made in accordance with a specific criteria established to guide decision-making in this area.

#### **Sec.1:11**

It is recommended that a protocol and procedures be established for the transfer of cases to another ANCR program or for ongoing services, and that these procedures are consistently applied.

#### **Sec.1:12**

It is recommended that transfers occur within the standardized time frame to ensure that children and families do not experience a gap or break in service during the case transfer process.

#### **Sec.1:13**

It is recommended that ANCR establish a committee to review service volume and develop practice standards, service guidelines, criteria for decision-making and workload management standards to ensure service time frames are met, and gaps or breaks in service do not occur because of workload issues.

### **After Hours Unit**

#### **Sec.1:14**

It is recommended that the AHU be dedicated to service delivery functions required after hours, including investigations, assessments, and crisis stabilization.

#### **Sec.1:15**

It is recommended that a working committee be developed to address the human resource issues in the AHU, including the part-time staff equivalency and reliance on casual staff and move toward the goal of promoting and sustaining full-time employees in all shifts. It is recommended that this committee review the issue of possible conflict of interest for AHU staff who are also employed with other CFS agencies or the Child Protection Branch.



#### **Sec.1:16**

It is recommended that a stronger criteria and framework be developed for the Service Request Forms. These forms should include, but not be limited to the following information:

- Information on the case plan for the child or family
- Date of last contact and face-to-face meeting
- Risk assessment
- Clear and accurate up to date information on the services requested

Once the criteria for Service Requests are completed, a plan for training all CFS Workers in the criteria should follow.

#### **Sec.1:17**

It is recommended that the role of the AHU be re-evaluated and a decision made whether providing case management services after hours to cases open to other CFS Agencies should continue and whether ANCR is adequately resourced to provide this service.

#### **Sec.1:18**

It is recommended that a communication strategy for the effective communication and sharing of information between program areas at ANCR and other child and family service agencies be developed. The strategy should include an information package on the AHU along with referral criteria and program guidelines.

#### **Sec.1:19**

It is recommended that case aides be contracted for all AHU shifts including the night shift.

#### **Sec.1:20**

It is recommended that a working committee with ANCR staff and representatives from other CFS Agencies be established to develop guidelines for effective communication, shared information, and access to specific information and case plans after regular work hours.

#### **Sec. 1:21**

It is recommended that the AHU shift scheduling system be modernized using available software.

## ***Section II: Abuse Investigations Unit Recommendations***

#### **Sec.2:1**

It is recommended that a streamlined and strengthened abuse referral criteria be developed for all referrals of cases for abuse investigations by the AIU.



#### **Sec.2:2**

It is recommended that criteria such as decision-making trees be used to guide Intake screeners through the decision-making process with respect to which cases require Intake or which require abuse investigations.

#### **Sec.2:3**

It is recommended that a committee be established to review the 978 abuse only cases assigned to Intake Supervisors with the task of closing all inactive cases and acquiring up to date information on the status of the cases still active with the AIU.

#### **Sec.2:4**

It is recommended that this committee make recommendations on feasible alternatives for case management in circumstances where there are no other child protection concerns, but an abuse investigation is in progress.

#### **Sec.2:5**

It is recommended that this committee develop policies and practice standards for service responsibilities, information sharing and record management when a case is referred for an abuse investigation.

#### **Sec.2:6**

It is recommended that ANCR complete a thorough analysis of referral data, abuse investigation findings and closings/transfers to determine the appropriateness of referrals to the AIU. Further expansion of the AIU abuse investigator positions should be put on hold until this analysis is completed. AIU staffing levels should be finalized based on this analysis.

#### **Sec.2:7**

It is recommended that ANCR take immediate action to relieve the workload of the supervisors in the AIU. Supervisor to worker ratio should be reduced from 1:8 to 1:7, and supervisors should be freed from the responsibility of coordination of the Child Abuse Committees (CACs).

#### **Sec.2:8**

It is recommended that an in-house AIU trainer/staff mentor position be established.

#### **Sec.2:9**

It is recommended that a Child Abuse Coordinator position be established, with responsibility to coordinate all functions associated with the CACs and the related tasks of liaising with interdisciplinary members of the child abuse team.



#### **Sec.2:10**

It is recommended that ANCR develop protocols and procedures for moving abuse cases between Child Abuse Committees if a backlog occurs at one of the committees. This is necessary to ensure that cases can be closed in a timely manner. ANCR should develop these protocols in conjunction with the CFS Standing Committee.

#### **Sec.2:11**

It is recommended that ANCR create case aide positions for the AIU that can perform the ancillary tasks currently being done by the AIU investigators.

#### **Sec.2:12**

It is recommended that ANCR consider implementing the "third report rule" which requires that any case (household not child) which has been reported three times within a 12 month period is transferred for investigation on the third occasion.

#### **Sec.2:13**

It is recommended that ANCR develop a strategy for consistent and continuous communication with the CFS agencies on whose behalf ANCR is providing abuse investigative services. This should include written protocols and procedures for partnering on services to families and children.

#### **Sec.2:14**

It is recommended that written protocols for abuse case transfers, clearly delineating the role of the case manager and the abuse investigator, should be developed. This should include a clarification of roles and responsibilities and a mechanism for accountability.

### ***Section III: Family Enhancement Recommendations***

#### **Sec.3: 1**

It is recommended that a quality assurance review of the Family Enhancement Unit be undertaken by the SFN Network of Care no later than 2013/2014.

