AN EVALUABILITY ASSESSMENT OF THE SUBSTANCE MISUSE INITIATIVE AT WINNIPEG CHILD AND FAMILY SERVICES

By

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Submitted to the Faculty of Graduate Studies
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ABSTRACT

The subject of substance abuse is a common issue faced by many families who receive services from child welfare agencies. Winnipeg Child and Family Services (WCFS) recognizes that many families and children come to the attention of the Branch because of parental substance use. Furthermore there is an acknowledgment that many families cycle through the child welfare system because of issues related to parental substance abuse. As a way to deal with this WCFS designed the Substance Misuse Initiative (SMI). The project is a new way for staff at the Branch to interact with families who were misusing substances. The program provides a holistic family centered approach to service. While the intention is to conduct a full evaluation of the Initiative at a later stage, this practicum reports on an evaluability assessment (EA) that was undertaken to determine the readiness of the program for evaluation and how this might proceed.

The EA was conducted in order to learn how the SMI is being implemented, if the project is being delivered in a manner that permits an evaluation of the Initiative's goals and objectives, and to determine the feasibility of implementing certain evaluation procedures. A review of Branch documents, interviews with key informants associated with the program, and case file reviews provided data for the EA. A summary of the information is provided which outlines the implementation of the program. This EA also includes a proposed evaluation plan, along with evaluation questions that could be used for the evaluation of the SMI.

The EA provided the Branch with various findings by detailing the design, implementation, and ability to further evaluate the program. The rationale for the SMI is based on the fact that substance abuse is a significant issue impacting the field of child welfare. As described in the

report, the Initiative was designed as one of three strategies that would attempt to reduce the costs associated with children coming into care and to enhance Branch service. The intent of the program is to work with families that abuse substances by developing a clear understanding of their needs. This understanding of a family's needs ensures an appropriate match between the family, substance abuse service providers, and other community resources. Developing harm reduction plans that ensure the basic safety of the children and reduce parental substance abuse, using motivational interviewing, and determining the parents' stage of change are important activities in the program.

Implementation challenges to the Initiative included the following: staff changes at the outset which resulted in some delays with start–up, as well as complications related to the referral process, internal collaboration, external collaboration, and engagement with families. Efforts have been made by management to overcome these issues although some implementation problems still require ongoing attention.

Many respondents agreed with the principals of the SMI, and noted the necessity of the project. Program staff acknowledged and supported the principles of the Initiative and noted that it allowed the Branch to serve a group of people who otherwise would not receive service. Training and consultancy with AFM were said to be useful to SMI staff and their work. Staff and management involved with the Initiative felt the project's focus on concrete needs and prevention were positive aspects of the program. Results from the EA were used to develop of an evaluation plan for the SMI. In addition, some of the findings from this EA were used by management to introduce modifications in programs delivery.

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CHAPTER 1

INTRODUCTION TO THE PRACTICUM

Defining the Problem

In Winnipeg there are a high number of children who are either abused and/or neglected. In the fall of 2002 approximately 50% of the cases referred to intake at Winnipeg Child and Family Services (WCFS) demonstrated substance misuse concerns (Winnipeg Child and Family Services [WCFS], 2003). Parental substance misuse was a significant factor in families cycling through the system, which resulted in children entering Branch care. A "Families Returning for Service Study" was conducted at the Branch. Findings from this study revealed that substance abuse along with physical abuse were the most common reasons for families coming to the attention of WCFS for services (Winnipeg Child and Family Services [WCFS], 2002). The authors also found that families who returned for service, during the window in which data was collected, were more than twice as likely to have previously had their children in Branch care.

In work done by Trocme et al. (2001), it was reported that about 135, 576 children living in Canada were abused and/or neglected in the year 1998. The authors also stated that 45% of these situations were substantiated child maltreatment cases. The study revealed that substance misuse was the most frequent presenting issue in child abuse/neglect cases, rated as 34%. Canadian statistics on substance abuse showed that about one in ten adult Canadians have problems with drinking (Single, Van Truong, Adlaf, and Ialomiteaunu, 1999). Chiodo, Leschied, Whitehead, and Hurley (2003), gathered data related to children's family of origin who were in contact with Children's Aid Society (CAS) in London and Middlesex Ontario. It was discovered that a majority of the children were aboriginal; therefore, the study focused on information related to

aboriginal families. The authors said that 38% of aboriginal children referred to the CAS in London and Middlesex had one parent with a substance abuse issue. Mazur-Teillet (2004) noted that 40% of aboriginal Canadians are under the age of 15. Of these children, 3.8% are under the care of child welfare agencies while only 1.35% of Caucasian children are involved with the child welfare system. The high number of aboriginal children in care is further related to social problems faced by aboriginal Canadians, which include unemployment, poverty, poor housing, alcoholism, and under-education. Aboriginal women and children involved with the child welfare system often find the system does not adequately meet their needs (Anderson, 1998). To overcome these issues, Timpson (1995) noted that the services for these families should focus on prevention and healing.

Although some of the following data is based on American research, there is reason to argue that the general pattern is applicable to Canadian families and the Canadian child welfare system. Work done by Banks and Boehm (2003) indicated that there is a strong correlation between substance misuse and child maltreatment. These authors noted that about 8 million children in the United States live with substance-abusing parents, which is a major concern for child welfare agencies. In addition, the article reported that three times as many children from families with substance abuse issues are abused in comparison to children whose parents did not abuse substances. As well, children from substance abusing homes are more than four times as likely to be neglected than children in homes without substance abuse. Of major concern is the fact that 67% of families who receive service from child welfare agencies require substance abuse treatment but only 31% obtain it.

In response to the negative effects of substance use on families, and WCFS's inability to provide many of them with more then the standard "caution and warn" service, the Branch created the Substance Misuse Initiative (SMI). This initiative was designed as a means to provide additional services beyond "caution and warn" as well as "outside referral". The program takes on principles outlined in the harm reduction model, includes aspects of motivational interviewing, and incorporates the stages of change for assessing and providing a preventative service to families. A complete description of the SMI will follow.

This practicum focuses on the completion of an evaluability assessment (EA) in order to determine how the SMI is being implemented and how it can be evaluated. The EA provided WCFS with data on whether or not SMI goals and objectives are likely to be met, if services are being delivered to their fullest extent, and which services appear to improve the quality of life for families dealing with substance use. Results from the EA are designed to assist the Branch in the development of an intended evaluation on the SMI. Data was collected from case file reviews as well as interviews with key stakeholders. The information gained in the data collection phase was analyzed to determine the feasibility of using various methodologies. From the analysis, recommendations are made regarding which aspects of the SMI can be evaluated as they exist and those that need to be modified in order to be evaluated.

