Child and Family All Nations Coordinated Response Network

Differential Response Pilot Project Evaluation
Final Report - March 2012

Prepared by:

HEALTH
in COMMON

Strengthening connections for healthy sustainable communities

200-141 Bannatyne Avenue, Winnipeg, Manitoba R3B 0R3 PHONE (204) 946-1888
TOLL FREE 1 (800) 731-1792 FAX (204) 284-2404 E-MAIL contact@healthincommon.ca

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EXECUTIVE SUMMARY

In January 2011, All Nations Child and Family Coordinated Response Network (ANCR) implemented a one-year pilot of a Differential Response (DR) process for streaming families. The DR Process utilized a set of validated assessment tools that collectively made up a Structured Decision Making (SDM) model to enhance services to families by offering a preventive, strength-based and solution-focused approach.

In order to review the appropriateness of the SDM model and inform decision making about the Structured Decision Making roll-out within ANCR, an evaluation of the Differential Response (DR) pilot was undertaken. Four evaluation questions were identified:

1. What is the most effective and appropriate way of implementing the SDM process within ANCR?
2. Are cases being streamed appropriately?
3. Does case planning engage children and families to meet identified needs?
4. What are the resource needs for SDM process implementation?

The evaluation utilized survey, focus groups, key informant interviews and document review to gather data from a variety of sources. The evaluation concluded that the pilot of the SDM model was seen as positive and beneficial by ANCR staff, ongoing service agency supervisors and families. Challenges identified in administering the tools at intake were identified and strategies for roll-out within ANCR identified.

Conclusions are reported for each of the four evaluation questions.

1. WHAT IS THE MOST EFFECTIVE AND APPROPRIATE WAY OF IMPLEMENTING THE SDM PROCESS WITHIN ANCR?

Based on the above findings it is recommended that the Differential Response Model be fully implemented at ANCR and that, where possible and feasible, the Structured Decision Making tools be used to stream cases into brief service, ANCR's Family Enhancement (FE) program or to an ongoing service agency. Different tools are best suited to different stages of assessment and case planning. It was unanimously agreed that tools for assessing safety should be used as early in the intake process as possible. Some concerns were identified in terms of the safety assessment tools' fit in some situations. These issues have already been addressed and the Safety Assessment and Probability of Future Harm tools used to assess risk and safety are only used in cases of alleged abuse or neglect.

The Caregiver and Child Strengths and Needs tools are used to assist with case planning. Almost all FE team members reported that they preferred to complete these tools with families themselves rather than have them completed at intake. Supervisors at the ongoing service agencies reported that they liked receiving case files with a complete assessment (Safety Assessment and Strengths and Needs) from intake. As such, it is recommended that intake workers complete the Strengths and Needs Assessment only on files that are being streamed to ongoing service agencies.

Over the course of the pilot, it was determined that the tools are being used accurately and consistently. Staff repeatedly indicated that the tools provide consistency and standardize the decision making

process. Ongoing training in clinical interview skills to support staff in gathering information and engaging with families would be valued. Supervision and continued support to build confidence with the tools themselves would also be beneficial. Ongoing communication within and across units, with supervisors and ongoing service agencies would also enhance learning by providing valuable feedback and helping intake staff know that assessments are being used and valued in case planning.

2. Are cases being streamed appropriately?

Comparing A-Team transfers to Tier II intake shows that the tools are effective in streaming cases away from protection. In 2011, Tier II intake transferred 50% (1641/3265) of cases to protection and 5% (159/3265) to FE. A-Team transferred 12% (35/289) of their cases to FE and 46% (132/289) to ongoing protection. Only 3% (51/1652) of FE cases were streamed into protection following preventive services.

Ongoing service agencies reported that the tools helped workers establish a starting point for working with families. It was felt that the assessments had improved with the use of the SDM tools and the overall product was valuable. Use of the SDM tools was felt to improve assessments and informed case planning.

In some cases it was felt that the tools took too much time to complete. Workers have found it difficult to decide if a full assessment is warranted for "brief services." Similarly, some high risk cases may take too long to complete at intake, potentially delaying transfers. While the tools provide consistent standards for assessments, workers still need to rely on their own individual judgment to determine the best ways to apply the tools, especially in some complex circumstances. Over the course of the one year pilot, the FE team only had to immediate reroute three files after completing the tools (one referral from Abuse and 2 referrals from the A-Team).

3. Does case planning engage families to meet identified needs?

Staff and families reported that the assessment process is a useful tool for engaging with families. Being able to identify strengths was appreciated. As well, the strengths and needs identified were useful in linking families with appropriate services. Ten FE case plans were reviewed and revealed that nine out of ten families were connected to external resources without difficulty and files were closed with the knowledge that the families were engaged with these outside resources.

Interviews with families conducted by the Southern First Nations Network of Care showed that families viewed the SDM process and FE services positively. The tools were also found to be culturally appropriate by families. Workers had some concerns about potential bias in the tools in regards to socioeconomic status and ethnicity. Improvements to the tools can be made in collaboration with the Children's Research Centre once 5 years worth of data demonstrating potential bias is presented.

4. What are the resource needs for SDM process implementation?

Completing the tools requires extra time on the part of workers. In intake, Safety Assessments are to be completed on all cases of potential neglect or abuse. Ongoing service agencies also like to receive files with completed strengths and needs assessments. Currently Tier II intake has 24 staff with an annual case load of 136 cases per worker. Adding 6 additional intake staff by integrating A-Team with Tier II intake would reduce case loads to 120 allowing for additional time to complete assessments. Ensuring

that all staff have clear guidelines as to when to complete which tools will support time management. Ongoing training and feedback will also enhance skills and reduce time spent on individual assessments.

The pilot has shown that use of the SDM tools by the A-Team results in higher number of cases being streamed to FE at ANCR. Thus, it is anticipated that with full roll-out of the tools, more cases will be streamed to preventive services at FE. Monitoring workload at the FE level will need to be carried out to ensure high standards of care are maintained and reduce staff burnout. Continued partnership development and collaboration will be required to build networks of resources and supports where families can be referred. Although the gaps in community-based family services are large, use of the SDM tools may provide opportunity to leverage resources towards improved coordination of care.

RECOMMENDATIONS

Based on the above findings it is recommended that the Differential Response Model be fully implemented at ANCR and that, where possible and feasible, the Structured Decision Making tools be used at intake to stream cases into brief service, ANCR's Family Enhancement program or to an ongoing service agency.

It is recommended that the use of the SDM tools for screening and referral at ANCR be implemented in the following way:

- *Crisis Response Program/After Hours Program:* In cases of alleged abuse or neglect, will complete a safety and risk assessment (when possible). Families deemed eligible for preventive services will be offered a direct referral to FE. Based on the initial screen, all other files will be either closed or referred to Tier II intake.
- *Tier II Intake:* Will complete a Safety Assessment and Probability of Future Harm on all cases where there is an allegation of abuse or neglect if not already completed by CRU. Based on the outcome they will either: (a) offer brief service and close the file, (b) offer a referral to FE at ANCR for preventive services or (c) complete a Child and Caregiver Strengths and Needs Assessment and refer to an ongoing service agency.
- *FE:* Will receive files directly from CRU, Abuse or Tier II intake with completed safety and risk assessments (where applicable) and will use the Child and Caregiver Strengths and Needs, if they meet the criteria, to complete case plans and provide preventive services for 90 days or offer brief services. At the end of the 90 days or the brief services the file will be closed or transferred to an ongoing service agency.

As part of the roll out and implementation of the SDM tools, it is also suggested that ANCR:

- Develop a strategic plan to address staffing needs upon implementation including:
  - Putting in place a strategic plan to monitor staffing needs in Intake and Family Enhancement units that will assist in minimizing staff turnover, ensure that teams are fully staffed and reduce staff burnout.
  - Integrating the existing six A-Team positions with Tier II intake to reduce caseloads at intake level.

- Review existing process for training and supervision to ensure that all staff using the SDM tools feel comfortable and confident in their use. This will include:
    - Continuing to provide opportunity for workers and supervisors to discuss cases and decision making on a one-to-one basis.
    - Offering a refresher course in SDM tools and definitions at least once annually.
    - Offering additional training as required including training in Clinical Interview Skills.
- Develop and communicate clear guidelines and criteria that will help guide staff's professional judgment in deciding when and how full assessments are completed. This will prevent delays and improve validity. These guidelines and criteria will need to be continuously reviewed and updated.
- Identify opportunities to increase communication between intake, FE and ongoing service agencies. This would provide a feedback loop by which intake staff are aware of the benefits the assessments have had in case planning and continue to gather feedback on how assessments could be improved. Use of the SDM tools has been shown to improve overall communication due to the fact that all staff and agencies share a common language. Having increased opportunity to review the process as a team would further enhance their use.
    - Within ANCR, consider implementing a periodic case review process with FE and intake staff whereby team members would review and reflect upon complex cases and discuss and share learning's from these cases.
    - Develop and disseminate a brief (one to two page) information sheet about the SDM tools to be shared with ongoing service agencies and external partners.
- Work with FE team members to continue to develop resources and supports that will address the needs identified in the SDM tools:
    - Identify and establish partnerships that will enhance the services being provided.
    - Develop and adapt internal resources as required.
- Undertake further evaluation in order to better understand:
    - The long term impact of the DR Model on children and families.
    - The best process for streaming cases to FE within ANCR versus ongoing service agencies.
    - Monitor for potential biases based on socioeconomic status or ethnicity and, after 5 years, present any identified biases to the Children's Research Centre with recommendations for improving the tools.

All Nations Child and Family Coordinated Response Network
Differential Response Pilot Evaluation

Project Summary

In January 2011, All Nations Child and Family Coordinated Response Network (ANCR) implemented a one-year pilot of a Differential Response (DR) process for streaming families The DR Process utilized a set of validated assessment tools that collectively made up a Structured Decision Making (SDM) model to enhance services to families by offering a preventive, strength-based and solution-focused approach. Two teams were selected for piloting the SDM tools:

- Assessment Team (AT / A-Team): a random selection of cases were sent to the Assessment Team and screened for current safety and risk (probability of future harm)= Manitoba Risk Classification, assessed for strengths and needs (Child and Caregiver Strengths and Needs Assessment) and streamed accordingly to either brief service, preventive care or ongoing protection based on the completed SDM assessment;
- Family Enhancement Team (FE) used the same tools on cases referred directly to them and provided short-term (90 day) preventive case management for families deemed low-medium risk.

The goal of the DR process was to pilot an assessment model using a comprehensive and consistent assessment in order to screen eligible families into preventive services.

Evaluation Scope and Purpose

In order to review the appropriateness of the SDM model and inform decision making about the tools roll-out within ANCR, an evaluation of the Differential Response (DR) pilot was undertaken. Four evaluation questions were identified:

1. What is the most effective and appropriate way of implementing the SDM process within ANCR?
2. Are cases being streamed appropriately?
3. Does case planning engage children and families to meet identified needs?
4. What are the resource needs for SDM process implementation?

In collaboration with ANCR staff and management and with Health in Common facilitating the process, an evaluation framework including indicators, data collection methods and tools was developed (see below). The evaluation was implemented from July 2011 to January 2012 with data collection occurring throughout. Data was collected from the one-year period of the pilots (January 31/2011-February 1/2012.

Evaluation Framework

Evaluation Question	Indicators	Data Source	Data Collection	Collector
1. What is the most effective and appropriate way of implementing the SDM process within ANCR? *(Are staff using the tools correctly? Which team should administer the tool? What are families experiences with different ways of administering SDM?)*	1a. All staff demonstrate required skills and training in the SDM process?	1ai. Personnel Files	1ai. File Review	Human resources
		1aii. AT & FE staff	1aii. 2 focus groups (one with AT staff and another with FE staff)	Health in Common
		1aiii. Supervisors (QA review)	1aiii. Document review of supervisor's QA review	
	1b. Total number of staff rating their level of competence in SDM process as high by unit (i.e. compare AT with FE)	1bi. AT & FE staff	1bi. Staff survey	Marnie
	1c. Staff and stakeholders report that the SDM tool provides an accurate and effective assessment	1ci. AT & FE staff	1ci. Staff survey	Marnie
		1cii. AT & FE staff	1cii. 2 focus groups (one with AT staff and another with FE staff)	Health in Common
		1ciii. External agency supervisors	1ciii. Key informant interviews (by phone)	Marnie
	1d. All files have a completed assessment that includes: face to face time with worker; identifies family and children's strengths and needs; and meets identified standards for file completion and CFS standards.	1di. Case files	1di. Chart audit on 20 randomly selected sample of charts (10 AT and 10 FE)	Marnie
	1e. ANCR staff report on their experiences with the SDM process	1ei. AT & FE staff	1eii. 2 focus groups (one with AT staff and another with FE staff)	Health in Common
		1eii. AT & FE staff	1ei. Staff survey	Marnie
2. Are cases being streamed appropriately? (*Is A team streaming more cases than intake is streaming to prevention? Are cases referred to FE from A team less likely to be referred to the protection stream than cases from all other sources?)*	2a. All files are complete for Manitoba Risk classification (Safety assessment + PFH)	2ai. File	2ai. Chart audit on randomly selected sample of charts (AT and FE)	Marnie
	2b. Number and type of cases being streamed to FE from A team versus intake	2bi. Database	2bi. Review of monthly reports	Marnie
	2c. Number and type of transfers made to protection by source (A team referrals that are transferred to protection versus all others)	2ci. Database	2ci. Review of monthly reports	Marnie
	2d. All ANCR and agency staff indicate transfers are appropriate and information is complete	2di. FE staff	2di. Focus group	Health in common
		2dii. External agency supervisors	2dii. Key informant interviews (by phone)	Marnie
	2e. All closed files indicate appropriate provision of service and resolution	2ei. Closed files tracking sheet	2ei. Tracking closed files by type of service and resolution	Marnie

3. Does case planning engage children and families to meet identified needs? *(The FE question)*	3a. Case plans completed on all files where appropriate	3ai. Client files	3ai. Chart audit on randomly selected sample of charts (AT and FE)	Marnie
	3b. All case plans are informed by caregiver's and child's strengths and needs	3bi. Client files	3bi. Chart audit on randomly selected sample of charts (AT and FE)	Marnie
	3c. Type of service provided and resolution of closed case plans	3ci. Client files	3ci. Chart audit on randomly selected sample of charts (AT and FE)	Marnie
	3de. ANCR services and external services (referrals) are available to meet identified needs	3di. Client files	3di. Chart audit on randomly selected sample of charts (AT and FE)	Marnie
		3eii. Client files	3eii. Review top ten identified needs for and identify available internal and external services for each	Marnie
4. What are the resource needs for SDM process implementation?	4a. Total number of staff involved in implementation of SDM	4ai. Supervisors	4ai. Interviews and document review of personnel files	Marnie
	4b. Number of cases carried	4bi. Database	4bi. Monthly reports on total cases referred, closed, ongoing and transferred	Marnie
	4c. Amount of time spent on cases	4ci. AT & FE staff	4ci. 2 focus groups (one with AT staff and another with FE staff)	Health in Common
		4cii. AT & FE staff	4cii. Staff survey	Marnie
	4d. Training and support inputs	4di. AT & FE staff	4di. Staff Survey	Marnie

METHODS

The evaluation used multiple methods of data collection, including:

STAFF SURVEY

All staff members of AT and FE were surveyed in November 2011 to collect feedback on the SDM tools and process. Twenty staff completed an anonymous survey. Results were collated and analyzed using descriptive statistical methods (average, frequency and simple cross-tabulations for comparison between teams). See Appendix I – Staff Survey Results.

FOCUS GROUPS

Two focus groups (one with A-Team members and one with FE) were held in January, 2012. Results from the staff survey were shared during the focus group to generate discussion and validate survey findings (See Appendix II – Focus Group Discussion Guide). The A-Team focus group included 6 participants and the FE focus group included 14 participants. The discussion was audio taped and transcribed for analysis. Analysis included coding all feedback into common themes and sub-themes, comparing A-Team to FE for any notable differences or similarities and summarizing the findings. See Appendix II – Focus Group Discussion Guide

KEY INFORMANT INTERVIEWS (ONGOING SERVICE AGENCIES AND INTERNAL SUPERVISORS)

Supervisors from external agencies that received an SDM assessed file from the A-Team were invited to take part in key informant interviews. Fourteen external agency supervisors agreed to participate and were interviewed by phone to obtain feedback on their perspectives and thoughts about the SDM process and tools. Agencies included in the key informant interviews were: Anishinabe CFS (1 supervisor); Winnipeg CFS (6 unit supervisors); West Region CFS (1 supervisor); Southeast CFS (1 supervisor); and Métis CFS (5 unit supervisors). Questions were asked about the appropriateness of the SDM tools and the assessment process. Feedback was summarized and reviewed for key themes.

Internal Supervisors of AT and FE were interviewed for their feedback on the SDM tools and processes. Responses were summarized into key recommendations.

DOCUMENT REVIEW

Internal agency statistics were reviewed to obtain a summary of case openings, transfers and closures. A random chart review was carried out on twenty files (10 AT and 10 FE) to review for completion of the tools and resolution. Findings from the Southern First Nations Network of Care DR-FE Pilot Program Evaluation were reviewed and included in the findings of this report. See Appendix III – Southern First Nations Network of Care, *Interviews with Clients of ANCR's FE Pilot Program*.

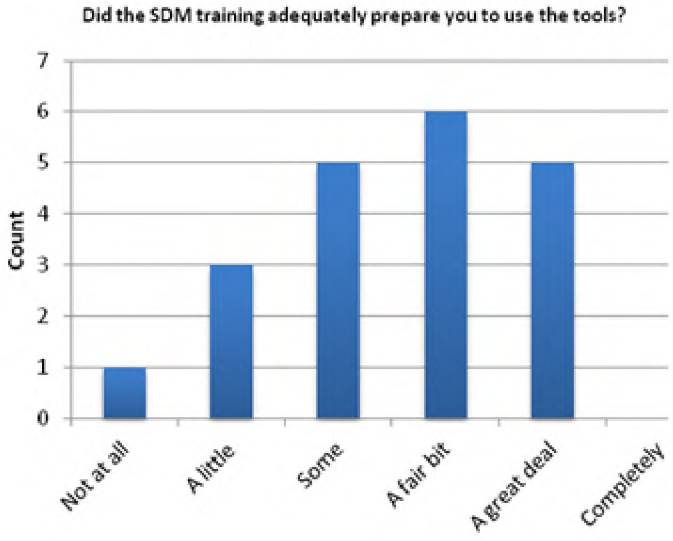
FINDINGS

ANCR implemented the SDM Model as a pilot initiative from January 2011 to February 2012. Information collected from all data sources over this time period is presented below.

1. WHAT IS THE MOST EFFECTIVE AND APPROPRIATE WAY OF IMPLEMENTING THE SDM PROCESS WITHIN ANCR?

As of February 2012, there are 20 staff involved in the DR Pilot. The A-Team is currently staffed with one supervisor, one administrative assistant and four social workers. The unit is funded to have six social workers in total but have consistently run with four to six workers at any given time due to staff turn-over. The only time in the course of the pilot project that the A-Team was fully staffed was over a three month period between September and December 2011. FE is currently staffed with two supervisors and 13 social workers. Seven of the 13 social work positions are within the First Nations Unit and 6 are within the Métis/General unit. Throughout the pilot, the Métis/General unit has been staffed by the same six individuals while the First Nations unit has had some staff turn-over with two empty positions between April and August 2011. FE currently has one unfilled social work position within the First Nations unit.