### ***Section IV: Telephone System Recommendations***

#### **Sec.4:1**

It is recommended that responsibility for the telephone system be assigned to an appropriate staff person to ensure the proper management of the system. This includes the development of operational procedures and regular updating of directories; provision of ongoing training and support for staff and management in the use of the system; and generating appropriate Perimeter system data for the purpose of reviewing and monitoring telephone activity and reporting progress.



#### **Sec.4:2**

It is recommended that staff and management - in particular the program manager, supervisors, and IT coordinator - are fully trained in the capabilities of the phone system, and that the phone system is fully utilized.

#### **Sec.4:3**

It is recommended that to support quality assurance, the Perimeter system be programmed to alert the CRU supervisor when a CRU worker has activated the make busy option for either 60 minutes continuously or 60 minutes cumulatively during a shift.

#### **Sec.4:4**

It is recommended that staff assigned to telephone screening maintain a service availability to accept phone referrals at a minimum level of 80% each day.

#### **Sec.4:5**

It is recommended that directories in the phone system be updated every 30 days at a minimum.

#### **Sec.4:6**

It is recommended that ANCR enter into a service agreement with Tiger Tel Communications for the purpose of establishing a suitable, cost effective fee for service arrangement with respect to answering services provided after regular work hours.

## ***Section V: General Recommendations***

### **Information Systems Management**

#### **Sec.5:1**

It is recommended that the Province and the 4 CFS Authorities make it a priority to ensure that all CFS agencies in the Province are fully utilizing the CFS Applications (CFSIS / IM) as a case management tool and that the Province immediately address the outstanding connectivity issues to provide all agencies with the capacity to do this.

#### **Sec.5:2**

It is recommended that the Province, jointly with the CFS Standing Committee, review the IM, and in particular those areas identified in this review where there is a lack of reporting. This review should look to determine the reasons for the non-reporting, and provide options for addressing these. One example is the 'Issues Management' information section.



## **Working Relationships with CFS Agencies, Collaterals, and Community**

### **Sec.5:3**

It is recommended that a strategy for the effective communication and sharing of information between program areas at ANCR and other child and family service agencies be developed. The strategy should include an information package on the ANCR programs, program guidelines, and referral criteria. The strategy should include a plan for ongoing and consistent communication. This strategy should be jointly developed by ANCR and the four CFS Authorities.

### **Sec.5:4**

It is recommended that a review of the terms of reference of the agency steering committee be jointly completed by ANCR and representatives from the steering committee, and that this committee have a meaningful and effective role in addressing service issues that arise.

### **Sec.5.5**

It is recommended that service recipients be given the opportunity to provide input into the change process through a 'consumer' survey. This survey should be done under the auspices of the CFS Standing Committee.

## **Case Management Issues**

### **Sec.5:6**

It is recommended that a quality assurance file audit of the ADP process be completed, to determine compliance, identify related service issues, and offer recommendations for improvement. This file audit should be conducted jointly by the SFN Network of Care and the Child Protection Branch.

### **Sec.5:7**

It is recommended that a committee be established to examine the process for section 28 transfers and make recommendations for improvements. This working group should include representatives from ANCR, the Province, the CFS Authorities, the judiciary, and CFS agencies. Agency legal counsel representatives should be included as part of this committee.

## **Training**

### **Sec.5:8**

It is recommended that the CFS Standing Committee, through the Joint Training Team, develop and implement training for CFS workers in:

- Case recording and documentation
- Authority Determination Protocol
- Section 28 transfer process

This training should occur on a regular and consistent basis.





## **Management**

### **Sec.5:9**

It is recommended that ANCR create a position of Director of Services, with responsibility for the management and oversight of programs and services. Responsibilities could include but are not limited to:

- Planning and coordination of the services of the Screening and Assessment Unit, the Investigation and Stabilization Unit, the After Hours Unit, the Abuse investigations Unit, and Family Enhancement Unit
- Supervision and mentoring of the Program Managers of these service units
- Ensuring the successful reconfiguration of the CRU, Tier II, AHU, and AIU
- Implementing internal quality assurance measures for service delivery
- Ensuring continuity and least disruption in services to children and families and CFS agencies during the transition / change process at ANCR
- Overseeing the development and consistent use of decision-making instruments for the Intake Screening and Assessment Unit
- Overseeing the development of policies, standards, guidelines and criteria for decision-making to support the delivery of quality services
- Ensuring adaptability of the reconfigured system to the larger child and family services system
- Oversight and evaluation of the new program model

## **Human Resources**

### **Sec.5:10**

It is recommended that ANCR, jointly with the Province and the MGEU, work towards establishing its own work force through a planned, orderly, and agreed upon process.

## **Transition and Change Management**

### **Sec.5:11**

It is recommended that an implementation process and structure be established to oversee the change management / transition work that will be required over the next three years, and that this process be resourced.



