THE METIS DR/FE PROJECT EVALUATION

COMPLETED FOR

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MICHAEL D CASLOR, MSW, RSW

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At first, I didn't agree with CFS involvement. But after meeting the worker, I adjusted and found them really helpful. The worker helped to ease the pain and helped me move forward.

...the workers put themselves in my shoes and helped me in whatever way they could.

It seemed a lot different than when I was growing up. I felt it to be more helpful, and less intrusive. I didn't feel threatened to have my kids picked up.
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The breadth and depth of this work would not have been possible without the support and courageous participation of many people.

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Thank you to my family for your continued love and support as I live out my dream.

And finally thank you to the Province of Manitoba for funding this research. May the CFS Systems of Manitoba continue to have the courage to review their work and the commitment and clarity to keep doing it better; our families deserve this.
EXECUTIVE SUMMARY

The importance of having ‘different responses’ for families in need of child welfare support has become an important aspect of contemporary child welfare practice around the world. This has assisted jurisdictions in better understanding how to serve families in a way that keeps children safe and that this approach may vary depending on the unique characteristics of each family. Across many jurisdictions, commonalities have emerged regarding why Difference Response (DR) is important, the key characteristics of a fully functional DR system, the challenges experienced during implementation, as well as the successes experienced by workers and families.

Recently the Government of Manitoba funded 14 Differential Response Projects in order to better understand how to create a DR approach in Manitoba as well as to better provide collaborative assistance to families as early as possible. This evaluation considers the two Projects implemented by the Metis and Inuit Child Welfare System; the Winnipeg FE Project and the Parkland Designated Intake Agency FE Project.

In order to better understand the implementation of the projects and its relative success, a variety of perspectives were incorporated. Efforts were made to consult with a representative sample of managers who oversaw implementation, FE staff who worked within the Projects, collateral service providers, as well as primary care givers who received the FE service. Case records, both paper and electronic, were also reviewed. The triangulation of these perspectives provided some clear findings.
The following findings relate to the characteristic of families receiving services:

- A wide variety of families received FE services. Families were identified as having a variety of risk factors and risk levels as well as various levels of voluntariness.

- A wide variety of services were received by families, which included informal family supports, supports provided from within the Metis and Inuit CFS system as well as externally provided supports and services. The majority of families found that the services they received were useful. A wide variety of family experiences are included.

Findings also relate to the degree to which a Signs of Safety (SOS) inspired collaborative, strength-based practice approach existed within the Projects.

- There was remarkable alignment across the perspectives of caregivers, workers and managers about the degree to which a collaborative strength-based practice approach existed within the Projects. This alignment was associated, in part, with the existence of a collaborative, strength-based approach to supervision.

The use and usefulness of the various tools and approaches was also considered, the key findings include:

- A relatively high percent of cases incorporated aspects of the Signs of Safety approach (including mapping and three houses) and the SDM® approach (including the Probability of Future Harm, the Risk Reassessment as well as the Family Strengths and Needs Assessment tools).

- Workers found that the Signs of Safety tools and approaches very practical and useful; workers are in full support of this practice approach.
• The broad usefulness of safety networks appears equivocal at this time as there are examples of when this made a possible difference for a family but there were also many examples of when they were hard to develop and maintain.

• Workers found the two Risk assessment tools (the Probability of Future Harm and the Risk Reassessment) somewhat useful; the Family Strength and Needs Assessment tool was assessed as least useful.

• The SDM® Probability of Future Harm tool was more accurate in anticipating future intakes and apprehensions than an alternate approach for measuring risk used within the Province.

• In general, workers are more confident that using the Signs of Safety approach would better assist them in making the right decisions for families than would following the SDM® approach.

Findings regarding the satisfaction levels of collateral service providers and primary caregivers receiving FE include:

• Collateral service providers, in general, noticed and appreciated the collaborative, strength-based practice approach of the FE workers.

• Primary caregivers who received FE services reported high levels of satisfaction with their overall experience. These satisfaction levels were more associated with the caregiver’s assessment of their worker’s collaborative strength-based practice than it was associated with the variety or expressed helpfulness of the services received.
Extensive effort was also undertaken to understand the implementation challenges experienced by the Metis and Inuit CFS system. Findings include:

- The criteria used to stream families to FE were unclear at times to the workers in Winnipeg since high risk and/or involuntary cases were being streamed to the FE Project; this struggle partly related to the helpfulness of information provided by at intake.
- Both projects found the service time limits (90 days for Parkland, and 6 months for Winnipeg) as unhelpful in many cases.
- There was a tendency to make transfer and closure decisions based on assessed risk, but that other factors were also being considered including: perceived workload in receiving units, worker engagement with the family, and the nature of the most recent worries about the family.
- Workers struggled with transferring a case to an ongoing service unit for these same ‘other factors’.
- While there are a variety of community-based services available in the various relevant communities, service gaps were also identified.
- Initial training was felt to be an appropriate investment by staff and management, but staff who have joined after the initial hire appear to have received far less training than the original staff.

More general findings were also discussed that relate to:

- The need for stronger partnerships across the CFS system in Manitoba are needed to minimize the number of transfers for families, the coordination and sharing of services
and supports, a rationalization and standardization of services provided pre and post ADP, and the alignment of assessment practices and streaming processes.

- The need for a full service spectrum preventative approach to child welfare in Manitoba
- The importance of a stable and balanced approach that ensures that professional practice skills continue to be understood and developed as well as ensures that prescribed practice standards are appropriate, relevant, and fulfilled.

These findings have collectively led to the following recommendations.

*Recommendations Regarding the Continued Implementation of the Metis and Inuit FE Projects*

1. A dedicated on site FE supervisor needs to be maintained for each project.
2. Practice skills continue to be sharpened through further implementation of the Signs of Safety practice approach.
3. The SDM® Risk reassessment tool should be completed before major decisions are made (closures or transfers, for example).
4. SDM® Family Strengths and Needs Assessments should not be required as SOS mapping already helps identify strengths and worries in a way that progresses the plan and the worker-family relationship.

*Recommendations for the Broader Metis and Inuit CFS System*

5. SOS skills demonstrations and training (including harm/danger statements, mapping, scaling, safety network development) and SDM® training (for the risk tools) be provided to all workers.
6. A practice model be formalized that embed SOS skills and tools within a formal practice approach; SDM® risk tools would be incorporated into the practice model as an information source for consideration at key decision points.

7. Peer group supervision becomes a core approach for sharing work, sharpening practice, and informing decisions that impact families receiving services.

8. The practice and supervision model would be intensively implemented in targeted ongoing service teams.

9. An ongoing implementation/process evaluation of the model should be completed over two years and should assess family, staff, and management feedback. The purpose of the evaluation would be to fine-tune the practice approach, supervisory approach, and case management processes.

10. Embed a full service spectrum philosophy of prevention across the system. Prevention can happen throughout the system including at Intake, VFS cases, Family Preservation, Protection cases, and Reunification. Preventative service is something far broader and more powerful than ‘a diversion at intake’; it is about keeping children safe.

11. Targeted partnerships with community based service providers be established to address expressed gaps in services and supports available in the community. These partnerships will enable more families to receive the benefits of a community-based service network.

Recommendations for the Manitoba CFS System

12. All DIAs would be given the same access to case histories in the Intake Module and CFSIS.
13. All DIAs would provide specialized assessment and referral supports (and not a robust service) within 90 days.

a. Assessments would include:

i. A safety assessment (including the provision of emergency services if required)

ii. A review of the current incident (including an abuse investigation if required)

iii. The SDM® PFH risk assessment (would be completed for all families at all the DIAs)

iv. Clear and concise harm and danger statements

v. A collaborative assessment of strengths, worries and next steps

vi. An assessment of the family’s willingness to work with CFS regarding the expressed danger and worries. This could be accomplished by completing a ‘voluntary family service agreement’ with families.

b. Referrals would be directed toward:

i. Community-based services (including resource centres) when an open file is not warranted. These community resources would be financially compensated by the CFS system as a service that supports diversions from the system, OR

ii. Ongoing services (after an ADP) in either an assessment stream (as a VFS case) or an investigative stream (as a Protection case) as the situation requires.
c. Services provided by the assessment stream would **not** be time-limited but approval would be required to extend services beyond certain time limits. This type of accountability would support time-limited service provision without requiring that the family transfer and change workers when longer-term support is required.

14. Referral (streaming) decisions at all DIAs would be influenced by voluntariness/engagement/motivation of family, nature of most recent incident and PFH risk (listed in descending order of importance).

**Recommendations regarding preparation for a full impact evaluation of FE services and the DR approach.**

15. A full impact evaluation of FE services (including the impact of community based services and safety networks) be undertaken in two to five years that focus on the achievement of the expressed long-term outcomes of Manitoba’s DR model.

16. PFH and Reassessment tools would populate ‘backend’ datasets (be fully embedded within CFSIS) and be readily available to Authorities.

17. Authorities would have access to anonymised PFH and Reassessment results from non project participants in order to identify proxy comparison groups.

18. The Metis ‘DR database’ would be fully maintained for both Projects until the impact evaluation has been completed.

19. Replace the current Metis Family Questionnaire with the Primary Caregiver Survey (see Appendix B) and have it be administered at case closure/transfer.
1. LITERATURE REVIEW

Child welfare systems around the world have been criticized for lacking a preventative approach for assisting families that struggle BEFORE these struggles begin to impact child safety (Child Welfare Information Gateway, 2008); this has resulted in systems that react to safety concerns instead of preventing them. The solution is to create a broader range of responses that direct families to appropriate supports, as often as possible, at the first signs of trouble (Sphere Institute, 2006).

The need for an early intervention stream of child welfare services and supports in Manitoba has also been documented (Office of the Ombudsman, 2006).

As a result, the Government of Manitoba, in collaboration with the four Child Welfare Authorities, has funded and piloted 14 DR/FE projects across Manitoba. These projects intend to create new resources to support families when mandated child protection services are not justified, but that in the absence of resources, these unaddressed struggles would likely become a concern of the child welfare system.

The purpose of these projects is to provide collaborative (not adversarial), early intervention services that aim to address each family’s unique struggles; these services would promote ongoing protective capacities for the child within his/her natural family whenever possible, therefore minimizing the need for a longer, more invasive service case.
WHAT IS DIFFERENTIAL RESPONSE AND FAMILY ENHANCEMENT?

Differential Response (DR) models within child welfare systems tend to include two or more streams of services that provide the most appropriate response possible for each family depending on their circumstances. DR is synonymous to ‘streams of service’. DR is also known as Alternative Response (AR), Dual Track, and Multiple Track (Schene, 2001).

Regardless of the term used, two major streams generally emerge:

1) An intervention related stream (often known as the ‘investigation’ or ‘traditional’ stream)

2) An assessment stream (known in Manitoba as ‘Family Enhancement’). Family Enhancement is synonymous with the early-intervention stream within a DR service system.

Typically, there are a variety of differences between these two streams of service (see Table 1 below).

Table 1: Stream Comparisons

<table>
<thead>
<tr>
<th>Eligibility Criteria</th>
<th>Investigation/Traditional Stream</th>
<th>Assessment /Family Enhancement Stream</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For incidences of more severe maltreatment (including sexual abuse and chronic neglect) or a criminal act</td>
<td>For low to moderate risk cases (families without basic necessities, educational neglect, absence of supervision, parent-child conflict, etc.)</td>
</tr>
<tr>
<td></td>
<td>Involvement is often mandated</td>
<td>Involvement is often voluntary</td>
</tr>
<tr>
<td>Process</td>
<td>Gather evidence in order to substantiate maltreatment</td>
<td>Collect information to assess a family’s needs and strengths and to provide services to meet those needs</td>
</tr>
<tr>
<td>Philosophy</td>
<td>Viewed as adversarial, surveillance focused, threatening and punishing</td>
<td>Viewed as engaging, encouraging, service focused based in individualized needs</td>
</tr>
<tr>
<td></td>
<td>One size fits all approach to investigating</td>
<td>Individualized, family centered approach to planning</td>
</tr>
<tr>
<td></td>
<td>Services are provided by mandated CFS workers</td>
<td>Services are provided by community-based organizations</td>
</tr>
<tr>
<td>End Result</td>
<td>A (un)substantiation of maltreatment, a potential apprehension</td>
<td>A safety plan and supporting services</td>
</tr>
<tr>
<td>Purpose</td>
<td>To keep children safe when they are in danger</td>
<td>To keep children safe (in their homes) before they are in danger</td>
</tr>
</tbody>
</table>

**WHY IS DR NEEDED?**

Simply stated, a system only has one response in the absence of different responses; this is generally an investigative approach for substantiating abuse and neglect. Critiques state that this ‘one size fits all’ approach does not serve families well (Drake, Jonson-Reid, Way, & Chung, 2003; English, Marshall, Brummel, Orme, 1999; Essex, Gumbleton, & Luger, 1996; Wolock Sherman, Feldman, & Metzer, 2001) and is a waste of time and resources (Besharov & Laumann, 1996).

Authors (English, Wingard, Marshall, Orme, & Orme, 2000) have suggested that child welfare systems are overwhelmed with the following systemic problems:

1. Families are referred that should not be.
2. The number of families referred exceeds the system’s capacity to serve.
3. Some families that should be referred are not.
4. Authoritative approaches are not appropriate for all families.
5. Families do not receive the services they really need.

The Child Welfare Information Gateway (2008) maintains that what is needed is:

1. A comprehensive assessment approach including the identification of family strengths and needs
2. Family involvement in the service planning processes
3. The availability of relevant services and supports
4. The capacity to provide a timely, preventative response to lower risk families

For these reasons, DR approaches specifically provide a variety of responses depending on the circumstance. Some ‘traditional’ responses may need to be more directive and adversarial, but many can be collaborative and ‘family-driven’ (Connolly, 2004). Regardless of the type of response, the focus is to assess, understand and respond to the family issues that lie beneath the
incident (Child Welfare Information Gateway, 2008); this typically includes targeted services or supports. This can be most appropriately accomplished with skilled workers in conjunction with engaged and empowered parents (Rohm & Bruce, 2008).

**HOW COULD STRUCTURED DECISION MAKING (SDM) AND SIGNS OF SAFETY (SOS) SUPPORT DR?**

Central to the implementation of any child welfare approach is the need to gather information, make decisions and follow through on those decisions as they relate to families and possible service providers. While these tasks are fairly universal, the approaches and philosophies to do them are endless.