Intent of the Substance Misuse Initiative

The SMI was developed as a Days Care Initiative. The purpose of the program is to provide a new type of service for substance abusing families who come into contact with WCFS. These services are intended to reduce the number of children who come into care, the number of days

children spend in Branch care, and the number of families who return for services. These cases relate to children who are abused and/or neglected. An additional component of the project includes engaging with families that abuse substances by providing support and education related to substance use. Increasing support to parents who abuse substances, enhancing workers' knowledge about substance abuse, as well as increasing employee job satisfaction are among some of the goals of the Initiative (see Appendix 1). The SMI team includes two community based early intervention personnel, four family preservation staff, two family support workers, one substance misuse specialist and fourteen intake workers from the Central and North-West Intake units at the Branch. This team of workers' assist families whose children are at risk due to substance misuse issues that result in neglect, abuse, abandonment, and lack of adequate supervision (WCFS, 2002).

Staff working on the SMI received training in the spring of 2003. Training included information on the stages of change, effective interventions, motivational interviewing, and harm reduction techniques. The team is expected to use this information to conduct assessments, to set goals for the family, and to help with treatment for families who accept services. An additional key component of the SMI is to collaborate with community service organizations that support families who are dealing with substance use issues. The North-West and Central intake units can refer families to the auxiliary workers for assistance in dealing with their substance use and parenting situations (WCFS 2003). Goals of this practicum were established by taking into consideration the intent of the Initiative and the design of the program in order to complete an evaluability assessment.

Goals for the Practicum

There was one practicum goal, which was to conduct an EA and produce a useable report for the Branch summarizing this experience. There were two objectives that helped to determine if this goal was met. The first objective was to present an EA of the SMI that conveyed relevant information that could be used in the development of an evaluation plan for the Initiative, also referred to as an evaluation framework. The second objective was to establish relevant evaluation questions for the SMI. The report has been completed and will be presented to a small committee for their feedback on both the helpfulness and any needed revisions prior to the final document being produced.

There were three personal learning goals for the practicum. The first learning goal was to learn how to conduct an EA by taking on the main responsibility for its implementation. My second learning goal was to gain an increased awareness concerning how substance misuse impacts child welfare. Objectives that helped me to achieve these learning goals were: developing skills necessary to conduct an evaluability assessment, working collaboratively with the quality assurance Team at WCFS, and conducting a further literature review of substance misuse. A log of my practicum experience was kept, which I analyzed to conclude if these personal learning goals and objectives were achieved. A third personal learning goal was to evaluate my work as a practitioner. This enabled me to assess whether my educational objectives were achieved. I evaluated my work by using the Utilization Enhancement Checklist (Brown & Braskamp, 1980) (see Appendix 2). This checklist is a tool used to focus my understanding of organizational context, planning and evaluation, evaluation process, and communication (Penrose, 2003).

The evaluation for this practicum addressed both the practicum experience and personal learning goals. It was anticipated that if the above goals and objectives were achieved then the practicum would assist in the completion of my educational goals. In addition, the EA was expected to help WCFS understand what could be effectively implemented in their future evaluation of the SMI. The second chapter of this proposal presents an overview of literature on substance use and evaluation. The third chapter outlines the design of the EA for the Initiative. The fourth chapter reviews the EA that was done on the SMI. The fifth chapter addresses the design and feasibility of further evaluating the program. The sixth chapter assesses how well I met the learning goals of this practicum.

CHAPTER 2

LITERATURE REVIEW

This chapter examines various aspects of substance abuse as well as how the evaluability assessment (EA) for the Substance Misuse Initiative (SMI) at Winnipeg Child and Family Services (WCFS) may be developed. The first section of this chapter reviews the characteristics of substance abuse and further leads to a discussion of the stages of change, the recovery process, and then how substance abuse affects the family. The second part of this chapter focuses on the purpose of doing an EA, followed by a brief explanation of internal evaluation, which touches on both outcome and process styles. The chapter ends with a review of the steps involved in conducting an EA.

Substance Misuse

Nature and Scope of Substance Use

Some of the succeeding data is based on American literature; there is enough similarity between Canada and the United States to apply the following information, at least in a general way, to substance misuse in Canada, and more specifically in Manitoba. Although the precise application of these results remains to be empirically established, it is commonly understood that the problems related to substance misuse in Canada are quite similar to those in the United States.

It is important that child welfare agencies be aware of the effects of drugs and alcohol on parenting so they can protect children accordingly. The literature review begins by exploring traditional views regarding why people use substances. Historically, and what many people still believe, is that substance use is a disease triggered by the frequent and dependent use of a

chemical. While this view has changed the following are some important facts that people have used to describe substance abuse. Several studies note the traditional belief that dependence on drugs or alcohol alters the normal functioning of neurons in the brain (Anonymous, 2003; Arrowhead, 2003; Powledge, 2004). This view says that dependence on a substance is an attempt by the brain to perform as usual but neurons are unable to re-establish homeostasis because they are under control of the chemical. Long-term substance use causes the brain to adapt to the chemical, resulting in dependence on the drug and a demand by the brain for its new homeostasis. The brain thinks it needs to have the drug for its new state of normality, even after the drug use has been terminated. When substance use stops, the individual no longer seeks to be "high" but wants to feel normal according to what their brain sees as the "new normal". Cocaine, methamphetamine (meth), solvents, and alcohol, are some of the drugs frequently used in Canada (Addictions Foundation of Manitoba [AFM], 1998; Arrowhead, 2003; Weir, 2001). Each drug has its own way of affecting the person who uses it and the various drugs affect each person differently.

Work done by Newsletter Council on Drug Abuse [NCDA] (2000) indicated that there is no harmless amount of drugs a person can consume. A common aspect of substance abuse is that the user feels a need to continue using the substance with anxiety and depression being the key triggers for relapse. Anxiety and depression play an important role in times of stress when the individual has to find ways of coping with overwhelming pressures (Madden, Hinton, Holman, Mountjouiris & King, 1995). The authors also stated that cognitive and emotional factors play an important role in the ability of substance users to maintain their sobriety, and that good coping skills are needed to increase a person's likelihood for success in their recovery. What frequently

occurs is that the thought of treatment increases anxiety and depression, which often makes treatment difficult. The aim then is to focus on success with individuals so they are more likely to succeed with recovery.

More modern approaches to understanding substance use say that both genetics and/or the environment are the key factors to understanding this issue (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 2002). One new model that has been adapted by the Addictions Foundation of Manitoba [AFM] (2000), is the biopsychosocial-spiritual model of substance misuse. This more current approach to understanding substance abuse says that this issue is a complex interaction of biological, psychological, social, and spiritual aspects within the person. In this model, substance abuse problems are seen as developing in numerous and differing ways; no one type of person is a substance abuser nor is there one definition for this issue. The biopsychosocial-spiritual model determines that successful treatment relies upon accurate assessments of each service providers' role as well as the family's responsibilities and the impact the drug has on the substance user. Matching the individual with the best and most effective treatment is stressed within this approach (AFM, May 2003). In order to address the issue of substance abuse and its impacts on child maltreatment many different levels of intervention are required (U.S. Department of Health and Human Services [USDHHS], 1999). A more complete outline of the modern views on the issue of substance abuse is provided later on.