# Appendices

Appendix 1: List of Commonly Used Acronyms

Appendix 2: Recommendations Regarding ANCR's Intake Services Program



## ***Appendix 1: List of Commonly Used Acronyms***

<b>ACRONYM</b>	<b>Definition</b>
ADP	Authority Determination Protocol
AHU	After Hours Unit
AIU	Abuse Investigations Unit
AJI-CWI	Aboriginal Justice Inquiry - Child Welfare Initiative
ANCR	All Nations Coordinated Response Network
AWOL	Absent without leave
BSW	Bachelor of Social Work
CAC	Child Abuse Committee
CBT	Competency based training
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CFS	Child and Family Services
CFS Act	Child and Family Services Act
CFSIS	Child and Family Services Information System
CIC	Child(ren) in Care
CPB	Child Protection Branch
CRU	Crisis Response Unit
DIA	Designated Intake Agency
DR	Differential Response
EPR	Emergency Placement Resources
FEU	Family Enhancement Unit
FTE	Full time equivalent
FYE	Full year equivalent
IM	Intake Module
JIRU	Joint Intake and Response Unit
JMG	Joint Management Group
MCT	Mobile Crisis Team
MGEU	Manitoba Government Employees Union
MRES	Manitoba Risk Estimation Scale
MSW	Master of Social Work
POS	Place of Safety
RJO	Reasonable Job Offer
SFNNC	Southern First Nations Network of Care/First Nations of Southern Manitoba CFS Authority/Southern Authority
SOR	Source of referral
WCFS	Winnipeg Child and Family Services
WFA	Workforce Adjustment Agreement
YASU	Youth Addictions Stabilization Unit



## ***Appendix 2: Background Paper Regarding ANCR's Intake Services Program***

**RECOMMENDATIONS REGARDING  
CHILD AND FAMILY ALL NATIONS  
COORDINATED RESPONSE NETWORK'S  
INTAKE SERVICES PROGRAM  
(A Continuum of Intake Services)**

**Submitted by:  
Anna Mazurkiewicz MSW**

September 21, 2009



The purpose of this paper is to examine and make recommendations about best practices and options available for structuring child protection intake (referral screening) and investigation services during and after business hours to streamline the referral and investigation phase of service and achieve the following goals:

- Increase consistency of decision-making on new reports/referrals regarding service eligibility and investigation response time
- Increase opportunities for managing workload more effectively to support quality service provision
- Decrease the number of case “hand-offs” and thus:
  - Decrease the number of workers involved with a family thus facilitating continuity of client-worker relationship, client engagement and increased client goal achievement
  - Reduce the risks inherent in case transfers (lengthy breaks in service, confusion about case responsibility, communication/information difficulties (“broken telephone) which may result in insufficient understanding of safety and risk)

#### **REVIEW OF SYSTEMS AND PRACTICE MODELS**

There are many similarities in child welfare practice in Canada, the United States of America, Australia and New Zealand. The following review summarizes child protection practice and systems pertaining to referral screening and investigation/assessment in these four countries.

The literature indicates that the process of screening referrals is highly unstable (inconsistent over time) due to reactive societal changes such as:

- Broad social trends/attitudes and changing legislation/policies vacillating in emphasis on protecting either the rights of children or their families
- Public reaction to publicized child deaths and a call for:
  - expanded surveillance - increased level of screening and investigation
  - lowering the threshold for child protection service eligibility to capture and array of “softer” concerns (investigating low-risk concerns)
  - When in doubt, erring on the side of caution to capture all concerns
- A dynamic characterized by public awareness of child deaths due to abuse, which leads to a substantial increase in the number of referrals, paired with inadequate agency resources and consequently an intervention threshold that lets in only as many cases through the “gate” to service as can be dealt with

New Zealand for example experienced a high level of media attention in 1988, 1994, 2000 and 2003 as a result of abuse-caused deaths of children who had previously received child welfare services. The number of referrals to child protection agencies rose from 30,254 in 1999-2000 to 53,589 in 2004-2005. Key stakeholders called for lowering the threshold for child protection investigations (widening the net)



to capture all concerns. An analysis of referral spikes from 2000 to 2004 revealed that the level of media attention each week was found to correlate with spikes in referrals.

Similarly, Ontario's child welfare system shifted in the late 1990s following a series of highly publicized child deaths and inquests. Practice in the province shifted from a "non-interventionist model" in which a family preservation philosophy shaped policy and practice, to a more interventionist, forensic / investigative approach. In 1998 the province implemented the Ontario Risk Assessment Model (ORAM). Amendments were made to the *Child and Family Services Act* expanding the grounds for a child being in need of protection to include neglect, new safety and risk assessments and standards for the provision of service were implemented, and detailed criteria for service eligibility were developed. Between 1998 and 2002, the number of substantiated investigations increased by 37% and the number of children in care increased by 32%.

There are other, agency and worker-based factors that can influence referral screening decisions. Screening occurs at the initial phase of service where it is inherently more difficult to make accurate decisions due to a high level of uncertainty as a result of:

- Lack, or ambiguity, or complexity of information
- Little or no contact with the family
- Lack or ambiguity of guidelines or criteria for determining eligibility for service whereby workers use their own discretion (where biases and practice triggers may influence decision-making)
- Ambivalence or resistance of the referral source
- Time pressures (often due to workload)
- Lack of experience and/or training of workers
- Limitations in human judgement

Practitioner "practice triggers" are case events that workers may have heard of (ex. child deaths, non-accidental injuries to infants, charges of criminal negligence against a worker) that result in anxiety and a defensive, "child rescue" approach to service where children are too easily removed from their families for fear of blame. This can occur in relation to specific case types or all case, as workers fear that a similar incident may occur on a similar case on their own caseload, or think that all of their cases have the potential to result in a negative outcome. This defensive approach at the referral screening phase of service would result in consistently erring on the side of caution and causing investigations to occur in situations that do not meet the statutory threshold.