While SDM provides an empirically-rooted approach for gathering information, making decisions and following through with a plan (Children’s Research Center, 2008), SOS provides a practice-based approach (Turnell, 2010). Even though these approaches are different philosophically (Morrison, 2010; Turnell, 2010), many jurisdictions including Massachusetts, Minnesota and California are integrating the two approaches, often within a DR context. The expectation is that together they provide a more complete child welfare approach, the ideal union of research and practice, of the experiential and the empirical.

SDM assesses immediate safety, longer term risk, changes in risk over time, and family strengths and (service) needs through the use of copyrighted, empirically-informed checkbox type tools (Children’s Research Center, 2008). SDM is a form-based practice approach that focuses workers on the most important factors that measure safety, risk, family strengths and family needs. The factors are scored and the ‘Safety’ score, for example, informs decision making about immediate removal of a child from a natural family. The ‘Risk’ score informs decision making
about the likelihood of future maltreatment; the ‘Risk Reassessment’ helps identify changes in risk over time. Finally, the ‘Family Strength Needs Assessment’ identifies empowering aspects of the family and areas of service need. A range of actions are recommended for each tool depending on how the family scores. The tools work together to create an evidence-based practice approach.

Supporters say that the strength of SDM is that it consistently (Institute of Applied Research, 2004c) and accurately (Johnson & Wagner, 2003; Johnson, 2004) determines which cases should be investigated, which children should be removed and which families require what intensity of services. This is accomplished by determining if risk factors are present in the family. Conversely, empirically-rooted risk tools are known to misclassify as many as 33% of families (Institute of Applied Research, 2004c). This misclassification is the result of ‘unexplained variance’ with the models that create the risk tools; these unexplained variances include family-specific characteristics. ‘Misclassifications’ can have profound impact on the children and families involved (Morrison, 2010). Turnell (2010) and Parton (1998) question approaches that frame child welfare within a macro risk-based rule model instead of a family-rooted safety or need model. SDM type approaches alone may not be enough (Myers, 2005; Parton, 1998; 2008).

SOS is a practical solution-oriented approach for partnering with families throughout assessment, case planning and service provision (Turnell & Edwards, 1997). The approach is about finding and leveraging a family’s ‘signs of safety’ into protective capacities that keep their children safe. There is no list of signs of safety to choose from because the list would be endless. There are no forms to complete prior to decision making because standardized forms could actually limit possibilities. SOS does provide a variety of approaches to help incorporate the
voices of everyone in the family into the entire decision making process; this gives the family true ownership and ‘buy-in’. SOS focuses on three key principles (Turnell, 2010):

1. A collaborative working relationship with all involved (families, co-workers, CFS management and external service providers)
2. A spirit of inquiry
3. Practical approaches for gathering information, making decisions and providing support

Turnell and Edwards (1997), along with other authors (Comer & Vassar, 2008; Forrester, Kershaw, Moss, & Hughes, 2008; Forrester, McCambridge, Waissbein, & Rollnick, 2008; Yatchmenoff, 2005), maintain that trusting, collaborative working relationships are the most important prerequisite to child safety. The SOS approach aims to build these kinds of relationships between social worker and the families that they work with. As much as possible, the approach uses the skills of the worker to focus their relationship on keeping children safe in kinship safety networks (Turnell, 2006). The tools are simple, practical (Lohrbach, Sawyer, Saugen, Astolfi, Schmitt, Worden, & Xaaji, 2005; Myers, 2005) and warmly embraced by front line staff (Department of Child Protection, 2010).

In summary, for SDM, collecting the ‘facts’, the right facts, and making decisions based on these facts is most important. For SOS, the process of hearing and understanding the family narrative and working with the family to make decisions is most important.

In many jurisdictions with an integrated SDM/SOS DR approach, SDM tools are primarily used to inform key decision points, including which service stream is most appropriate and ongoing reassessments of this decision. SOS approaches primarily guide the worker’s practice between and through these key decisions; what you do with the family and how workers bring the family along the journey. While the implementation of this integrated approach is very new in most
jurisdictions (the notable exception is Minnesota), initial feedback provides promise and a lot of lessons have already been learned.

WHAT HAVE WE LEARNED ABOUT THE KEY COMPONENTS OF A DR APPROACH?

According to Schene (2001) and others, the key components of a successful DR system appear to be:

1. An ongoing focus on safety

Regardless of the stream, authors (Child Welfare Information Gateway, 2008; Kirk, 2008; Schmid & Sieben, 2008; Turnell, 2010) are clear about the importance of maintaining safety throughout a family’s involvement with child welfare services. Safety always needs to be addressed first and in no way should be compromised as a result of any child welfare service decision.

2. A systematic decision-making process for streaming cases

According to Trocmé, Knott, & Knoke (2003) the success of a DR model is contingent on the ability to assign families to the most appropriate service stream. While the work of Kirk (2008) points to the relevance of using risk assessments over any other type of assessment when it comes to streaming decisions, others suggest that using risk measures distracts from and/or complicates the work of keeping children safe (Morrison, 2010; Parton, 1998; Rycus & Hughes, 2003; Wald & Woolverton, 1990). In the end, most jurisdictions do not rely on risk scores alone to make the decision (Merkel-Holguin, Kaplan, & Kwak, 2006). These jurisdictions not only consider risk but also legislative limits, previous reports, presenting family characteristics, family willingness and
capacity, type of maltreatment, and the ages of the children in streaming decisions (Merkel-Holguin, Kaplan, & Kwak, 2006; Schene & Kaplan, 2007). For more information on various United States streaming criteria and processes, Merkel-Holguin, Kaplan, & Kwak (2006) is one of the most exhaustive resources available.

Probably the most well known streaming process is Olmstad, Minnesota’s use of the Red Team (Sawyer & Lohrbach, 2005). This group decision making approach involves a group assessment of factors and a group decision about the most appropriate service stream. It appears that most established processes establish core eligibility criteria for streaming but also allow room for professional discretion (Merkel-Holguin, Kaplan, & Kwak, 2006; Schene & Kaplan, 2007), see Figure 1.

This is especially important when a case is not clearly eligible for just one stream. The approach of appropriately balancing quantitative risk levels and professional discretion have generally required time, practice and reflection before the most appropriate balance is reached and reliably maintained over time (Department of Social Services Commonwealth of Virginia, 2007, 2008; Institute of Applied Research, 2004c). Evidence suggestions that FE streams are used more often as systems become more comfortable with their streaming process (Department of Social Services Commonwealth of Virginia, 2008).
3. An ongoing ability to reassess the appropriateness of a family’s service stream and change streams as needed

Research has suggested that when workers are willing to reassess previous decisions in relation to new information and change their decision, it is a sign of an effective practice (Munro, 1996). It is for this reason that the streaming decision should be reassessed on an ongoing basis (Merkel-Holguin, Kaplan, & Kwak, 2006; Schene, 2001). Schene and Kaplan (2007) suggest that assessment and decision making should be ongoing and cumulative as a trusting working relationship grows.

4. An approach for truly engaging families about their struggles (that compromise child safety) AND their strengths (that can create safety)

The importance of family engagement in child welfare systems has been a dominant topic of research in recent years (de Boer & Coady, 2007; Ferguson, 2001, 2003; Loman & Siegel, 2005; Marts, Lee, McRoy & McCroskey, 2008; Schene & Kaplan, 2007; Schmid & Siebe, 2008). In essence, family engagement is the vehicle for building a trusting working partnership, and it is in that kind of partnership that struggles can be most productively discussed and overcome (Institute of Applied Research, 2006, 2006b).

Comer & Vassar (2008) describe six key principles for building partnerships with families (and co-workers). These principles can serve as values that workers should embody in practice.

a. Everyone desires respect
b. Everyone needs to be heard
c. Everyone has strengths

“The single most important factor in minimizing error is to admit that you may be wrong”. Munro (2002)
Munro (2010; 2011) has recently emphasized the importance of, the often overlooked and undervalued, professional practice skills that are an essential skill set for effective social work practice within the child protection system. She maintains that systems that deemphasize these practice skills offer a less effective service system.

5. A focus on creating natural kinship supports for a family whenever possible

A growing body of literature has highlighted the importance of using kinship supports to create safety for children (Child Welfare Information Gateway, 2008; Marts, Lee, McRoy & McCroskey, 2008; Schene, 2001). This approach is often less intrusive, more culturally appropriate and less expensive than more formalized service providers (Connolly, 2004). It is for these reasons, in part, that SOS focuses on the development of informal ‘safety networks’ of family members and friends to create safety (Turnell, 2010) and not the over-reliance on paid service providers. Inevitably, many cases would also benefit from more formal supports and/or services.

6. A wide variety of the right supports and services are available from the agency and the community

The introduction of a DR system requires that the child welfare system partner with community based organizations to offer the right services for the FE population (Child Welfare Information Gateway, 2008; Marts, Lee, McRoy & McCroskey, 2008; Schene, 2001). Community-based organizations are important service providers for the FE stream due to their impartial, non-
stigmatizing, non-mandated status. These characteristics come together to provide struggling families with services that they are most likely to accept voluntarily (Conley & Berrick, 2008; Wise, 2003).

The experience of researchers (Dale, 2004; Ferguson, 2001, 2003; Institute of Applied Research, 2008, 2009; Schene & Kaplan, 2007) has shown that the services and supports most likely needed by FE families include:

a. Food and clothing  
b. Rent and utility support  
c. Transportation  
d. Child care  
e. Parenting classes  
f. Addictions services  
g. Budgeting and financial services  
h. Anger management/domestic violence classes  
i. Counselling (including trauma support)  
j. Crisis support

It would be reasonable to ensure that these services and supports are broadly accessible within the communities that FE families reside; should a service gap exist, the service ought to be made available through the support and collaboration of the child welfare system (Child Welfare Information Gateway, 2008; Schene, 2001; Wise 2003).

7. Intensive training and ongoing support for staff, supervisors, administrators and community partners

As discussed above, successfully implementing a DR approach is a learning experience that involves learning new tools (i.e. SOS and SDM tools), new decision making processes (i.e. service streaming decisions), new approaches for working with families (i.e. case conferencing and safety mapping), as well as new relationships with external service providers. These shifts
not only require initial training and ongoing mentoring, but also continual support from all levels of the system in order to clarify and embed the changes into an entrenched practice (Child and Family Policy Institute of California, 2006; Child Welfare Information Gateway, 2008; Schene, 2001). Munro (1998; 2011) has suggested that embedding reflection and collaborative learning into all decision making processes, both at the practice and management levels, can provide this needed ongoing support.

**WHAT HAVE WE LEARNED ABOUT DR IMPLEMENTATION CHALLENGES AND OPPORTUNITIES?**

As discussed above, there appears to be seven key components of a DR system; the degree to which each is present and functional serves as a measure toward full implementation and maintained service quality. Equally clear is that the road to full implementation involves overcoming specific implementation challenges; these challenges can act as roadblocks to progress or complications to overcome. The assessment of these challenges often requires that an evaluation is undertaken during implementation and adjustments are made mid-stream (Child Welfare Information Gateway, 2008; Schene, 2001).

The following is a distilled and consolidated consideration of what has been learned about the broad challenges and opportunities experienced by jurisdictions implementing DR.

1. The maturation of the streaming process and service streams

Many authors (Department of Social Services Commonwealth of Virginia, 2007, 2008, Institute of Applied Research, 2008; Schene & Kaplan, 2007) have suggested that the process of streaming cases takes time and experience to operate effectively. Early streaming decisions from Virginia showed that in some counties 0% of cases were streamed to FE while in other counties
80% were. The author (Department of Social Services Commonwealth of Virginia, 2007) suggests that this is a sign of screening and assessment issues typical of the early stages of implementation. These issues include a lack of clear streaming criteria and/or an unsystematic approach for streaming cases that cannot be clearly streamed using the criteria; clearly these two issues have a cumulative compounding impact. The solution generally involves changing, clarifying and often expanding the criteria for the FE stream. In Nevada (Institute of Applied Research, 2008), the criteria for FE was expanded to include: a) families with previous substantiated reports, b) families with children of any age, and c) cases of less severe physical abuse/inappropriate discipline. The solutions have also involved the development of a group-based decision making process for those cases without a clear stream; those cases require more reflection, discussion and discretion (Sawyer & Lohrbach, 2005).

The voluntary nature of the FE service has also created complications for implementation; that is, families that may be eligible for the FE stream of service don’t want help (Kirk, 2008; Schene & Kaplan, 2007). Kirk (2008) has suggested that some families are perhaps told to or coerced into volunteering. While this practice is notably contrary to the spirit of the FE stream of service, Turnell and Edwards (1999) maintains that some coercion may still be required in collaborative partnerships with families. While the use of coercion within the FE stream appears to occur, this author suspects that this issue is most typical of the early stages of implementation as well. It seems reasonable that as a DR system matures and staffs’ practices fully embody the spirit of partnership (see 2. below), and relevant services are available (see 6. above), and streaming criteria become more effective (see 2. above), that there would be fewer involuntary families.

While each jurisdiction creates different criteria and decision making processes and have required different adjustments during implementation (Merkel-Holguin, Kaplan, Kwak, 2006), it appears
that the FE stream is used more extensively over time as the operation of the streaming process becomes more clear and effective (Shusterman, Hollinshead, Fluke, & Yuan, 2005; Department of Social Services Commonwealth of Virginia, 2008).

2. The partnership pushback

As suggested above, the introduction of an FE stream of service also requires that a spirit of partnership embody all aspects of practice. This includes how workers partner with families, how workers partner together throughout the child welfare system as well as how the child welfare system partners with community based service providers.

a. Partnering with families

Notwithstanding the concerns expressed by Littlechild (1998), most authors (Connolly and McKenzie, 1999; Prilleltensky, Laurendeau, Chamberland & Pierson, 2001; Schene & Kaplan, 2007; Sherry, 2008) have been clear about the importance of the worker’s philosophy and values being in line with a shared responsibility for decision making and maintaining child safety WITH the family. Again, this kind of partnership is characterized by actions that show that everyone desires respect, everyone needs to be heard, everyone has strengths, judgement can wait, partners share power, and that partnership is a process [not an end result] (Comer & Vassar, 2008). These are principles and values more easily adopted by some workers than others (Bagdasaryan, Furman & Franke, 2008).

b. Partnering within the CFS system

This spirit of partnership regarding shared decision making and child safety also extends to relationships between staff and branches of the child welfare system. Workers need to move
away from a ‘personal and private style of working’ toward peer-group collaboration, group supervision, and group decision making (Munro, 1998).