All 20 staff received initial SDM training. The earliest training occurred in November 2010 (11 staff) and the most recent training was held in October 2011 (3 staff). None of the staff have had additional formal training in the year since the pilot was implemented. When asked to comment on the overall quality of the training, one person felt the training didn't prepare them adequately to use the SDM tools, eight out of 20 felt the training gave them some preparation, and 11 out of 20 felt well prepared to use the SDM tools following training. Following the tools implementation, 10 out of 19 felt that they were well supported to use the tools; seven felt somewhat supported in the tools' use while two felt that they had no support at all when needed. Twelve staff reported having accessed additional support or training for the SDM tools. 50% of these individuals (6/12) found the additional support to be very helpful and 5/6 found this support to be somewhat helpful. One individual did not feel that the additional support provided was at all helpful.



Staff capacity and confidence in the use of the SDM tools contributes to their overall use and effectiveness. In both survey and focus groups, staff demonstrated a high level of confidence in the use of the tools. Seventy-five percent of staff (15/20) rated their skill level using the tools as good or very good. Team members felt that the tools themselves were a good training tool for new staff, stating "*The tools are great for someone new in the field*" and *"they are especially useful for training new workers."*

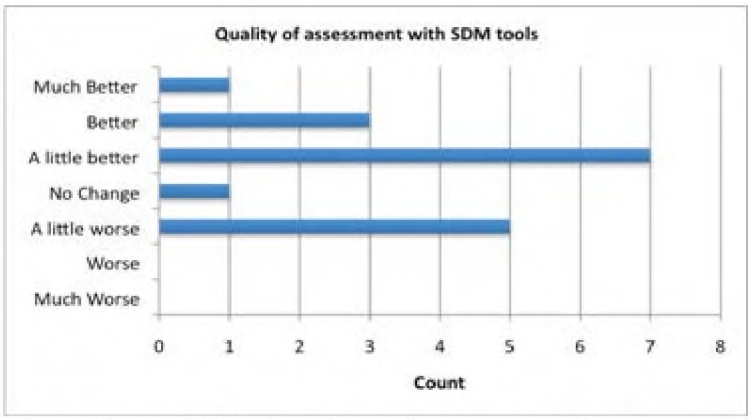
In focus group discussions, staff felt that the tools enhanced their skills: "*When we first started (I was) concerned that the tool would be the 'be all and end all' and we would lose some assessment skills, but I feel it ended up adding to it and not taking away from it."* Others spoke of the way in which the tools provide structure to the assessment process while still enabling staff to apply their own critical thinking skills in how they interpret and apply the findings from the tools. Staff reported that supervisors provide them with support to complete the assessment whereby staff will *"go back to [the] definition and supervision, 'what does it say' and base your decision on that, and go back to that to hash it out."*

Individual strengths and skills contribute a great deal to the tools' use. Staff repeatedly indicated that the SDM tools are only one aspect of the overall assessment that includes one's own analytical and interpretive skills. *"When I look back at the first ones I did, I asked more or different questions than I would have. The tools, on their own, aren't providing the thorough assessment. You add to it with your own skills."* Included in this is the ability to effectively engage with families through rapport building and having the clinical interviewing skills to ask questions in a natural and unscripted way. Supervisors in the ongoing services agencies echoed this sentiment stating that the tools provide an accurate assessment *"but doing the tools still depends on the workers' ability to engage with families to get full information."*

In one-on-one interviews, AT and FE supervisors identified additional issues around training and assessment skills. Supervisors indicated that workers have to be reminded to "read the definitions" with regard to the SDM tools. This is very important so that all workers are answering each domain correctly based upon the written definitions and not where they think or feel that they should be scored. Additionally, workers have to be reminded to have their written narratives match their tool results. They are often not sure if the matching narrative should be within their day to day recordings, a separate write up or within their transfer/closing summary. The workers continue to develop their clinical interview skills to improve family engagement and reduce the need to bring the tools to the home to conduct a formal interview.

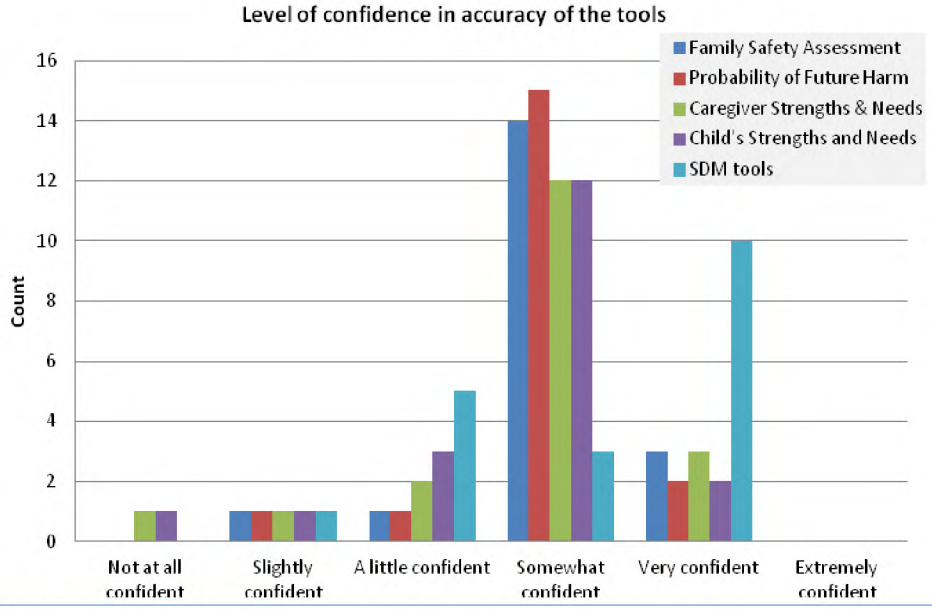
Given the scope and timeframes within which the evaluation was carried out, it was determined that an audit of 20 randomly selected files (10 A-Team and 10 FE) would be carried out as a brief overview of adherence to the SDM process. The audit indicated full compliance with the tool's implementation within the two teams. All ten FE files reviewed had full assessments completed and care plans were informed by the identified needs. Similarly, 8 out of 10 A-Team files had assessments completed with the two missing assessments being due to an electronic intake transfer to another region and to a file being carried over and assessed on another parent. When annual A-Team completion rates for 2011 were reviewed, Manitoba Risk Classification was completed on 271 of 286 files (93.8% completion), Caregiver Strengths and Needs was completed with 182/286 families and with 348 children.

According to staff the tools *"provide structure and provide (the) same information across the board."* Almost one-third of staff surveyed (5/18) rated the overall quality of the assessments as being very good or excellent. Most (12/18) felt the quality of assessments was good to excellent with the remaining 6 staff rating the quality of assessments as average. Nobody rated the assessments as poor or fair. Similarly, most staff (11/17) felt that the implementation of the SDM tools had improved the overall quality of assessments.



In phone interviews with supervisors at the Ongoing Service Agencies, feedback on the quality of assessments was very positive. One supervisor commented that the SDM *"transfers are great."* Thirteen of the 14 supervisors interviewed said that they noticed a difference in the product (one person was brand new to the position so couldn't compare to anything). Of the thirteen who commented on the tools' accuracy, all felt that the assessments provide accurate information about the family. Feedback included the following statements:

> *"I believe that using the SDM tools give more accurate information about the family as more questions are being asked."*
>
> *"It gives good initial information which is added to once our workers get to know the families better."*
>
> *"I feel that the files I received from the ANCR FE unit had fairly accurate information as they have in theory been working with the family for a period of time so there is more accurate information than if it would have come from an Intake team"*



Within ANCR, staff and supervisors reported some challenges in the overall accuracy of the assessments provided by the SDM tools.

While confidence in the overall SDM tools is high (primarily in the range of somewhat to very confident) ANCR staff identified multiple factors that may impact on the tools' accuracy.

- *Timing:* When assessments are completed at intake, families may not be able or ready to disclose fully to the intake worker. Taking time to build rapport and trust between worker and family increases the likelihood that families will share fully during the assessment. Staff from both teams felt that the Caregiver and Child Strengths and Needs assessment tool provide more accuracy if completed later in the process, when workers and case managers have had more opportunity to engage with family and gain trust.
- *Family situation*: Families referred to ANCR are often in situations that are unstable and rapidly changing. In these cases, information gathered at intake may be different than that gathered after referral to FE or ongoing care. As contexts and situations change, earlier assessments may seem inaccurate due rapidly changing circumstances. In these cases assessments need to be reviewed with families at a later time.
- *Fit*: For some specific situations, the tools themselves do not fit the context. One instance in which it has been consistently difficult to score cases has been in cases of parent/teen conflict and in cases of self-referral. In both these cases, the Probability of Future Harm is difficult to score as there is no allegation of abuse of neglect and workers do not know how to answer many of the questions.[1] As well, if a violent partner is not living in the home, they are not included in the assessment resulting in a low risk assessment. Some of the workers would like to assess the secondary caregiver (knowing that he/she will likely come back or be a part of the children's lives) but has temporarily left the home and so technically is not to be counted. Conversely, if the child welfare concerns only pertain to one of the child's residence, workers wondered if it was fair to complete a risk assessment on the other home.

Staff's overall experience with the tools appears positive. Within A-Team, effective time management was an issue where multiple staff questioned the value of time spent on some cases given the nature of the issues to address within a short-term intake setting. This applies to very simple cases in which the time spent on the assessment may be more than is needed in order to resolve a simple issue. Additionally, some cases present serious concerns and require immediate referral which would be delayed by a long assessment. Related questions about where the SDM tools best fit were raised by ongoing service agencies. One supervisor felt that the SDM tools were too thorough to be used at an intake level: *"yes there is enough information and I sometime worry that it is too much information for an Intake agency to be able to do on all cases."*

Outside of some exceptions (i.e. extremely low risk or extremely high risk cases) it was generally felt by most participants that receiving a fully assessed file was beneficial. In the ongoing service agencies, it

[1] Note: This issue has already been addressed as staff have been directed not to complete the Probability of Future Harm in cases where there is no allegation of abuse or neglect.

was felt that *"with the addition of the SDM portion of the assessment it appeared to be a high quality product especially comparing it to the usual transfer summaries that are inconsistent;" "The SDM assessed files seem to gather better and more information about the children as opposed to the usual transfer packages which only say one or two sentences about each child, if that."* FE team members all agreed that risk assessments should be completed at the front end (i.e. intake) however most felt that they would prefer to complete the Caregiver and Child Strengths and Needs Assessment themselves toward building a case plan with families.

The biggest concern raised by both FE and A-Team members was that the tools took away from the time workers are able to spend with families. Primarily, staff were concerned with the amount of paperwork required taking this time away from families stating: *"I think we are spending an awful lot of time on paperwork, and not enough on families;" "Too much time on paperwork and not enough time with families;"* and *"3 years ago I spent 30% [of my time] on paperwork now I spend 30% of my time with families."* While this seemingly contradicts the fact that staff repeatedly stated they liked the tools and enjoyed doing the assessments, when questioned further, it is clear that the time factor is a function of high caseloads rather than dislike of the tools themselves. (Providing training and having clear criteria in place and communicated about which assessments to complete when will ensure time is not spent on assessments when they aren't warranted).

In 2011, the Southern First Nations Network of Care which mandates ANCR, evaluated the experience of families with the Family Enhancement pilot program. Nine families were interviewed for the pilot evaluation. The evaluation concluded that families "are generally pleased with the services received thus far from their experience with ANCR's Family Enhancement pilot program" (SFNNC, 2012). Families described having had positive experience with the assessment process itself. Four out of nine families interviewed felt the assessments completed by FE were helpful. According to the studies' authors, "the interaction with the social worker filling out the assessments, the resulting plans, and referrals to support programs were highly appreciated by the parents in understanding how to move forward in dealing with their family's situation"(p. 132).

In cases where families found the tools to not be helpful reasons provided included: "a belief that the forms did not adequately capture the complexity of the family's situation; (and) the tools didn't take into account past information and experiences that led up to the problems the family was currently facing" (p.123). These concerns reiterate those raised by staff in reflecting on the accuracy of the tools. Staff had concerns about the tools not fitting within certain complex situations as well as being unnecessarily punitive in regards to family history. This was of particular concern in cases of prior false allegations that were scored as negative based solely on past contact with CFS. To address these concerns, ANCR has made efforts to ensure that the tools are only completed in instances where they are fully appropriate – for example, the Probability of Future Harm and Safety Assessment are no longer completed in circumstances where there has been no allegation or abuse or neglect. This change in practice should alleviate the concerns around tools not fitting in certain situations, for example in cases of parent/teen conflict.

2. Are cases being streamed appropriately?

A review of A-Team contacts reveals that 345 files were received by A-Team between January 31, 2011 and February 1, 2012. Of these files, 56 had assessments pending leaving a total of 286 "open" cases. As indicated above, Manitoba Risk Classification and Probability of Future Harm Assessments were completed on 93.8% of all open cases.

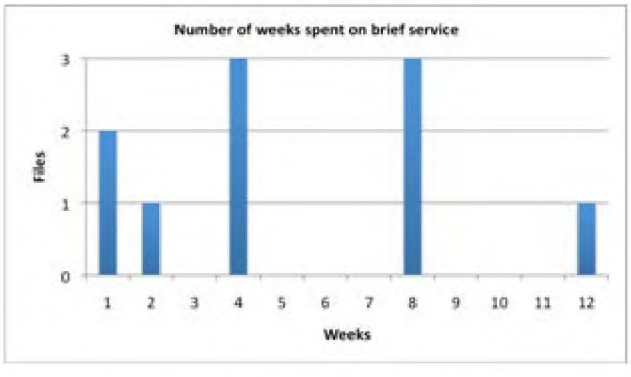
46% of all files assessed through A-Team were referred to ongoing protection. 35/289 (12%) of all cases assessed by A-Team were referred to FE for preventive care. When compared to Tier II intake; a greater number of cases (50%) were referred from Tier II into protection and only 6% to FE. These numbers indicate that SDM tools were effective in reducing the number of cases referred into protection and were able to divert more eligible families away from a protection stream towards preventive care within FE. Over the course of the one year pilot, out of 250 files, three files were referred to FE and immediately rerouted; one referral from Abuse and 2 referrals from the A-Team.

The rate of transfer from FE to ongoing service agencies is even lower. Taken over an average of 275 cases per month, FE transfers an average of 12 files to ongoing service agencies each month for a transfer rate of 4%. Of the 12 transfers each month referred to ongoing service agencies, 4 go to ongoing FE services and 8 change streams into protection. This means that on a monthly basis, FE transfers 3% of their files into protection. (See Appendix IV FE Pilot Year Stats).

	Assessment Team	Tier II Intake
Files received	345	3256
Transfers to protection	46%	50%
Referrals to Family Enhancement	12%	6%

In addition to assessments and referrals, A-Team provides brief service (referrals and resources) to families whose files were immediately closed (i.e. not transferred to either FE or Protection). Ten closed A-Team files out of 115 were randomly selected and reviewed to assess for appropriate provision of brief service. Two files were closed without Manitoba Risk Classification: one was closed and a new file opened on another parent; another was referred to another agency when the family moved. Of the eight remaining files, Manitoba Risk Classification identified one file as being "no risk" (closed immediately) and 7 files were assessed as "low risk."

Of those assessed as low risk: 2 were closed when concerns were unsubstantiated and services were refused; 3 were closed and referred to external resources; 3 were closed and families accessed their own external resources. The number of weeks spent on brief service ranged from one week (2 days) to 12 weeks spent on one file. Six of the brief service cases were open for between 1 and 2 months.



The purpose of implementing the SDM tools into the DR process was to improve consistency and confidence in the family assessments and to inform the referral process. Staff reported that the SDM

tools have definitely improved consistency and provide more structure and consistency to the streaming process. The tools provide a standard decision making tool that allows staff to confidently determine the best course of action and allows A-Team to clearly determine families eligible for preventive support with FE. While the tools have simplified and standardized assessments, some challenges remain:

- The workers in the Family Enhancement program often have a hard time deciding whether or not to complete a Case Plan with families or if the service is just "brief services". Often families simply need to be linked with community resources or need some immediate support. In these, no to low risk circumstance, criteria are needed to determine the best course of action.
- The workers have difficulty with cases that come out as medium risk in the MB Risk Classification as they have to decide if the family could benefit from FE services or needs to be transferred directly to protection services. Often the only criterion is whether or not the family is willing to engage with preventive services and this is difficult to gauge at the intake level.
- If the PFH score suggests a family is appropriate for an FE approach but their level of engagement or other factors suggest otherwise, criteria should exist to help workers decide whether to override the PFH and transfer to protection or transfer as scored but with an explanation.
- The difference between children being assessed as "safe," "safe with a plan," "conditionally safe" and the difference between all three is difficult for workers to determine. As this question routinely comes up in supervision, more direction is needed for workers on this matter before roll-out.
- Workers also often struggle with completing the Probability of Future Harm Tool within the ten-day time period. There are often families who are in 'avoidance mode' and will not meet with the workers. In such cases workers feel unclear if they are just to fill out the form with the information that they have (which might be incomplete) or wait until they have all the information they need but which will not meet the expected time frame.

The above scenarios demonstrate that while the tools provide consistent standards to follow, workers still need to rely on their own judgment in making decisions about routinely complex cases. Balancing time constraints with a desire to be thorough in assessments will remain a constant challenge with the DR process. Adequate support and supervision guided by clearly outlined criteria can assist staff in terms of working through some of the more complex cases they encounter.

Among all staff, there was general agreement that the Manitoba Risk Classification (Safety Assessment and the PFH) tools should be done at intake as is current practice. Almost all FE team members prefer to complete the Child and Caregiver Strengths and Needs themselves. Only one FE team member disagreed stating *"having initial questions already answered helps form better case plans."* All others said they liked being able to complete the Strengths and Needs Assessment themselves, for example: *"I prefer to do [it myself] in terms of strengths and needs, agree with probability of future harm [done] beforehand."* A-Team members had similar concerns about the time that is sometimes required to complete a full

assessment at intake stating, *"Caregiver and Child Strengths and Needs Tools are great tools, just that at intake, how to address certain files versus what the ideal is because we can't keep the files for 6 months to track them down."* Supervisors in ongoing service agencies expressed similar concerns stating:

> *"I disagree with Intake doing the Caregiver and Children's strengths and needs with families because it provides a template which is not really a true indicator of the family. This tools meant to be done by worker who will be working on case plan with the family and doing this tool at Intake does not service to the family at all and may actually give false results because Intake doesn't have enough information to go on … in saying that, I do think that the assessments have improved using the other SDM tools as a guideline of what is going on with the family and it gives me confidence in helping my workers out with the family from that point. I generally have more confidence in the assessments where the tools have been done".*
>
> *"I do believe that in some cases a very well done PFH is all that you need to complete at the Intake level".*

In addition to the time it takes to complete the SDM tools at intake, A-Team staff expressed concern that their findings wouldn't be applied at the case planning stage: "*Why would you engage with the family that much, and then we are done, then [the family] will go to a new worker who may not agree with any of this;" "with Caregiver and Child Strengths and Needs you are doing complete assessment and the family service worker could be making a different assessment after meeting them."* However, discussion with FE team members and ongoing service agency supervisors indicate that the assessments completed at intake are beneficial and used in case planning stating having the assessments done *"gave me something to start somewhere with (the) family."*

Supervisors at ongoing service agencies were asked if they thought getting the files fully assessed represents best practice. As noted above, one supervisor disagreed with the practice of having SDM tools completed at intake. Two supervisors were undecided stating, "*I am not sure of this and think that it wouldn't hurt to re-assess this as time goes on. It might be important for ANCR whether or not all of the work that is done assessing the families is actually worth their effort since things often change with families shortly after we get the files."* Out of the 14 supervisors interviewed, 11 said they liked receiving a fully assessed file:

> *"We think the SDM assessment is a great starting point for us and we simply confirm with the families what was assessed at Intake. We think that it is an excellent tool that is being used well at ANCR"*
>
> *"It is nice to have the files assessed by the SDM tools and they are looking forward to receiving them all that way"*
>
> *"It provides a starting place for the worker who can add information as they get to know families to work toward putting them in to FE involvement. … The*

workers likely need to re-do the SDM assessments as they gather further information but it is a good start. … The workers are finding some of the questions quite intrusive so they like to get a relationship with the families before they start asking intense questions within the SDM"

"They (the workers) find it very helpful to have all the tools done by ANCR before we receive the file. The social workers in general are finding the SDM product very helpful and appreciate the work being done before it gets to us"

"It is nice to have the SDM's completed and to have more thorough information on the family and their goals for service when we receive that transfer as the workers can begin at that place and the family does not have to feel like they are starting from scratch. It also helps to remind the family what they agreed to work on and to review their goals. The strength needs is very helpful in learning about the family".