While some referred cases are clear-cut, many more fall within a "grey area". The core dilemma centres around finding a reasonable balance between not intervening until it is too late (and a child is maltreated) and minimizing unnecessary intrusions into families' lives. Errors are inevitable - whereby some innocent families are investigated (false positive error) or some families where abuse/neglect has occurred have been screened out (false negative error). The outcomes of referring too many cases with "soft" concerns for investigation are that the agency expends a disproportionate amount of limited resources on investigations (many of which are unnecessary) and has few resources left to maintain



caseload sizes that allow for thorough investigations and provision of high quality ongoing child welfare services to higher risk cases. Secondly, being investigated is not a neutral experience for families, but rather has social and emotional costs which must be balanced against the benefits of casting a "wider net". While raising the threshold for investigation raises the risk of failing to investigate a report on a child truly in need of protection, it is likely that a high risk case would be immediately identified and fall into the "clear cut category. Grey-area, chronic cases where a child may be at risk of maltreatment would most likely be re-referred. It is extremely important to pay close attention to cases with multiple referrals and to err on the side of caution when they return. Therefore, while some margin of error is unavoidable, all efforts need to be made to provide referral screeners with clear guidelines or clinical tools to assist in decision-making to ensure that appropriate cases are investigated.

James Mansell of the Ministry of Social Development in **New Zealand** indicates that when referral screening is branch-based, screening social workers can adjust the intervention threshold to deal with surges in demand. Branch-based referral screening is a "naturally self-adjusting system". The demand for service is managed by screening in (for investigation) or out when work pressure (workload, caseload) is higher or lower. When capacity is believed to be low and the number of referrals high, then the threshold for taking in new cases will rise not through management directive but simply because of staff awareness. In order to improve consistency of approach to referral screening across sites (so that referrals are accepted or rejected based on the needs of the case) a pilot call centre was established in the Auckland metropolitan area in October 1997 and rolled out all over New Zealand in 2001. This "decoupling" of referral decision-making from local office capacity resulted in a significant impact on workload at the investigation and assessment phase of service. The disadvantages of this model are that telephone screeners have a lower level of awareness of other resources available in the referred family's community and secondly that they receive little feedback about the outcomes of cases that they have screened in for investigation. Therefore they have little information about the effectiveness of their information gathering, analysis and decision-making processes and thus little opportunity to make continuous improvements in their practice.

The **Urban Institute in the U.S.** conducted a survey of state child welfare agencies in 1997 and collected data about states' screening policies and number of referrals. Most states had implemented state or county telephone hotlines generally staffed by child welfare intake workers who:

- Receive calls and record allegations,
- Check agency records to determine current or historical involvement with child welfare
- Make decisions about whether to refer the case for investigation
- Make the response time decision (in some cases).

The survey found that few states had explicit guidelines for delineating the types of referrals that should be screened in or out, and even fewer states used formal instruments to guide the screening process. The eligibility for service decision was made in a number of ways:

- The screener made the decision



- The screener recorded the information and the supervisor made the decision
- The supervisor approved the worker's decision or recommendation
- The investigator who received the file from a screener made the decision

Training requirements for screeners varied by state. Some states required that screeners have several years of child welfare experience while others did not (which might explain the system whereby the worker documents the information received from the referral source and the supervisor makes the service eligibility decision).

Since the above survey was conducted, most states have implemented a differential response model of service provision and Structured Decision Making (SDM) clinical tools to support decision-making. The Structured Decision-Making model was developed by the Children's Research Centre in Wisconsin U.S.A. It consists of a set of well-researched and evaluated clinical tools that provide enhanced support to decision making that help the child protection worker to review each child protection decision-point in an objective, systematic, strengths-based and comprehensive manner. Use of the model promotes consistency among child protection workers and agencies by providing a framework to ensure consideration of standardized assessment criteria known to have statistical relevance to particular child and family outcomes.

The SDM model includes decision-making trees which guide intake screeners through the decision-making process with respect to which cases require child protection investigations vs. those that do not meet the statutory threshold for intervention. Two examples of these tools are provided (appendix 1 California and appendix 2 North Carolina).

**Olmsted County Child and Family Services in Minnesota** was one of the first agencies in the U.S. (in 1999) to implement a differential response model of service and the SDM clinical tools. The differential response model authorized the agency to provide a family assessment process (rather than a "traditional", forensic investigation) to families with reports that present as low or moderate risk of child maltreatment. The agency has also implemented the Signs of Safety, strengths-based, safety-organized approach to child welfare developed by Andrew Turnell in Australia. As part of this initiative, the agency moved to a group decision-making approach to review, evaluate and direct (RED) cases accepted through intake screening as cases requiring a child protection response. The RED team consists of social workers from intake (screening), investigation, assessment and ongoing services who agreed to participate on the team for at least six months. Intake screeners gather information and present it to the team, which reviews all screened-in cases and decides on the most appropriate disposition - a traditional response, a domestic violence response or an alternative response which is the family assessment process.

The RED team reviews all of the information and answers the following questions:

1. Does the report meet the statutory threshold for intervention?





2. If the report does not meet the statutory threshold for intervention, should it be referred for community services?
3. Does an accepted report require a traditional forensic child protection investigation?
4. Does the report present as exposure to domestic violence and should it be referred for domestic violence-specific intervention?
5. Does the report present as a child concern that can be addressed through an alternative response approach?

A safety assessment and an actuarial risk assessment are conducted for all families, regardless of which approach is being utilized.

**Australia** is a federation of states and territories, with eight different child protection systems. The National Child Protection Clearinghouse published a National Comparison of Child Protection Systems which is a description of child protection practice in the eight systems as of April 2005. The core components of intake (referral screening phase of service) were essentially the same in all of the jurisdictions.