In addition, the potential exists that the creation of a DR system complicates the administration of services by creating disparate service streams. Various service stream teams need to move toward all aspects of coordination and collaboration unencumbered by this added structural element (Child and Family Policy Institute of California, 2006). The degree to which this can be easily accomplished is limited by the degree of organizational complexity and the ‘entrenchness’ of the current practice.

c. Partnering with community service providers

The increased reliance of community based services within DR systems has pushed child welfare systems into closer partnerships with community service providers (Child Welfare Information Gateway, 2008; Marts, Lee, McRoy & McCroskey, 2008; Schene, 2001); however, these partnerships have been slow to develop in some jurisdictions (Bagdasaryan, Furman & Franke, 2008). In some cases it has required active promotion and marketing to prospective service providers in order to create the most relevant services possible (Sphere Institute, 2006). Central to the complexity of partnering with community service providers is: 1) the acceptance of the belief that community partners are more effective at keeping some children safe (Schene & Kaplan, 2007) and 2) the legal ability to share confidential child welfare related information (Child and Family Policy Institute of California, 2006).

Workers may implicitly believe community-based service providers do not have the experience, education, history with the family, or the legal mandate to keep children safe; this results in less than a true partnership (Connolly, 2005). Ironically, the greatest value of these service providers
IS their impartial, non-stigmatizing, non-mandated status; the nature of service that families may actually want to volunteer for (Wise, 2003). For this reason, community based service providers need to be full partners in getting the right services to the right families (Schene, 2001).

California, and likely others, struggled with their legal right to share sensitive child welfare related information with outside service providers (Child and Family Policy Institute of California, 2006); this seemed to be clarified with a legal decision, and/or changes to law and/or appropriate consent forms. While Bagdasaryan, Furman & Franke (2008) noted that the use of community resources in small communities could compromise confidentiality of some families, in other ways it also provides a less stigmatizing alternative to child welfare services. Regardless of the reason why information sharing and partnerships may be slow to develop, authors (Child Welfare Information Gateway, 2008; Marts, Lee, McRoy & McCroskey, 2008; Schene, 2001; Schene & Kaplan, 2007; Wise, 2003) are clear of its importance.

3. Unstable informal supports and formal services

The use of more informal supports (kinship safety networks) and community based service providers does require that these supports and services be available and functional. Although Turnell (2010) has provided significant guidance in the development of safety networks, Schene & Kaplan (2007) noted the concerning deterioration of some safety networks. These safety networks need to be maintained in order to be consistent with the SOS approach to FE.

The lack of reliable community based services is also noted (Child Welfare Information Gateway, 2008; Institute of Applied Research, 2009; Schene & Kaplan, 2007; Wise, 2003). This includes services that are not available, services that are not offered to the family (not known), services not funded by the CFS system (not affordable), or acceptable to the family (not
appropriate) (Institute of Applied Research, 2009). It appears inevitable within the implementation of a DR approach that the right external services need to be available, appropriate, offered, and paid for by the CFS system. In addition, workers need to navigate the differential use of informal safety networks, externally provided services and mandated child welfare services.

4. Work/caseload disparity between service streams

One of the key characteristics of an FE case is the more collaborative, time intensive approach to planning and decision making. As a result many jurisdictions, including Manitoba, have limited caseloads of FE workers to facilitate the implementation of the model; this has not necessarily been true for the ‘traditional’ stream of services. This disparity could complicate and contaminate streaming and practice decisions. For example, the FE stream of services are likely more intensive and ‘present’ on a day to day basis than the ‘traditional’ stream of services, which is the stream where actual child welfare concerns are more likely to exist. It becomes a reasonable question, notwithstanding streaming criteria, which stream of service is more appropriate for a family with ongoing struggles and in need of support? In many circumstances workers could view FE’s more intensive approach as preferred. It is possible that this is a factor in the growing use of FE stream services over the implementation of DR (Shusterman, Hollinshead, Fluke, & Yuan, 2005; Department of Social Services Commonwealth of Virginia, 2008). Notwithstanding some initial work (Institute of Applied Research, 2006b), research has not fully assessed the degree to which the collaborative practice approach impacts on success vis-à-vis the comparatively smaller caseloads. In the end, both likely have some importance regardless of the service stream.
HOW DO WE KNOW IF DR IS WORKING?

The success of DR approaches are assessed using a broad range of indicators including: child safety, service utilization, family satisfaction and engagement, cost effectiveness, staff perceptions and collateral perceptions.

In general, evaluations of differential response systems have demonstrated positive outcomes, particularly in terms of sustained child safety, improved family engagement and satisfaction, increased community involvement and service provision, as well as enhanced worker satisfaction (see Child Welfare Information Gateway, 2008). A more detailed analysis of relevant evaluations is noted in Table 2.

Ferguson (2003) has been clear that any evaluation of ‘success’ in child welfare must also include the perspectives of professionals and families using the service (i.e. satisfaction and perceived effectiveness) and not only an administrative analysis of statistically-related child outcome measures (i.e. recurrence of maltreatment, etc.).

This multi-modal approach helps ensure that evidence based practice (Children’s Research Center, 2008) is inter-related to and interdependent with practice based evidence (Ferguson, 2003). It is expected that this broader definition of success will lead to more practical and actionable findings; findings informed by the union of research and practice, of the experiential and the empirical.
Table 2: Comparison of Outcomes by Author

<table>
<thead>
<tr>
<th>Identified ‘Positive’ Impact</th>
<th>Identified No Impact</th>
<th>Identified ‘Negative’ Impact</th>
</tr>
</thead>
</table>
2. **SCOPE AND CONTEXT**

   **A. SCOPE**

   The DRFE evaluation is limited to the two projects implemented by the Metis and Inuit CFS system (see Appendix A for more about the structure of Child and Family Services in Manitoba). These projects include:

   - Family Enhancement (FE) Project in Winnipeg
   - Designated Intake Agency (DIA) FE Project in the Parkland region

   Each Project implemented a practice approach that utilized Signs of Safety (SOS) during the day-to-day work with families, as well as the Structured Decision Making® (SDM) tools to inform major decisions. A broad range of SOS skills and tools were used including mapping, scaling, 3 houses and safety network development. The projects also utilized the Probability of Future Harm, the Risk Reassessment, and the Family Strengths and Needs Assessment from the SDM® suite of tools.

   Each Project is designed to support the prevention/early-intervention (FE) efforts of the Province’s Differential Response strategy. Within the strategy, families served by a DIA could be referred to the FE stream (and potentially receive services from one of the Metis Projects) or to the Protection stream (and be referred to an ongoing service unit of the local culturally appropriate agency). FE services are meant to be more collaborative, family centred, and strength-based; this approach is understood to lead to better family engagement around mitigating potential dangers to children and lower the likelihood that families come further into the child protection system.
Although streaming criteria have been drafted for implementation, variations in interpretation have led to a variety of experiences and opinions; the Metis’ experiences and opinions about appropriate FE criteria are shared later. Regardless of these variations, in general a ‘FE’ family in Manitoba is:

- low or moderate risk, and
- in agreement to receive the FE service.

FE families exclude sexual abuse cases where the perpetrator is likely to have access to the child, cases involving serious non-accidental injury to a child, cases where prior DR was unsuccessful, cases where there is an ongoing investigation, cases with children in care, cases that have a supervision order, and cases that have an immediate safety concern. FE cases could be categorized as either FE (Part II of the CFS Act) or Protection (Part III of the CFS Act).

**B. CONTEXT**

The Projects were implemented within distinct geographic locations and within different parts of the CFS system.

Winnipeg is the largest city in Manitoba and consists of over 600,000 residents and covers approximately 600 square kilometres. As with most large urban cities, the economy is driven by a variety of sectors.

The Winnipeg FE Project is designed to serve families who require more than 90 days of services that may have already been provided by the local Designated Intake Agency (All Nations Coordinated Response Unit or A.N.C.R.) but may not require a long term CFS case in an ongoing
services unit. The Winnipeg FE Project is intended to service families for approximately six months at which time the case is closed or transferred to ongoing services.

The Parkland region is primarily rural and consists of approximately 40,000 residents and covers approximately 28,000 square kilometres. Agriculture is the primary industry driving the local economy.

The DIA FE Project in Parkland is a unit within the local Designated Intake Agency (Metis Child Family and Community Agency) in Parkland that provides intensive support to some families with an open intake. The Parkland Project is intended to divert families from the ongoing CFS system by providing a short term (approximately 90 days) robust service at intake. Project staff were located in two locations within the region, Dauphin and Swan River.

The staffing composition of each Project varied slightly and is outlined below. While the Parkland Project had planned to include a Mentor within its composition, this did not come to fruition within the evaluation timeframe.
### Project Staff Composition

<table>
<thead>
<tr>
<th></th>
<th>Winnipeg</th>
<th>Parkland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supervisor</strong></td>
<td>1</td>
<td>1 (shared with intake staff)</td>
</tr>
<tr>
<td><strong>Social Workers</strong></td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td><strong>Mentors</strong></td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td><strong>Cultural Worker</strong></td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

In general, social workers are responsible for completing the SDM® assessments, mapping plans with families and collaterals, and are ultimately responsible for key decisions.

Mentors, who tend to have some postsecondary training but not a social work degree, provide extra support to families who require it. These supports could include, but are not limited to, providing transportation, assistance in finding safe affordable housing, assisting parents with parenting skills, as well as building relationships with and providing support to children in the household.

The cultural worker was available for families who were interested in learning more about their heritage, participating in traditional sharing circles, or getting connected with Metis resources in the community.

The evaluation is focused on the review of these two Projects in relation to the following scope:

- The implementation of each Project (including the degree to which the project was implemented as expected, things that went well during implementation, implementation struggles, and key ‘learnings’)
- The volume of families receiving services (including volume served, service utilization, demographics of service users, and how cases flowed through the process)
- The spirit in which services were provided (including the degree to which strength based principles are incorporated into practice)
- The use and usefulness of Signs of Safety and SDM® tools and approaches
- Satisfaction levels of families receiving services, collaterals, and of workers providing the service.
3. METHODOLOGY

Due to the diverse scope of the evaluation, various data collection approaches were utilized to fulfill the components of the evaluation. A brief overview of the focus of each approach is noted below.

<table>
<thead>
<tr>
<th>DATA COLLECTION APPROACH</th>
<th>SPECIFIC FOCUS OF DATA COLLECTION APPROACH</th>
</tr>
</thead>
<tbody>
<tr>
<td>FILE REVIEW</td>
<td>Archival data collection * Volume of families served, service user demographics, use of SOS and SDM® tools, flow through the process</td>
</tr>
<tr>
<td>PRIMARY CAREGIVER INTERVIEW</td>
<td>Telephone interviews and secondary mail out survey Service utilization, spirit of the services provided, caregiver satisfaction level</td>
</tr>
<tr>
<td>COLLATERAL INTERVIEW</td>
<td>Telephone interviews Collateral service provider satisfaction levels</td>
</tr>
<tr>
<td>STAFF FOCUS GROUPS</td>
<td>In person focus group The implementation of each Project, usefulness of the tools</td>
</tr>
<tr>
<td>MANAGEMENT FOCUS GROUPS</td>
<td>In person focus group The implementation of each Project</td>
</tr>
<tr>
<td>STAFF FEEDBACK FORM</td>
<td>In person questionnaire Spirit of the services provided, usefulness of the tools and approaches, staff satisfaction levels</td>
</tr>
<tr>
<td>MANAGEMENT FEEDBACK FORM</td>
<td>In person questionnaire The implementation of each Project, spirit of the services provided</td>
</tr>
</tbody>
</table>

*In each case the family’s hardcopy paper file was cross referenced with CFSIS (Child and Family Service Information System) to ensure that all available information was collected.

A hard copy file review, cross referenced with a CFSIS review, provides a comprehensive approach for tracking families while being served by the DR unit as well as the assessment tools completed during this time.

Telephone interviews were used to collect the stories of the primary caregivers in each family; specifically the services they received, the spirit of the service provided by Metis staff as well as their satisfaction levels with the services received. This approach was chosen for its accessibility, efficiency, and the relative anonymity it provides to participants. At least five attempts were made to contact each primary caregiver by phone. For those that were not able to be contacted by phone, a paper copy of the survey was mailed to the primary caregiver. Participants received an honorarium of $20.
Focus groups with staff and managers focused on the implementation process and progress of the projects. This approach enabled various perspectives to be discussed and debated among participants. Accomplishments were celebrated, challenges were discussed, and potential solutions to these challenges were suggested.

At the end of each focus group, a feedback form was completed by focus group participants. The staff form was a self-assessment of the spirit of their own practice, as well as their satisfaction levels with their work, the service approach, and the prescribed tools.
4. SAMPLES AND RESPONSE RATES

Due to the size of the projects, efforts were made to collect information for all primary caregivers receiving DR services, all staff providing support as well as all managers involved in the implementation and oversight of the projects.

A convenience sample of collateral service providers was provided by DR staff; for this reason, the total number of collateral service providers involved with DR families was not able to be determined.

One focus group was completed with each Project. The Winnipeg focus group included social workers, mentors, and the cultural worker. The Parkland focus group included the DR social workers; intake staff were also included during parts of the focus group.

The management focus group included the current supervisors for each project, as well as agency managers that were involved in the development and implementation of both projects.

<table>
<thead>
<tr>
<th>SAMPLING STRATEGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>FILE REVIEW</td>
</tr>
<tr>
<td>COLLECTION OF PFH TOOL</td>
</tr>
<tr>
<td>PRIMARY CAREGIVER INTERVIEW</td>
</tr>
<tr>
<td>STAFF FEEDBACK FORM</td>
</tr>
<tr>
<td>MANAGEMENT FEEDBACK FORM</td>
</tr>
<tr>
<td>COLLATERAL INTERVIEW</td>
</tr>
<tr>
<td>STAFF FOCUS GROUPS</td>
</tr>
<tr>
<td>MANAGEMENT FOCUS GROUPS</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Census of all 103 families</td>
</tr>
<tr>
<td>Census of 89 completed tools</td>
</tr>
<tr>
<td>Census of 89 open primary caregivers</td>
</tr>
<tr>
<td>Census of 10 current DR staff</td>
</tr>
<tr>
<td>Census of 8 current management staff</td>
</tr>
<tr>
<td>Convenience sample provided by workers</td>
</tr>
<tr>
<td>One per project; Two in total</td>
</tr>
<tr>
<td>One in total</td>
</tr>
</tbody>
</table>

The response rates for each data collection approach were very high; in many cases a full census was achieved. This ensures that the perspectives shared by evaluation participants were fully representative of the population involved in the projects. Two relatively low response rates are noted below.
Of the eight managers who participated in the focus group, five completed the Management Feedback Form (63% response rate); it is difficult to determine if this impacts on the representativeness of managers’ feedback received.