The most common substance abused in North America is alcohol (AFM, 2001; NIAAA, 2002). It can take from months to years to affect the person, and may lead to the abuse of other drugs (AFM, 1998; Hassett & White 1989). A person may abuse alcohol without being an alcoholic,

meaning s/he may drink too much and too often but is not dependent on the substance (NIAAA, 2002). According to AFM (April 2003), it is now believed that alcohol abuse can occur because of genetics, but that lifestyle is also a factor. Genetically, someone can be born with preconditions that increase the chances they will abuse alcohol. However, new beliefs involve an appreciation that environmental factors, such as friends who also abuse substances, stress, and the accessibility to alcohol, increase the risks for abusing this substance. Alcoholism cannot be cured because even if an alcoholic has not been drinking for a long period s/he can still suffer a relapse. A harm reduction plan can, however, decrease the negative effects of this sort of substance use.

Individuals from either gender, people from all races, and individuals from any nationality can experience alcohol abuse, with more men than women abusing the substance (NIAAA, 2002). People who abuse alcohol often also have additional problems in their lives. These struggles include not being able to meet work, school, or family responsibilities, drunk driving, and drinking-related medical conditions. As stated by the NIAAA (2002), most alcoholics must avoid all intoxicating beverages to be free of the effects of the drug. Those who do not may be able to control their consumption by reducing their intake to casual use only. For many alcoholics, counseling and/or medication is needed to help them control their use of the substance. When it comes to treatment for alcohol abuse there are varying levels of success. Some people stop drinking and remain sober, others have long periods of sobriety with bouts of relapse, and yet others cannot stop drinking for any length of time. What is important to note is that the longer a person abstains from alcohol the more likely s/he is able to stay sober.

Another popular drug frequently used in Winnipeg is cocaine (Arrowhead, 2003). Its effects appear almost immediately after a single dose and disappear quickly. Taken in small amounts cocaine usually makes the user feel euphoric, energetic, talkative, and mentally alert. The use of cocaine can also temporarily decrease the need for food and sleep. Some users find cocaine helps them perform simple physical and intellectual tasks more quickly while others experience the opposite effect. Certain users of cocaine report feeling restless, irritable, and anxious (Arrowhead, 2003, p.5).

Methamphetamine (meth) is another commonly taken drug in Canada (Anonymous, n.d.). The effects of meth are similar but longer lasting than the effects of cocaine, yet the cost is much lower; thus, it is commonly referred to as the "poor man's cocaine" (Anonymous, n.d.).

A common substance abused by younger people is solvents (Weir, 2001) According to Lien (2002), the abuser may become violent or badly disturbed. Solvent users often act out their problems, overreact, display antisocial behavior, show a lack self care, and panic easily. The high from using solvents lasts longer than both meth and cocaine because they take longer to be excreted from the body. Low cost and the long lasting escape from reality makes solvent abuse appear like a retreat for the abuser (Participants Handbook and Workshop Guide [PHWG], 1992). Of particular concern with the use of solvents as well as cocaine, meth, and alcohol are the changes in behavior that may cause parents to neglect and or abuse their child.

Dore (1998) explained that substance use often leads to poor attachments between parents and their children, which may result in delayed child development. This is a concern in the field of

child welfare. Using alcohol or drugs (AOD) often means parents are unable to attend to their childrens' needs for a structured environment that is necessary for optimal growth. Substance abuse makes parents more easily irritated, impatient, and less likely to feed their child because they are not hungry and fail to appreciate that their child needs nourishment on a regular basis.

Understanding the Stages of Change

As stated earlier, traditional views on substance abuse state that it is a disease triggered by frequent and dependent use of a substance. Substance abuse service providers used to believe that people should abstain from their substance of choice in order to live healthier lives. A new model for approaching and assisting individuals with substance abuse issues was developed from a more contemporary view concerned with helping people change. This new understanding is outlined as six stages of change that support an individual's recovery (Prochaska, Norcross, & Diclemente, 1994).

According to Prochaska et al. (1994), in order for people to move through the stages of change, social service providers should use specific processes or techniques to assist the person in making change. Work done by Prochaska, DiClemente, and Norcross (1992), indicated that not all substance users improve their lives because many drop out of treatment, resist therapy, become defensive, or the worker and client do not relate. Thus, it is important that social service providers deal with substance abuse by understanding what stage of change a person is in and by using the best treatment at each stage. Social workers must also be aware that people do not follow a linear progression through the stages but often relapse and start earlier stages over again. In each stage of recovery the person must accomplish a set of tasks before they can go on

to the next stage. The time spent in each stage varies for each person but dependant substance users, if they are to recover, eventually go through all stages.

A transtheoretical model is used to understand which processes of change are best suited in each stage of change for substance abuse (AFM, April 2003; Prochaska et al., 1992). This view considers a person's readiness to change as well as how shifts in behavior occur. Relapse is a common occurrence with substance abuse so it is not seen as failure but an opportunity to try things differently. Most substance abusers, whether they end their use or not, relapse about four to seven times. The recovery process for substance abuse is long and cyclical so relapse is not seen as a lack of motivation to recover. What is important is the correct matching of treatment interventions to the stage of change the user is in (AFM, April 2003; Prochaska, et al. 1994).

Work done by Prochaska, et al. (1994), described the six stages of change that people go through when going through recovery. The Addictions Foundation of Manitoba has adapted this model in their treatment program for substance abusers. The first stage of change is the pre-contemplative stage where there is no intention on the person's part to change behavior. Prochaska et al. (1994) added that others may think there is a problem but the individual does not. Often when substance abusers go for treatment they do so because of pressure from others and thus are at the highest risk of drop out from programs (AFM, April 2003). People in this stage often feel demoralized and lack information about the consequences their substance abuse has on themselves and others. External forces such as maturation, a sudden event that triggers concern for the person, or pressure from others are needed to help pre-contemplative individuals understand their substance use.

Encouragement and support from family and friends is integral to successful change efforts of pre-contemplative people. As users in this stage become more aware of their substance use, they are more willing to make change to overcome it. The longer they wait to change, the harder it is to do so. It is important not to pressure people in this stage but instead to encourage them to identify the negative impacts of their behavior. The reason for this is because substance abusers in this stage will discuss their use and employ defensive coping strategies to condone why they use the substance (AFM, April, 2003). Individuals within this stage do not respond positively to expressions of concern, avoid learning about their substance abuse, and are often unable to accept the consequences of their behaviors.

The second stage of change is contemplation (Prochaska et al., 1994). In this stage people are aware of their problem and are serious about wanting to overcome it but have not yet made a commitment to take action. The person has received information about their behavior and identifies that they connect with those behaviors. The individual is willing to accept that they have a problem but are ambivalent to change. There is a knowledge in the person about how to change but the individual is not yet willing to do so. In some cases the person can stay in this stage for years before a change occurs because they feel they have a lot to give up. In order to move to the next stage, the individual must start focusing on solutions rather than the problem and think about the future, not the past (Prochaska et al., 1994).