While some of the states had a centralized "hotline" to accept all referrals, others screen referrals locally by dedicated screeners. All agencies had an after hours emergency service that responds to referrals and crisis situations after business hours.

Referral screeners in all of the states check agency records for prior contact/service. The Northern Territory has a unique feature - a "third report rule". This rule requires that any case (household not child) which has been reported three times within a 12-month period is transferred for investigation on the third occasion. If upon investigation the reports have been found to have no substance or to be malicious in nature, the supervisor may override the third report rule from being triggered in subsequent reports, but must document the rationale for doing so.

In several of the states, the screeners may have follow-up telephone contact with anyone (most commonly schools, other professionals) who may have relevant information that would inform the screening disposition decision, but only for a limited period of time. Every system has a time-frame within which the referral screening disposition decision must be made and follow-up calls cannot delay the decision.

All of the states use clinical tools to assess immediate safety and risk of future harm at the screening phase of service. Each state has priority ratings for the referral which determine the response time (when an investigation must commence). One state has already implemented the Structured Decision-Making (SDM) package of clinical tools, while others had expressed an intention to follow suit.

Contact has been made with the Crisis Unit in **Edmonton, Alberta**. The unit is a 24 hour, seven day per week Children's Services Office and provides after hours provincial services as well as provincial 1-800 phone lines including the Child Abuse Hot Line and the Bully Hot Line. The unit screens all incoming reports from across the province (excluding Calgary) and sends those that require child protection



intervention to appropriate geographically-based offices for follow-up. The unit provides after-hours investigations and crisis intervention for all new referrals and calls regarding open cases in the city of Edmonton requiring an immediate response.

The unit provides the following services:

- 24-hour intake, receiving and assessment of all calls concerning child abuse (excluding Calgary which has its own Crisis Unit)
- Investigation of urgent referrals after hours in Edmonton, documentation and transfer to geographically based office for follow-up next working day
- Urgent after-hours investigations required outside of Edmonton are sent to on-call workers in the appropriate geographical areas (except Calgary) including delegated First Nations agencies
- Placement of children and youth who need to come into care
- Placement of children and youth who need to come into care
- Protection of Sexually Exploited Children Program after hours
- Child at Risk Response Teams coordination and dispatch 24 hours. This unit is connected to the police and respond to urgent matters (abuse investigations)
- Inter-provincial document service for Children's Services across Canada
- "check on the welfares" - drop-ins to families receiving ongoing protection services to monitor the safety of children
- Crisis response involving all children currently receiving services in and out of care
- Respite day care coordination
- Safe Visitation Coordination for Family Violence Services

Full staffing of the unit comprises 44 staff members of which 35 staff provide the core work of Screening, Assessment, Investigation and placement. After hours, the unit is supported by an on-call manager.

The centralizing of the screening function has "de-coupled" these decisions from considerations of capacity/workload. The provision of screening by child protection workers 24 hours a day (without utilizing an answering service), minimizes "losing" referral calls after business hours, which may occur when an anxious referent wishes to remain anonymous and will not leave a telephone number with an answering service where he/she can be contacted at a later time by an intake screener, or who may change his/her mind and not call on the next business day to speak with a day-time screener.

In **Ontario** child welfare services are provided by 53 geographically-based Children's Aid Societies (CAS), which are provincially-funded agencies governed by boards of directors. As part of a larger "transformation" of child welfare services, the province implemented in 2007 a differential response model of child protection service provision, including new clinical tools (the California version of the Structured Decision Making model) and new practice standards. While the SDM model included decision-making trees to assist with intake screening decision-making, the province decided to revise/update and continue to utilize the Eligibility Spectrum (Appendix 3) in use in the province since



1998. The Spectrum is a clinical tool that “was designed to assist Children’s Aid Society staff in making consistent and accurate decisions about eligibility for service at the time of referral”. The goal of the tool was to “support a consistent, and therefore dependable, response pattern by the organization and the province.” The tool has sections and scales relating to different forms of abuse/neglect corresponding to the grounds for finding a child in need of protection contained in the Ontario *Child and Family Services Act*. Each abuse/neglect type has four levels of severity (extremely severe, moderately severe, minimally severe, and not severe), with descriptors corresponding to each level of severity. Intake screeners code referrals by choosing the level of severity that most closely corresponds to the information provided by the referrals source. All cases coded “moderately severe” or higher required a child protection investigation and those that were “extremely severe” were responded to within 12 hours. With the implementation of the new child protection standards, the criteria for screening in a case for investigation have been broadened and the response time decision is no longer dictated by the Eligibility Spectrum Code.

Each Children’s Aid Society in the province decides how to organize or structure its staff in order to provide child protection services and while there are many commonalities there are also many differences from agency to agency. All agencies have moved to having “specialist” intake screeners and in most cases they are placed together on screening teams with supervisors. The Ontario Child Protection Standards require that screeners perform the following tasks:

- Obtain and document within 24 hours a full and detailed report from the referral source
- Check agency and provincial databases as well as the provincial Child Abuse Register for records of past involvement with a CAS
- Screen all referrals for the presence of domestic violence
- Make a decision about the most appropriate response (child protection investigation, community link service, non-protection report for concerns about community caregivers or no direct contact)
- If an investigation is required, make a decision about the most appropriate response time (within 12 hours or within 7 days) and the case is transferred to an investigator. (The response time decision is determined by the level of urgency or the assessed level of present or imminent threat to the safety of a child.)