A 65% response rate was achieved of primary caregivers with an open child welfare case who participated in one of the DR projects. Concerns could be raised that this relatively low response rate limits the representativeness of their responses; this is due to the fact that those who did not respond could be significantly different than those who did respond. This would limit the validity of the results.

For these reasons, extensive comparative analysis was undertaken to determine if there were any significant differences between the families who did participate in the Primary Caregiver Interview and those that did not.

The table below shows that no significant differences exist across a broad range of applicable characteristics. This helps affirm the representativeness of the caregiver feedback received.
### DIFFERENCES BETWEEN FAMILIES WITH AND WITHOUT CAREGIVER FEEDBACK

<table>
<thead>
<tr>
<th></th>
<th>Families WITHOUT Caregiver Feedback</th>
<th>Families WITH Caregiver Feedback</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=</td>
<td>36</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td><strong>CHILDREN CHARACTERISTICS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Four or more Children Involved</td>
<td>8.3%</td>
<td>15.1%</td>
<td>$X^2=0.905$, p. = .342, Not Sig.</td>
</tr>
<tr>
<td>Child under 2</td>
<td>30.6%</td>
<td>30.2%</td>
<td>$X^2=0.001$, p. = .971, Not Sig.</td>
</tr>
<tr>
<td>Medically Fragile child</td>
<td>2.8%</td>
<td>7.5%</td>
<td>$X^2=1.279$, p. = .528, Not Sig.</td>
</tr>
<tr>
<td>Development, Physical, Learning Disabled child</td>
<td>16.7%</td>
<td>20.8%</td>
<td></td>
</tr>
<tr>
<td>Child with mental health/behaviour problems</td>
<td>12.1%</td>
<td>23.3%</td>
<td>$X^2=1.540$, p. = .215, Not Sig.</td>
</tr>
<tr>
<td>Youth in conflict with the law</td>
<td>20%</td>
<td>9.4%</td>
<td>$X^2=1.988$, p. = .157, Not Sig.</td>
</tr>
<tr>
<td><strong>CAREGIVER CHARACTERISTICS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Adults in Household (shown as mean)*</td>
<td>1.47</td>
<td>1.38</td>
<td>$t=-.823$, p. = .413, Not Sig.</td>
</tr>
<tr>
<td>Provides insufficient emotional/psychological support</td>
<td>11.1%</td>
<td>7.5%</td>
<td>$X^2=0.333$, p. = .564, Not Sig.</td>
</tr>
<tr>
<td>Employs excessive inappropriate discipline</td>
<td>0%</td>
<td>5.8%</td>
<td>$X^2=2.091$, p. = .148, Not Sig.</td>
</tr>
<tr>
<td>Domineering</td>
<td>2.9%</td>
<td>5.8%</td>
<td>$X^2=0.404$, p. = .525, Not Sig.</td>
</tr>
<tr>
<td>Past or current mental health problem</td>
<td>30.6%</td>
<td>34%</td>
<td>$X^2=0.113$, p. = .738, Not Sig.</td>
</tr>
<tr>
<td>Past or current alcohol, drug problems</td>
<td>44.4%</td>
<td>32.1%</td>
<td>$X^2=1.406$, p. = .236, Not Sig.</td>
</tr>
<tr>
<td>History of abuse/neglect as a child</td>
<td>50%</td>
<td>43.4%</td>
<td>$X^2=0.376$, p. = .540, Not Sig.</td>
</tr>
<tr>
<td><strong>HOUSEHOLD CHARACTERISTICS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Homeless at any time during investigation</td>
<td>0%</td>
<td>5.7%</td>
<td>$X^2=2.109$, p. = .146, Not Sig.</td>
</tr>
<tr>
<td>Domestic Violence within 12 months</td>
<td>27.8%</td>
<td>15.1%</td>
<td>$X^2=3.494$, p. = .174, Not Sig.</td>
</tr>
<tr>
<td>Experiencing severe financial difficulties</td>
<td>22.2%</td>
<td>29.7%</td>
<td>$X^2=0.451$, p. = .502, Not Sig.</td>
</tr>
<tr>
<td>Prior Child Protection Investigation</td>
<td>77.7%</td>
<td>58.5%</td>
<td>$X^2=4.361$, p. = .225, Not Sig.</td>
</tr>
<tr>
<td>Number of Prior Abuse Investigation (shown as mean)</td>
<td>.305</td>
<td>.358</td>
<td>$t=-.419$, p. = .677, Not Sig.</td>
</tr>
<tr>
<td>Prior Injury to Child from Abuse/Neglect</td>
<td>8.3%</td>
<td>7.5%</td>
<td>$X^2=0.018$, p. = .892, Not Sig.</td>
</tr>
<tr>
<td>Previously Received Ongoing Services</td>
<td>50%</td>
<td>50%</td>
<td>$X^2=0.008$, p. = .930, Not Sig.</td>
</tr>
<tr>
<td>Case served in Winnipeg*</td>
<td>77.8%</td>
<td>72.4%</td>
<td>$X^2=0.386$, p. = .534, Not Sig.</td>
</tr>
<tr>
<td>PFH level</td>
<td>Low 11.1% Mod 36.1% High 52.8% V High 0%</td>
<td>Low 15.1% Mod 34% High 47.2% V High 3.8%</td>
<td>z=0.133, p. = .894, Not Sig.</td>
</tr>
<tr>
<td>Length of time the family had been served by the DR Project (shown as mean months)*</td>
<td>6.9</td>
<td>7.8</td>
<td>$t=-.838$, p. = .404, Not Sig.</td>
</tr>
<tr>
<td><strong>CURRENT REPORT CHARACTERISTICS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report is about abuse</td>
<td>13.9%</td>
<td>15.1%</td>
<td>$X^2=0.025$, p. = .874, Not Sig.</td>
</tr>
<tr>
<td>Report is about neglect</td>
<td>41.7%</td>
<td>39.6%</td>
<td>$X^2=0.037$, p. = .847, Not Sig.</td>
</tr>
</tbody>
</table>

*Denotes factors not taken from SDM® PFH tool
5. **FINDINGS**

A. **The Characteristics of Families Receiving Service**

i. **Volume of Families Receiving Service**

At the point that the archival file review was undertaken, 77 families had received support from the Winnipeg Project and 26 families had received support from the Parkland Project. The status of each case is noted in the adjacent table.
ii. **Demographics of Families Receiving Service**

A variety of demographic information was reviewed for each family to better understand the types of families receiving support from each Project. Many of the characteristics were collected from the Probability of Future Harm SDM® tool (exception is noted by an *) since these characteristics have been found to be key factors for involvement in child protection services. Characteristics of the primary caregivers, the children and the household are presented below. The percentage of families with each characteristic are displayed.

**Characteristics of Primary Caregivers**

![Bar Chart](image.png)

Winnipeg parents = 63
Parkland parents = 26
Characteristics of Children

Winnipeg parents = 63
Parkland parents = 26

Characteristics of Household

Winnipeg parents = 63
Parkland parents = 26
The following table displays the Probability of Future Harm risk level based on the most recent tool completed. It should be noted that 59% of cases from the Winnipeg Project were at least High Risk and 35% of cases from the Parkland Project were High Risk. High Risk cases in the Parkland Project only reportedly remained in the Project if the level was a result of historical factors only.

Further analysis was undertaken to determine changes in risk level once the Risk Reassessment tool was completed, for all cases with both a PFH and Reassessment tool. Interestingly, the vast majority of cases did NOT experience a decrease in risk level while being served by each Project (61% and 50%, respectively).
Changes in risk shifted slightly when only families with closed cases are included. It should be noted that Parkland did not close with any families if risk had increased, while 25% of Winnipeg’s closed families did see an increase in risk level during their time in the Project.

Change in Risk Levels Over time for Closed Cases by Project

Note: Includes all families closed to DR (excluding transfers to ongoing services), measures from PFH Level to most Recent Risk Reassessment Level.
Risk was often reassessed during the time families were served by the DR Projects and decisions were most likely made while considering the most recent risk assessment. The following analysis specifically considers the most recent risk level (regardless of whether it was from the PFH or the Reassessment tool) and the status of the case (a proxy for the most recent decision made).

For each Project the expected gradient is demonstrated between risk and action on the case; as risk increases, cases are less likely to be closed and more likely to be transferred to an ongoing service unit. Interestingly, there are exceptions to this trend; some low risk cases remain open and some high risk cases close. It appears that risk level is a factor, but not the sole factor, when considering these decisions.

![Graph: Status of Winnipeg Families by Most Recent Risk Level]

Winnipeg families = 64
Risk, as assessed by the PFH, also appears to be positively related to number of intakes and apprehensions reported for families being served by the Projects; as risk goes up, the likelihood of intakes and apprehensions goes up. The noted exception is that very high risk cases have a relatively low monthly rate of intakes.
To be clear, the number of actual families that experienced a new intake or an apprehension while being open to an FE Project are noted below.

<table>
<thead>
<tr>
<th></th>
<th>Number (%) of Families that Experienced an Intake or Apprehension During Time with the Project</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Winnipeg</td>
</tr>
<tr>
<td>New Intake</td>
<td>36 of 77 (46.8%)</td>
</tr>
<tr>
<td></td>
<td>Parkland</td>
</tr>
<tr>
<td></td>
<td>4 of 26 (15.4%)</td>
</tr>
<tr>
<td>Apprehension</td>
<td>14 of 77 (18.2%)</td>
</tr>
<tr>
<td></td>
<td>2 of 26 (7.7%)</td>
</tr>
</tbody>
</table>
The current status of each of these families’ cases is identified in the following two tables. In Winnipeg, the vast majority of families who experience an intake or an apprehension remain open to FE services. In Parkland, while the numbers of very small, families are more likely to be transferred when these events happen; this would be consistent with their more limited role as a DIA service.

The Status of Families Who Experienced an Intake or Apprehension while receiving Winnipeg FE Services

The Status of Families Who Experienced an Intake or Apprehension while Receiving Parkland FE Services
iii. Service Utilization

A key component of DR systems is to create plans that address the worries and needs of the family, in a relatively short term time frame. In Parkland, the majority of families (65%, 17/26) were open in DR for less than 90 days, and 96% (25/26) of families were not served for more than 6 months. In Winnipeg, the distribution is more dispersed; 21% (16/77) of families were served for less than 90 days, another 21% (16/77) of families were served for more than 1 year, and the rest were served between these timeframes (see chart below).

Parents were asked to identify the types of supports and services that the agency’s workers connected them with. While this approach is limited somewhat by the parents’ recollection of services received, it does provide a pretty clear picture of services received from their perspective. The percent of families reporting that they received each service and support is noted below by Project.
Interestingly, project data suggest that 54% of Winnipeg families and 0% of Parkland cases actually received mentor support; which closely aligns with the parents’ perspective. Project data also suggest 21% of Winnipeg cases and 0% of Parkland cases actually received cultural worker support; however this service may be somewhat over reported by the primary caregiver.

The amount of each service or support received by the families was not available for most service types; specific information was available for Mentor support provided to families by the Winnipeg Project.

<table>
<thead>
<tr>
<th>Monthly hours of mentor support to families in Winnipeg DR Project</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>2.34</td>
</tr>
<tr>
<td>Median</td>
<td>1.56</td>
</tr>
<tr>
<td>Mode</td>
<td>0.13</td>
</tr>
<tr>
<td>Min</td>
<td>0.13</td>
</tr>
<tr>
<td>Max</td>
<td>8.36</td>
</tr>
<tr>
<td>N</td>
<td>40</td>
</tr>
</tbody>
</table>
The primary caregivers were also asked to report the helpfulness of each service and support received. Responses suggest that of the informal supports, family members were found to be most helpful, followed by friends and neighbours. Comments from caregivers that found each helpful are also noted.

However, caregivers did not always find these informal supports helpful, as noted by the following comments.

‘The worker tried, however the family and friends weren’t willing to help.’

‘There was no help from [worker] because we had our own help from others if we needed it.’

‘The worker was not here to bring us closer to family, friends. She was there to help me, help my kids, and manage our home, and each other.’
Caregivers also discussed their experience with the Metis CFS specific resource; the percent of caregivers that found each helpful was fairly consistent across roles and projects. Comments from caregivers that found each Metis resource helpful are also noted.

*Note % of caregivers that received the service/support who found it either helpful (4 out of 5) or very helpful (5 out of 5).

There were also examples when these Metis resources were not helpful, the following comments were made regarding Metis CFS supports by relatively dissatisfied caregivers.

‘[Name of son] did not want to call these workers because he feels it would interfere with his independence.’

‘I already knew the majority of stuff that the cultural worker was saying.’

‘None, I was supposed to get a mentor, but didn’t; also, a family support worker and didn’t.’

‘The worker was supposed to help obtain information about our heritage and to obtain Metis card, however failed to connect with us.’

‘Personally, I feel they both didn’t have enough life experience, have children, or live in low income homes, to relate or help me appropriately.’
A variety of community-based services and supports were also provided to many families which many caregivers found helpful. The percent of families that found each helpful and some comments regarding the helpfulness of services are illustrated below.

Other families, who did not find these external services helpful, had the following experiences.

'\textit{I was supposed to get these services but didn’t.}'

'\textit{They were supposed to provide some counselling services, however, they didn’t follow through with it.}'

'\textit{Tried to connect with Parenting training and counselling but they were booked.}'
iv. The Families’ Flow Through the DR Process

Due to the relative complexity of the CFS system in Manitoba and the various paths that a family could take through the system, simple flow charts were created to illustrate how families journeyed to and through each DR Project.

For example, families were referred from three sources; the Designated Intake Agency (as a transfer from ANCR), the Metis Child Family and Community Services Agency (as a transfer from on ongoing service unit), and from another source/agency (as a result of the family relocating into Winnipeg, for example). Note the arrows toward the Winnipeg DR Project.

Families also tended to have three paths through the Project: as a transfer to an ongoing service unit (denoting change in ‘service stream’), as a closed case, or as a DR case that remains open. Note the arrows flowing away from the Winnipeg DR Project.
A similar flow chart was created for families served by the Parkland Project. Most families came from the local Designated Intake Agency. A family was also referred from within the Metis Child Family and Community Agency in that region (as a referral from an ongoing service unit). There were only two sources from which families were referred.