The third stage of change is preparation: in this phase a person combines intention with behavioral aspects to change (Prochaska et al., 1994). The individual intends to take action in the near future but in the past has done so unsuccessfully. These people have made incomplete

changes but are now committed to making bigger changes within the months to follow. For substance abusers, this stage is a constant re-evaluation of the self, a step which is necessary to increase their confidence to change (AFM, April, 2003). The focus at this time is on solutions that prepare the person to handle unexpected challenges as well as prepare them for the first steps of taking action to change.

At the preparation stage there are three major tasks that must be accomplished. The first task is for the person to fully understand why s/he is making changes in his or her life. The second pursuit is to learn how to make life changes. The third requirement is to prepare others for the change that is going to occur in order to build support and understanding from those around the individual. It is very important that people in this stage take the appropriate amount of time to plan how they will change and inform others about it. This can be a threatening time for the individual because the thought of change is frightening. Supports are needed to help the individual learn to deal with change as it occurs even though there is no motivation to change. What becomes important is that the person begins to not only think but also act in order for change to occur. This process eventually moves the person to the action stage of change (Prochaska et al., 1994).

The fourth stage of change is the action stage, which occurs when people modify behavior, experiences, or environment in order to overcome their substance use (Prochaska et al., 1994). This stage shows the most overt changes and receives the most recognition from others. The individual begins to eliminate harmful behaviors and replace them with new ones. Although changes in action are important, as stated earlier, it is equally important that changes in thought

occur as well. Thought changes include altered awareness, emotions, and self-image, which carry on into the next stages. Substance abusers must increase supports and motivation to change, alter their environment, and learn to say no to the substance (AFM, April, 2003). The biggest commitment of time and energy is required in the action stage because it is a period when relapse often occurs due to feelings of being overwhelmed. People in the action stage often feel an increase in self-esteem and belief in themselves. It is very important that sufficient resources and supports are accessible in order for people to get through this time.

In the fifth stage of change, or the maintenance stage, the individual sustains change over a period of time and builds on that change as it occurs (Prochaska et al., 1994). This stage is characterized by the achievement of goals which then become a permanent part of the person's life. It is important that people in this stage learn new coping skills that they can use in the long term. One new skill is to build self-efficacy, which involves learning new ways to handle ongoing temptations. Dedication and recognition are additional skills that prevent old behaviors from reoccurring. This is especially true during stressful times when feelings of loss and longing occur (AFM, April 2003).

In the maintenance stage of change the person works towards preventing relapse and recognizes the gains that have resulted from ending their chemical use. The person has stopped their use all together, for at least six months, but can still revert back because of a spiral effect, which occurs when the person goes back to earlier stages and has to restart treatment (Prochaska et al., 1994).

The sixth and final stage of change is called the termination stage (Prochaska et al., 1994). At this time the person no longer needs to attend to the tasks in the maintenance stage. This is the ultimate stage for people who are trying to improve their lives. Former substance abuse is no longer a temptation or a threat to past behaviors returning (AFM, April, 2003). The person has the knowledge and confidence to cope so they do not revert to previous substance use. While not all people reach this stage, those that do possess new behaviors, attitudes, and lifestyles which are permanent and comfortable parts of their life (Prochaska et al., 1994).

The transtheoretical model provides some direction for professionals to utilize when working with substance abusers. First, professionals need to be aware that it is easy to put substance abusers in the action phase before they are ready: most people are not in this stage at the onset of treatment and are thus not ready for action. As stated above, people in earlier stages of change need different kinds of treatment in order to get to the action phase. Second, social workers must remember that in order to facilitate change in any person these people need helping relationships, consciousness raising, and self-liberation at the right time (AFM, April 2003). Thus, the transtheoretical model relates to the use of a harm reduction plan, which is described in detail later on, because it helps service providers to accurately assess each individual family's case and provide appropriate services.

By understanding what stage of change a person is in it is then important to know which processes of change work best for each stage in order to help the person progress to the next stage. Processes of change are techniques such as consciousness raising, self-reevaluation, self-liberation, counter-conditioning, stimulus control, reinforcement management, helping

relationships, dramatic relief, environmental reevaluation, motivation, countering, and social liberation. Together the stages and processes of change, when balanced, help predict who will be successful and complete their treatment through to recovery (Prochaska et al., 1992).

Social service personnel need to use the appropriate processes of change in each stage of change. When someone is in the pre-contemplative stage of change it is good practice to use consciousness raising, dramatic relief, reward, self-reevaluation, helping relationships, and environmental reevaluation. In the contemplative stage of change helping professionals should focus on these same processes but to a greater extent than in the pre-contemplative stage. In the preparation stage the most helpful processes include motivation, environmental control, countering, social liberation, and helping relationships. When a person is in the action stage of change the best processes to use are motivation, countering, environmental control, reward, helping relationships, and social liberation. In the maintenance stage the best processes to use are motivation, countering, environmental control, and helping relationships. In the termination stage all the above processes can help individuals abstain from their substance use (AFM, April 2003).

In each of the stages of change there are recommendations that will help substance abusers increase their motivation to change. In the pre-contemplative stage clients should be educated about their substance abuse. Questions can be asked to see if the individual has thought about their use. It is also good practice to advise the person of legal actions that may occur in relation to their use and the impacts such use may have on their life. In the contemplative stage helping professionals should discuss how the person will make changes. At this time it is a good idea to ask the person to cut down on intake and write a list of things they feel could help them change.

Practitioners should advise people to find someone who can assist them in making change. This person should be someone who is also aware of the change list, and can help with success of recovery. At the action stage clients can negotiate a goal for change they will adhere to until the next visit. At each consecutive meeting the practitioners should address how well goals are being met and congratulate the person on any changes that are made. If change is not made the worker should express concern and help identify new ways to achieve goals (AFM, May, 2003; Mattaini, 1997).

Current Treatment and Recovery Strategies

In a document written by USDHHS (1999), the report stated that there are no easy answers to working with families who are dealing with substance abuse issues. These authors say that flexibility and comprehensiveness are key skills to have when assisting families where substance abuse is an issue. Workers in the field of child welfare and substance abuse should be skilled and knowledgeable about the current approaches that are being implemented to help families with substance abuse issues (USDHHS, 1999). While it may not always be easy to incorporate the new methods in the field of child welfare, attempts to do so could provide a more family-centered service (Hampton, Senatore, & Gullotta, 1998).