The most common model across the province has “specialist” investigators conducting child protection investigations. All investigations include the completion of a safety assessment and an actuarial risk assessment. Some agencies have investigators placed on investigating teams with supervisors, while others have mixed teams with investigators and ongoing workers placed on teams together. Few CASs have generic workers who perform both functions.

At the conclusion of an investigation (one month from referral, two months by exception with supervisory approval) the worker must decide whether the reported concerns are verified, if the child is in need of protection and whether the child and family require ongoing child protection services. If that is the case, then the file is transferred to an ongoing (family service) worker.



The provincial child protection standards require that the transfer occurs within ten days in order to ensure that children and families do not experience a gap or break in service during the case transfer process. This standard was included following an analysis of Ontario Paediatric Death Review Committee Reports, Reports on the Death of a Child and one Coroner's Inquest Report, which revealed that case transfers are high risk points in the life of a case. Two child death reports contained recommendations for expeditious transfers between investigators and ongoing workers or from one case manager to another after finding that significant delays in the transfer process in two cases, allowed for protracted periods of time to occur between direct contacts with the clients.

The Children's Aid Society of Toronto (CAST) has multiple offices or branches providing child welfare services throughout the city. Prior to 1999 each branch had one or two intake teams who screened their own referrals and conducted investigations regarding families who resided in their geographical area. The implementation of the Ontario Risk Assessment Model (ORAM) resulted in a rapid surge of referrals and investigations and the branches did not have adequate capacity to deal with the increased demand. In addition, it was found that there was a lack of consistency in screening decisions and investigation practices across the branches. As a result, the agency located all of its referral screening and investigation services in one central location. The screening function was removed from individual investigating teams and is currently being conducted by two teams of screeners each having its own supervisor. Bringing together the investigating teams resulted an increased capacity to assign investigations across all of the teams and in a more equitable distribution of cases for teams and workers. In the previous model when investigating teams were spread out in branches across the city, they had to be fully self-sufficient. If a team on one end of Toronto received a volume of investigations that exceeded their capacity to respond to, while a team on the other end of the city received few investigations in any given day or week, there was virtually no ability reassign cases because of the geographical distances between branches. Currently, "overflow" investigations can be reassigned from one team to another, which has resulted in more equitable workloads, improved response times, improved thoroughness of investigations, and greater consistency of practice.

The Catholic Children's Aid Society of Toronto has centralized the referral screening function, but investigations continue to be conducted by geographically-located teams.

Peel Children's Aid is located in an office in one central location in Peel Region (just outside of Toronto). The agency has two intake screening teams each with its own supervisor and 12 investigating teams consisting of 5 workers and 1 supervisor each. The agency had some time ago conducted a pilot whereby all urgent referrals requiring an immediate response were transferred for investigation to 12-hour "specialists". While the rest of the agency's investigators liked the model as their day-to-day work became less crisis-driven and more predictable, the agency found that the 12-hour investigators found the arrangement to be stressful. The 12-hour response workers dealt with continual, long-term unpredictability of how many urgent cases would be received each day and how many hours overtime they would be working (depending on what time the referral was received and when the investigation could commence). Over time, these workers applied for other positions in the agency and it became very difficult to recruit workers to replace them. The pilot was eventually discontinued.



Peel CAS has been implementing the Signs of Safety child welfare practice framework for approximately two years, including the RED team collaborative approach to referral decision-making. Due to the very high volume of referrals that are received by the agency each day, it would be virtually impossible to review all of them by one RED team and it was impractical to form more RED teams. Peel has developed criteria for which cases should be reviewed by the RED team and the approach is felt to be very helpful.

The Children's Aid Society of Brant has a hybrid model. Community-based teams located for example in a public housing complex or on Six Nations Reserve, and individual workers located in schools have a high level of day-to-day interaction with their "neighbours" who contact them with concerns about children. These teams and workers conduct their own screening of referrals. A centrally located team of screeners deals with referrals for all other teams who are located in the agency offices. Brant CAS exemplifies a model that is designed to be responsive to the unique needs of its neighbourhoods/communities.

All CASs have an emergency after hours service which screens incoming referrals, conducts immediate investigations and responds to crises related to children in care with the goal of maintaining children and youth in their placements. Generally, after hours workers do not perform any ancillary tasks and only provide direct service to open cases currently receiving service if an immediate investigation is required.

The most common model entails agencies contracting with an answering service which receives all calls made to the agency after business hours. The service establishes if the call is about an emergency with respect to a child and directs referents to an on-call after hours worker who screens the call in the same manner as would be done during the day. If the screener determines that an immediate investigation is required, the case is assigned to an on-call worker, who conducts the investigation, completes the required documentation and passes the case on to a daytime investigator on the following working day. All agencies have a roster of supervisors who are available for consultations and approvals of safety plans. Some agencies have one worker who screens all of the incoming after hours calls and assigns those that require investigations to investigators who are on stand-by, while others have a "first-up" worker who screens all calls until such time when they need to conduct an "immediate response" investigation, at which time the next worker on the roster resumes screening subsequent calls/referrals. The latter model is less preferable as it eliminates any potential for the screening decision to be caused by reluctance to conduct an investigation.