"I think the assessment tools should be used at Intake as they are point of intake and need to gather as much info and report risk level for the ongoing case worker to have as much info as possible when they begin to engage a family. I however really do like the Strengths and Needs tool and can see it being used as a more regular ongoing assessment tool".

"Yes, it is good to have standard, thorough information coming from ANCR and to help newer workers understand what constitutes a good assessment. Many of the ANCR transfers recommend a lot of things but lack the information to back up the recommendations and the SDM full assessment will force workers to do their due diligence in collecting the necessary information. Also, it will give the on-going service units a better sense of how quickly to react to cases and where to begin as the risk has been outlined.

"I think that the assessment is better with the use of the tools but I think it depends upon how long ANCR has the case. If there is a lag in service (i.e. if it takes a month or two for my unit to get the file) then we will likely re-do the tools but if it comes right away, we will begin to work with the family based upon ANCR's assessment. There is no need to re-invent the wheel on those cases as they are ready to go. I think the SDM tools will bring all of the agencies together to a degree such that we are all speaking the same language. It appears to be a very good tool that brings consistency to the Intake process which is something that has been lacking-some units produce a better product than others. The tool allows us to focus on important points within the family which is good for everyone"

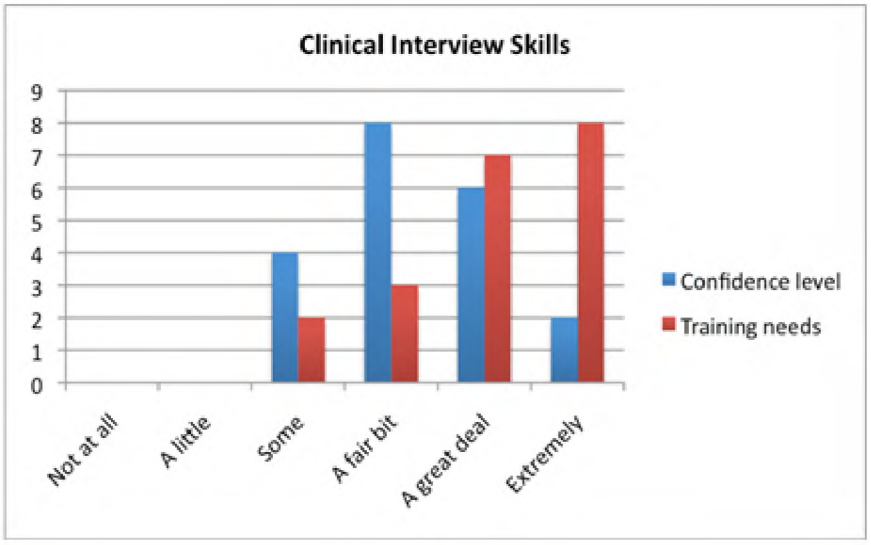
The supervisors' feedback confirms much of what was stated by A-Team and FE staff in terms of balancing the need for a full and thorough assessment with effective time management. Continued

understanding of when to complete the SDM tools and when to transfer directly will require ongoing review. In particular, if the family's situation is likely to change considerably in the time between intake and assessment, staff need to consider this in deciding how much time to spend on the assessments. Continued learning could be supported by ensuring open and regular communication between all service providers. Intake staff need to hear that the assessments they provide are being utilized in case planning in order to validate the time they are spending with families. One A-Team member stated that she would like to *"hear from ongoing agency working with the family for 6 months to a year, how accurate our initial assessment was of the family."* Similarly, providing feedback on how assessments can be improved to support case planning at the FE or protection levels will enhance ongoing service provision.

3. Does case planning engage children and families to meet identified needs

Generally, ANCR staff stated that they enjoyed using the tools with families and having an opportunity to build relationships through the assessment process. In regards to the Caregiver and Child Strengths and Needs, staff appreciated the opportunity to include a strengths-based discussion. Concerns were raised by staff who found some questions to be intrusive. Specifically, several staff expressed concerns with the questions related to CFS history as they judged these to be unfairly punitive; "*people felt penalized because they called previously for help and (it) gives them a negative score.*" A few staff expressed concerns about perceived inequities in the tools' impact on families of low socioeconomic status or ethnicity including First Nations and Newcomers. Feedback from families interviewed by the Southern First Nations Network of Care was positive in terms of the cultural appropriateness of the services offered.

Challenges raised by staff included the fact that time spent completing paperwork takes away for opportunities to provide follow up support to families *"The time consumed in paperwork has risen and affects time available to families."* and *"I think a lot of time is spent doing the paper work and more time could be spent engaging with our families."* Becoming familiar with the tools themselves and continued development of clinical interview skills will assist staff to become better at engaging with families and completing assessments more rapidly. Although staff feel generally confident in their ability to use clinical interview skills to complete assessments, it was also felt that more training would be helpful.



Ten files from FE were reviewed to determine the degree to which case planning was informed by and met the families' specific needs. All ten files indicated that case plans were informed by the Caregiver and Children's Strengths and

Needs tools. In nine of the ten cases, families were connected to external resources without difficulty and the files were eventually closed with the knowledge that the families were engaged with these outside resources. In addition to the external resources involved with those families, two families also had extended family as a built-in resource to them. In the case that did not have external resources involved, the extended family was providing supports and no formal resources were required to assist with the case plan. Families were supported to access external resources such as the Family Center, Addictions Foundation of Manitoba, AA, the school system, criminal justice system, Children's Special Services, Wolseley Family Place, summer camps for children, church and ANCR's family resource centre.

The families themselves provide the most salient voice in terms of the degree to which the SDM tools engage with and meet families' needs. All parents interviewed by the Southern First Nations Network of Care stated that the FE pilot program fit the specific needs of their families. Many families provided examples of the positive difference their involvement with FE has made in their lives:

> *"Since we have been involved with the FE program, it's been a lot easier to be able to talk with our son and we've changed a lot of the dynamics in the home as well."*

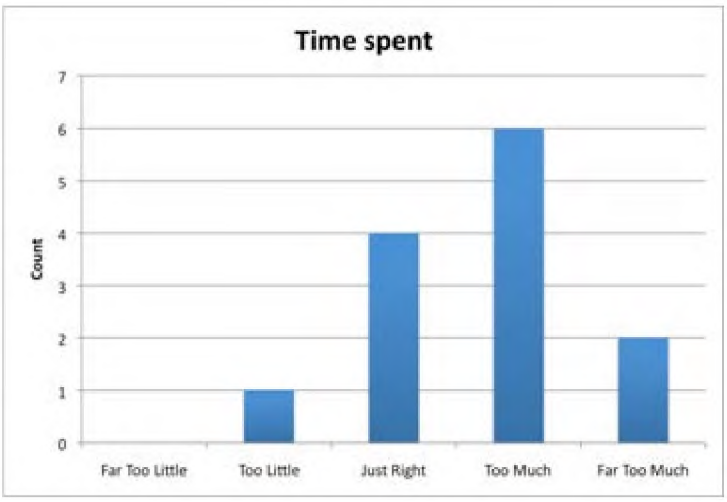
In another example the report states that "the FE worker connected (a mother) to services and programs that ensured that her son would get the help he needed. In the process she was also able to get some help." Families rated the services offered as being "very important" with their overall assessment of the program "described as being good, positive, and very positive to excellent."

4. What are the resource needs for SDM process implementation

At full staff, the A-Team consists of six workers. In one year, the A-Team assessed 345 files or 58 files per person annually. Tier II intake has 24 staff who saw 3265 cases in 2011 for an annual case load of 136 cases per person. Combined, A-Team and Tier II intake results in 30 staff and an estimated annual case load of 120 cases per person ((345 + 3265) / 30). When surveyed, staff reported that on average the tools require three hours with families to complete. Only one person felt that this time represents too little time on the tools. Most (8/13 or 62%) felt the tools took too much or far too much time to complete with four staff finding that the tools took just the right amount of time. In focus groups, staff stated that they felt the time spent per family was worthwhile but difficult to manage in the context of high case loads.

Using the SDM tools to standardize the referral process represents best practice. A well documented, complete assessment also improves continuity of care. However, thorough and accurate assessments require proper training and adequate time to spend on assessments. Managing staff turnover and workloads will be critical to ensure a successful roll out and use of the SDM tools within ANCR. Proper supervision and support as well as ongoing training (including clinical interview skills) will be necessary to ensure that staff feel confident using the tools as part of the intake process. Staggering roll out across units, and reducing case loads as tools are adopted and learned will support staff learning and help staff adjust and integrate the tools into practice.

While the time spent completing assessments (including paperwork) poses a challenge there is clear value in the use of the tools for streaming the information they provide for ongoing case management. Having clear guidelines in place outlining the tool's use, providing adequate training, giving staff adequate time to learn the tools at roll-out, and making sure all staff know when tools should and shouldn't be used will ensure that the time spent on the SDM process is used most effectively.



As indicated by the increased number of transfers to FE from A-Team, full implementation of the SDM model will result in an increased number of referrals to FE. While this is a strength in terms of diverting a greater number of families away from protection, the impact this will have on workload within FE will need to be continuously monitored.

The SDM model relies on the ability to refer families to existing community resources to enhance services. Currently ANCR provides two resource centres that can support families. Continued review of commonly identified needs will support planning and focus resources towards areas of greatest need and priority. In this way, the tools can support enhanced planning and service provision at the community level. Continued partnership development and collaboration will be required to build networks of resources and supports where families can be referred. Although the gaps in community-based family services are large, use of the SDM tools may provide opportunity to leverage resources towards improved coordination of care.

Conclusion

Staff are well trained and supported in the use of the SDM tools. Overall level of confidence in the use of the tools is high. Confidence in their ability to use clinical interview skills is also good but more training would be appreciated. Using the tools provides staff with structure, consistency and training. The tools themselves are also considered to be effective training for new staff as they provide a thorough overview of all aspects to address during intake. Staff consistently use their own critical thinking skills in the interpretation and application of the tools themselves. Team supervisors support and engage with staff in decision making, an important aspect of the overall decision making process.

Compliance with the tools themselves is high, nearly 100%, and most staff would agree that the quality of assessments has improved with their use. Staff at ANCR and ongoing service agencies generally felt that the tools provide high quality and accurate information that enhances case planning.

Challenges identified in the tools' use include:

- *Knowing which cases don't warrant a full assessment at intake*. In some cases the amount of time spent on assessment during intake is considered too high. Family circumstances may change considerably between intake and referral, raising questions about the validity of a full assessment at intake. In general, however, workers appreciated having the assessments completed beforehand and used this information as a starting point for engaging with families. Some areas would be revisited due to changed circumstances but the initial assessment provided a contextual basis for case planning.
- *In some situations the Probability of Future Harm Tools didn't fit with circumstances*. Upon clarification from the tools' developers, it was determined that the PFH tools would only be completed in cases of alleged abuse or neglect. These changes have been implemented and should address concerns about the tools' fit.

Outside of some exceptions (extremely low risk or extremely high risk), it was felt that having a completed assessment prior to referrals provided better and more information for the worker receiving the referral. Most importantly, families reported positive experiences with the FE pilot and the SDM assessment tools.

The use of the SDM tools appears to result in a greater number of referrals to FE. This is based on the fact that proportionally more cases are referred to FE from A-Team than from Tier II intake. As a result, more families are being streamed towards preventive care that may otherwise have ended up in protection.

Workers continue to face difficulties and challenges with streaming of complex cases. Given the nature of the child welfare system and all its inherent complexities, such challenging cases are not uncommon nor will they go away. Providing ongoing training (both on the tools themselves and clinical interview skills), as well as offering support and supervision are key factors towards ensuring that staff have the resources required to make decisions when facing more challenging circumstances or cases. While the tools themselves provide structure and consistency to the process, they should not and do not, replace

individual professional judgment. The more staff feel supported and prepared to address these situations, the more confident they will feel with the overall process.

High workload is another reality of this job. With the implementation of the SDM tools, both intake and FE workloads will increase. The SDM tools take approximately three hours to complete and the added paperwork takes away from time spent on follow up and family engagement. With the tools use, it is anticipated that the number of cases referred to FE will increase. High turnover and staff burnout are not uncommon. Strategies to address increased workloads, reduce stress and burnout need to be considered to maintain a competent and cohesive team environment within ANCR.

The tools provide many benefits towards improved engagement with families. Having a tool that identifies strengths as well as needs is appreciated by workers and families alike. The tools themselves provide opportunities to engage with families and focus on identified needs. Some concerns were raised about questions being intrusive, punitive or judgmental. Additionally, not all families are ready to engage fully at the intake stage of the process. Guidelines that support intake workers in making their own judgments about the degree to which strengths and needs are to be assessed at intake may be beneficial. For example, a worker who has made their best efforts to complete the assessment but feels that the family is not ready or is resistant should have the ability to transfer a file without completing the strengths and needs assessment. This would save time and frustration and reduce the likelihood of inaccurate assessments due to a family unable or unwilling to disclose full information at intake.

The use of the SDM tools will have resource implications at the intake and case planning level. At intake, workers will need adequate time to carry out the assessments. Currently, prior to implementation of the SDM model, Tier II intake workers have a case load of approximately 136 cases per year. At the current rate, adding six intake workers to Tier II intake will result in an annual case load of 120 cases. Further follow up and evaluation will be required to determine the degree to which this is manageable after adding the SDM tools to the intake assessments.

As has already been demonstrated, the SDM model will increase the number of referrals to Family Enhancement. Currently, FE workers carry approximately 275 cases monthly. Clear benefits have been identified in providing support for eligible families outside of the formal child protection system (i.e. ongoing service agencies). These benefits include using a front end approach that may keep families from going further into the system. Additionally, FE team members have the opportunity to form partnerships to meet identified needs and support programming (for example; work with two resource centres to enhance services and the purchase of services from external agencies to meet needs). Geographically, access to resources varies across the province. Offering preventive services at ANCR can provide families with more consistent access to available supports and resources. An additional benefit lies in the fact that, prior to closure, all files have a full assessment completed. This reduces subjectivity in the decision to close a file and ensures that all closures are fully documented and reviewed.

One limitation of having cases streamed into FE at ANCR first is the increased number of workers involved with the family whose file may eventually be transferred to an ongoing service agency.

Ensuring continuity of care and good communication in the transfer process would help ease the family's transition between agencies.

The pilot of the SDM model was seen as positive and beneficial by ANCR staff, ongoing service agency supervisors and families. Challenges identified in administering the tools at intake were identified. The greatest challenge is the need to balance thorough assessments within a very short time frame. Some of the questions on the tools are not appropriate in all circumstances nor are the tools themselves a good fit for all families. As a standardized process, the SDM tools apply the same standard to all families, thus minimizing potential for personal bias or subjectivity in the assessment process. However, the tools themselves may have inherent bias based on socioeconomic status or ethnicity. Ongoing monitoring of potential impact and inequitable outcomes based on family characteristics should be carried out. Identified biases can be communicated to the Children's Research Centre who will make changes to the tools based on five years of monitoring.

Changes have already been implemented that ensure tools are used only in applicable situations (e.g. not completing a risk assessment if there is no allegation of abuse or neglect). Ongoing evaluation of the tools' use at intake will help further identify the best practice guidelines. Completing a full assessment at intake may not always be possible. However, when carried out, these assessments inform decision making about where to stream cases thereby diverting eligible families away from protection towards preventive services. Once referred to a case worker, either at FE or an ongoing service agency, the improved assessments provide a starting point for engaging with a family to develop supportive and relevant case plans.

RECOMMENDATIONS

Based on the above findings it is recommended that the Differential Response Model be fully implemented at ANCR and that, where possible and feasible, the Structured Decision Making tools be used at intake to stream cases into brief service, ANCR's Family Enhancement program or to an ongoing service agency.

It is recommended that the use of the SDM tools for screening and referral at ANCR be implemented in the following way:

- *Crisis Response Program/After Hours Program:* In cases of alleged abuse or neglect, will complete a safety and risk assessment (when possible). Families deemed eligible for preventive services will be offered a direct referral to FE. Based on the initial screen, all other files will be either closed or referred to Tier II intake.
- *Tier II Intake:* Will complete a Safety Assessment and Probability of Future Harm on all cases where there is an allegation of abuse or neglect. Based on the outcome they will either: (a) offer brief service and close the file, (b) refer directly to FE for preventive services or (c) complete a Child and Caregiver Strengths and Needs and refer to an ongoing service agency.
- *FE:* Will receive files directly from CRU or Tier II intake with completed safety and risk assessments (where applicable) and will use the Child and Caregiver Strengths and Needs, if they choose, to complete case plans and provide preventive services for 90 days or offer brief services. At the end of the 90 days or the brief services the file will be closed or transferred to an ongoing service agency. [The other option. There are cases when they are going to do the CSN, but there are also going to be brief services.]

As part of the roll out and implementation of the SDM tools, it is also suggested that ANCR:

- Develop a strategic plan to address staffing needs upon implementation including:
  - Putting in place a strategic plan to address staffing needs in Intake and Family Enhancement units that will minimize staff turnover, ensure that teams are fully staffed and reduce staff burnout.
  - Integrating the existing six A-Team positions with Tier II intake to reduce caseloads at intake level from 136 to 120 per person annually.
- Review existing process for training and supervision to ensure that all staff using the SDM tools feel comfortable and confident in their use. This will include:
  - Continuing to provide opportunity for workers and supervisors to discuss cases and decision making on a one-to-one basis.
  - Offering a refresher course in SDM tools and definitions at least once annually.
  - Offering additional training as required including training in Clinical Interview Skills.

- Develop and communicate clear guidelines and criteria for intake staff to determine when and how full assessments are completed and when particular tools are not used so as to avoid delays or gathering inaccurate data from families unable or unwilling to fully participate in the assessment. These guidelines and criteria will need to be continuously reviewed and updated.
- Identify opportunities to increase communication between intake, FE and ongoing service agencies. This would provide a feedback loop by which intake staff are aware of the benefits the assessments have had in case planning and continue to gather feedback on how assessments could be improved. Use of the SDM tools has been shown to improve overall communication due to the fact that all staff and agencies share a common language. Having increased opportunity to review the process as a team would further enhance their use.
    - Within ANCR, consider implementing a periodic case review process with FE and intake staff whereby team members would review and reflect upon complex cases and discuss and share learning's from these cases.
    - Develop and disseminate a brief (one to two page) information sheet about the SDM tools to be shared with ongoing service agencies and external partners.
- Work with FE team members to continue to develop resources and supports that will address the needs identified in the SDM tools:
    - Identify and establish partnerships that will enhance the services being provided.
    - Develop and adapt internal resources as required.
- Undertake further evaluation in order to better understand:
    - The long term impact of the DR Model on children and families.
    - The best process for streaming cases to FE within ANCR versus ongoing service agencies.
    - Monitor for potential biases based on socioeconomic status or ethnicity and, after 5 years, present any identified biases to the Children's Research Centre with recommendations for improving the tools.