The harm reduction plan is an alternative to the traditional ways of dealing with substance use. This model shifts the focus from the drug use to its consequences or effects. In this model the effects of substance use are evaluated to determine if they are harmful or helpful to the drug user and their community without focusing on whether the behavior is ethically right or wrong. A wide range of policies and procedures are designed to reduce the harmful effects of the substance

use (AFM, May 2003; Hassett et al., 1989; Marlatt, 1996; Rothschild, 1998). The emphasis of the harm reduction model is on reduction and/or elimination of the drug. If necessary, the substance abuser can attend a treatment program when s/he is ready to deal with his/her substance abuse issues.

Research shows that the harm reduction method is very effective in assisting families with substance abuse issues (Rothschild, 1998); what must come first in the field of child welfare is the well-being of the child/ren. Guiding legislation and principles state that parental needs come second to the well-being of children. It is important for workers to recognize that substance use alone does not constitute child abuse or neglect, and that accurate assessments are needed to determine whether or not a child is at risk. Child protection and substance abuse services workers should adopt an integrated approach to case management in order to reduce the impact of the parent's substance use while simultaneously ensuring the safety of the children.

Work written on the harm reduction approach indicated that the model is quickly becoming the preferred choice for the treatment of individuals with substance abuse issues (Marlatt, 1996; Rothschild, 1998). The authors defined harm reduction as "the application of methods designed to reduce the harm (and risk of harm) associated with ongoing or active addictive behaviors" (Marlatt, Somers, & Tapert, 1995, p. 147). A harm reduction plan is developed with strategies which will signal the parent when s/he is feeling the triggers to consume substances as well as outlining ways to minimize use. Boundaries are set so parents can deal with treatment as well as ensure their child's safety. As a part of the agreement, the parent will notify the counselor if s/he breaks the agreement (MCFD, 2001). Marlatt (1996) added that the model sets out principles and

procedures to reduce harms caused by substance misuse, and that services should match the individual's needs.

Rothschild (1998) has stated that it is good practice to begin treatment by looking at the individual to understand why they use a particular drug. The focus is on the person and how the substance serves them. The psychological state of the user is considered and respected because of the belief that the substance is needed to help the person get through the day. The role of the practitioner is to help the person see both positive and negative effects that arise from substance use. It is important that clients feel safe and comfortable during their treatment; thus, a practitioner must help substance users deal with their fears and help them to overcome them.

According to AFM (May, 2003), it is good practice for helping professionals to establish a rapport with families that have substance misuse issues by engaging in discussion with them about their history of use, current use, as well as any concerns they have about their use over the past year. The practitioner should ask questions and explore the client's responses in order to clarify concerns the client may have. Once all the data is collected and understood it is time to advise clients about their substance use. This can be done while expressing care and concern using specific data about behaviors and their consequences while gently describing changes that can be accomplished. It is important that helping professionals let their clients have a chance to respond to what is being said and ask questions about what they have heard. Suggestions can then be offered to clients such as reducing intake, safer practices for use, abstinence, self-monitoring of use, and referral for further assessment. Families can be connected to outreach programs for external connections that provide advice on ways clients can reduce harm and

avoid the stigma associated with use. These programs offer information and advice on the harms of various drugs as well as ways to stay safe from violence, aggression, sexual disease, and assault (Marlatt et al., 1995; Marlatt, 1996; Rothschild, 1998).

A harm reduction agreement can be used as a three party agreement that provides a guide to share necessary data for the parent, caseworker, and substance misuse counselor. This agreement sets out the importance of safety and well-being of children and establishes a framework for collaboration, integrated planning, and service delivery for the family. The agreement also opens up a line of communication for sharing data, clarifying mandates, establishes roles and responsibilities, and setting realistic limitations (AFM, May 2003; Marlatt et al., 1995; MCFD, 2001).

Another important factor in the harm reduction approach is recognizing that while abstinence would be the ideal situation, any alternatives that reduce harm are positive. An insistence solely on abstinence will likely result in high rates of recidivism and may discourage people from continuing their efforts to change their behavior (AFM, May 2003; Marlatt, 1996; Marlatt et al., 1995). The harm reduction approach does not insist on abstinence but instead uses a step down approach to reduce negative consequences of the behavior. The approach uses a "bottom up" tactic where the individual acts as his or her own advocate along with those directly involved in assisting in the recovery. Some steps to recovery include looking at the intake of the substance and establishing how to change environments so cravings are less prominent (Mattaini, 1997).

Motivational interviewing is also a key element in assisting persons with substance abuse issues. According to Ryan, Plant and O'Malley (1995), motivation is considered a critical component in a person's readiness to receive assistance in order to change their behavior. Motivation is a great asset in treating substance abuse because without it, relapse and other negative treatment outcomes may occur. There are two types of motivation for change: internal and external. When an individual has internal motivation to change they have a greater confidence in their treatment and in their ability to seek help from others. When people are externally motivated the outcomes from treatment are heightened; external motivation may come from courts or family pressure. When linked with internal motivation, the person does much better dealing with and overcoming their substance use. The greater the substance abuse, the greater the internal motivation needed to overcome it. In some cases it may be necessary for people to experience emotional distress and/or life or psychiatric problems before they are motivated enough to follow through with treatment.

Motivational interviewing is used as a way to motivate unmotivated people to change and receive treatment. Mattaini (1997) and Miller (1996) have discussed ways to use motivational interviewing. These authors indicated that it is important for practitioners to build a positive rapport with individuals by establishing concern in a non-punitive manner. Miller (1996) noted that when a helping professional uses a confrontational form of therapy, substance abusers have more setbacks and lack motivation to change. Practitioners should be aware of and avoid being judgmental and, thus, provide effective assistance to help people increase their motivation to change (AFM May, 2003). Supportive help can involve the service provider asking what the person thinks about changing their behaviors, if they are ready for change, how they feel about

their use, and if they want further assistance in dealing with their substance use. The practitioner should arrange a follow-up consultation in order to show continued support of clients.

The second task in motivating people is to express concern about the substance abuse in a non-threatening way with minimal confrontation. This is congruent with the harm reduction approach. Practitioners start by discussing general areas of concern that link to the substance use. This discussion can start by asking open-ended questions which then coax the client to think about and explore their substance use with the counselor. It is also important that the counselor ask questions with sincerity and let the client know s/he is the expert in their life. Practitioners can then elaborate on connections that come out of the conversation. Once the information is clearly known the worker can show concern and help the client decide how they will improve their life. This should be handled in a problem-solving manner, without confrontation, so the client feels s/he has control and understanding from the worker (Mattaini, 1997; Miller, 1996).

Helping professionals should be conscious of the physical and medical factors associated with quitting substance use. Withdrawal and tolerance are important medical conditions that clients must be aware of when overcoming their substance use. Withdrawal can often be life-threatening and must be addressed in a way that ensures the client's personal safety. Environmental factors, such as going to bars or peer pressure, can trigger people to use alcohol or drugs. Substance abusers must find ways to deal with these triggers and learn to say no to them in order to avoid having a relapse. This is important because when, or if, the individual has a relapse s/he may feel depressed and build on their negative thoughts. As a result, practitioners should be aware of the pressures that substance abusers experience so they can help these individuals build self-efficacy

and focus on the positive situations that increase motivation. The underlying notion is that people who abuse substances need to want to change before they can. People need to be ready for change and learn to be comfortable with detachment because this is what they are going to experience in their recovery. Substance abusers need to know they are not to blame for their use and that others have no control over the factors that lead to substance use (AFM, May 2003; Mattaini, 1997).