Families flowed through the Project as either a transfer to an ongoing service unit (denotes a change in ‘service stream’), were closed, or remains open.
B. The Spirit in Which Services Were Provided

One of the key components to a DR Project that embraces Signs of Safety is the strength-based, collaborative spirit of service provision. Since research has shown the importance of family engagement in keeping children safe, the spirit in which services are provided is important to review.

The degree to which the strength-based, collaborative spirit of practice is in place was assessed using the following scales. Staff were asked to assess their own practice, primary caregivers were asked to assess the practice of their worker, and managers were asked to assess the practice of each Project team.

<table>
<thead>
<tr>
<th>Staff Self Assessment Scale</th>
<th>Primary Caregiver’s Assessment Scale</th>
<th>Manager Assessment Scale for each Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>I understand where my families are coming from</td>
<td>Did the agency’s workers really listen and understand your unique situation</td>
<td>Listening and understanding each family</td>
</tr>
<tr>
<td>I ask about things that are going well for the family</td>
<td>My workers want to know about things that are going well</td>
<td>Seeking out strengths, what is going well</td>
</tr>
<tr>
<td>I believe my family and I respect each other</td>
<td>I believe my worker and I respect each other</td>
<td>Showing respect for the family</td>
</tr>
<tr>
<td>I believe that families feel more hopeful after we meet</td>
<td>I feel hopeful when I meet with my worker</td>
<td>Creating a sense of hope for the family</td>
</tr>
<tr>
<td>I respect my family’s beliefs and customs</td>
<td>My worker respects my family’s beliefs and customs</td>
<td>Honouring the family’s beliefs and customs</td>
</tr>
<tr>
<td>I talk about maintaining child safety with the family</td>
<td>My worker kept talking about my child’s safety</td>
<td>Focusing on children’s safety</td>
</tr>
</tbody>
</table>

*See the appropriate Appendix for more detail.

Assessing the degree that the practice exists from these three perspectives will help triangulate an actual assessment of the practice.
Remarkable alignment existed across these three stakeholder groups for the Winnipeg Project; each stakeholder assessed the existence of a collaborative, strength-based spirit of practice at the same level.

More varied perspectives existed across the stakeholder groups associated with the Parkland Project; the parents and managers tended to have a more moderate assessment of the spirit of the practice relative to the staff.

Workers were also asked to assess the degree that a collaborative, strength-based approach to supervision existed in each of their Projects. This is important since it is broadly understood that supervisors have a key role in modeling the implementation of a collaborative, strength-based approach. Comparatively, the spirit of collaborative strength-based supervision is more fully implemented in Winnipeg.
Existence of a Collaborative, Strength-Based Spirit of Supervision

- Group Supervision is used to inform planning and decision making
- Appreciative inquiries are used during supervision
- Supervisors model collaborative learning, appreciation, and reflection

Winnipeg staff = 4
Parkland staff = 3

Note: Average score from each 10-point likert scale question displayed
Note: 10 approximates ‘totally present’.
C. The Use and Usefulness of SDM and SOS Tools and Approaches

Separate from the spirit of the practice, both Signs of Safety and SDM® include planning and decision making tools. While these tools and corresponding approaches are distinct in many ways, many jurisdictions have found it useful to combine the approaches as an integrated practice. The degree to which these two approaches are used and found to be useful is described below.

After cross referencing each family’s paper file with electronic records within CFSIS, the number and percent of files with each of the following tools was identified for each Project. While the use of the SOS tools were comparable between the Projects, the Parkland Project appears to have a higher completion rate for the SDM® tools.

![Use of Tools](image)

- **PFH = SDM® Probability of Future Harm Risk Assessment tool**
- **FSNA = SDM® Family Strengths / Needs Assessment tool**
- **Reassessment = SDM® Risk Reassessment tool**
When workers were asked to assess the usefulness of each of the tools, some clear preferences emerged across Projects. The Signs of Safety tools were felt to be more useful than the SDM® tools in general, while the FSNA tool was felt to be least useful. Comments supporting the usefulness of each tool are also included.

Several comments were also shared by workers about why some assessed specific tools as less useful.

‘SDM feels like just a form that you have to fill out.’

‘Do I learn anything from the FSNA that I would not have known after a map?’

‘The narratives (used to backup the SDM scores) take an enormous amount of time.’

‘We do these (SDM) tools because we are told to.’

‘Families don’t really see the benefit (of using the SDM tools).’

‘The FSNA just spits out the “holy trinity” of CFS work – anger management, addictions, parenting skills.’
The usefulness of the SDM® PFH risk scores could also be considered within the context of the risk scores assigned to families at the Designated Intake Agency (ANCR), but using a process separate from the SDM® approach. Therefore, most families receiving services from the Winnipeg Project were assigned a risk level at the end of the intake period. A second risk score was determined using the SDM® PFH once the family’s case was opened within the DR unit.

Of the Winnipeg cases in which an ANCR risk score and a PFH score was found (N=56), there was no significant correlation between the two risk scores for these cases ($r_s = .107$, $p = .431$, not sig.). The cross tabulation of the two risk scores are noted below.

<table>
<thead>
<tr>
<th>ANCR Risk Level by PFH Level Crosstabulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Count</td>
</tr>
<tr>
<td>ANCR Risk Level</td>
</tr>
<tr>
<td>Low Medium</td>
</tr>
<tr>
<td>Medium</td>
</tr>
<tr>
<td>Medium High</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

It should be noted that the average time required to complete the PFH risk assessment for these cases was 4.6 weeks from the DR opening date (N=53, due to missing dates for 3 cases); this suggests that there was at least this much time between the ANCR risk assessment and the DR PFH assessment. The lack of correction between the two risk scores should be interpreted with caution; changes in the family composition or behaviour over this period of time could explain a portion of this variation.
Notwithstanding this consideration, analysis was undertaken to determine the extent to which the ANCR risk assessment was associated with subsequent intakes while the family received services from the Winnipeg DR Project.

The ANCR risk scoring approach does not appear to be as closely related to the number of future intakes and apprehensions as the SDM® PFH risk score is. The PFH tool appears to be the more useful for anticipating future intakes and apprehensions.

![Average Number of Intakes in Winnipeg by ANCR Risk Level](chart1)

![Average Number of Intakes by Project and PFH Level](chart2)
Percent of Winnipeg Families that Experienced an Apprehension During FE Services by ANCR Risk Level

![Bar Chart]

Winnipeg families = 68

Percent of Families that Experienced an Apprehension During FE Services by PFH Risk Level and Project

![Bar Chart]

Winnipeg families = 63
Parkland families = 26
Staff were asked how confident they felt using each approach to make the right decision for the family. In general, staff felt more confident using the SOS approach than the SDM® approach. Some comments both positive and negative are also provided.

![Social Worker Confidence in Using the Approach(es) to Inform Decisions](chart)

- "The combination of maps, safety plans, and harm/danger statements gives me confidence."
- "SDM is a huge investment in time and is not the basis of decision making."
- "I can close more confidently if the risk lowers."
- "I feel confident that by using the Signs of Safety approach my actions are the right ones for my families."
- "SOS improves EVERYONE’S confidence in the plan."
- "I feel confident that by using the Structured Decision Making approach my actions are the right ones for my families."
- "Making decisions (at intake) based on the PFH can almost be dangerous since the decision is based on a PFH with only partial information (about the family’s history)."
- "If a wrong decision is made, we get to go back with the family and change the decision."
- "Winnipeg staff=4, Parkland staff=3."
D. **Satisfaction Levels and Related Analysis**

i. **Staff**

Staff satisfaction was assessed by considering the degree to which staff enjoyed coming to work, work related stress, and a supportive staff team existed. While the level of enjoyment coming to work was consistent between the Projects, it also appeared that lower levels of stress were associated with a more supportive team; this finding is somewhat speculative.

![Staff Reported Job Satisfaction](image)

Note: Average score from each 10-point likert scale question displayed.

ii. **Collaterals**

A list of 23 collateral service providers was provided by DR staff; multiple phone call attempts were made to contact each service provider. These collateral service providers included social assistance workers, youth justice workers, child day care workers, disability specialists, and medical professionals. In the end, a response rate of 78% was attained (N=18).

Of the 18 respondents, 13 had previous experience working with CFS in relation to one of the families they also provided service to.
Of these 13 service providers, 85% (N=11) identified that there were things noticeably different about this experience with CFS. Key differences that were noted are illustrated below.

**Compared to experiences with other CFS workers was there anything noticeably different about this experience?**

- 'Very Strength-based, very holistic approach. Making sure that the family is together, rather than a punitive issue.'
- 'It helped to bring the family group together. It helped to bring information to the forefront, and to clarify different questions that the family all had about each other.'
- 'It seems that she was trying to build a solid support network for the family.'
- 'It is the answer for a lot of our families.'
- 'She helped with transportation which was beyond her scope. The family wouldn't have been able to get to services without her help.'
- '[Worker] was very much on top of what their needs were, and it can be difficult to get ahead of other social workers. Quite often, other social workers defer to the foster parents too much, and don't get involved.'
- 'They were definitely advocating for the family. However, possibly too much... They were looking for (us) to do more than they were able to.'
- 'If the plan wasn't working, then they just tried something new and kept going. They didn't give up.'
- 'They helped to bring the family group together. It helped to bring information to the forefront, and to clarify different questions that the family all had about each other.'
- 'It seems that she was trying to build a solid support network for the family.'
iii. **Primary Caregivers**

When primary caregivers were asked if the supports provided by the DR Project helped before things in their family got really bad, many responded that things had already gotten bad before they got involved. Responses from other families are illustrated below.

![My Worker helped us before things got really bad.](image)

Caregivers were also asked if they would recommend that a friend get in contact with their worker if they had a friend who needed help. A similarly high percent of families from each Project were likely to recommend their worker to another family, see the following table.
Since caregiver satisfaction was relatively comparable between the Projects, it would be helpful to better understand other factors that associated with high levels of satisfaction. If these factors could be isolated and better understood, it could greatly inform the further implementation of the Projects.

Five factors were considered: length of time with the DR Project, most recent level of risk, the number of supports/services that the family reported that they had received, the caregiver assessed helpfulness of the services received, and the caregiver assessed collaborative, strength-based practice of their worker. Correctional analysis determined that the helpfulness of the service, the number of services and the collaborative strength-based practice of the worker were significantly associated with caregiver satisfaction. The strongest correlate with caregiver satisfaction was the collaborative strength-based practice of the worker. More detailed information about the analysis is provided below.
### Key Measure of Caregiver Satisfaction

<table>
<thead>
<tr>
<th>Factors Associated with Satisfaction</th>
<th>Key Measure of Caregiver Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall if you knew another family who needed help would you suggest they should call your worker for help?</td>
<td>$r_s = -0.030$, Sig. = .824, N = 52, NOT Sig.</td>
</tr>
<tr>
<td>The length of time the families received services from the DR Project</td>
<td>$r_s = -0.122$, Sig. = .390, N = 51, NOT Sig.</td>
</tr>
<tr>
<td>Most Recent Level of Risk</td>
<td>$r_s = 0.318^*$, Sig. = .029, N = 47, Statistically Sig.</td>
</tr>
<tr>
<td>The average helpfulness score of services received by parent</td>
<td>$r_s = 0.334^*$, Sig. = .022, N = 47, Statistically Sig.</td>
</tr>
<tr>
<td>The number of services that the caregiver identified they had received</td>
<td>$r_s = 0.590^{**}$, Sig. = .000, N = 55, Statistically Sig.</td>
</tr>
<tr>
<td>The Caregiver Assessed Strength Based Practice of the Agency’s workers</td>
<td></td>
</tr>
</tbody>
</table>

**Spearman’s correlation is significant at the .01 level (2 tailed), *Spearman’s correlation is significant at the .05 level (2 tailed)**

The three factors that were significantly associated with caregiver satisfaction were entered into a (forward method) multiple regression model. The purpose of this analysis is to isolate the ability of each factor to predict (explain the variance of) caregiver satisfaction. The model was able to explain 51% of variation in caregiver satisfaction, a significant model from a statistical point of view. Of the variation explained, the collaborative strength-based practice of the worker accounted for almost all of the variance explained (and 49% of the total variance). The model’s ability to predict caregiver satisfaction did not significantly improve when the helpfulness of services or the number of services was added to the regression model. Statistical details are provided below.
Results for Multiple Regression Analysis—Factors Predicting Caregiver Satisfaction

<table>
<thead>
<tr>
<th>Factors</th>
<th>R</th>
<th>R²</th>
<th>β</th>
<th>t</th>
<th>p</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strength Based Practice</td>
<td>.69</td>
<td>.48</td>
<td>.64</td>
<td>5.38</td>
<td>&lt;.001</td>
<td>40.23</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Helpfulness of Services</td>
<td>.70</td>
<td>.49</td>
<td>.07</td>
<td>.51</td>
<td>Not sig.</td>
<td>20.91</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Number of Services</td>
<td>.71</td>
<td>.51</td>
<td>.15</td>
<td>1.2</td>
<td>Not sig.</td>
<td>14.55</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>

Note: Due to the relatively small sample size (N=46) these findings should be interpreted with some caution.
E. The Implementation of the Projects

i. The Implementation of Key Components of a DR Approach

1. A systematic decision-making process for streaming cases

The streaming of Family Enhancement families to the Winnipeg Project is a two-step process. However, staff have expressed some concerns that this two-step process has created delayed transfers to their Project on a number of occasions. Most families are coming from the local DIA (ANCR); see pages 55-56. Those who have chosen to receive services from the Metis and Inuit CFS system are referred to the Metis Child Family and Community Agency; this is step 1. This ANCR referral *may* include a recommendation that the family is appropriate for the Winnipeg FE Project. Managers at the Metis Agency review the intake report and decide which unit should serve the family, which may be the FE Project; this is step 2. The key streaming decision for the Metis and Inuit CFS system is step 2 and this is based solely on the Intake Report sent from ANCR.

ANCOR intake reports tend to include a lot of detail about the current incident and the family’s history of involvement with CFS; both are helpful. Nevertheless, there have been some concerns about making streaming decisions based on these report.

‘Streaming is basically based on the ANCR report, but sometimes there is not enough information to make a good decision, since PFHs are not completed.’