Acknowledgements and References

We would like to thank all those who offered their time and feedback towards the completion of this evaluation. In particular, thank you to all A-Team and FE Team members and supervisors who provided feedback by completing a survey and/or participating in a focus group. Also, we would like to acknowledge the valuable input of those supervisors from Child and Family Service Agencies who completed a phone interview as part of this evaluation.

Information from the Southern First Nations Network of Care was generously provided in the report: *An Evaluation of Differential Response/Family Enhancement Pilot Projects Implemented by Four Southern First Nations Child Welfare Agencies in Manitoba, a report conducted by Marlyn Bennett under a contract from Southern First Nations Network of Care (SFNNC).* The full report is available at www.southernetwork.org

This evaluation report was prepared by Marnie Saunderson, Differential Response Coordinator, ANCR and Bohdanna Kinasevych, Evaluation Consultant, Health in Common.

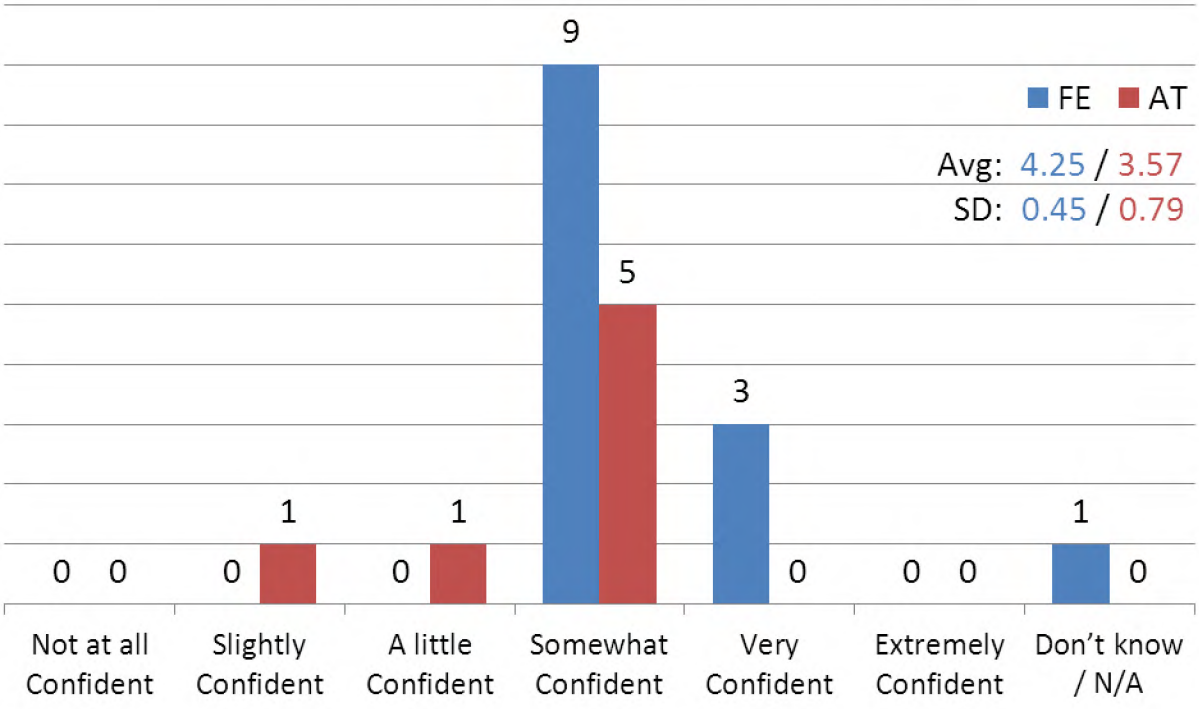
Differential Response Survey Results

For open-ended responses (Questions 5, 8, 20, 28, 31, 32 and 33) bullets summarize some of the key issues identified on the survey. Italics reflect paraphrased quotations.

For rated responses, the value above the bar represents the number of people who chose that response. "Avg" is the average response based on a scale of 1 – 6 for all questions except Q16 (scale 1 – 5), Q18 and Q19 (scale 1 – 7). "SD" is the Standard Deviation. While the average tells where the values for the response are centered, the standard deviation is a summary of how dispersed the values are around the average.

Two responses (questions 2 and 18) include a value of significance shown as "$p < 0.05$". For those questions there was a notable difference in average rating between Family Enhancement and the Assessment Team.

1. When using the Family Safety Assessment tool, how confident are you that the tool gives you an accurate assessment of the child's current level of safety?



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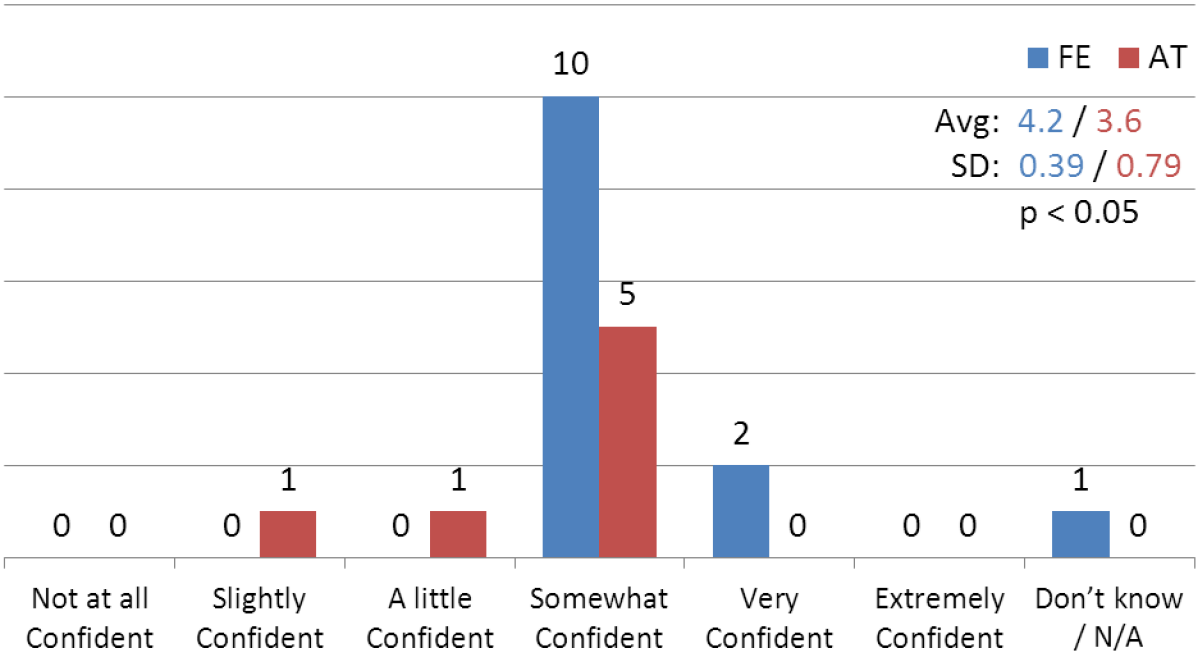
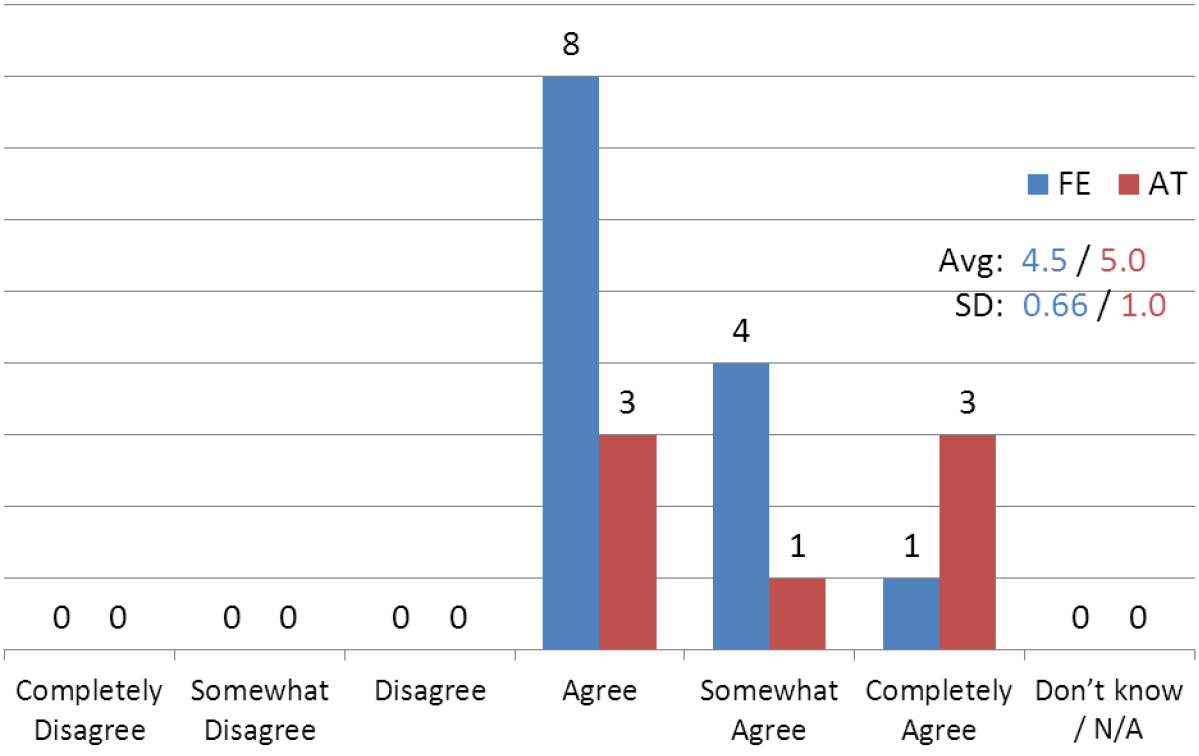
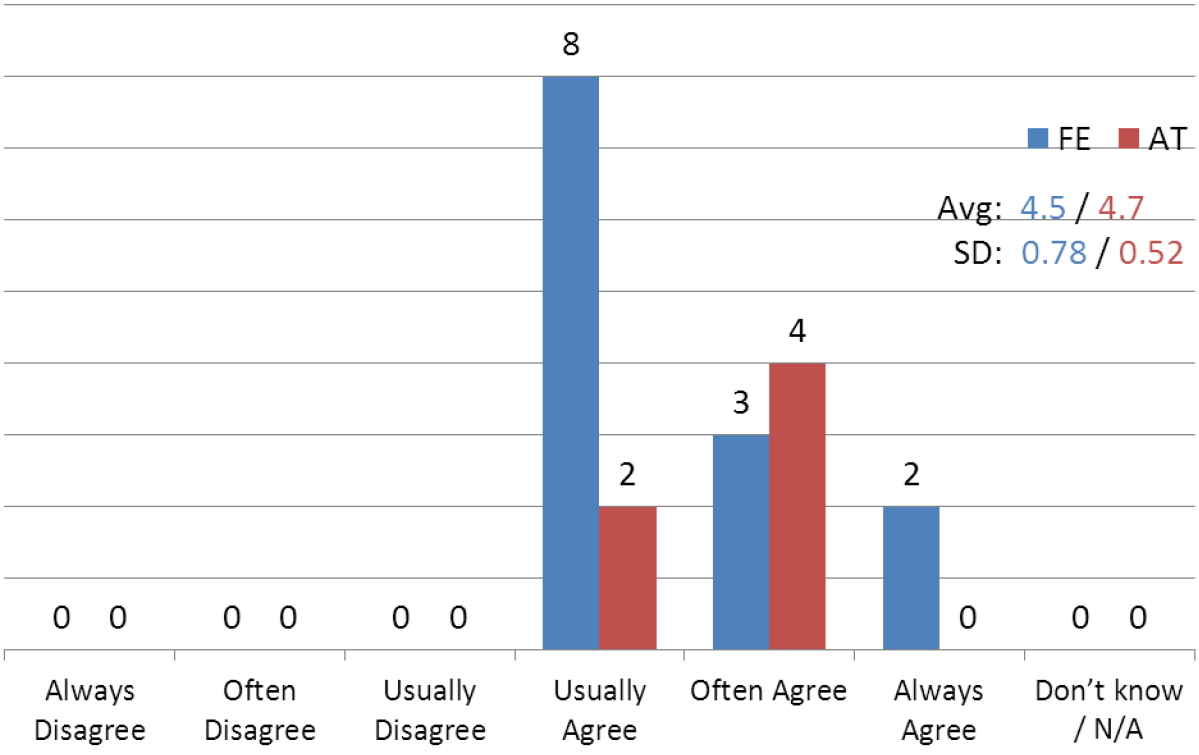
2. When using the Assessment of Probability of Future Harm tool, how confident are you that the tool gives you an accurate assessment of the potential of future risk to children in the home?



3. The process of using the two tools to determine the Manitoba Risk Classification is easy to understand



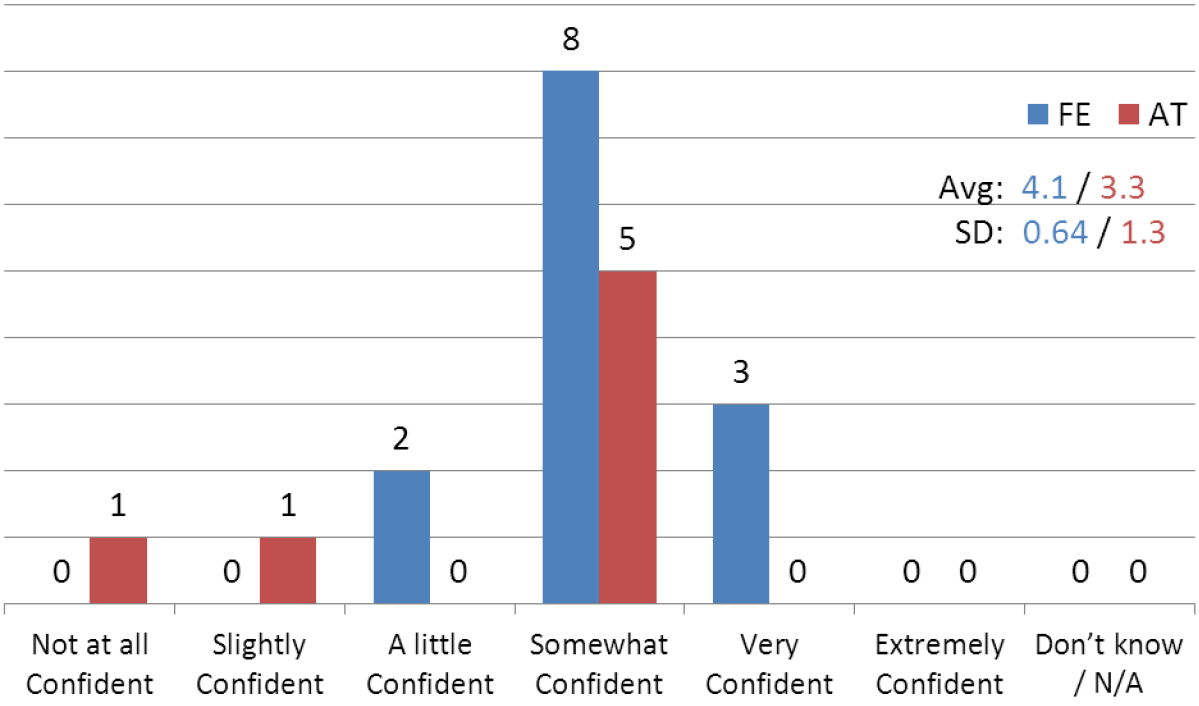
4. In general, how often do you agree with the Manitoba Risk Classification determined by the two tools?



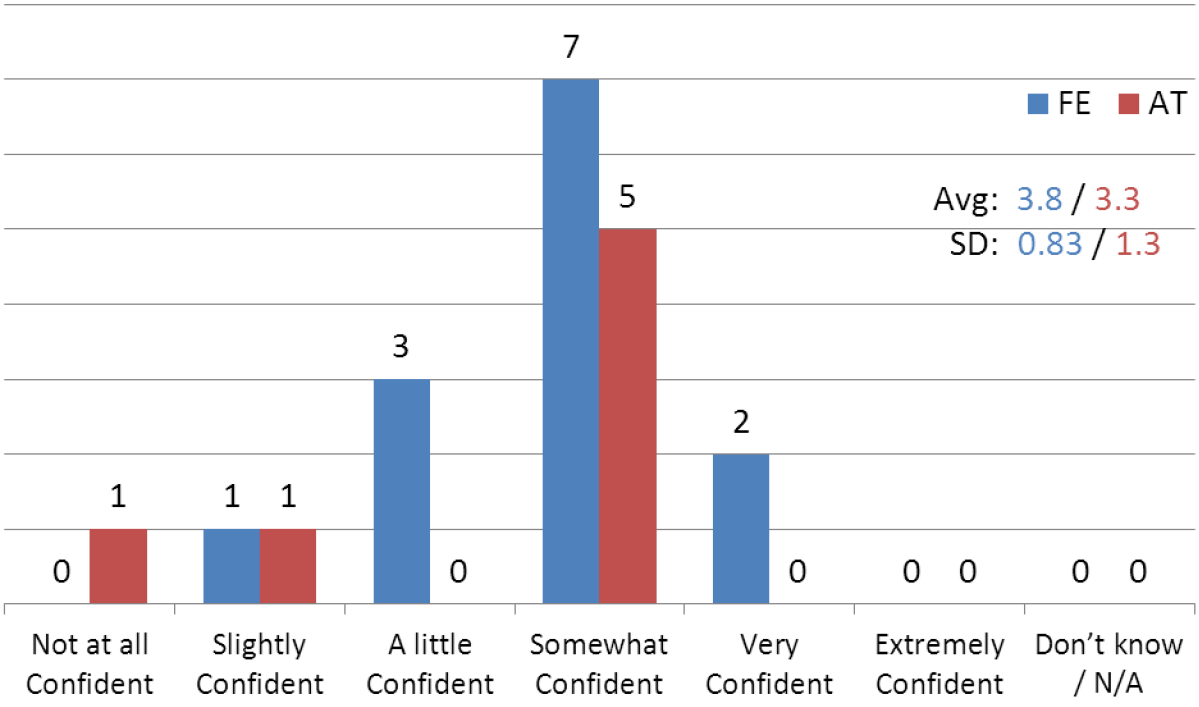
5. In general, how often do you agree with the Manitoba Risk Classification determined by the two tools? - Additional comments:

- Problems with tool: *doesn't adequately address issues where teens are at risk to families; doesn't reflect positive changes*
- Needing clarification on tools: *What does safe with plan mean … when using SA?; further discussion re: when to use override*
- Subjective
- Useful in training new staff

6. When using the Caregiver's Strengths and Needs tool, how confident are you that the tool gives you an accurate assessment of the family?