Research done by Miller (1996) and Isenhart (1995) suggested that in order to initiate behavior change clients must overcome their ambivalence to change. It is good practice for social service personnel to provide feedback to clients about their AOD use as well as provide information on the effects of substance use. The person must take responsibility for change emphasizing that their decision to change is one that they alone control and no one else can make for them. Advice is given on how to make change including a variety of different ways that change can be accomplished. Empathy tends to help the person in their decisions to change. Additionally, brief interventions can strengthen a person's self-efficacy for change. Practitioners should reinforce keeping an optimistic attitude as well as the ability of the person to succeed in their recovery. Many substance abusers benefit from participating in a drug rehabilitation program where they receive education, guidance, and support. Programs like Alcoholics Anonymous, Narcotics Anonymous, or Cocaine Anonymous, as well as treatment facilities, can offer these services, but it is important is that the individual openly acknowledges their substance use. A recovery plan for relapse should be developed by the social worker and client, including safeguards for dealing with and coping with pressures encountered in the recovery process. The plan should include ideas on where to live, as well as thoughts on how to build a new network of friends. In work

done by Hohmans & Butt (2001); Peterson, Gable & Saldana (1996) it is noted that many substance abusers will have to move away from their neighborhood and friends in order to stay away from their substance use; this is often a big part of efforts to avoid relapse.

An additional way to assist parents who misuse substances is by concentrating on their parenting skills. Workers can teach them how to enforce effective discipline, how to reinforce positive behaviors, and educate them on child development (Peterson et al, 1996). One thing to watch for in substance abusing parents is depression, which can get in the way of their abilities to effectively parent. Female substance abusers often do not see that their use affects family functioning. Thus, in initial assessments, it is important that workers examine not only the present substance abuse but also the history of the use and how it has affected the family.

Once a person is motivated they are more likely to be ready for change and recovery (Isenhart, 1995). There are four stages in the developmental model of recovery: substance use, transition, early recovery, and ongoing recovery (Hohmans et al., 2001). The substance use stage is marked by the intake of the substance along with an increase in loss of control after each consumption. At some point, the person comes to realize their loss of control and develops a sense of despair. The transition stage of recovery is the beginning of abstinence which is driven by both external forces such as court orders as well as internal desires to change lifestyle habits. At this time the person is shifting in and out of a realization that their substance use is out of control, which can possibly be regained. For example, the person may turn back to substance use if s/he feels their use is under control.

Research done by Hohmans et al. (2001), showed that early recovery stages are marked by abstinence and the awareness of being a substance abuser. The person is integrated back into the community, family, or work. Clients in this stage have finished treatment but should continue to attend programs in order to create an environment of continued support towards maintaining abstinence. The environment must support early recovery so substance users can begin the process of reinterpreting who they are. The ongoing recovery stage is characterized by the identification of long-term problems and individuation. Healthy relationships and internalized attitudes and behaviors that support the recovery process are important. However, relapses can occur in the recovery stages because of such things as depression, denial of the substance abuse, unsupportive environment, isolation, poor eating and sleeping habits, and irritation or annoyance.

In relation to child welfare, a vast majority of families involved in the system are headed by low-income single mothers (Azzi-Lessing, & Olsen, 1996 and Hampton et al., 1998). Many women who abuse substances are low-income and also may be dealing with other issues, such as violence and depression (Prasanna, Schuler, Black, Kettinger, & Harrington, 2003; Poole & Isaac, 2001). Further concerns are raised with the knowledge that lower income families are twice as likely as higher income families to have drinking problems (Single, et al., 1999). There are areas that workers can focus on when dealing with mothers that have substance abuse issues, which are presented as components that impact parenting. Hohmans et al. (2001) discussed three components in the recovery process that impact parenting behaviors for mothers with substance misuse issues. The first component is for the mother to accept the ongoing role of AOD in her situation. The second aspect is for the parent to adjust to the environmental changes of abstinence. The third element is for the mother to gain self knowledge and understand that

substance use takes over an individual's life even after it is no longer present. During abstinence from drugs and alcohol, the user needs to be reminded of the changes that have occurred in their life. They must overcome and deal with the environmental changes that must be sustained to remain alcohol or drug free and learn to cope, accept and not judge their internal reactions to change and their new identity that may have developed during this change.

Substance Misuse and its Impact on Child Welfare

Many families who come to the attention of the child welfare system are abusing substances (Dore, 1998). The effects of substance abuse in the postnatal environment are damaging to child development (Hampton et al., 1998). Child neglect has been documented extensively among drug using families (Trocme et al., 2001; Wasserman & Leventhal, 1991). Individuals most frequently affected by AOD abuse are parents in their mid-twenties with two or more children in the home (Jones and McCullough, 1992). Children whose mothers are substance abusers may experience a high proportion of emotional and physical neglect because of their mothers' unavailability (Hampton et al., 1998). Children of substance abusing mothers often live in chaotic environments, characterized by frequent moves, minimal contact with fathers, increased foster care placements, fewer concrete resources, and a lower income (Hawley, Halle, Drasin, & Thomas, 1995). For those children who do enter care a lot of the child welfare resources are spent on them to adequately care for these children (Hampton et al., 1998).

According to Wegscheider-Cruse (1988), any type of drug use can cause family members to fall into various "coping roles" that are more rigidly fixed than in families without substance abuse issues. One of these roles taken on by a child of a substance abuser is the "family hero". This is

an adult role taken on by the child. The task for this person is to provide self-worth, hope, pride, and success to the family. A child assumes this role because of his or her parent's inability to be emotionally available to the children. The "family hero" will observe what is going on in the home and begin to feel that the situation is his or her fault. This child attempts to make things better for the family and works diligently to change their home situation.

In addition to parental substance abuse impacting on roles and relationships within the family as described above, it also impacts parenting skills, and in turn the well-being of children in the family. Substance users are often unable to put their child's needs first and provide them with a safe and healthy home. Many parents who abuse substances are unable to consistently carry out every day parental duties, provide a stable home environment, and lack the ability to meet their own personal needs. The impacts on the children can be extensive ranging from parental behaviors that put children at risk, lack of supervision, lack of adequate food, poor clothing and shelter, inadequate health care, increased family violence, and prenatal harm. These impacts may result in poor school performance, unhealthy peer relations, increased involvement in physical, emotional and sexual abuse, as well as insecurity because of the unstable environment at home (MCFD, 2001).

As stated above, children are adversely affected by their parent's substance use. In a study conducted by Califano (1999), the author stated that human costs due to substance use are endless, with children under the age of five being most at risk. (Banks et al., 2003; Califano 1999).