Winnipeg FE Staff

Since assessments of risk done by ANCR do not use the SDM® PFH tool, staff have worried that this has led to inconsistent risk assessments and streaming decisions. Previous analysis shows that once the PFH tool is completed by the FE Project, after the streaming decision has been made, a large proportion of families end up being high risk (see page 44); this does accentuate the
staff’s concern as the Project was not originally targeted to these families. It should also be noted that ANCR reports do not tend to have a consistent assessment of ‘voluntariness’ or ‘engagement’; the other key criteria for streaming families to FE.

In the end, families have been streamed to the Winnipeg FE Project based on the information available. These decisions have led several Winnipeg FE staff, with previous experience in ongoing service units, to the same conclusion:

‘Based on current streaming and cases, what is the difference [between the streams]? Our families have risks at all levels, including involuntary cases. Besides fewer cases, more paperwork due to the SDM, and the strength-based approach, I don’t see any difference in the families we serve. Just how we serve them is different.’

Winnipeg FE staff

When staff were asked which was the most important factor in streaming cases to FE, risk or voluntariness; virtually everyone who attended the staff focus group stated ‘voluntariness’ is the most important factor. One staff said it best; a realization that has very interesting implications for streaming decisions.

‘I believe this approach works for almost anyone who wants to work, regardless of risk. It is just hard to collaborate with someone who doesn’t want to.’

Winnipeg FE staff

The Parkland Project is more closely aligned with their local DIA, since the Parkland FE Project is a unit attached to the DIA. For this reason, FE project staff report having close consultations with Intake staff regarding the appropriateness of families at intake for FE. Staff report that streaming happened in an efficient and informed manner. In the earlier days of the Parkland FE Project, the line between when the Intake ended and the FE began was fairly fluid, but this
transfer process has been formalized more recently. Although it appears that the criteria for streaming families to FE are quite strictly followed in Parkland, complications have emerged.

For example, there is a referral practice that gives each family one opportunity to receive FE services; if the family requires later support from CFS they would be ineligible for the FE Project. While this does loosely relate to the criteria excluding cases where ‘prior DR was unsuccessful’, many staff felt that it should not be assumed that requiring later support meant that prior support was unsuccessful.

Since the Parkland FE Project is within the DIA, they only have 90 days to work with the family; if further support is required beyond this timeframe the family is to be referred to an ongoing service unit within one of the local agencies. This very limited timeframe has worried some staff.

‘All the assessment we do really “peels back the layers”, that is not ethical to do within a 90 day period after which we refer them on [to an ongoing service unit and another worker].’

Parkland FE Staff

Notwithstanding this limitation, another staff noted successes.

‘There has been some success in closing families within the 90 days and they have not come back yet.’

Parkland FE Staff

On another note, the PFH tool is done at Intake in Parkland and risk does greatly inform the streaming decision. In Parkland region only low and moderate risk cases generally get streamed to FE (with the exception of families assessed as high risk due to only historical characteristics), and staff report that there are not many low or moderate risk cases in the area. This has lead more of these cases to be opened to FE.
‘There is some question whether a new category of clients are now being opened that otherwise would have been closed.’

Parkland FE Staff

‘...we should have a higher threshold for FE cases in Parkland.’

Metis CFS Manager

2. **An ongoing focus on safety**

When it came to the focus of FE, many similarities emerged between the two projects. Discussions about the general focus and purpose of FE tended to include some conversation about how will we know that we are being successful? Staff agreed that expectations of keeping cases closed as a result of FE, is not a good measure of success or realistically an indicator of keeping children safe. The broad consensus was that the opposite is more true; that staff wanted their families to call back if they needed help again with their children and not wait until someone else ‘called them in’. This would give staff a profound sense of success.

More specifically, the focus on safety does differ slightly between the Projects. Due to the Parkland Project’s low risk threshold, there are several cases where safety is not applicable within work of the FE Project; these could include worries solely focused on truancy for example. This would again suggest that perhaps the threshold is too low and that these sorts of cases should be referred to the local school division to address.

While the focus on safety is generally understood, there is some confusion about the appropriate path to achieve it. For example, within the collaborative, strength-based approach is there a place for drug testing and involuntary criminal record checks? Do these approaches fit the philosophy of FE?
There was also some confusion about what to focus on within the time allowed by each Project; 90 days for the Parkland Project, six months for the Winnipeg Project. For the Parkland Project, FE staff are torn between addressing the worries regarding the specific incident addressed in the intake or addressing a broader list of worries and needs that evolve from later assessments. For the Winnipeg Project, who have six months to work with families, they appear to have been able to more consistently address some of the underlying worries and needs that impact on child safety. This more extended period of contact appears to have made some very empowered working relationships with families, this in turn complicates decision making that needs to be made about child safety (close the file or transfer the family to an ongoing service worker) at around the 6 month mark. This is discussed more immediately below.

3. **An ongoing ability to reassess the appropriateness of a family’s service stream and change streams or close the case as needed**

Decisions regarding transfers and closures appear to vary and are unclear to many working within the Projects; the struggle seemed to revolve around ‘what are we expected to do within the DR approach’ and/or ‘what would be best for the family’.

In Winnipeg, there were examples of when elevated risk caused a family to be transferred and examples when a family with elevated worries (and/or very high risk cases) were retained in the FE Project. There were several examples when children were apprehended and the family remained with the Winnipeg Project.

‘Hard for us to transfer cases back to ongoing. Some have even become CICs and stayed with FE’.

Winnipeg FE Worker

‘We have been reluctant to transfer files to ongoing services.”

Parkland FE Worker
‘[Knowing when to transfer a case to ongoing services has been] unclear in pretty much every way.’
Metis CFS Manager

The thought process behind the ‘what does the DR approach expect us to do’ generally involves an appreciation that the DR model expects those with immediate safety worries (potentially leading to an apprehension in Winnipeg) or elevated risk to be transferred to ongoing services because the working definition of FE generally excludes families in these situations.

The counter debate involves the confidence that, based on the worker’s relationship with the family, the family’s best chance of getting the kids back soon is retaining the case in FE, updating the safety plan with the family, and working toward reunification. Workers worry that if the family is transferred to an ongoing service unit, that even short delays caused by the transfer process, workloads at ongoing service units, or a new worker reengaging the family would not be in the best interests of the family. In general, this is the reason why families are ‘hard for us to transfer’.

Other workers seem to have a bit more confidence about understanding when FE cases are transferred to ongoing services.

‘It appears that elevated risk and lack of cooperation from the family are key indicators of when a transfer is needed.’
Winnipeg FE Worker

While there is some debate among staff about the degree that risk should play in transfer decisions, based on the comments from staff above, it is largely agreed that a lack of cooperation should remain a key factor in deciding how best to serve the family. Staff also explained
examples when risk was elevated simply because the family mentioned historical abuse and addictions within the family; while this impacted the SDM® PFH risk score, it seemed inappropriate to transfer a case as result of this new information. During one of the staff focus groups the following phrase was coined.

'Trust me, work with me, talk to me, oops (you said too much), now I have to transfer you'.

This phrase illustrates the felt incongruence between prioritizing a collaborative practice approach within an FE service but also requiring a change in stream when risk elevates. This also helps explain why some families closed even when risk increased over time. For now, it appears that risk and a lack of cooperation are the two factors that currently influence transfer decisions.

The service timelines associated with each Project, 90 days for Parkland and six month for Winnipeg, does appear to influence closure decisions. Due to the hesitation of both projects to transfer families’ cases, briefly discussed above, it has become easier to close families as they approach the service timeline limit.

‘We close more cases and are less likely to monitor open cases. Keeping these cases closed is not a good goal, we want families to call...when they need help, which is happening.

Winnipeg FE Worker

For these families the service limits may not complicate service provision, but for others it has. Staff from both Projects have also expressed the inappropriateness of the service limits as it is not informed by family circumstances, work that may be remaining, or emerging needs. This leads to transfers and impacts on the continuity of service for the family.
‘Six to nine months timelines is too short as it takes months to engage.’
Winnipeg FE Worker

“It is a challenge to know when to close a case.”
Winnipeg FE Worker

‘[How many families] can we really help in 90 days?’
Parkland FE Worker

In all, there appears to be circumstances where the service time limits are not in the best interests of families but other situations where it has moved workers toward closing stabilized families, and not simply ‘monitoring’ the family with an open case. While it appears that service time limits were sufficient to help close some cases, it ought not to be the only solution; as practice confidence grows among workers and the benefits of collaborative approach ease a family’s ability to call for help when they need it.

4. **An approach for truly engaging families about their struggles (that compromise child safety) AND their strengths (that can create safety)**

According to staff from both Projects, Signs of Safety has provided invaluable resources for engaging and working with all members of the family. In many instances, this has led to more engagement, investment in the plan and therefore progress for families.

‘Being open and honest with families have prevented some kids from coming into care.’
Winnipeg FE Worker

‘Families appreciate transparency of being open and honest….putting out our bottom line out there in the harm/danger statements.’
Winnipeg FE Worker

‘I get hugs and flowers from my families.’
Winnipeg FE Worker
‘Families end with a strong enough relationship with the FE workers that they can call back for more support and help.’

Parkland FE Worker

Winnipeg staff also felt that part of the unit’s success related to the fact that the supervisor, social workers, mentors, administrative staff and cultural staff were all committed to a strength-based, collaborative approach in all they did.

‘The right staff are in the right positions now, you know staff with right approach, skills, team approach, an ability to connect.’

Winnipeg FE Worker

In spite of successes in Parkland, the spirit of the services provided was somewhat more conflicted; this is in part a result of the close relationship between the intake unit and the FE unit.

‘It was difficult living between the intake approach (mandatory investigation focused) and the FE approach (SOS focus) because we were workers for both, we had to wear two hats each day, it depended on the case.’

Parkland FE Worker

‘There are intake supervisors, but it has not worked for them to head the DR program as the approach of the two units is very different.’

Parkland FE Worker

5. A focus on creating natural kinship supports for a family whenever possible

Safety networks have been developed, particularly in Winnipeg, and have had good results from the perspective of staff.

‘There is much more involvement with extended families now, like with cousins and aunties.’

Winnipeg FE Worker

‘Safety networks have kept kids out of care; there are examples when we can also return these children more quickly.’

Winnipeg FE Worker
Staff also mentioned that there have been some challenges in developing and maintaining extended family involvement with families within both Projects.

‘Embedded family issues (addictions, mental health, etc) complicate maintaining networks, some family members ‘stir the pot’.’

Winnipeg FE Worker

‘Sometimes feels like the worker needs to investigate the network members, which does not go over well with the family.’

Winnipeg FE Worker

‘We need to build in CFS worries about safety network into the safety plan; that makes things harder.’

Winnipeg FE Worker

‘Service providers have sometimes been very positive members of networks when the family cannot be as helpful.’

Winnipeg FE Worker

‘It is hard to establish a network without ‘investigating them first’.

Winnipeg FE Worker

‘There’s a system dependency where a lot of family supports are wanting to get paid by CFS.’

Parkland FE Worker

‘Sometimes it works really well IF they have supportive families, but often the families are not the greatest supports to utilize.’

Parkland FE Worker

6. A wide variety of the right supports and services are available from the agency and the community

In general, it does not appear that many new community resources were created to support the FE Projects, with the notable exception of the MAGA Resource Centre in Winnipeg and the Case Conference Planning Consultant in Parkland.
Otherwise, the Projects simply referred families to existing community based resources as appropriate. For Parkland, one of the most helpful existing resources has been the D.A.R.T. (Dauphin At Risk Teens) Program. The helpfulness of the Case Conference Planning consultant has lessened somewhat as many FE workers would prefer to case conference/map with their own families as this is key in building strong working relationships with their families; contracting out this service has become less helpful than when originally conceived.

Parkland staff also identified key need areas where there was not enough access to some quality community resources. Primary concerns involve waitlists, inconsistent follow-through on referrals, and an inconsistent volume of services available. More community based resources are needed throughout the region, including:

- mental health services
- supports for parent-teen conflict
- individualized Triple P parenting supports
- transportation services

Due to the geographic size of the region, resources are centralized in Dauphin and Swan River, but many families who require supports live outside these centers. Staff report that where transportation supports are required, the only option for some rural families involves a $100 taxi ride to receive services in the cities.

The general lack of resources in the region has created interesting working relationships with collaterals.

‘We don’t want to become the resource for the resources. Others are expecting us to serve their clients. Education wants help with truancy at school, mental health services want us to stabilize moms with mental health concerns.’

Parkland FE Worker
‘The system is backwards, the collaterals think that a new resource has been created for them in FE.’

Parkland FE Worker

Regarding the Winnipeg Project, the new M.A.G.A. Resource Centre has been a great resource for counselling, groups, and respite services. Staff have appreciated and utilized these services. Staff have also identified that there are several areas of need that require more services. They include more formal partnerships for providing:

- group support for women needing emotional, parenting, or addictions support
- supports for men needing employment, parenting skills, and anger/domestic violence issues
- safe and affordable housing

More generally, staff report that the practices around referral to external service providers vary greatly from worker to worker. Those that tend not to refer to external service providers assert the position that ‘services don’t equal safety’ and that engaged working relationships with families and a network of support can, in some cases, provide sufficient safety for children; services are not the default response for this scenario. This position roughly aligns with the Signs of Safety literature. Others maintain that a key component of FE is to direct families to community supports outside the child welfare system. This assists in the diversion of families away from dependence and entrenchment in the system; therefore services are the default response. This position roughly aligns with the Differential Response literature relating to the ‘assessment’ or ‘early intervention’ service stream.
7. Intensive training and ongoing support for staff, supervisors, administrators and community partners

Staff received extensive training near the beginning of the Projects. A breakdown of the training provided is noted below.

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<tr>
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<th>Average days of training from Sept 2009 to March 2011 for Winnipeg staff</th>
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<tbody>
<tr>
<td></td>
<td>SOS related Training</td>
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<tr>
<td>Social Workers</td>
<td>8.9</td>
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<tr>
<td>Mentors</td>
<td>5.1</td>
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Note: Specific Training provided to Parkland social workers were not available in as much detail but are understood to include the foundational training sessions noted below.

A variety of foundational training sessions were provided by notable experts, they included:

- Structured Decision Making Training (two days) with Dr. Raylene Frietag, Children’s Research Centre of Wisconsin
- Signs of Safety Training (two days) with Dr. Andrew Turnell, Resolutions Consultancy of Western Australia
- Signs of Safety Overview, Mirco-skills, and Advanced Training (four days) with Chad Hayenga and Bill Schulebgerg of Connected Families, Minnesota

In addition, unit supervisors attended a Differential Response Conference hosted by the American Humane in Columbus, Ohio during the fall of 2008.