Generally speaking, after hours services only respond to emergencies. Out-of- province requests for service are received by daytime screeners and served by daytime staff. Process servers are only used to serve individuals who may pose a safety threat to the worker. Case management activities on open cases are generally conducted by the families' regular workers. After hours workers only respond to after-hours emergencies or new referrals/allegations on cases receiving service. This ensures that there is a continuous capacity to respond to any new high-risk situations arising after business hours.



While a handful of CASs after hours workers are full-time (salaried) employees, the most common model entails a CAS contracting with workers to perform the after hours function for a specified number of nights per week or month. In the Greater Toronto Area (GTA) for example, a worker may be employed full-time by CAST, but might reside in the Peel Region and elect to work one night per week or one weekend per month for Peel CAS's after hours service.

In this type of model, after hours workers are paid for the number of nights or weekends that they work per month. Some agencies pay a flat rate for each night or weekend worked, whether the worker has gone out to perform an investigation or not. Others have a "graduated" formula whereby a different rate is paid for screening referrals, being on "stand-by and providing direct face-to-face service (ex. immediate investigation, crisis intervention in a foster home, placement of a child).

Most CASs have implemented a transportation service that is provided by volunteer drivers. This requires having dedicated staff who will recruit, screen and support/supervise the volunteers, as well as a coordinator who receives drive requests from social workers and assigns drivers. Drivers track (document) the number of kilometers driven and are compensated for mileage usually at the same rate as agency social workers. Larger agencies who have multiple branches or office locations have centralized this service, whereby all drives are coordinated by one person for all requests across a city.

## **RECOMMENDATIONS**

### **Introduction**

In order to meet the goals outlined earlier, a multi-pronged approach is required that would involve:

- Modifications being made to the way that screening services, assessment/investigation services and support services are organized (structured),
- The development of new, clear descriptions of roles and responsibilities,
- The implementation of improved aides to decision-making (guidelines, criteria or clinical tools)
- The implementation of systems/processes that will assist in effectively managing workload for staff, thus maximizing opportunities for the provision of quality service that is in compliance with policy/standards

### **Hours of Accessibility to Services**

Any service reorganization that will be implemented should result in screening and investigation services that will be provided as fully as possible from 8:30 am and into the evening hours. It should be recognized that while agency business hours are from 8:30 a.m. to 4:30 p.m., many stores, banks, business etc. are open into the evening hours – many until 9:00 p.m. and on weekends. The public is accustomed to and expects to have access to services after 4:30 in the afternoon and on weekends. Children and their parents are more available to participate in service after school and work hours. Similarly, it would be more convenient for referents (other than school personnel) to contact the agency



with their concerns about children after working hours. It would therefore be optimal if screening and assessment/investigation services were available at these times.

### **Workload Management**

Most typically, service time-frames are not met and gaps or breaks occur in service to clients because of workload issues, particularly at the front end of service. Referrals are not received by agencies at a steady rate from day to day, or from hour to hour. While some volume trends can be gleaned from examining statistics, it is generally not possible to predict how many referrals will be received each day or week and particularly how many of these will result in immediate investigations. This randomness in service demand presents a significant challenge in terms of workload management.

The assignment of new cases (investigations) from screeners to investigators needs to be carefully managed so as to ensure an equitable distribution across teams and workers. Equity is not necessarily achieved simply by counting the number of cases assigned to each worker. Supervisors who assign cases to workers need to consider the complexity of the case. A multi-victim sexual abuse investigation for example requires many more hours of direct service (interviews) and documentation than a parent/teen conflict case. When case assignment occurs randomly or mechanically by geographical area or specialization, the ability to manage workload (and manage time on the worker level) is compromised. An example would be when investigating teams are organized by geographical areas and all families requiring an investigation in their particular areas are automatically sent to that team. Similarly, if all immediate response investigations are automatically directed to the immediate response team, and 48 investigations automatically go to the 48 hour team etc. the teams are "at the mercy" of a random rate of receipt of new cases. This results in difficulties in time management for workers and an uneven quality of service being provided to clients. The system adjusts itself to its capacity. Workers will take more shortcuts for example when they have an overwhelming workload and will provide a more comprehensive and timely service when their workloads are more reasonable.

### **Role Definition**

It is important to find an appropriate balance between too much role "specialization" or "specificity" and too little. An assessment/investigation (regardless of the time-frame within which it must be commenced and completed) requires the same qualifications, knowledge and skills. Specializing in "high risk" vs. a "low risk" assessment/investigations compromises the ability to manage workload. However, all assessments/investigations should be completed by child protection investigators. The provision of other, ancillary tasks by these workers "waters down" their role (particularly if those "other" tasks do not require the professional qualifications and experience of protection social workers), makes the management of workload more difficult, detracts from the workers' ability to provide timely "core" service, and in all likelihood those "other" tasks take second place to investigations and are not completed as effectively as they might otherwise be.

While one particular model is suggested (below), it should be recognized that the various concepts and components of this model can be configured in a number of ways. While approximate staffing levels are



suggested, more precise decisions about the numbers of required staff in the teams/units would require an analysis of actual service volumes.

### **Recommendations**

1. It is recommended that services currently being provided by the After Hours Unit (AHU), Crisis response Unit (AHU) and Intake Services Unit (Tier 2) are reorganized as follows:
  - a) One central 24-hour referral intake and assessment (screening) team
  - b) One multi-service support team
  - c) Four investigation and assessment teams
  - d) One after hours team

Each team will have a supervisor and all of the teams would be overseen by one program manager. If it is felt that this would result in an unmanageable workload for one program manager, then teams a, b, and d could be assigned to one program manager and all four investigations teams could be assigned to another program manager.