Due to the denial inherent in substance abuse, parents are often very skilled at hiding their AOD use and may lack motivation, resources, or the capacity to end their use. Other reasons why some parents do not seek treatment include the fear of losing their children if they disclosed the extent of their AOD use, or the necessity to enter residential treatment. These are just a few of the factors that contribute to parents not seeking treatment. Even when parents do enter treatment, the recovery process is often slow and may not progress at a rate that is in keeping with the immediate needs of the child for a safe, stable, consistent environment. The result is that children from substance abusing parents often enter foster care and tend to stay for longer periods of time than other families that receive help from child welfare agencies (Banks et al., 2003; Peterson et al., 1996).

Families that experience parental substance abuse face many challenges, in particular the impact of substance abuse on the development of a healthy parent-child relationship. For example, according to Hohmans et al. (2001), some substance abusing mothers do not have a good understanding of their child's development and may expect too much from their child. The potential to develop a healthy attachment between mother and child may be compromised as a result of the substance abuse, which for many may stem from a history of poor attachment with their own parents. Even parents who are in recovery face many challenges with respect to parenting and meeting the needs of their children. A mother may have feelings of grief over poor parenting and other past negative behaviors they displayed while they were using chemicals. Mothers may notice their child's misbehavior for the first time and realize that it stems from neglect endured while she was under the influence of the alcohol or drugs. Mothers may also feel they have to make up for lost time and want to be the best parent they can, while their children

continue to react negatively and not listen. This response from the child often leaves mothers feeling inadequate, which can increase the risk of relapse. In some cases, normal development of children is seen as a threat to mothers, and may also cause relapse. Thus, in the recovery process, attention to parenting issues through individual or group counselling is necessary for many mothers to increase their success in recovery.

Many women who experiencing substance abuse face other challenges including being a lone parent, poverty, domestic violence, childhood history of abuse, social isolation, poor housing, etc (Trocme et al., 2001). According to Hohmans et al. (2001), women with a low income are more prone to experiencing difficulty with recovery from substance abuse than their male counterparts. It has been suggested that reasons for this are related to some additional issues that are more prevalent with women such as limited vocational skills, histories of sexual abuse, and few social supports. In addition, substance abusing women are frequently in relationships with men that misuse substances, leading to less-supportive associations. Previous issues that alcohol or drug users often experienced include physical or sexual abuse as children. Thus, substance abuse occurs as a way for people to cope with the trauma of their childhood. Substance abusers are often isolated, engage with other AOD users, and become involved in violent relationships with substance abusing partners (Dore, 1998).

Treatment for substance abuse is often geared towards men and may not give as much weight to parenting issues and relationship issues that are of key importance to many women. Therefore, special services for substance abusing women are necessary in order to help them not only deal with their AOD use, but also to help them with parenting issues and past experiences.

As stated by Peterson et al. (1996), the number of women who are using alcohol and drugs has grown over the years. Women with serious substance abuse issues often lose custody of their children, with some mothers choosing to relinquish their parental rights to family members or friends. The concern is that the unique needs of substance abusing mothers are not being met, which leaves their children at continued risk of harm and of entering the child welfare system. To add to this issue, Linares (1998) noted that recovery for substance abuse is slow. It is hard for child welfare agencies and substance abuse treatment providers to jointly meet the needs of children and their parents. Linares (1998) emphasized that children require a healthy permanent home, while at the same time their parents need long term treatment necessary for complete recovery. Training child welfare staff on the current approaches to substance abuse can lead to the necessary parental changes that ensure the safety of the children. The issue remains that the policies of child welfare focus on permanency and ensuring the safety of the children. Both these systems face the reality of potentially incompatible "time lines" between the immediate needs of the child for safety and stability and the long term treatment/recovery needs of the parent.

As stated above, over the past decade many children who come to the attention of child welfare agencies are from single parent homes where the mother has a substance abuse issue. According to Jones et al. (1992), in America, over 3 million women are in need of AOD related treatment each year. The authors go on to say that many children who are apprehended were likely removed because of neglect brought on by parental substance use. This demonstrates the strong relationship between parental substance use and child maltreatment.

Many negative outcomes follow for children who reside with substance abusing parents. As indicated by Jones et al. (1992), quite often the necessary money, time, and emotional investments for healthy child development is not provided from substance using parents because finances and energy are focused on obtaining drugs or alcohol. Parental attention, guidance, and discipline of children in families with substance abuse issues are seldom consistent because memory and the perception of a child's needs are affected by the AOD use. Children in families where substance abuse is an issue are more inclined to have impaired abilities to problem solve, to cope with stress, to communicate effectively, to consistently apply good standards, and to take responsibility for doing small tasks. These children have difficulty interacting with and supporting others. According to Kovalesky (2001), a role reversal may occur resulting in children looking after their parents. The child becomes concerned about his or her parent's behavior and tells him/her their actions are not safe.

Substance use by parents can affect the physical, emotional, and developmental needs of children. Trocme et al. (2001) noted that in 44% of child investigations at least one child functioning issue was documented by the child welfare worker. Maltreatment occurred in 48% of the cases involving physical, emotional, and cognitive issues. To further this, the study also revealed that almost half of the cases substantiated children with behavioral problems. Guber, Fleetwood, & Herring (2001) stated that children from homes where their parents abuse substances are more prone to hyperactivity and conduct disorder, to drug and alcohol use, to clinical levels of anxiety and depression, to low levels of self esteem, and to a perceived lack of environmental control. Exposure to drugs often means children experience violence, sexual assault, neglect, and abandonment. An end result is that children's trust of and attachment to

their parent suffers. Jones et al. (1992), indicated that adolescent boys and girls who grow up in a family with substance abuse issues frequently drop out of school and become parents at a young age leaving these children economically disadvantaged when they are older.

It is important to acknowledge that in the long term children who are exposed to parental AOD use are often significantly harmed developmentally. These children need, more then ever, to feel a sense of trust and attachment with a primary caregiver in order for them to develop to their fullest potential. Services for substance abusing families should center on the child's need for a safe, secure, and predictable environment including a stable, loving, consistent, and interactive caregiver so that the children can develop adequately (Jones et al., 1992).

Trocme et al. (2001) stated in their research that 34% of families who come to the attention of the child welfare system, in Canada, have substance abuse issues with 29% of those families lacking the social supports needed to improve their lives. Guber et al. (2001) outlined parenting difficulties that are often found among substance using individuals. These problems range from poor family-management skills, loss of parental control, low frustration tolerance, unrealistic expectations of children, and poor family boundaries. Besinger, Garland, Litrownik, and Landover (1999) explained that parents with substance abuse issues often do not follow through with orders for screening or evaluation of their substance use. The authors also noted that parents who use AOD often have higher stress levels in relation to their parenting and often use more punitive discipline with their children.