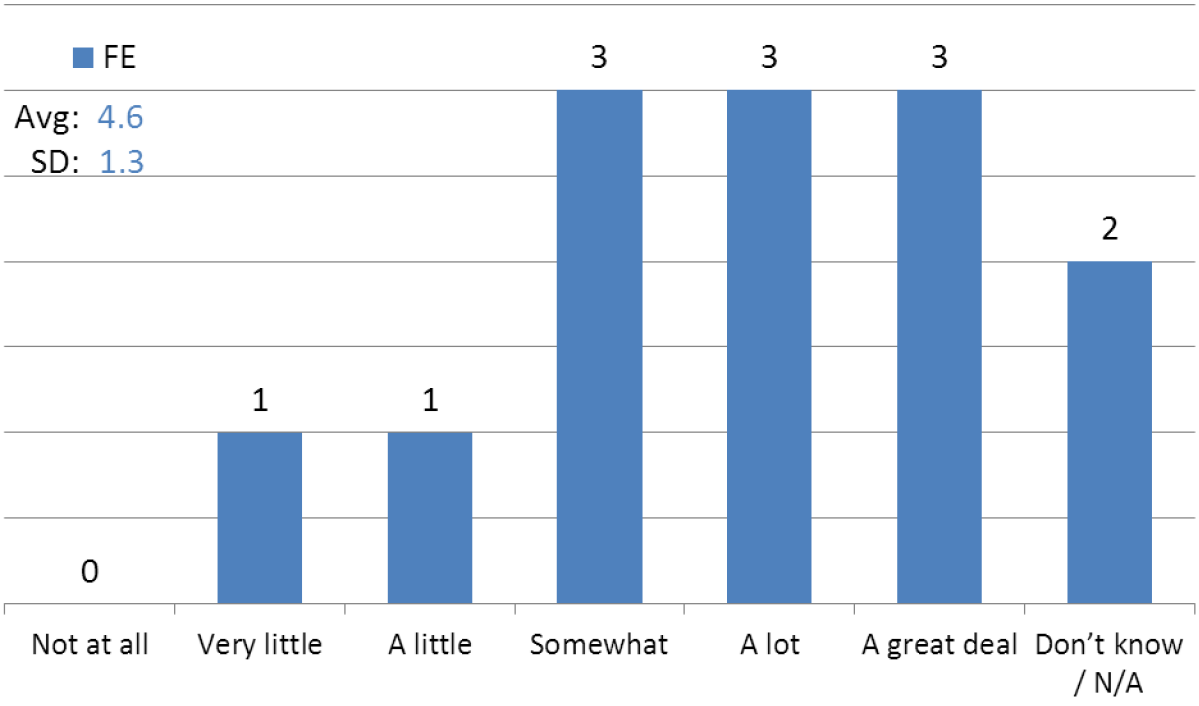
7. When using the Children's Strengths and Needs tool, how confident are you that the tool gives you an accurate assessment of the children within the family?



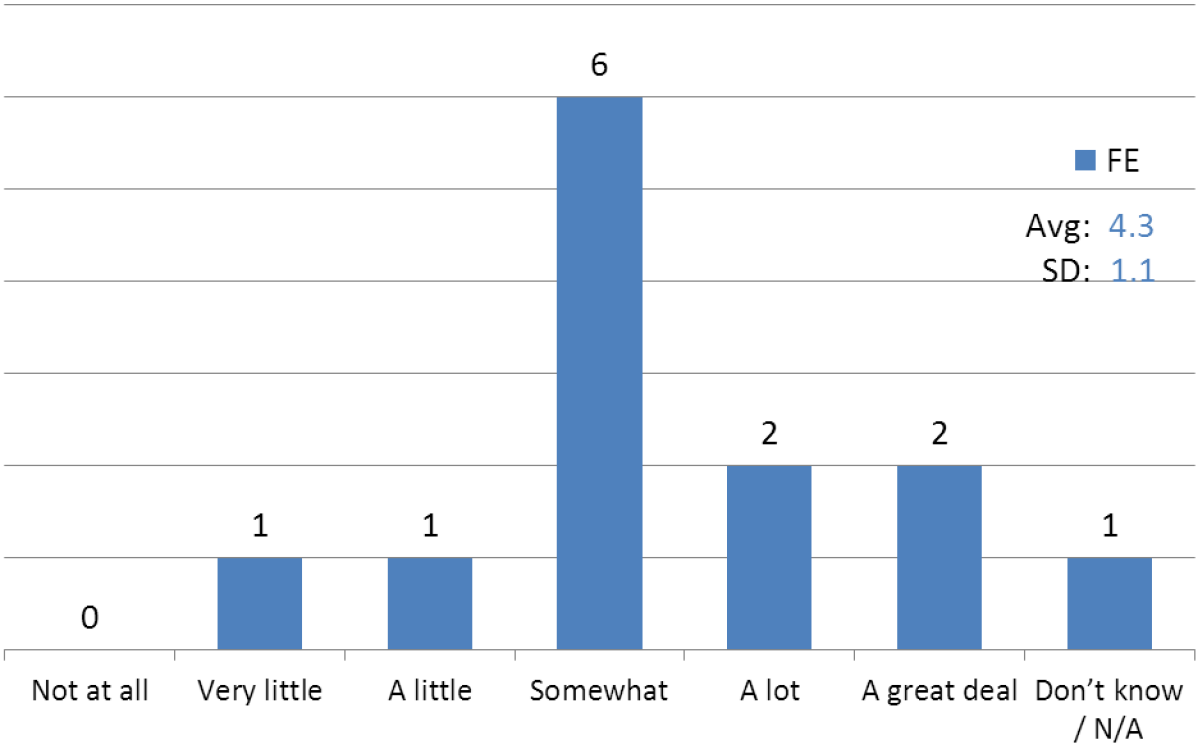
8. When using the (Children's Strengths and Needs or Caregiver's Strengths and Needs) tool, how confident are you that the tool gives you an accurate assessment of the children within the family? – Additional comments:

- Problems with tool: *Does not show risk teenagers pose to parents and siblings; alcohol issues.. comes up as a strength?; Doesn't reflect families needs*
- Ensures complete assessment
- Useful in training new staff

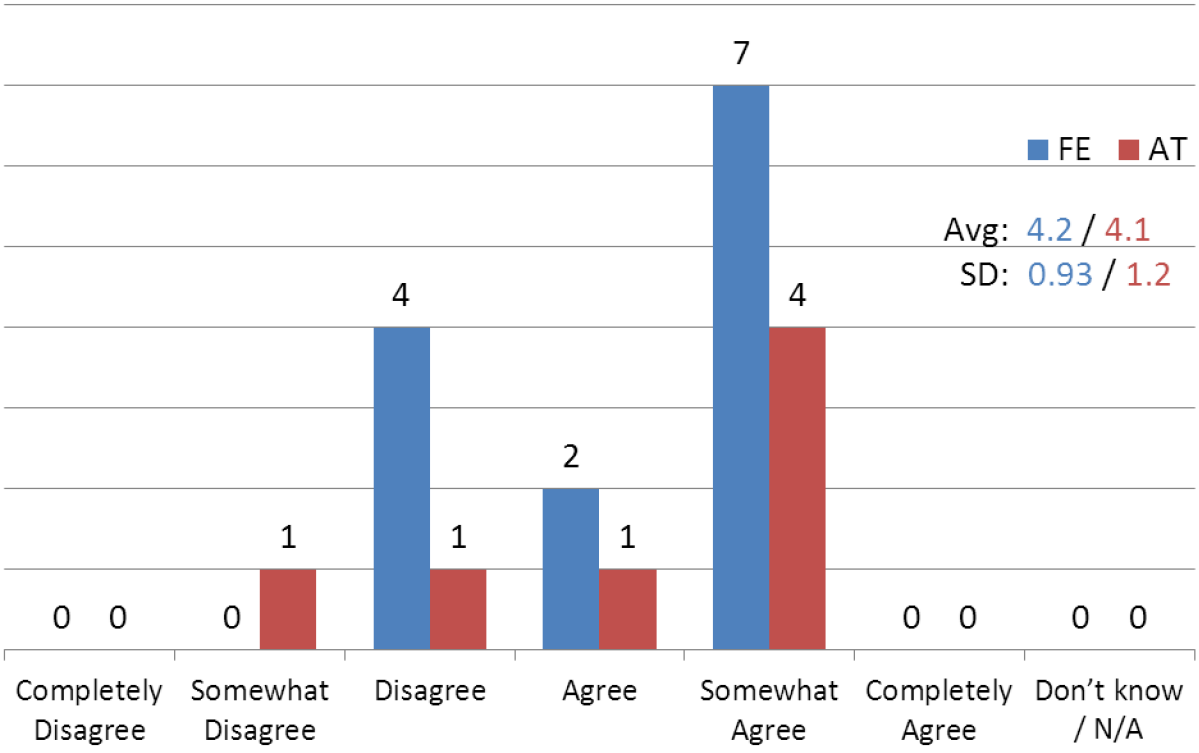
9. To what extent does receiving case files that are already assessed by the A-Team enhance the services provided to the family?



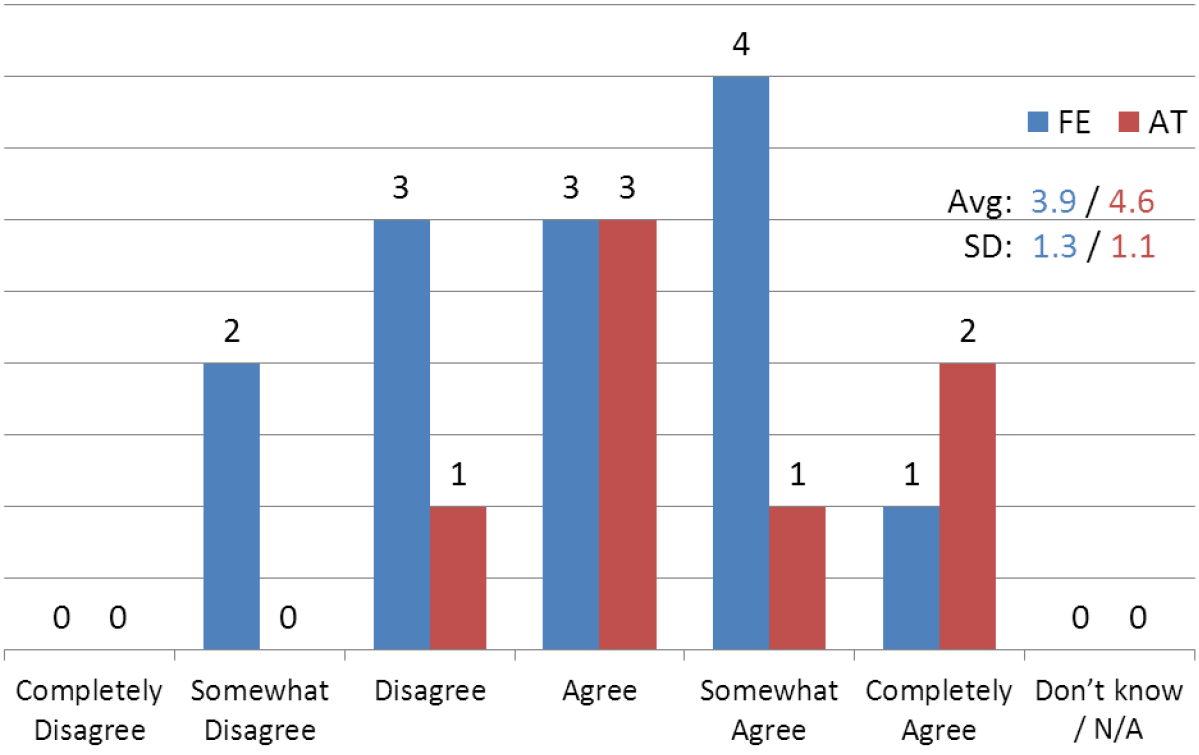
10. To what extent does completing assessments entirely yourself enhance the services provided to the family?



11. Information provided by the SDM assessment tools provides accurate information about the family.



12. Information provided by the SDM assessment tools provides enough information about the family.



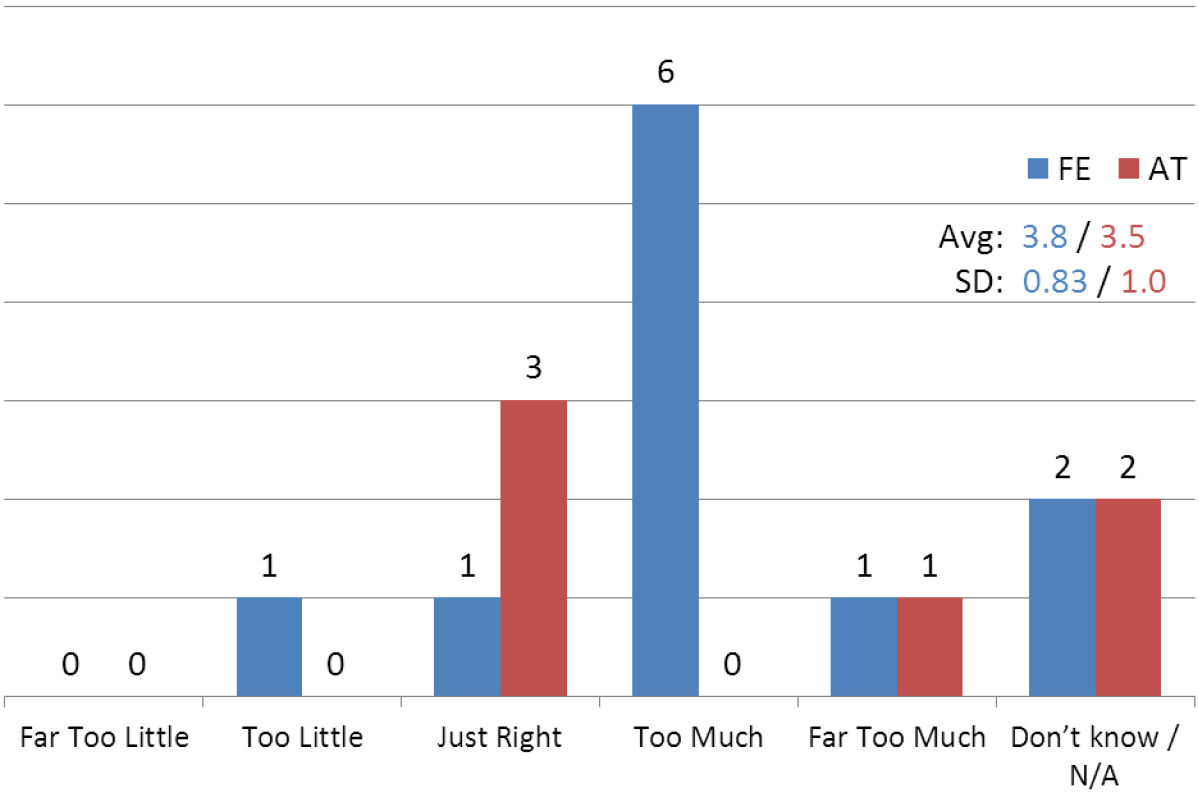
13. How would you rate the overall quality of the assessment provided?

14. Approximately how much time is spent with a family completing the SDM tools?

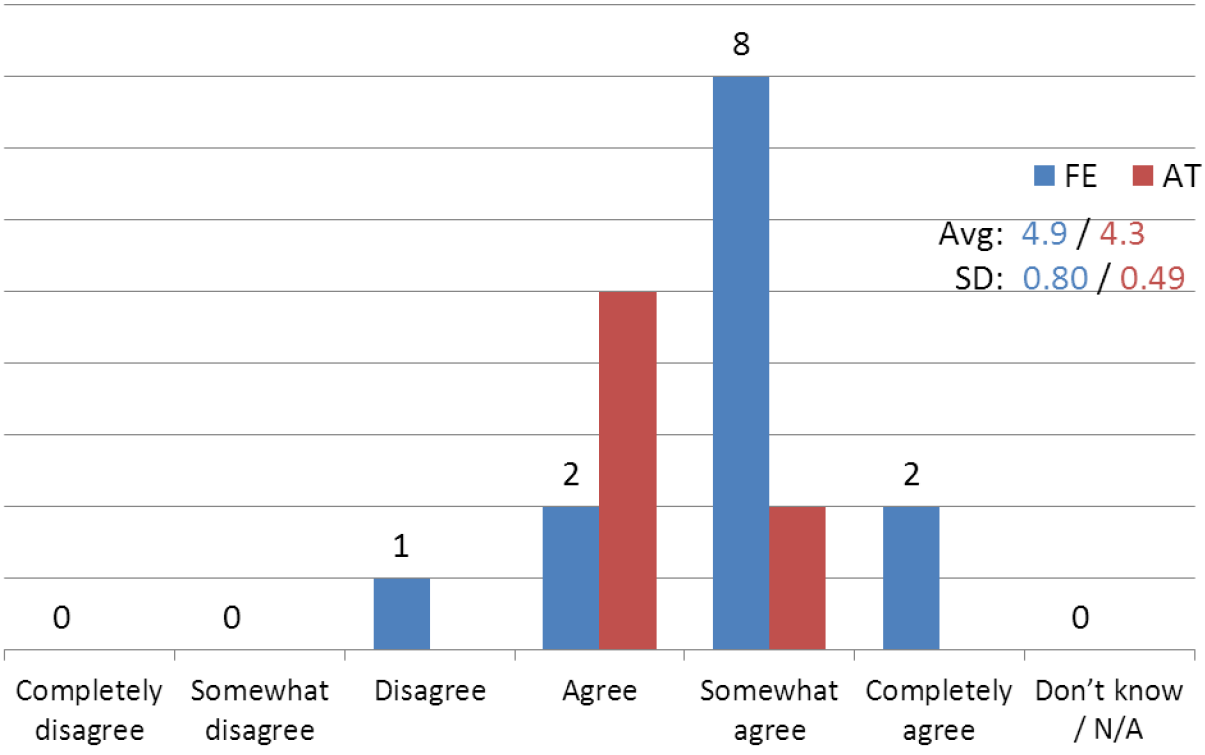
15. Approximately how much more or less time is spent on a case with the additional tools? (*If you have not done any other type of assessment please leave blank*):

	14. Average time spent with family completing SDM tools	15. Average increase in time spent with the additional tools
FE	2.7 hours	3.1 hours
AT	3.6 hours	1.0 hours
Both	3.0 hours	2.8 hours

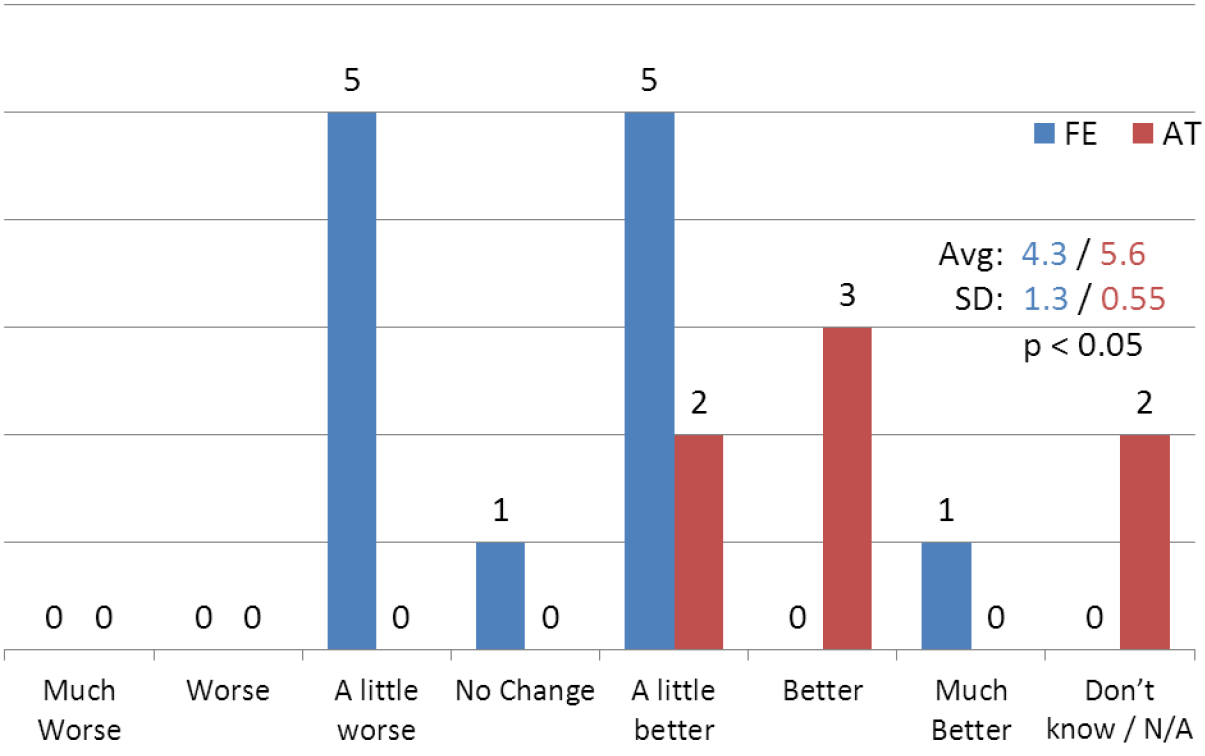
16. Do you think the time spent on the additional tools is:



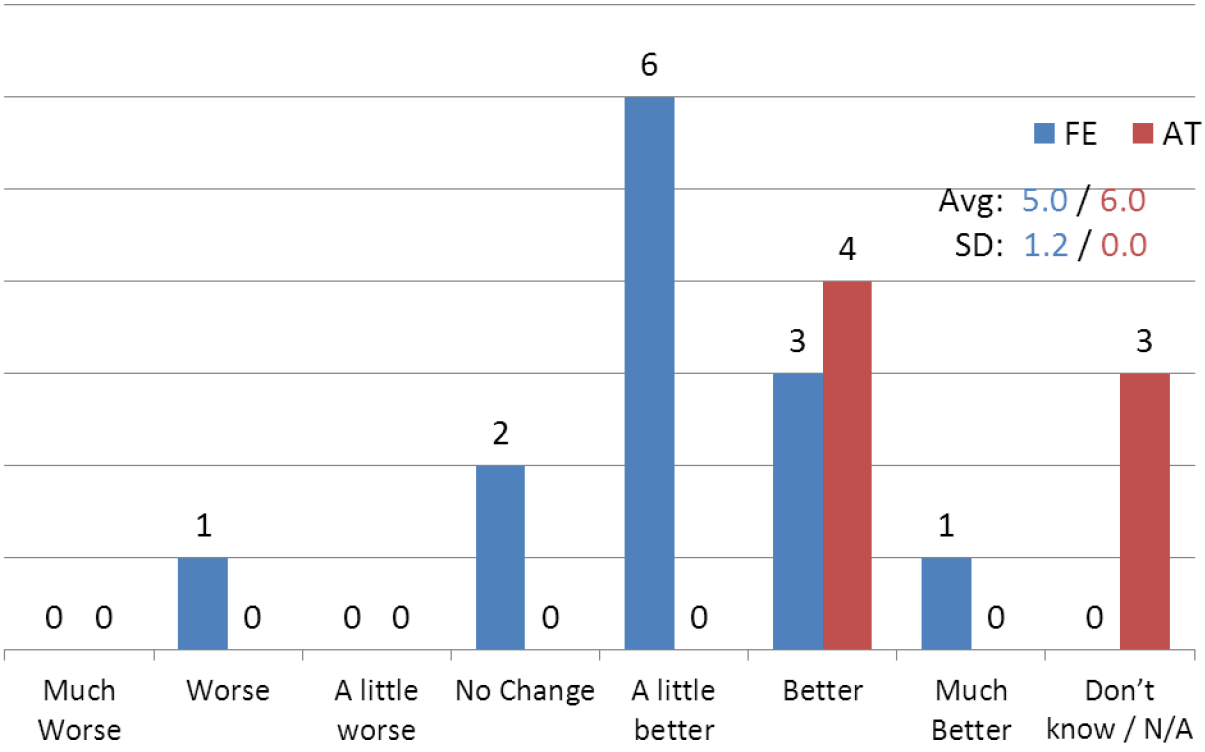
17. To what extent would you agree or disagree that the SDM process represents best practice for assessing families?



18. How has the implementation and use of the SDM tools impacted the assessment process?



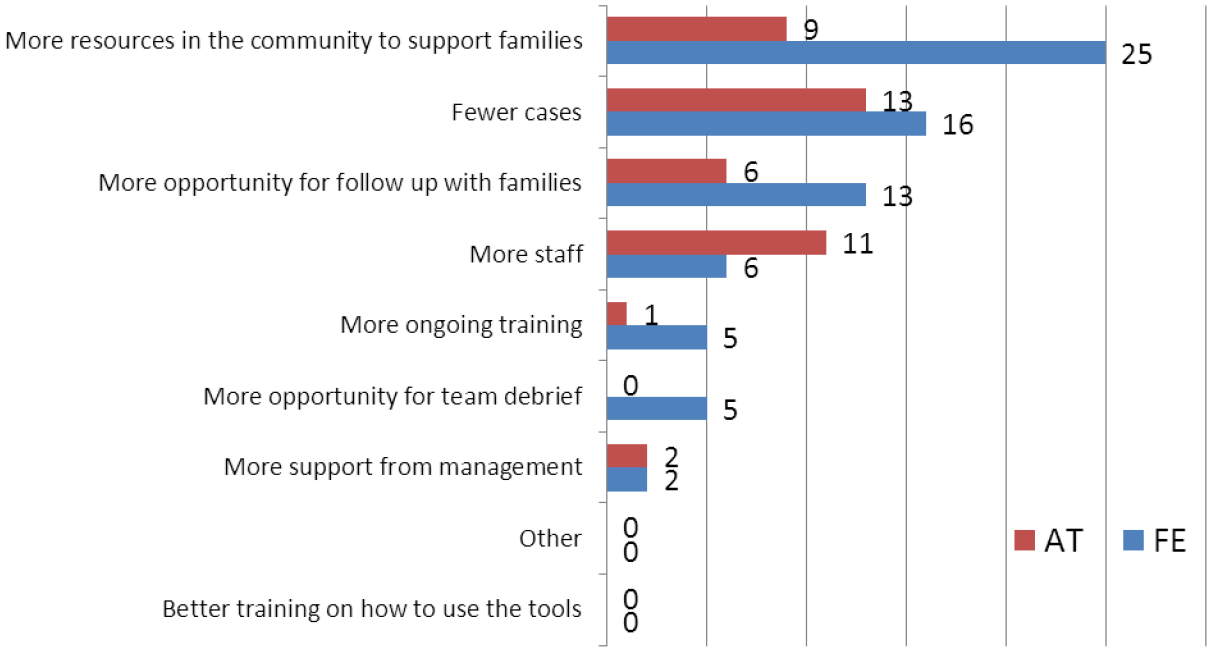
19. How has the implementation and use of the SDM tools impacted on the quality of case assessments?



20. Additional comments about the SDM process:

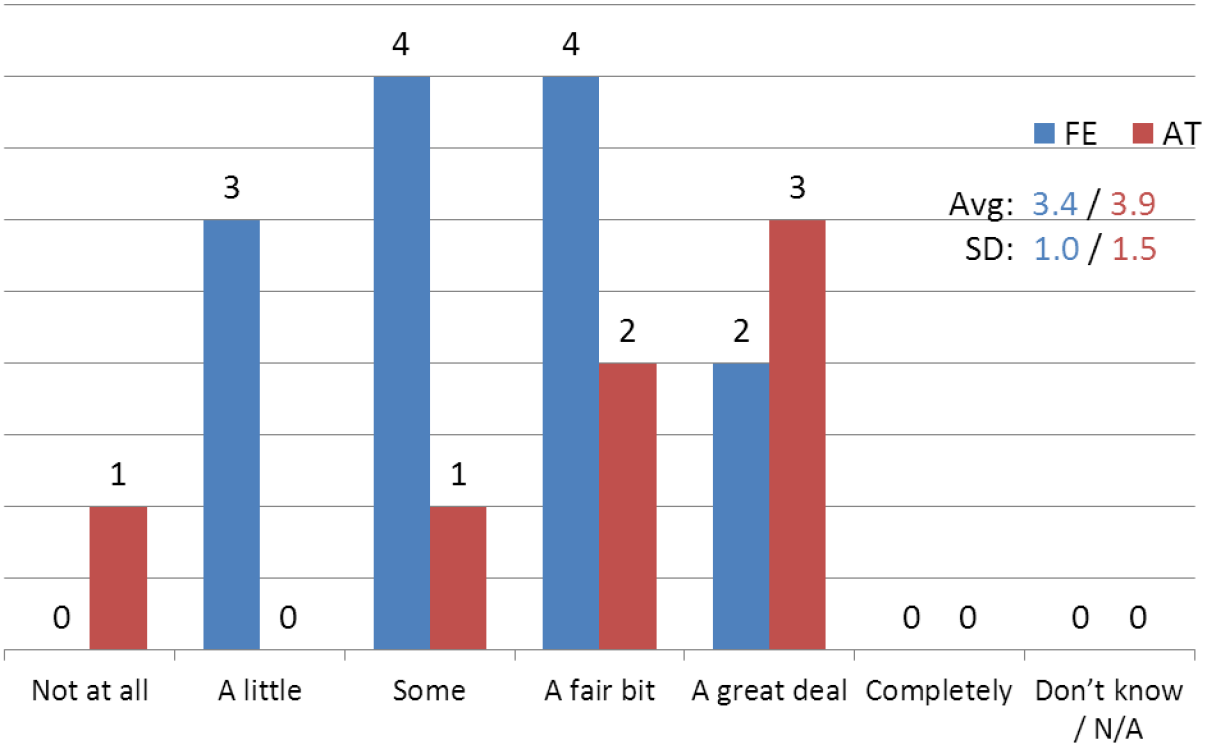
- Problems with tools: *do not always appear accurate; Doesn't always catch identified needs; does not fit with some complex cases*
- Time consuming: *leave little time to spend with families working towards change*
- Opportunity to focus on the positive
- (FE worker) Beneficial to have assessment completed before referral is made to FE
- Useful in training new staff

21. What 3 things do you feel would improve the SDM assessment process? (Choose 3 only: number your first choice 1, second choice 2 and third choice 3)

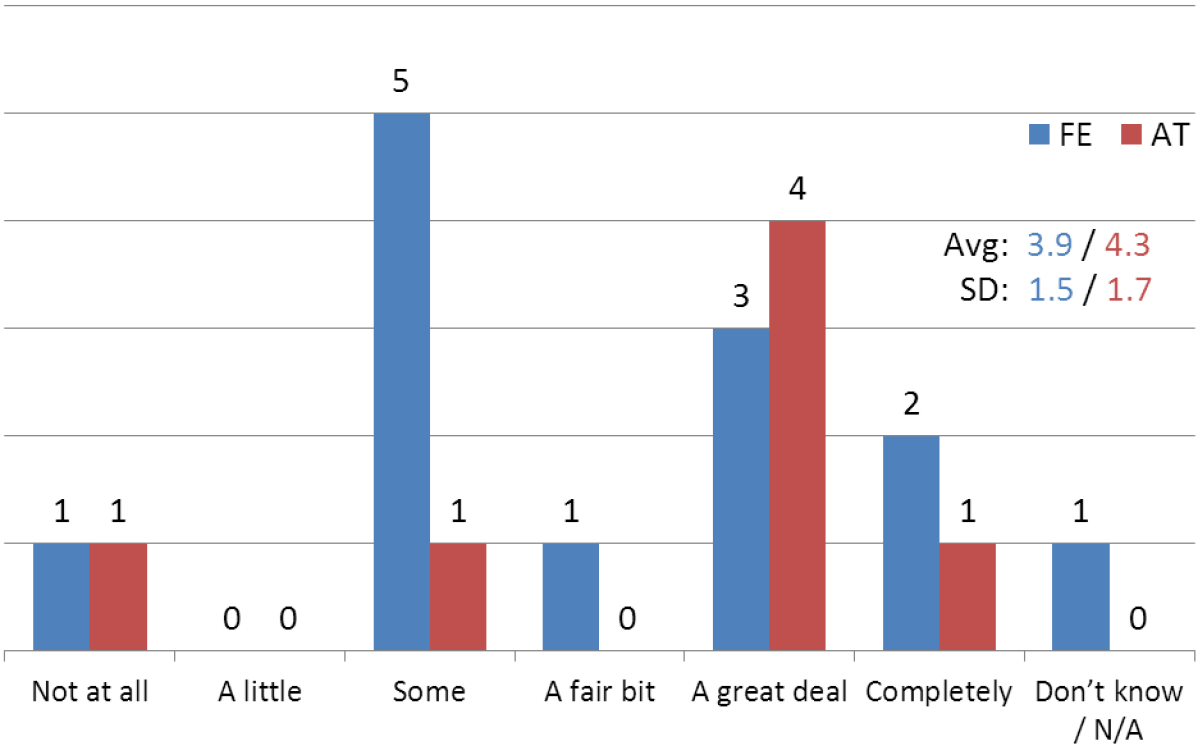


22. How would you rate your overall skill level in using the SDM tools?

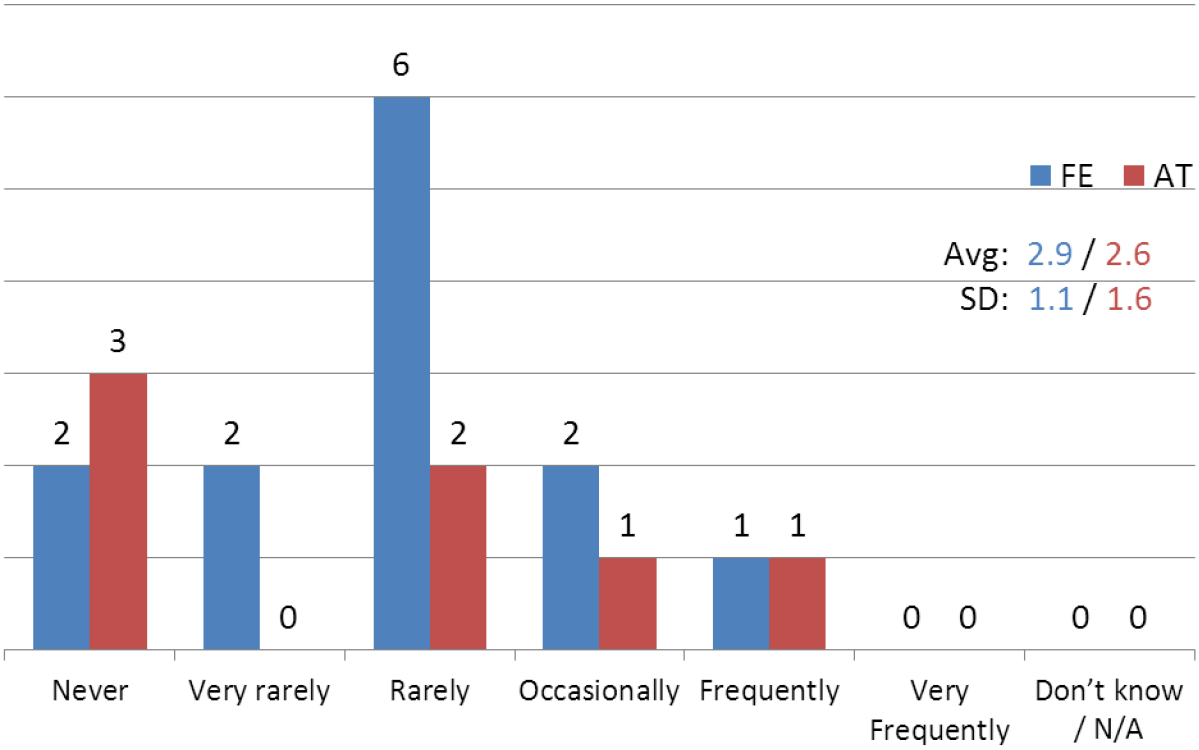
23. Did the two-day SDM training adequately prepare you to use the SDM tools?



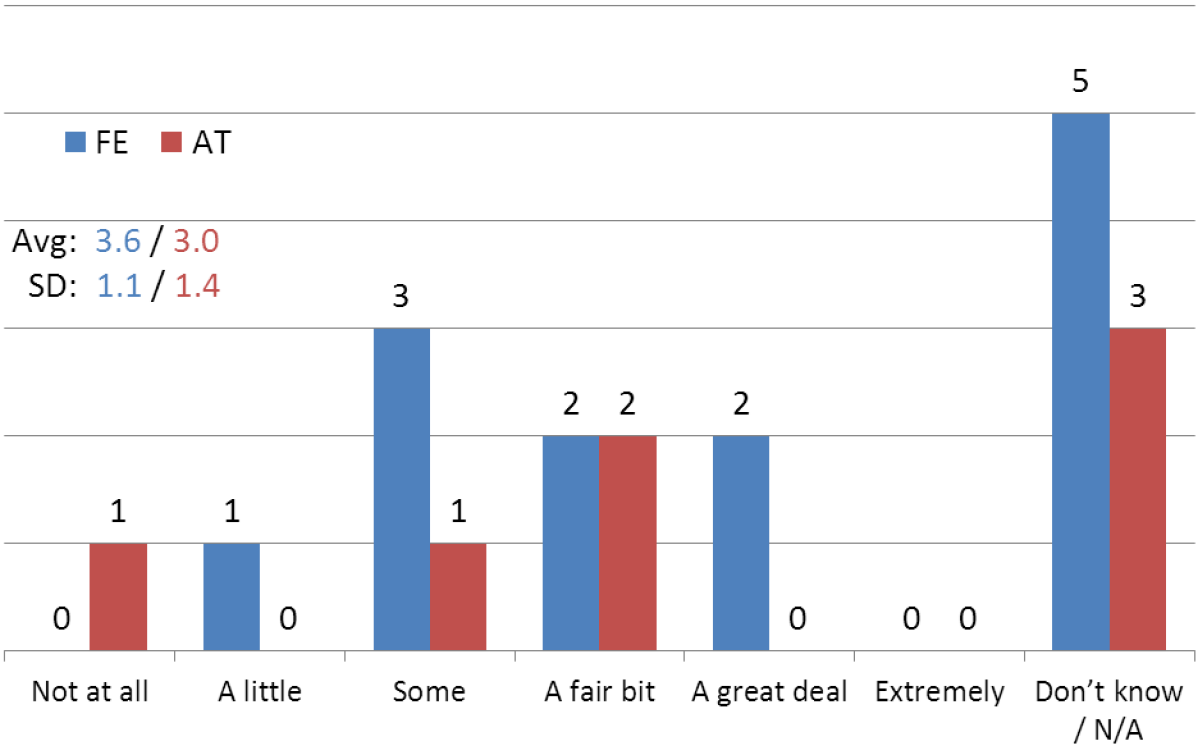
24. Following the SDM training, did you feel you had enough additional support when you needed it?