Staff also received a variety of general child protection related training sessions which included standards, Aboriginal awareness, suicide prevention, attachment, and FASD training.
While the initial training was roughly similar for staff of both Projects, staff noted that staff that more recently joined the Projects were not provided these same levels of training as the initial staff. The initial workers generally felt that the training was sufficient; workers who joined the Projects later generally felt that they required more training.

Staff from Winnipeg felt that there was regular ongoing support from their supervisor, who had been the same person since the conception of the Winnipeg Project, and that this support was a key reason why the Project was seeing success. In spite of this, staff still did have some concerns about the supervisor position.

‘Is the DR coordinator/supervisor role reasonable? Should it be two roles? We all need more Bill time.’
Winnipeg FE Worker

‘Our supervisor is engaged in many other activities, he may not have enough time with and for staff.’
Winnipeg FE Worker

Staff in the Parkland region, who went through three supervisor changes, had a slightly different experience; their need for ongoing support is summed up nicely below.

“We need a stable supervisor to keep the team together and focused…”
Parkland FE Worker

While the level of support provided to and by administrators was not explicitly considered within the scope of this work, general impressions suggested that the Metis and Inuit CFS system in general was heavily supporting the Projects and committed to growing successful aspects of the SDM and SOS practice into the broader Metis and Inuit CFS system.
The initial and ongoing supports provided to collaterals about the FE projects and their practice approach was also not explicitly considered within the scope of this evaluation, but comments from staff suggest that more relationship building may be required to bring some of these working relationships to full fruition.

‘Some schools just want us to take the kids into care, they are not collaboratively looking for better solutions.’
Winnipeg FE Worker

‘...it is important to build in community training that ties to cultural sensitivity awareness.’
Winnipeg FE Worker

‘There still needs to be more development with other sister agencies and grass roots organizations.’
Parkland FE Worker

‘We need a worker to build those bridges with the community [resources].’
Parkland FE Worker

## ii. Reflections on Implementation Challenges and Opportunities

### 1. The maturation of the streaming process and service streams

While the actual criteria being used to initially stream families to FE or refer families back to ongoing services is not fully clear, there appears to be some combination of criteria (risk, safety, engagement, etc.) and discretion being considered. This, in general, is consistent with the literature regarding streaming cases within a Differential Response model.

Staff’s experiences suggest that the most relevant criteria for streaming cases to an FE project is the family’s willingness to collaboratively work to address worries and needs associated with the case. Staff have noted that they question the opening of FE cases for some families who tend to be low risk and present with no harm statements and very unclear danger statements; perhaps these cases do not require FE services. While discretion will always have a role in streaming
decisions, the companion criteria used to inform streaming decisions require some adjustment, clarification and standardization across Projects (as well as across the system); this is also typical of other jurisdictions evolving streaming processes. Since previous analysis has suggested that the SDM ® PFH assessment does provide more guidance in anticipating future intakes and apprehensions than other risk assessment approaches, it should be incorporated more broadly across the system; this may result in changes to the risk assessments completed by some DIAs.

The evidence from this evaluation and the experiences of other jurisdictions point to service streams primarily, but not solely, distinguished by the voluntariness/engagement of the family. This approach would lend to the use of an assessment stream (using the SOS strength-based collaborative practice approach) and an investigative (using more traditional investigative approach) stream for Manitoba. Families in the assessment stream would be ‘Voluntary Family Service, or VFS, cases; families in the investigative stream would be ‘Protection’ cases. Each stream would be supported to serve families with a broad range of risk levels, worries, and needs requiring support. Each stream would also provide services on an ongoing basis (and not be time limited); this would limit unnecessary transfers (and changes in workers) due simply to arbitrary service limits of some units. In order to ensure that assessment services are as time-limited as possible, the provision of services beyond certain time-limits would require an increasing level of approval. For example, the extension of assessment stream services for more than 6 months requires supervisory approval and the extension of assessment services for every consecutive 12-month period require Director approval. Each level of approval could require an explicit explanation of the current harm/danger statements, risk level (and changes in risk over time), the successes and struggles with the current safety plan, as well as the worries and next steps associated with the current family map. This would support intensive, short-term involvement
with applicable cases without compromising the continuity of services for families requiring longer-term support.

2. The partnership pushback

Analysis has suggested that, in general, there is remarkable congruence between the perspectives of families, workers, and managers regarding the presence of a collaborative, strength-based practice approach. This congruence appears to be associated, in part, with the degree to which a collaborative group supervision model exists. By and large, families have appeared to value this practice approach and have responded well to this spirit of service.

Partnerships are also important across the Metis and Inuit CFS System. Enhanced partnerships within the Metis and Inuit system could support broader use of group supervision models for growing and sharpening SOS practice skills across the system. This could involve a more supported implementation of SOS in units already experimenting with and supportive of the practice as well as an opportunity for other units to receive SOS training and begin experimenting with how the practice skills and tools could assist their work. The following recommendations support the Metis and Inuit CFS system journeys toward greater system-wide practice depth and service quality.

The addition of a DR service model, to an already complicated Manitoba CFS system, has appeared to have further impacted collaborative service provision across Authorities. System-wide partnerships are required to minimize the number of transfers for families, the coordination and sharing of services and supports, a rationalization and standardization of services provided pre and post ADP, and the alignment of assessment practices and streaming processes. In addition, the system as a whole should grow to rely on a balance of empowering professional
practice skills/discretion and prescribed practice standards. In the absence of partnerships regarding these issues, the quality, consistency and continuity of services to families, including the outcomes of children, will be negatively impacted. The following recommendations serve to guide the system toward these expressed goals.

While it appears that collateral service providers have noticed and appreciated the collaborative strength-based practice approach of the FE Projects, staff have also noticed that some collaterals are not as interested in collaboratively finding solutions for families; this could be a result of the collaterals’ restricted practice approach, limited time, or lack of a full understanding of the purpose of the FE project. Efforts should be made more regularly by workers to maintain and create formal working relationships with collateral service providers.

Staff also suggested that the rate that they refer families to community based services varied between workers; some workers are more likely to partner with collaterals service providers than others. This appeared to be related, in part, to the worker’s belief about the appropriateness of community based service provider involvement with the FE and/or SOS approach. It seems reasonable to include the provision of external service providers in the family’s plan once the following have been clearly and collaboratively created with the family: harm/danger statements, a safety plan, and a map with associated next steps (which would include a community service-based intervention).

3. Unstable informal supports and formal services

Workers have been clear that creating safety networks with extended family members have been difficult at times due to families not wanting to involve their extended families or the lack of family members that can provide a supportive role. There are other illustrations where the safety
network has been embraced by the family and effective in minimizing CFS involvement. The success of safety networks appears to be equivocal at this time and more training, mentorship, and group supervision is likely required before the skills required for creating safety networks are in full fruition. A fuller review of the impact of safety networks should be undertaken.

The quality and availability of the right kind of formal community based supports vary by Project, but previously discussed findings do identify expressed service gaps from the perspectives of FE workers. Efforts should be made to specifically collaborate with community based service providers that have the capacity and expertise to fill this expressed service gap. This will assist in the development of exhaustive service networks that can support a family’s individualized needs; inter-disciplinary case conferences would be used to coordinate services in relation to the current worries.

4. **Work/caseload disparity between service streams**

In order to fully attain a continuum of services across the Metis and Inuit CFS system, further work is required to address the felt workload disparity between the FE Projects and the ongoing service units. FE staff from both Projects, but primarily the Winnipeg Project, have reported reluctance to transfer families to Metis ongoing service units due to a perceived (and likely real) concern that due to the workloads of ongoing service units the intensity and regularity of service would drop; this in spite of the escalating worries experienced within the family. As a result the Winnipeg Projects, most notably, have continued to serve Metis families even after, in some cases, an apprehension. While staff have expressed reasonable reasons for retaining this family within the Project (i.e. the worker’s strong working relationship with the family, and the expected short term nature of the apprehension), concerns about the workload of other units ought not to
limit the most appropriate decision for the family. Efforts should be made to distribute workload across the system; this would ease the stress within the system and support the evolution of a system that is able to provide prevention focused services across the service spectrum (and not only emergency/crisis ongoing services).
DISCUSSION

While the findings have provided some clarity regarding:

- the characteristics of the families receiving services
- service utilization
- the spirit in which services were provided
- the use and usefulness of various aspects of the SOS and SDM approaches
- the satisfaction levels of key stakeholders as well as
- the degree to which the Metis FE projects have been implemented

Other, more conceptual aspects of the Projects require further discussion. These include the relationship between Differential Response streams and prevention as well as the importance of balancing the importance of and support for professional practice skills and prescribed practice standards.

The relationship between the Differential Response streams and the concept of prevention is varied and complex. An over simplification of the relationship would suggest that the Assessment/FE stream is the prevention stream and traditional/investigative stream is the intervention stream. It appears that the jurisdictions with most experience implementing Differential Response, most notably Massachusetts and Minnesota, do not make this simple association. Some jurisdictions do refer to the Assessment/FE stream as an early-intervention stream though, as it is designed to provide support earlier than would have been received without that stream of service in an effort to ‘prevent’ the need for traditional/investigative services. This author suggests that this perspective invites Manitoba to consider a ‘full service spectrum prevention approach to child welfare’. As the default response, this approach views each point of contact with the child welfare system as an effort to ‘prevent’ the families from becoming more deeply involved in the system. For example:
• Efforts at intake are focused on addressing needs and safety worries in order to prevent the case from being transferred to an ongoing service unit.
• Efforts at the assessment stream are focused on addressing needs and safety worries in order to prevent children from coming to care and/or the possible provision of involuntary services.
• Efforts at the investigative stream are focused on addressing needs and safety worries in order to prevent children from coming to care.
• Efforts regarding families with children in care are focused on addressing needs and safety worries in order to return the children home.

It should also be said that at no matter what point in the system, CFS services prevent harm to children. In this way, prevention is the default purpose of all we do; a ‘full service spectrum prevention approach to child welfare’. For these reasons, the relationship between Differential Response streams and the concept of prevention is more inclusive and interrelated than simply assigning prevention efforts to a single stream of service.

Much can also be discussed regarding the relative importance of professional practice skills vis-à-vis prescribed practice standards within child welfare-related decision making and governance. Systems that emphasize prescribed practice standards often have elaborate rules to be followed and/or decision matrixes to guide actions on a case; these systems would tend to develop elaborate audit and compliance assessment processes. Systems that emphasize professional practice skills would conversely emphasize the development of a ‘learning organization’ characterized by critical thinking and skill development. Munro (2010; 2011) suggests that many systems have deemphasized the importance of professional practice skills and elevated prescribed practice standards and compliance. This could be said about Manitoba as well.

While most systems have implemented aspects of both, it is worth suggesting that striking a stable balance between skill development and compliance with standards is key for a well functioning system; a system suffers when either extreme predominates. England’s experience
(Munro, 2010) suggests that a pendulum exists between these two positions and that the pendulum adjusts toward prescribed compliance-based standards after a tragedy, like a child’s death. This occurs, in part, as a result of a perceived lack of confidence in or presence of practice skills. As a system adjusts toward prescribed compliance-based standards (and away from practice skills), practice skills further deteriorate (as the system is not supporting or requiring its development). This leads to an under-skilled system too deeply entrenched in compliance-based practices. Conversely after a tragedy in a stable well-functioning system, at least equal investment would be made in understanding and filling practice skill gaps as is made for monitoring and enhancing compliance-based monitoring approaches. This more balanced and stable approach ensures professional practice skills continue to be understood and developed as well as ensures that minimum prescribed practice standards are appropriate, relevant and fulfilled.
6. CONCLUSIONS AND NEXT STEPS

Recommendations Regarding the Continued Implementation of the Metis FE Projects

Since the success of the Projects has been associated with the collaborative, strength-based practice and supervision model, the formalization of a FE project practice approach (which would incorporate the use of the most helpful tools and approaches assessed) and the further development of collaborative, strength-based supervision support should be prioritized. It is therefore recommended that:

1. A dedicated on site FE supervisor needs to be maintained for each project.
2. Practice skills continue to be sharpened through further implementation of the Signs of Safety practice approach.
3. The SDM® Risk reassessment tool should be completed before major decisions are made (closures or transfers, for example).
4. SDM® Family Strengths and Needs Assessments should not be a required tool as SOS mapping already identifies strengths and worries in a way that progresses the plan and the worker-family relationship.

Recommendations for the Broader Metis and Inuit CFS System

Since there is evidence that this collaborative, strength-based practice and supervision model is helpful for a wide range of families, there is warrant in expanding these skills and practices throughout the Metis Agency as well as intensively piloting this practice and supervision model within a couple of ongoing service units. These steps will assist in the refinement of staff skills throughout the Metis and Inuit system as well as provide practical tools and approaches for assisting families regardless of their nature of involvement with the system. These skills also give
workers more confidence and direction to know when and where to refer families to community-based services. Therefore it is recommended that:

5. SOS skills demonstrations and training (including harm/danger statements, mapping, scaling, safety network development) and SDM® training (for the risk tools) be provided to all workers.

6. A practice model be formalized that embed SOS skills and tools within a formal practice approach; SDM® risk tools would be incorporated into the practice model as an information source for consideration at key decision points.

7. Peer group supervision becomes a core approach for sharing work, sharpening practice, and informing decisions that impact families receiving services.

8. The practice and supervision model would be intensively implemented in targeted ongoing service teams.

9. An ongoing implementation/process evaluation of the model should be completed over two years and should assess family, staff, and management feedback. The purpose of the evaluation would be to fine-tune the practice approach, supervisory approach, and case management processes.

10. Embed a full service spectrum philosophy of prevention across the system. Prevention can happen throughout the system including at Intake, VFS cases, Family Preservation, Protection cases, and Reunification. Preventative service is something far broader and more powerful than ‘a diversion at intake’; it is about keeping children safe.

11. Targeted partnerships with community based service providers be established to address expressed gaps in services and supports available in the community. These
partnerships will enable more families to receive the benefits of a community-based service network.