#### *Duties and Responsibilities of the Referral Intake and Assessment Team*

- Receive, assess, document and direct all incoming child protection reports
- Provide information/consultation to public and other professionals
- Receive, process and forward requests for other services (ex. Adoption or foster case applicants), and general inquiries
- Receive calls regarding children in care and forward for investigation (if abuse is alleged) or for follow-up (to the child's worker or to the multiservice support team after business hours)
- Process and forward all out-of-jurisdiction requests for support/service
- Receive and document all calls regarding cases currently receiving service and forward documentation to relevant workers

The screening team would be fully operational from 8:30 a.m. to 11:00 p.m. seven days a week and would provide a reduced "skeleton" overnight service after 11:00 p.m.

- The screeners would rotate through shifts for the entire 24 hour period
- After 11:00 p.m. the answering service would receive all calls and direct those that are referrals (whether urgent or not) to the overnight screener

The team would have its own supervisor who would provide clinical supervision, case consultation and approvals during office hours. The multiservice support team supervisor and the supervisor of the assessment/investigation team who is working from the 3:00 p.m. to 11:00 p.m. shift would be available to the screeners during this time period and a supervisor would be available by telephone only during the overnight shift. The screeners should be experienced child protection workers. The level of staffing for each shift would have to be determined by an analysis of demand (call volumes).





### *Duties and Responsibilities of the Multi-Service Support Team*

This team would provide the full range of its services from 3:00 p.m. to 11:00 p.m. Monday to Friday and only case monitoring of families receiving service and emergency child-in-care service from 8:30 a.m. to 11:00 p.m. on weekends and statutory holidays. The full range of services includes:

- Service of court documents
- Case monitoring of high-risk families that require monitoring after 16 business hours (requires developing new criteria)
- Transportation (during the hours of its operation only)
- Process requests for foster-home/adoption studies

And

- Provide support to children in care and their care givers in emergency/crisis situations
- Provide clerical support/backup to the screening team after business hours

The criteria and referral forms for accessing these services will have to be written. The team supervisor would review all requests and assign them.

Team composition:

- 1 supervisor
- 1 clerical/administrative support worker
- 1 court document server\* (depending on volume)
- 2 drivers\* (number depends on volume of requests)
- 2 child and youth workers
  - To provide monitoring of high risk families receiving ongoing service
  - To provide child management support to children in care and their caregivers
  - To re-place children after hours if child management support is not sufficient to maintain child in current placement
- 1 social worker to process requests for foster home/adoption studies

\* Court document servers and drivers don't require any particular academic qualifications.

### *Duties and Responsibilities of the Investigation and Assessment Teams*

These teams will each have 1 supervisor and six investigation/assessment social workers. Each team will be responsible for the following:

- Finish all investigations begun by after hours (overnight) workers,
- Assess/investigate all cases received from the screening team requiring
  - Immediate investigations
  - Within 24 hours investigations



- Medium risk (within 48 hours) investigations
- Low risk (within 5 working days) investigations

These four teams would rotate through a schedule that would cover the time period from 8:30 a.m. to 11:00 p.m. It is suggested that the rotational period might be weekly and that each week, three teams work during regular business hours, while one of the four teams works from 3:00 p.m. to 11:00 p.m.. This team would conduct any investigations that require an immediate response. This type of a schedule would provide an overlap of the two shifts (3:00 to 4:30 p.m.), whereby immediate response investigations received during this overlap period would be investigated by the evening team.

The intent would be to have an expanded capacity to provide immediate response investigations into the evening hours. These investigations would then be begun and completed by the same worker without necessitating a "hand-off" next day. Only cases that are investigated after 11:00 p.m. would be passed on to a day worker.

This model would facilitate a more effective management of workload. The screening supervisor could send cases to investigating teams on a rotational basis (taking into consideration vacancies, sick leaves, vacations, etc.) or develop some other process for ensuring an equitable distribution of cases across the four teams. The supervisors of the investigating teams would also assign cases in a manner that would achieve an equitable distribution of workload for workers

Most importantly, would support greater continuity of service to families.

#### *Duties and Responsibilities of the After Hours Team*

This team would provide emergency child protection services (only) from 11:00 p.m. to 8:30 a.m. from Monday to Friday and from 11:00 p.m. on Friday to 8:30 a.m. on Monday, and on statutory holidays. These workers would be on stand-by (at home) to receive any immediate or 48 hour investigations from the screener on overnight duty. A supervisor would be available to these workers for consultation by telephone.

It would be worthwhile to consider an alternate model for the provision of overnight emergency child protection services. Rather than having a dedicated overnight team, ANCR could provide an overnight emergency "service", with all (or only those who are interested) child protection workers across the city being on a roster for this shift for additional remuneration (over and above their regular salary). This model would free up this team to become an additional (fifth) investigation and assessment team (although the agency would have to estimate how much would be spent on the "service").

2. It is recommended that all referrals with no apparent child protection concerns 18 that require support are assigned directly to ongoing case managers in agencies for service.



3. It is recommended that ANCR implement more detailed criteria, guidelines or clinical tools to guide decision-making with respect to need for child protection investigations and response times (example provided as appendix 4).
4. It is recommended that ANCR consider implementing the "third report rule" which requires that any case (household not child) which has been reported three times within a 12-month period is transferred for investigation on the third occasion.
5. It is recommended that ANCR consider developing a volunteer drive program that would provide service-related transportation to children in care and families receiving child protection services.

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