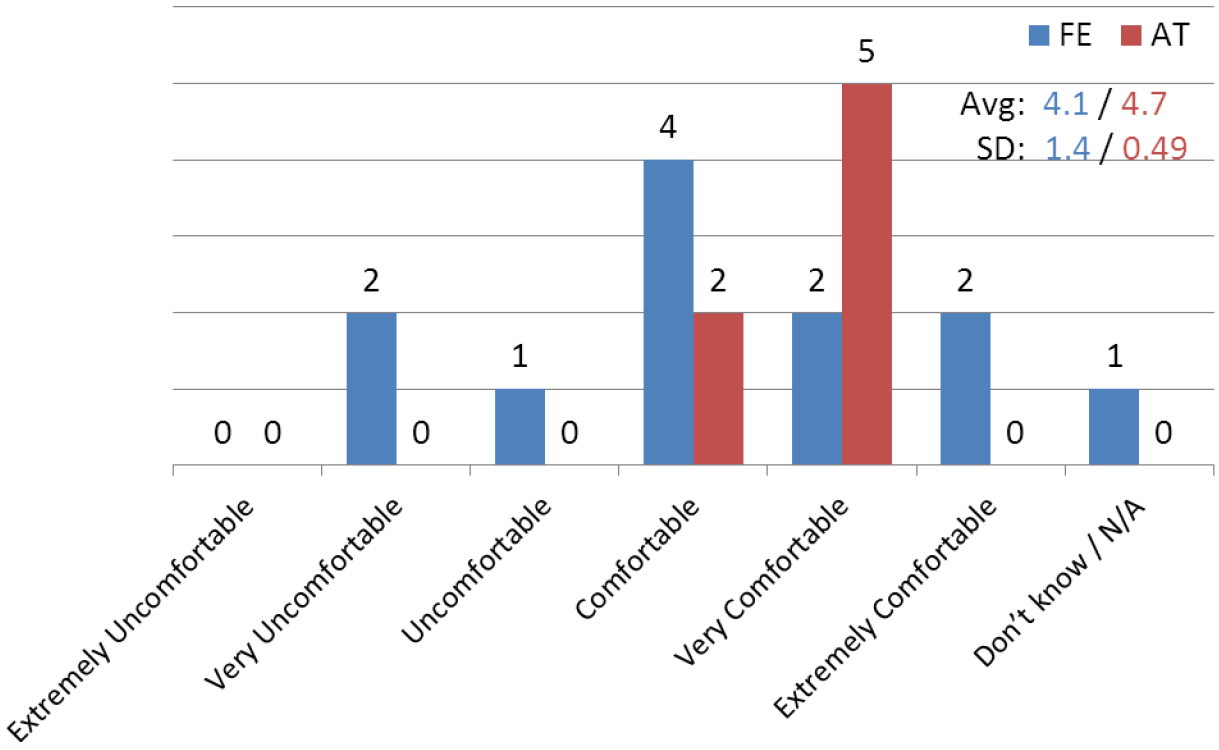
25. How regularly are you accessing any type of ongoing SDM support (SDM trainer, refresher courses, etc.)?



26. If you have accessed any additional support or training, how helpful has it been?



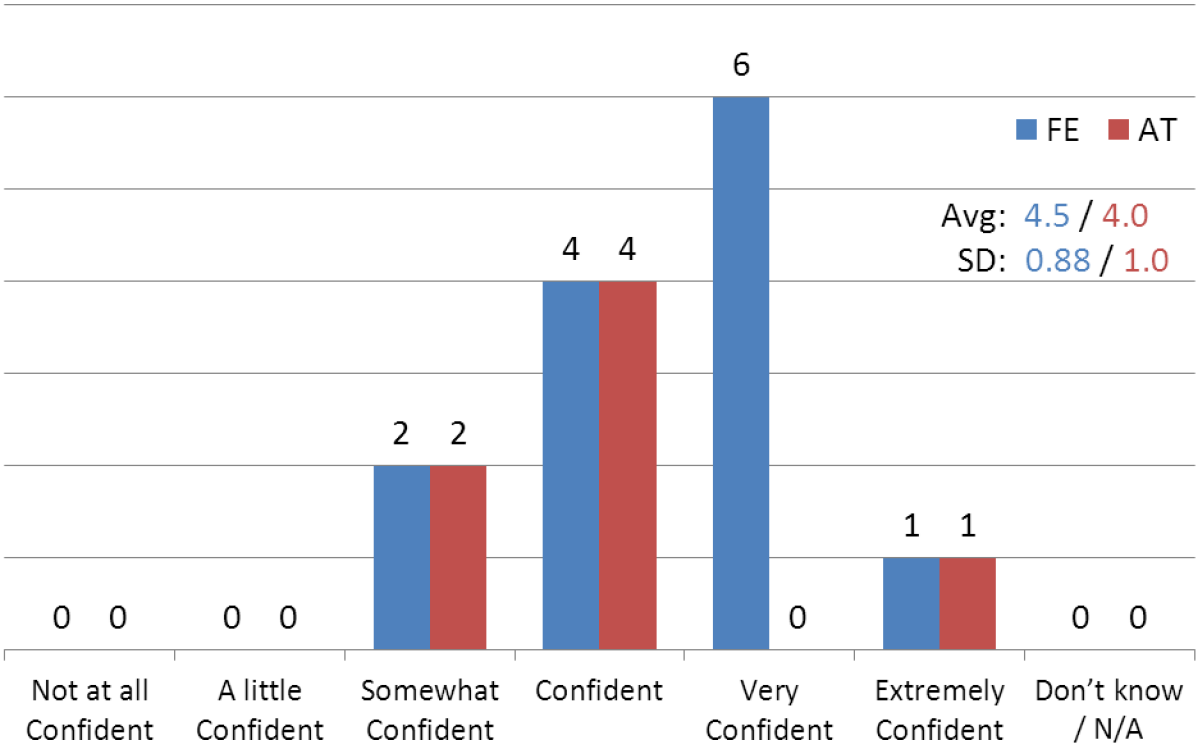
27. How comfortable are you asking all of the questions included in the assessment tools?



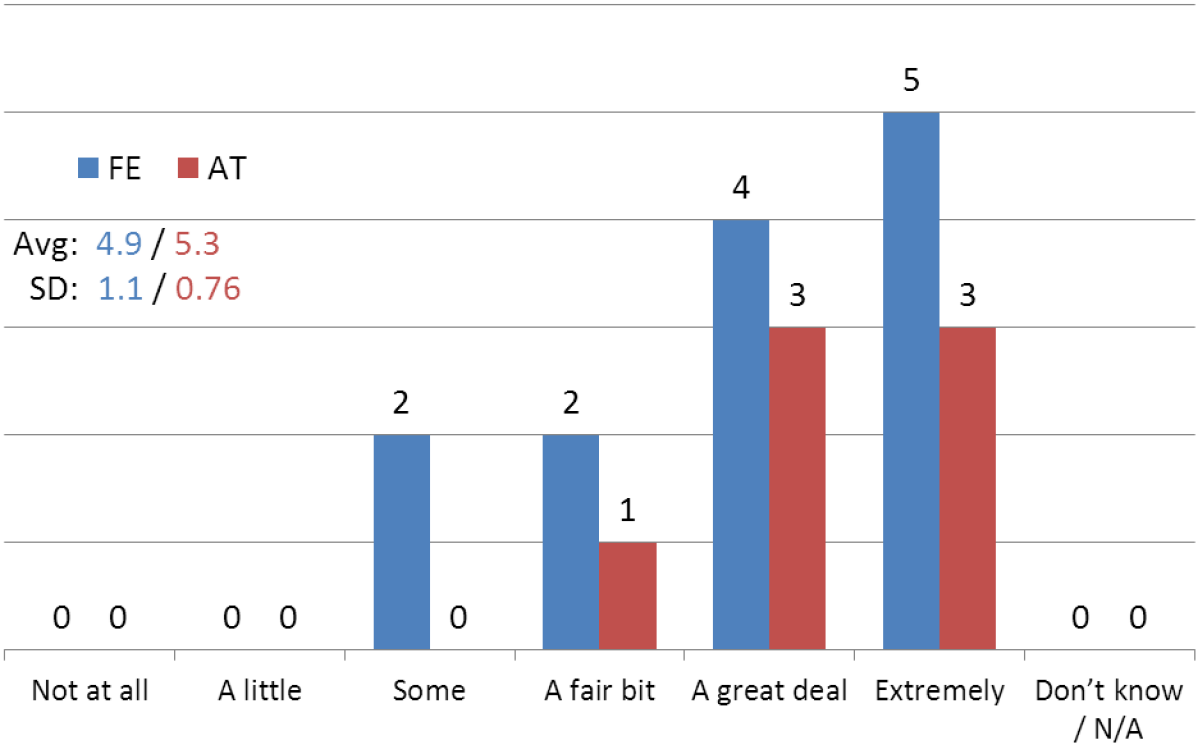
28. If you answered 1, 2, or 3 for question 27 what would make you more comfortable?

- Opportunity to observe others in the field
- Difficult when having to track down/or force clients
- Allow time for families to tell stories
- Will seek assistance if required

29. How confident are you with your ability to use clinical interview skills to complete the assessment?



30. How helpful would Clinical Interview Skills training be for this job?



31. What (if any) challenges have you had with the SDM process?

- Impact of previous false reports to CFS
- Problems with tools: *doesn't address inter-generational and parent/teen conflict issues; focus on negative*
- Skills/training development: *"learning how to ask the right questions in the beginning"*
- Time consuming

32. In your experience thus far, how would you envision the SDM tools being used at ANCR in the future?

- Increases consistency: *forces workers to ask necessary questions at intake; giving consistent approach*
- Process: *could be used at FE, CRU and Intake levels; may not be completely accurate at this level to guide ongoing case planning*
- Time consuming: *Caregiver and Child SN are too lengthy for an intake agency;*

33. Any additional comments:

- Tools don't address parent/teen issues
- Often files that are medium MRC aren't suitable for DRIFE
- Provides guidance and consistency: *Questions are relevant*
- More community-based resources and supports required

Focus Group Discussion Guide: **Child and Family**
All Nations Coordinated Response Network (ANCR)
Differential Response Service Delivery System

Facilitator Introduction:

Purpose of meeting: Welcome everybody and thank you for coming today.
My name is Bo (*and introduce Marnie*) and we will be asking questions and *facilitating* the discussion. I would also like to introduce Daniel who will be taking notes.

You have been invited to this focus group as a case worker in the SDM process. Your feedback is very important and will be used to help inform the deployment of the SDM process. The goal of today's focus group is to learn about implementation, case streaming, meeting families' and future program needs.

Marnie: Explain why the pilot is being evaluated – how decisions will be made, what will happen, etc.

How the focus group will work:

This focus group will last up to one-and-a-half hours. I will ask you some questions about your experience with the SDM process. Sometimes I will ask for everybody in the room to respond to a specific question, but you are free to respond and discuss as a group. Your anonymous responses will be summarized as a group and shared with program administrators in a written report.

There *are no* right or wrong answers.

Your comments here today will remain anonymous – your names will not be used in reports, nor will specific answers be attributed to you.

What is said and what happens in the group will be written down and audio recorded by Daniel for accuracy. Recordings will be deleted after transcription. No information will be attributed directly to an individual.

Participant Introductions

Before we begin, let's go around and have everybody tell us your first name.

Discussion Questions:

Write down each question to be asked including prompts or follow up questions to help generate ideas or discussion. Begin with very broad or general questions first, then move to more specific ones as you proceed. As participants share ideas, cycle through the group, ensuring that each participant has a chance to speak. When comments related to one question are finished, summarize them, making sure there is agreement with the summary.

Go Around:

1. Describe your experience using the SDM tools as a pilot over the past year.
    a. Are the tools clear and easy to use?

Open Discussion:

2. Share some results of the questionnaire
    a. Q11, Q12, Q13 (SDM Tools - Accurate, enough, quality)
        i. Any comments on the results?
        ii. Are the tools accurate, effective?
        iii. Are they being used correctly?
        iv. What has been the family's experience?
    b. Q16, Q17, Q19 (Time spent, best practice, change in quality)
        i. Any comments on the results?
        ii. How do you feel about the time spent?
        iii. They take more time – is the extra time valuable?
        iv. Benefits for them / for the family:
        What makes it worthwhile? What makes it challenging?

3. How could the process be improved?
    a. Are transfers appropriate?
    b. Adequate time allotted for additional assessment?

4. *FE Only:*
    a. What are the benefits / disadvantages to the family of having it done one way versus the other?
        i. (Streaming via AT versus doing everything yourself)
    b. Which team should administer the tools?

Go Around:

5. Final comments: Thinking about everything you have heard and yours and families' experiences with the SDM tools, what one thing would be the most important consideration about the tools' future use at ANCR?

Thank participants and remind them how the information will be used. If participants want a summary of the final report be sure to consider how you will provide this to them.

Interviews with the Clients of ANCR's FE Pilot Program

Interviews were conducted with nine parents involved with ANCR's family enhancement pilot program. The interviews took place in the month of June at the offices located on Portage Avenue in Winnipeg. The interviews, on average, were completed anywhere within 20-40 minutes. The following seven sections set out the responses from the nine parents to seven key questions relating to the family enhancement services they received from ANCR's family enhancement pilot program.

Involvement with ANCR's FE Pilot Program

The nine parents interviewed for this pilot evaluation each started off their interviews explaining how they became involved with ANCR. The majority of the parents (4 out of 9) indicated that they became involved with CFS as a result of someone calling the agency about concerns with the family. Three of the parents voluntarily called ANCR for assistance in dealing with a family issue while one parent indicated that she became involved with ANCR because of a previous contact. All indicated that their contact with ANCR resulted in a referral to the FE pilot program.

The prime reason why most of these parents became involved with the FE pilot program was as a result of conflict either between themselves and their teenage children along with their teen's drug use, possible gang involvement, the teen's defiant attitudes and in some cases, instances where their teenagers were deliberately missing school. These parents unanimously expressed feelings of inadequacy and feeling challenged about how to appropriately and adequately deal with the specific situations facing their families.

Other reasons that the parents cited for having contact with ANCR's FE pilot program included an instance where one mother needed additional resources to help her adopted son who required additional resources because of some undiagnosed conditions (FASD, ADHD, and ODD) that had been unknown prior to contact with ANCR. One of the nine parents had also indicated that they previously had prior contact with CFS. This particular mother noted that she had tested positive for drug use and ANCR became involved with her family once again. Another parent shared that someone had anonymously called into CFS concerned that she was leaving her children alone at home alone while she went off to work. While this allegation turned out to be untrue, the mother decided to keep the social worker's contact information on a whim that she

might need help in the future. A number of months later she was presented with a situation where she did indeed need help. This mother then voluntarily contacted the same social worker for assistance where she learned about the family enhancement pilot project operating out of ANCR. Her decision to voluntarily contact ANCR for assistance resulted in an approach that was palpable to her, and solidified to her that she had made the right decision by calling CFS for assistance, as she shared,

> *I thought I needed extra help so I decided to call the social worker and she said there's a program called the family enhancement program. She said they don't take the kids or anything like that. They help and work with the parents. I said great, that's what I would like to get involved with. So I said sure.*

Accuracy of SDM Assessment Regarding the Family's Situation

The parents were asked whether the SDM assessment forms accurately assessed their family's situation. The responses were variable.

Four of the nine parents considered the SDM assessments to be helpful. The interaction with the social worker filling out the assessments, the resulting plans, and referrals to support programs were highly appreciated by the parents in understanding how to move forward in dealing with their family's situation. This understanding was captured in the following narratives provided in two of the parents' responses below:

> *We had an idea of what we could do and had ongoing plans ... like the program we have been going to, its been really good because we didn't know how to talk and communicate and deal with different conflict situations with our son, especially when it is such a crisis and a heightened conversation to be able to remain calm, what's helpful to say, what's harmful to say. Where we can take things. It's been really helpful to us.*

> *Oh absolutely. The worker that I was assigned to, she was so awesome. So this social worker met with me from the FE program and with my son. ... We actually met for the first time over lunch which I thought was nice, just sort of relaxed, have some lunch, have a conversation, you know, she could ask my son too, what's going on with you? ... And then we kind of just did some assessment as far as putting all the tools in place to benefit my son. I want to give him the proper tools to be able to achieve that and that seemed to be at the time that I met her. Also, like he was completely expelled for several months prior to me even contacting child and family. That was another piece. She got him back in school. It was just so awesome all my entire experience from start to finish. The first, like I said, we met with the therapist at MacDonald Youth Services and she was able to introduce herself and her part in our journey together and our goals together as a family, to work towards having a peaceful home life. So that was the first part, getting him the therapy once a week. He really, really enjoyed that. It was extremely helpful and important for him to have an outlet of someone, not mom, not school teachers, somebody, just a complete outside person that he could feel that he could talk to ... and he actually requested a woman, because he said that he didn't want to cry in front of a*

man. You know I thought that was really great. And so he was going there once a week. And then we looked at some further things

Three of the nine parents indicated that they were unsure of how helpful the SDM assessments were. They acknowledge completing the assessment forms with their workers and knew that "they had been completed and entered into the computer."

Some of the parents responded that the SDM assessments were both helpful and unhelpful. Some of the reasons offered about why the assessments were unhelpful stem from: (1) a belief that the forms did not adequately capture the complexity of the family's situation, or (2) that the tools didn't take into account past information and experiences that led up to the problems the family was currently facing. As one of the mothers indicated, she felt her situation was difficult to explain and became distraught in explaining that the assessments "kind of hit home and makes you feel bad, it makes you look bad and you're really not bad."

Perspectives on the FE Services Offered

All of the interviewed parents were of the opinion that the services offered through the FE pilot program fit the specific needs of their families. The parents we talked with were dealing with situations where their teenagers were dealing with drug addiction, depression, missing school, being defiant, and dealing with undiagnosed behavioral issues (i.e. ADHD, FASD, ODD). Mostly the parents remarked that the biggest issue facing each of them was not knowing how to deal with the needs of their children until they were able to connect with a worker through the FE program as this mother reflected:

I don't know how we would have dealt with the situation the way it was. Our son was in full crisis and he needed to be removed from the home or else it was going to be harmful. We needed a lot of help. We needed to have time to be able to talk things out, to know how to deal with different situations, to know how to help our son and encourage him in the right direction. Since we have been involved with the FE program, it's been a lot easier to be able to talk with our son and we've changed a lot of the dynamics in the home as well. Our son has been going to AFM youth counseling. That was recommended too, which is great. As well ... we've realized there's a depression there as well and probably ADHD that was never diagnosed and so that may be part of the starting point of some of the issues that are happening with our son. So we would have never had any idea that those issues were present and we wouldn't have had help for him if we had not become involved with the FE program.

Another mother reiterated that she struggled for a long time on finding the right supports for her son to the point that she quit her job to focus full time on finding the resources to help her son. The FE worker connected her to services and programs that ensured that her son would get the help he needed. In the process she was also able to get some help, which relieved the stress she was under in trying to find these resources on her own.

Yes, absolutely! Yah because like I said, I was struggling. I didn't know how to get the right help for him and the worker was just amazing with that. I struggled for a really long time, phoning so many different places to try to get help for him. Meeting at the school. Like I even had to give up my job literally to just focus on making phone calls to try to get help for my son. I really got frustrated. I didn't feel that anyone was helping me. I would phone. There were a lot of waiting lists. I found out about some of the programs and services that were being offered and then other ones that had stipulations that your child had to be on medications or harming themselves or others. Some of them had a lot of stipulations that didn't apply to us. So my FE worker, we went through step-by-step, ok, let's get him into therapy and she helped us do that. And she came with us to my son's school and we had a meeting, like, let's get him back at the school, doing his school work. She helped me to get a tutor that would come every day and do the school work with him to help him kind of get back on track because he had been out of school for quite some time. That was amazing, like the turn around. I can't even express to you how quickly ... within 8 weeks; he was like a normal kid again because he had those tools. He needed the therapist, he needed the school, and he needed the tutor to help him with school. The FE worker helped me to get those things in place. And then after all that, it was, let's get some help for mom now. Hey let's do the family enhancement program. They have 'Surviving the Teen Years' classes. Wow, what an amazing, amazing experience that was for me. Like I'm constantly telling other parents, I had actually a woman say to me today, yah I kind of heard about your son and that you had a hard time but its good now, what did you do? And I tell them everything from start to finish. Don't be afraid to call child and family services. Oh some people think, child and family services, oh those are the people who come and take away your kids. And they don't unfortunately have a positive understanding of how helpful the agency can be. They are there to help. If it wasn't for them, I don't even know what would have happened. I didn't know what I was going to do. Like I said, I had to leave my job. I'm back at work now. Everything is so positive.