**Recommendations for the Manitoba CFS System**

The DR system in Manitoba is currently being piloted and much has been learned about how the system is working and not working from a variety of perspectives. Collaborative efforts should be made across the system to reduce the number of transfers for families, to coordinate and share services and supports, to rationalize and standardize services provided pre and post ADP across the system, and to align assessment practices and streaming processes. The evaluation has provided insight into each of these areas that require some attention. For the purpose of providing service continuity and culturally appropriate services (post ADP) for the greatest number of families possible, the following recommendations should be implemented:

12. All DIAs would be given the same access to case histories in the Intake Module and CFSIS.

13. All DIAs would provide specialized assessment and referral supports (and not a robust service) within 90 days.

   a. Assessments would include:

      i. A safety assessment (including the provision of emergency services if required)

      ii. A review of the current incident (including an abuse investigation if required)

      iii. The SDM® PFH risk assessment (would be completed for all families at all the DIAs)
iv. Clear and concise harm and danger statements

v. A collaborative assessment of strengths, worries and next steps

vi. An assessment of the family’s willingness to work with CFS regarding the expressed danger and worries. This could be accomplished by completing a ‘voluntary family service agreement’ with families.

b. Referrals would be directed toward:

vii. Community-based services (including resource centres) when an open file is not warranted. These community resources would be financially compensated by the CFS system as a service that supports diversions from the system, OR

viii. Ongoing services (after an ADP) in either an assessment stream (as a VFS case) or an investigative stream (as a Protection case) as the situation requires.

c. Services provided by the assessment stream would not be time-limited but approval would be required to extend services beyond certain time limits. This type of accountability would support time-limited service provision without requiring that the family transfer and change workers when longer-term support is required.

14. Referral (streaming) decisions at all DIAs would be influenced by voluntariness/engagement/motivation of family, nature of most recent incident and PFH risk (listed in descending order of importance).
Recommendations regarding preparation for a full impact evaluation of FE services and the DR approach.

Due to the lack of a proxy comparison group, it was not possible to fully assess the impact of the DR approach and/or FE Services on the expressed long term outcomes of the DR Projects; at least not within a quasi-experimental design. The following recommendations serve as the prerequisites required for future long term outcome evaluations:

15. A full impact evaluation of FE services (including the impact of community based services and safety networks) be undertaken in two to five years that focus on the achievement of the expressed long-term outcomes of Manitoba’s DR model.

16. PFH and Reassessment tools would populate ‘backend’ datasets (be fully embedded within CFSIS) and be readily available to Authorities.

17. Authorities would have access to anonymised PFH and Reassessment results from non project participants in order to identify proxy comparison groups.

18. The Metis ‘DR database’ would be fully maintained for both projects until the impact evaluation has been completed.

19. Replace the current Metis Family Questionnaire with the Primary Caregiver Survey (see Appendix B) and have it be administered at case closure/transfer.
References


APPENDIX A: ORGANIZATIONAL CHART OF THE MANITOBA CFS SYSTEMS
APPENDIX B: PRIMARY CAREGIVER INTERVIEW

Hello:
Some time ago you should have received the attached letter from [name of supervisor] of the Metis Child, Family and Community Agency.

I am with an organization called Building Capacity and we have been asked by the Metis Child Welfare system to ask you about how services are going and if you are getting the help you need.

Answering the questions will only take about 15 minutes, and we will be paying you $20 if you return the completed survey by March 31, 2011.

Not completing the survey will not impact your CFS case in any way.

Your experiences and opinions are important to us so that we can better understand how to make the child welfare system more helpful for families.

We won’t tell anyone in the child welfare system who said exactly what, so you don’t have to worry about what you should or shouldn’t say. But we are going to explain to them the kinds of things that were helpful to families just like yours.

Again, if you return the completed survey in the self addressed envelope, I will send you a letter with $20 in it.

That’s just our way of saying thank you for helping us understand what we need to do to in order to make CFS services better.

Thank you for your consideration,

Mike Caslor
Building Capacity

Name of Differential Response Worker.
All of the questions relate to only the time that you were receiving Differential Response services. This was when you had the worker noted above.

What kinds of people and supports did the agency help bring into your life?

Did the agency’s workers connect you with:

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<td>family members that could maybe help?</td>
<td>❑</td>
<td>❑</td>
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<tr>
<td>friends that could maybe help?</td>
<td>❑</td>
<td>❑</td>
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<td>neighbours that could maybe help?</td>
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Of those you did connect with, to what extent did these people help your family?
On a scale between 1-not at all helpful and 5-totally helpful.

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<tr>
<th></th>
<th>1 not at all helpful</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 totally helpful</th>
<th>Not Applicable</th>
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What did you find most helpful?
Thinking about only the time when you were receiving differential response services. Did the worker connect you with any of the following Metis CFS services?

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<td>Family Support Worker</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Cultural Worker</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

Of those you did connect with, to what extent did these services help your family? On a scale between 1-not at all helpful and 5-totally helpful.

<table>
<thead>
<tr>
<th></th>
<th>1 Not at all helpful</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Totally helpful</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentor</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Family support worker</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>Cultural worker</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

What aspects of these Metis services (mentor, family support worker, cultural worker) helped you the most?

...
Did the agency workers connect you with any other services during the time that you were receiving differential response services?

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Resource Centre</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Addictions treatment</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Parenting training</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Employment training</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Basic needs (food, clothing, shelter, etc)</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Of those you did connect with, to what extent did these services help your family?
On a scale between 1-not at all helpful and 5-totally helpful.

<table>
<thead>
<tr>
<th>Service</th>
<th>1 Not at all helpful</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Totally helpful</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Resource Centre</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Addictions treatment</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Parenting training</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Employment training</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Basic needs (food, clothing, shelter, etc)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

What aspects of these external services helped the most?
Each of the following questions relate to your experiences working with the agency differential response workers.

On a scale between 1-not at all true and 5-totally true, how true are each of the following questions and statements?

<table>
<thead>
<tr>
<th></th>
<th>1 Not at all true</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Totally true</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the agency’s workers really listen and understand your unique situation?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Did the agency’s workers deal with you in an honest manner?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Did the agency’s worker do what they said they were going to do?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Did you have a choice in what happened with the agency? In designing a service plan?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Did the agency’s workers clearly tell you what you needed to do to get the agency out of your life?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My workers want to know about things that are going well.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I believe my worker and I respect each other.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>I feel hopeful when I meet with my worker.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My worker involved me and asked for my ideas regarding all decisions made about me and my children</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My worker respects my family’s beliefs and customs</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My worker kept talking about my child’s safety</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My worker helped me deal with some other problems I had to deal with (regarding Housing, my child’s school, etc.)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>My worker got us help BEFORE things got really bad</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Can you explain more about how the worker may or may not have helped BEFORE things got really bad?

Do you believe that your family received the help you really needed from the agency? Explain why or why not.
Overall, if you knew another family who needed help, would you suggest they should call your worker for help?

<table>
<thead>
<tr>
<th></th>
<th>1 Not at all</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5 Totally</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Do you have anything else that you feel like I need to understand about your experience with the Differential response workers?

As promised, we would like to send you $20 as a simple way of saying thank you for giving us this time and answering our questions so honestly.

Who should the cheque be addressed to? Where would you like the cheque sent?

If I don’t receive a name and full mailing address I won’t be able to mail you the $20.

Contact Information:

First and Last Name

Mailing Address (please include city and postal code)

Thank you for this time and I have appreciated your interest.

Again, the things that you have told me are important and will help us better understand how to make Child Welfare services as helpful as possible.

I will not tell anyone in the child welfare system who said exactly what, but I will tell them the kinds of things that were helpful and were not helpful for families just like yours.

I will be mailing out the cheques shortly after receiving the survey back.

Thanks again and have a good day.
Mike Caslor, Building Capacity

Visit us at www.manitobaconsulting.ca
APPENDIX C: STAFF FEEDBACK FORM

The following questions will assist in better understanding your individual experience with Differential Response as it relates to Signs of Safety and Structured Decision Making. Asking for your feedback in this format has also kept the focus group as short as possible. Your individual responses and comments will remain anonymous at all times. Thank you for your interest and participation.

Each of the following questions relate to how you work with families, assess each statement on a scale from 1 to 10. Please check the most appropriate box for each of the statements below.

<table>
<thead>
<tr>
<th></th>
<th>I Not at all</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10 All the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I ask about things that are going well for the family</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>I believe my family and I respect each other</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I believe that families feel more hopeful after we meet</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand where my families are coming from</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I respect my family’s beliefs and customs</td>
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</tr>
<tr>
<td>I talk about maintaining child safety with the family</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>I only focus on my families’ problems</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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</tr>
</tbody>
</table>

In approximately what percent of your cases were you able to create a working safety network? Circle the most appropriate response.

1. 0%
2. 10%
3. 20%
4. 30%
5. 40%
6. 50%
7. 60%
8. 70%
9. 80%
10. 90%
11. 100%

To what extent have these safety networks really helped families keep children safe?

1. 1 Never
2. 2
3. 3
4. 4
5. 5
6. 6
7. 7
8. 8
9. 9
10. 10 With every family
Each of the following questions relate to what you do with families, assess each statement on a scale from 1 to 10.

<table>
<thead>
<tr>
<th>Task</th>
<th>1 Never</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10 With every families</th>
</tr>
</thead>
<tbody>
<tr>
<td>I create danger statements with families</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I create safety plans with families</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>I can make clear distinctions between harm and danger</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can make clear distinctions between safety and strengths</td>
<td></td>
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<td></td>
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<tr>
<td>I map/case conference with families and support networks</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I use scaling questions with families</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>I look for ‘exceptions’ to the family’s problems</td>
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</tr>
<tr>
<td>I incorporate the voices of children into the planning (using three houses or the safety house or words and pictures)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Each of the following questions relate to what you do in your practice, assess each statement on a scale from 1 to 10.

<table>
<thead>
<tr>
<th>Task</th>
<th>1 Never</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10 All the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Probability of Future Harm tool is completed as soon as possible</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The SDM Reassessment tool is completed when required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know when the SDM Reassessment tool should be completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The SDM `procedures manual’ and definitions are strictly followed</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signs of Safety practice and SDM tools seamlessly inform my work</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>Group Supervision is used to inform planning and decision making</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appreciative inquiries are used during supervision</td>
<td></td>
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</tr>
<tr>
<td>Supervisors model collaborative learning, appreciation, and reflection.</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>
Please assess your response to each of the following statements on a scale from 1 to 10. Please check the most appropriate box for each of the statements below.

<table>
<thead>
<tr>
<th></th>
<th>1 Never</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10 All the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>I enjoy coming to work to help the families on my caseload</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The stress of the job is really getting to me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel confident that by using the Signs of Safety approach my actions are the right ones for my families</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel confident that by using the Structured Decision Making approach my actions are the right ones for my families</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My team is supportive and we work together well</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What is your current position? Circle the most appropriate Response.
1. Social Worker
2. Mentor
3. Student
4. Cultural Worker

Which Pilot Project are you with? Circle the most appropriate Response.
1. The Parkland DIA Pilot
2. The Winnipeg FE Pilot

Years of post secondary education

Years of social service experience

Years of child welfare experience

Years of experience in your current position

Your Name

Thank you for the time and consideration required to fully complete the questions. Your experiences will be very important in moving your DR approach forward.
APPENDIX D: MANAGEMENT FEEDBACK FORM

In order to collect as much information about the Pilots as efficiently as possible, please answer the following questions. These questions may also assist in focusing our broader discussion as the morning unfolds.

These are my reflections about (circle the correct answer):
1. The Winnipeg DR Pilot
2. The Parkland DIA Pilot

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do we have a clear understanding of who is eligible for FE services?</td>
<td></td>
</tr>
<tr>
<td>What needs to be more clear?</td>
<td></td>
</tr>
<tr>
<td>Do we have a good working relationship with the source of referrals?</td>
<td></td>
</tr>
<tr>
<td>What would make it better?</td>
<td></td>
</tr>
<tr>
<td>Do we know when to close the case? What needs to be more clear about case closures?</td>
<td></td>
</tr>
<tr>
<td>Do we know when to transfer a case to ongoing services? What needs to be more clear?</td>
<td></td>
</tr>
<tr>
<td>Do staff have the right skills for this more collaborative approach to working with families? What training is needed?</td>
<td></td>
</tr>
<tr>
<td>Is staffing stable?</td>
<td></td>
</tr>
<tr>
<td>Are regulations and policies supportive to a FE approach? What needs to change?</td>
<td></td>
</tr>
</tbody>
</table>
To what extent has the DRFE project created new community partnerships for service provision?

Do we have the right community resources available to support families? What is missing?

Consider any progress that you have seen happen regarding the spirit of (principles of) service delivery, how would you describe each of the following:

<table>
<thead>
<tr>
<th></th>
<th>In full fruition for all workers</th>
<th>Rooted in some workers/ others experimenting</th>
<th>Some workers experimenting/ others not interested</th>
<th>No one is really trying it yet</th>
<th>I don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening and understanding each family</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Dealing with the family honestly</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Following through on promises</td>
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<td>Giving the families choices throughout the process</td>
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<td>Being clear with the family about what would close their case</td>
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<td>Seeking out strengths, what is going well</td>
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<td>Creating a sense of hope for the family</td>
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<td>Honouring the family’s beliefs and customs</td>
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<td>Focusing on children’s safety</td>
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<td>Giving the family the help that they are asking for</td>
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APPENDIX E: COLLATERAL INTERVIEW

Hello: My name is [interview name]. I am working with Building Capacity, a consulting service that has been hired to review the Metis CFS’s Differential Response Pilot Projects.

Part of the review includes hearing from collateral service providers about their experiences with the project. The Projects coordinator, [coordinator name], provided your name and number to me since you have had contact with [worker name], who is one of the workers.

I am wondering if I could have 5 minutes of your time. I know very little about the type of contact that you have had with this worker and I do not want to talk about any details of the case since I know that this is sensitive information. But I would really like to hear about your experience with the worker and the approach he/she used to help the family. So all I know about your involvement with [worker name] is [details].

Do you recall the situation (or another situation when you recently worked with this worker)?
1. Yes
2. No

Have you had other experiences working with THIS worker?
1. Yes
2. No

Have you had experiences working with OTHER CFS workers?
1. Yes
2. No

If yes, compared to experiences with other CFS workers, was there anything noticeably different about this experience?
1. Yes
2. No

1 If so, what differences did you notice?

2 To what extent do you believe that this situation contributed to the health of the family and/or safety of the children?

3 To what extent do you believe that this situation has impacted on your working relationship with CFS workers?

4 Do you have any other comments that you would like to tell me?

Name of Organization

Name of Person