Some of the services offered to families included the opportunity to participate in a support group to help them understand their teenagers. One of the parents remarked on how helpful this program was to them in realizing that they were not alone in dealing with teenagers:

Some of the things that my husband and I felt that were really helpful were the group meetings. What we found was we didn't feel like it was just us in the group meetings, that it wasn't just us that were dealing with this kind of situation. It wasn't just us looking for solutions for our family. And so when someone would share about something going on in their home, we kind of related to that, we understood and thought, oh yah, we're going through that too. And then some of the solutions some of the other parents had or things that they had tried were good suggestions for us as well. So we kind of noticed that it helped. As for myself, we didn't feel like we were the only ones going through this (laughing). So I really appreciated the group meeting, definitely, it made a big difference.

The following commentary is by a mother who noted that both she and her son's needs were met when she became involved with the FE program. Not only did

the FE worker talk with her and her son but also referred her to a program that helped the mother understand the issues of having a teenager involved in drugs. She talks below of how it helped her and him change significantly.

> *My son got very involved with using drugs. And that was a really huge concern. And that was very much evident in his behaviour. She again helped me and referred me to a program for parents at AFM and that was to teach parents how to help their kids if they were using drugs. Cause I didn't know. So I took that program, which helped me to deal with my son when he's doing drugs. I also then brought my son there too… they did an assessment to see how bad was the problem. Did he need to be enrolled? He didn't want anything to do with that. But he stopped using drugs completely … So everything has just been a tremendous, positive, complete turn around. And now we can actually move forward. He's looking at getting a full time job for the summer. So everything has been a real turn around and like I said, I don't know what would've happened. I don't want to think of how terrible … if I didn't know, I may have just had to give up and say you need to go into a group home because I can't have you in my home if you're using drugs, if you're not in school, if you're smashing the house, yelling, swearing, disrespecting me. And for a long time, you don't think as a parent you're going to make those tough choices. Like if was the best thing and it was for him too. And he was very receptive to everybody and I was surprised cause previous to that, I would try to get people to talk to him, other than just me, and he wouldn't want anything to do with them. The FE worker was so great with talking with him. Like the way she talks to him on his level, that's what he wants. If he is ever in a situation with an adult and feels that they are talking down to him, he'll put up a wall completely and won't have anything further to do with them and its respect. They want that respect but I say you've got to give respect to get respect too. But that I think its right in front of you, you just speak to them on the same level, you're not preaching and talking down and you know what, everyone we had been involved with, treated him really respectfully and that's why I think we got such a positive response from him.*

The services offered through the FE pilot program were considered very important to the families that we interviewed. As one mother noted, "the FE program is really important. Because of it, I can be open about some of the challenges that I face as a parent and I feel that they [CFS] are there to help me."

Sometimes parents stated that all they need is someone to talk to. One parent noted that the FE worker she had been dealing with "was there when she needed to talk and she listened without judgment and that felt good." Another parent noted that they learned about resources that they had not been aware of. Similarly, another remarked, "it really helped having the worker there for backup" while another parent noted that her FE worker was "a great person who was very easy to talk to." She further added, "I could tell her anything and I didn't feel like I was being judged."

Some of the parents also remarked that they found the information that FE workers provided about programs, community resources, including contact and emergency numbers and resource sheets on how to deal with conflict as being

informative and useful. The group meetings also provided information and invited guest speakers which families found helpful as this mother reflects in the commentary below:

> *One sheet in particular that stands out, we had these sheets to take home and could fill them out with the teenagers and it asked, how well do you know your teenager and the teenager could fill it out too, how well do you know your mom and dad? And did we have a blast with that. It was really funny to float the answers and then kind of compare. You know what you think you know about that person. They're pretty accurate. Like I let my daughter be involved too even though that wasn't the purpose but just so she could feel a part of it as well. A lot of the materials were so helpful and so important. And then they had guest speakers. They had someone from Mood Disorders ... so a lot of the guest speakers that came and the material we learned about and like I said, and most importantly, the support that we could get together, parents helping the other parents.*

Cultural Appropriateness of the Services Offered

The parents we interviewed for the evaluation believe that the services offered by ANCR's FE program were culturally appropriate. Some parents expressed the perspective that it didn't matter whether services were appropriate or not but what mattered was the importance of ensuring that the services provided enabled parents "to keep their children" at home. One mother indicated that not only were the services culturally appropriate but the agency was able to provide age appropriate services to all the family members. For instance, she noted that when she attended group programming at the ANCR location that they were able to provide her with babysitting services as she had younger children that needed to be cared for while she attended this programming. One of the parents assumed that the question as asked was only applicable to parents who were identified as Aboriginal. She responded to this question with, "I think it is more directed towards Aboriginals, which is ok too."

One mother felt that the FE worker she engaged with was respectful of who she was as a Métis woman, even though she did not know much about her own Métis background. For this mother she learned more about who she was as a Métis person from the FE worker. She noted that,

> *The worker was very culturally appropriate. She asked me, do you have a Métis background? Well I do, but I have never really learned about it because it was from my grandmother's mother. So my great grandmother was actually, which I find really interesting and nice to know, she was the medicine woman for our people. But she married a Scotsman. So it's interesting. So my grandmother was Métis and scots. So that was really interesting to learn.*

Another parent shared that it was important that services were offered in a way that was culturally appropriate. She indicated that she appreciated the fact that her FE worker was of Aboriginal descent. She explained that it "made her happy" to be engaged with a worker that reflected who she is as an Aboriginal person.

Overall Assessment of FE Program

The responses to the question asked about the parent's overall experience of the services and referrals made by the FE program were described as being good, positive, and very positive to excellent. Some of the mothers indicated that through their experience with the FE program they learned a lot and it really opened up their eyes to how CFS can actually help their families. The following selective narratives below capture some of the different comments made by the parents in response to this question:

> *[1] Excellent! Very welcoming. Very professional! There are no judgments, which really means a lot. So there is no judgment. I've never been disrespected by anyone that I have ever met. There have been smiles; they've always been welcoming. No, no there was nothing demeaning. They are here for help.*
>
> *[2] I was very reluctant because I felt like I was just being accused. But it turned out to be a very positive experience. I'm learning things and a lot of the stuff that's been said, I already knew it. But its like ... reinforcement, I guess is the word that I'm looking for. And I know that if I have problems, I know I have the backing and I know who I can contact and even if its not the right person, they can direct me to the person that can help us in some way.*
>
> *[3] I think at first I was very hesitant to try and reach out and get help just within myself I felt concerned because I think there's been ... a stigma that child and family services has had for a long time and I felt concerned. I was very worried about doing the wrong thing for my son because I didn't know what would result. And I just wanted to do the right thing. And it was very concerning for me when I walked in. So when I was referred to the program, I was hesitant but I was ok, we need something, we need to figure this out, we need to do this. And so when we started to meet with the worker and we started to come to the groups, it was really encouraging because I think it helped all of our family ... everything is coming together and so I feel much better about things now and much more hopeful.*
>
> *[4] Just an absolute blessing to our lives and I'll start crying because I'm just so happy right? Like its tears of happiness. You know, its just so amazing and so wonderful, and just all the help. And like I keep saying I don't know where we would've been without the help. And that was exactly what we needed. I was getting pretty frustrated. I thought there was no one out there that could help.*

Significance of the FE Program

Parents remarked that they and their families have experienced many significant changes as a result of the services offered through ANCR's FE pilot program. Again, the voices of the families are instrumental in understanding why they believe these services are significant. Two of the following commentaries capture some of the different thoughts that were imparted to us by the parents about the significance of the FE services offered by ANCR:

> *[1] I think that the most important thing for me is that's its been about all of our family. I think that sometimes there are programs or there are resources*

that are just about the person who is going through the situation. I think part of the programming that needs to be raised was, as a family. Dealing with the parenting aspect of it, dealing with what kind of plans can we have? What can we do before it becomes a crisis, … that's the biggest thing because I think that things would've escalated to that point very, very quickly, if we wouldn't have had help when we did. And that is the last thing we wanted to happen as parents. We want to be able to know, how do I deal with this? What can I do to help and if you don't know, if you don't know what's available or you don't have anything available, you're just kind of left to figure it out. And I'm really glad we were able to figure it out (laughing). It was a very challenging situation.

[2] In all honesty I feel like it was personally directed at me. And I know that it's directed for everybody but that's how I feel. I feel like it was specifically, here you are, here's the information, use it to your advantage kind of thing. I have taken it very personally in a positive way in that respect.

For some of the other parents the most significant impact of the services offered by ANCR was the access to workers who were empathetic, understanding and available when parents needed to vent and talk about the issues impacting their family as this mother noted:

What's significant for me is the FE worker gave me the time and was there when I needed to talk. She knows how hard I work at home and she acknowledged that and let me know that I'm too hard on myself. She said, you've got a large family; you're never going to have a clean house, like perfect. But I'm trying. It was nice to hear that and she listened while I talked and shared … She always let me know that I wasn't stupid. She would let me talk on even though I could see her look at the clock and you know I would go on and on because I'm so surrounded with kids that I don't know when I'll next see an adult to talk. So I appreciated her taking that extra time to sit and listen to what I had to say."

The following comment by another ANCR client explains the significance of the programming and services that the FE worker arranged for her son. These services she feels really helped her son change for the better and more importantly it gave him the tools to make decisions on his own rather than forcing him to make decisions to appease others.

And people that even know us comment, wow, look at how different he is. Even his school, the principal, everybody, wow what a difference, He's like a different kid really. And really, seriously, it's because of the tools. We gave him the tools that he needed to be successful and to make the right choices. … And then now he's even just making these choices on his own. I don't even say a word anymore. When the experience started and he was going to the therapy and having the tutor, he let go of 2 or 3 friends that were, in my opinion, very toxic for him in life, on his own, not me saying anything to him. I actually overheard a conversation when he said, "I can't hang out with you anymore." This boy was really heavy into drinking and had showed up intoxicated at my home twice. And my son, he doesn't know I heard the conversation but he said, I can't be friends with you, I'm trying to be better in my life, and you know what, if you get sober and that and you're not drinking, I would love to

be friends with you again, but until you make better choices and clean up your life, I can't be around you. Wow! Right?

One mother pointed out that the most significant experience for her was that the staff at ANCR went out of their way to help her. She shared being grateful for the extra mile that her worker would take in helping her. She noted that her worker had driven her to a number of places a couple of times which she felt was considerate and very helpful. She shared that "If I could, I would give the worker some money for gas because of it, but right now, it's not feasible but yah, she's been really, really good."

For many of the mothers the FE workers are not only helpful but they are seen as powerful advocates that are important to the parents involved in the FE program. Some of the parents indicated that they didn't want to lose the connection to their workers, as this one mother jokingly expressed:

The FE worker gave me other resources, which other people weren't giving me and that means a lot other places I could call for help. Snowbird Lodge was one and what a Godsend that was too, especially for my son. I want him to be proud of his Aboriginal descent you know? Anyways, the worker was good in the fact that she gave me other numbers, other avenues, reading material ... just the honesty overall it was very beneficial. So yah, yah, she was there for me and she is still there for me. And if I lose her I'm going to very pissed. You hear that? You don't want me to be pissed (laughing).

For another mother involved with the FE program, what was significant to her was the assistance her worker was able to provide her when she was out of financial options. She shared what was significant to her about the FE worker assigned to her family:

I was supposed to get my child support money at the beginning of the month and I didn't get it and of course, welfare didn't want to help me. I didn't know what else to do. So it's like, oh my god, panicking, crying and stuff like that. I talked to my worker and I told her the whole situation. She spoke to her supervisor and they really helped me out with some groceries. I was so thankful for that. I know that it was only a one-time emergency but still that so helped me a lot because I wasn't going to get welfare assistance for a while.

Lastly, one mother expressed appreciation knowing that the FE worker she dealt with was able to relate to her as a parent because the worker shared that she struggled too and had challenges with her own children. This tiny little bit of personal information from the worker was refreshing to this mother because she knows that sometimes social workers are just fresh out of university and don't understand the challenges of parenting because they don't have children of their own.

Suggestions for Improving the Program

The parents we talked to provided few remarks on how to improve upon the services offered through ANCR's FE program. One parent indicated that there

Story of Significant Change

Sarah* is the mother of a teenage son who was recently arrested for shoplifting. The family was referred to ANCR where they met a social worker from the family enhancement program. After some discussion with the FE worker the family learned that Sarah's son was hanging around with other youth who got him involved with drugs. He was subsequently missing school and engaging in risky activities like shoplifting. They asked the FE work for resources and for information for how to deal with their son's situation, as the issues he was dealing with were unchartered territory for the family. They were referred to a number of community resources (i.e. the youth addiction stabilization unit, AFN youth counseling, and MacDonald Youth Services) that would be helpful not only to the whole the family but to her son as well. She spoke of the helpfulness of a program called "Surviving the Teen Years" which was described by Sarah as a support group for parents dealing with similar issues. Sarah reports that she and her husband found the support group helpful because it provided them with tangible solutions on how to improve the situation with their son. She indicated that she and her husband no longer felt as if they were alone in dealing with their son's addiction problems.

... continued on page 131

* This is not her actual name – we have changed her name to protect the confidentiality of his identity.

was no improvements necessary because the FE program appropriately dealt with her family and did exactly what it was supposed to do and that it resulted in her keeping her children and connected her with resources to improve her parenting. Another parent noted that she "really had nothing to compare it to" and therefore was unable to provide suggestions on how the FE program could be improved.

One mother indicated that there wasn't a need to improve upon the services received however she felt that it would be important to extend one of the programs which she attended with other parents on surviving the teenage years. The following narratives captures why she made this suggestion:

> *The only suggestion that I have was when we filled out an evaluation for part of the family enhancement program, that surviving the teen years group meetings that I mentioned. The only thing that I said was that I would like it to go longer because it was only once a week. I think it was four weeks or six weeks? ... All the parents that attended were all in the same situation and it was so important to have that support network with other parents. 'Wow, I'm not the only one going through this!' How awesome, I mean there were tears, there was laughing, there was such a support group that was built there. The parents could really encourage one another and we all wished we could keep going further and longer. That was the only suggestion I think a lot of the parents had ... too bad it had to come to end. I mean you can't run programs forever and I know that. But it was so extremely helpful, not only the material that was provided to us and the suggestions and stuff and the paperwork ... And we just never wanted it to end.*

One mother adamantly stated that her experience with the social workers from the FE program "from start to finish, every single piece of everything that we did, I can't even honestly think of one thing that could have been better. It was just so wonderful!"

Some of the suggestions made by the other parents for improvement included the following:

- Ensure the FE program is available in different locations in the city (the mother who made this suggestion indicated that she had to travel from Transcona to participate in meetings at a downtown location. She indicated that her family found it extremely difficult to make it to programming on time when it was located so far from their home);
- Ensure that parents are made aware that programs like the FE program at ANCR exist because then "maybe mothers who truly need help won't think they need to hide" from CFS;
- More referrals to other programs within the city should be made;
- Ensure that FE workers are not constrained in the decisions that need to be made on behalf of families. One mother shared that her FE worker was "only able to provide assistance to her child in a limited way" and because of this, she suggested that FE workers should be given the ability "to go beyond their framework to allow parents with younger children (under 12) to access groups to help them" instead of saying "your child is not 12 or your child is isn't bad enough." She feels that workers

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Sarah shared that when she first became involved with ANCR she was originally hesitant about reaching out to CFS for help because of the negative stigma. She and her husband worried about doing the wrong things and making things worse for her son because she didn't know what would result. Meeting with the FE worker and attending the support groups provided Sara and her family with resources and information that helped them deal with the different issues that were going on. With the assistance of the FE program and the resources and counseling which they learned about from the social worker, Sarah and her family report that they have been able to move forward. Reaching out to CFS for assistance provided their family with a plan on how to deal with the issues in the best way possible for their son and family. They have learned how to deal with conflict, remain calm and how to communicate with their son in crisis situations. Her son has since received counseling and has returned to school. Sara reports that he is doing much better. The most significant experience about the family enhancement process for Sara was the support they received from the FE worker which used a process that involved the entire family because it required the concerted effort of the whole family to deal with the issue. ¶

can make good judgments about the real needs of children and therefore need enough room to be able to make decisions to access all programming necessary for children, especially for those children who are under 12 who have high needs;

- Offer not only emotional and physical support but offer financial support to struggling parents to complete programming that increases the understanding of their parental roles;
- Offer a youth retreat for teenagers so that they can learn respect again because as one mother noted "there is no respect from teenagers today."

Concluding Remarks and Observations

The sense one can extrapolate from the overall sum of the comments made by the parents we interviewed is that they are generally pleased with the services received thus far from their experience with ANCR's family enhancement pilot program.

ANCR Family Enhancement Team SDM Pilot Year Stats

January – December 2011[1]

Month	Cases	New cases	Closed	Transferred	Transferred (FE)	Transferred (Protection)	# days open
Jan	260	61	30	10			
Feb	274	78	31	6			
March	321	63	21	12			80
April	221	46	18	17			93
May	250	64	33	18			84
June	309	52	23	21	10	11	89
July	250	32	13	3	1	2	112
Aug	282	59	20	4	1	3	117
Sept	229	19	16	14	4	10	123
Oct	209	28	51	10	2	8	109
Nov	183	30	26	10	1	9	112
Dec	190	30	31	12	4	8	102
Totals (Jan – Dec)	**2978**	**562**	**313**	**137**	**23**	**51**	**1021**
Monthly Average (June – Dec)	**275**	**42**	**30**	**12**			

[1] Due to technical issues with data collection systems, complete statistics are not available for January to May 2011

Child and Family All Nations Coordinated Response Network – Differential Response –Logic Model

Components:

Assessment Team (AT) - *Establish an Assessment Team to effectively assess and stream children and families through the implementation of Structured Decision Making.*

Family Enhancement (FE) - *Implement and integrate Structured Decision Making to assess and provide focused prevention services to children and families.*

Component	Activities	→ Short-Term Outcomes (Year 1) →	Intermediate Outcomes
AT FE	1. Establish tools and structure	a. Improved planning for DR process development and roll out b. Tools meet standards and requirements c. Well-integrated tools (across agency)	• Improved service delivery model (AT/FE) • Integration (Collaboration) with wider system (AT/FE) • Client experience (Change for the families) (AT/FE) o Acknowledgement of strengths o Clients are being heard o Needs are correctly identified and responded to o Clients are more engaged in the process (feel like a part of the process) • Service providers (internal and external) receive the information they need to provide ongoing service to families (AT/FE) • Informed and accurate assessments ensure appropriate and effective service provision with better outcome for families (FE) • More effective program development
AT FE	2. Use standardized tools to assess safety and risk	a. Consistency in safety and risk assessment process and practice b. Improved reporting and documentation	
AT	3. Determine service stream	a. More effective case streaming b. Clearer delineation of roles	
AT FE	4. Strength-based assessment	a. Consistently meet standards for face to face contact with families and children b. More strength-based collaborative approach with families and children c. Better information for case planning	
FE	5. Case plan and service delivery	a. Planning consistent with provincial and authorities' standards b. Service integrated with assessed family needs c. More strength-based collaborative approach with families and children	
AT FE	6. Transfer and / or close case	a. Cases are streamed appropriately with consistent comprehensive summary of strengths and needs	

Long-Term Outcomes:

1. Child safety
2. Child wellbeing
3. Child's sense of belonging within the family
4. Empowering families and communities
5. Effective intervention
6. Inclusive services