In a study done by Sun (2000), the author reported that many mothers who abuse substances have dreams of living a better life. These individuals often care about how people in their lives view them and long for a peaceful life. The author also said that these women do not want their children to remember them using the drugs or how they acted when taking them. In the study, it was discovered that many substance abusing mothers want to get an education and find a good job so they can become financially independent. It was suggested that the child welfare system take the opportunity of crisis that results from the substance abuse and use it as an opportunity for intervention. Child welfare workers can work with the entire family and take the time to help these mothers restart their lives. Non-judgmental and non-authoritative attitudes are known to assist these women. Workers can help these mothers to recognize and achieve their goals. Case management and planning should incorporate feasible goals and future plans that the mother can achieve.

In order to meet the needs of the entire family it is imperative that the child welfare system provide the entire family with services (Azzi-Lessing et al., 1996). Children should be kept safe, while at the same time, parents should be provided with the necessary assistance to recover from their substance use. The field of substance abuse and child welfare should link services in a comprehensive and well-coordinated manner. The authors stated that child welfare and substance abuse treatment providers should cooperatively work together by broadening and improving their communication with each other. Azzi-Lessing et al. (1996) further said that all staff from both child welfare and substance abuse treatment facilities should be trained on one anothers' systems. Families should receive empowerment-based services to help them deal with their

issues. Culturally-competent service delivery is also considered an important practice in the treatment of substance abusing families.

Services for Substance Using Families

Without proper services and care children from substance abusing families often develop more adjustment problems than other children. These struggles for the children include behavioral problems, as well conduct disorders, and attention deficit disorders. On addition, children from substance abusing families often function less well than other children (Semidar, Feig-Randal, & Nolan, 2001). Dealing with substance abuse requires a variety of levels of intervention: there is no one way to help a family. The key is to be flexible and knowledgeable about substance use and how it affects the family (USDHHS, 1999). Substance using parents need help coping with change, developing empowerment skills, confronting the reality of their situation, and require assistance finding a new place to practice the behaviors they are developing (Kovalesky, 2001).

Many substance-using parents are faced with hard choices in the management of their family and recovery. Supports are needed in order for parents to transition back to family involvement and their parenting responsibilities (Gregoire & Schultz, 2001). Parents need help re-establishing their role in the family, assistance in developing supports for the recovery process, as well as education and skills to be effective parents and to avoid AOD use (Guber et al., 2001). Thus, early detection and intervention is important and relevant to the healthy development of the children and recovery for the parents' (Jones et al., 1992).

Curtis and McCullough (1993) reviewed data on various programs that aim to prevent or treat substance use. They found that all too often child welfare workers are not adequately trained to deal with issues related to substance abuse. According to Kovalesky (2001), the issue of AOD use is complicated and requires a lengthy service in order for the problem to be overcome. Effective collaboration between child welfare workers and community substance abuse agencies is necessary to enhance and increase services. Besinger et al. (1999) have added that a holistic approach to service with specialized programs to intervene and educate parents on the effects of their substance use is essential.

As said by Hampton et al. (1998), substance abuse treatment providers and child protection workers both work with substance abusing parents but these two disciplines approach them differently. Often misunderstanding and mutual distrust between these professional organizations prevents collaborative working relations. This conflict arises because of the general nature behind substance abuse; thus, child welfare workers need to learn more about substance abuse in order to provide more effective services. Conversely, substance abuse treatment service providers need to better understand the child welfare system. By doing this the two agencies can attempt to collaborate and better serve families (Hampton et al., 1998).

As stated by Hampton et al. (1998), the difference between the child welfare and substance abuse treatment providers relates to whom each organization serves. For the child welfare agency, the child at risk is the primary client and the parent's needs are secondary. In the field of substance abuse, the substance abusing individual is the principal client, and any children living with that person then enter into decisions about what services could be offered. Child welfare and

substance abuse treatment service providers have different goals for their clients. AOD facilities are concerned with reducing substance use. Child welfare agencies focus on ensuring the safety of the children. In the child welfare system, it can be difficult to consider permanently placing a child in a home where the recovery process from substance abuse is long and involves frequent relapse. Substance abuse treatment providers often find it difficult to collaborate with the child welfare system because contacting them may jeopardize any trust that is being built with their client. Confidentiality is always an issue because of strict standards the government has set around privacy and the release of information. Different agency goals and expectations for clients, the gender and age of the person, the number of social supports, and adequate housing also impact the recovery process for substance abusers (McAlpine, Courts-Marchal, & Doran, 2001). Hampton et al. (1998) have noted that these issues make it a challenge for child welfare agencies and substance abuse treatment facilities to build collaboration, which is beneficial to assisting families dealing with substance abuse issues.

Services for substance misusing families should address the parent's ability to appropriately perceive, understand, and respond to the needs of their children (Jones et al., 1992). Parent and peer support groups should be available and made aware of to these families. The service provider should attempt to restore stability and promote optimal development and health for the entire family. The program should be realistic about the abilities of the family, should work with all family members, and have consistent funding. A focus on preservation and the inclusion of family support workers as well as empowering community mentors should be components of the program in order for successful outcomes for families. Professionals within programs that work

with substance abusing families should be aware of and address the issues of poverty, alienation, and loneliness in order to fully assist the family.

Principles that apply to child protection cases involving parental substance abuse were outlined in a document written for a Canadian program that was developed to work with substance abusing families (Ministry of Children and Family Development [MCFD], (2001). This report explained, along with some of the services other documents noted, that accurate assessments of the impact of a parent's substance abuse requires the use of a holistic approach to service. The holistic approach takes into consideration the biological, psychological, social, and spiritual aspects of the parent's substance use. As well, integrated case management between the child protection and substance abuse service workers should be conducted for a more complete risk assessment, plan for treatment, and development of a risk reduction plan.

Workers should be knowledgeable of the effects of AOD use and understand the patterns of use and recovery. Thus, services in programs for substance abusers should include help for parents to deal with factors related to potential histories of sexual or physical abuse and assistance in the development of stronger parenting skills (Jones et al., 1992). Motivating and building skills for parents are necessary processes in the service delivery to AOD users. Workers should advocate for families to enhance their chances of getting the help they need. Also important is the need for culturally-competent, accurate assessments.

According to Jones et al. (1992), understanding the nature of the chemical involvement, duration and frequency of use, as well as the presence of underlying issues in the home are imperative. In

addition, these workers should be aware of a parent's level of motivation to change, the family support system, the availability of treatment services, and an understanding of the family issues that impact recovery. Workers should assess the level of attachment between parents and their children, the level of commitment from parents to care for their children, as well as assess family strengths that may promote a healthy lifestyle. Unstructured daily routines, missed appointments, and bizarre behaviors are characteristics of substance abusers that workers should be conscious of when determining the family needs. The assessment must take into consideration the best interests of the children above all else. Furthermore, work with the family should shift from dealing only with the parent to an inclusion of significant others (Gregoire et al., 2001).

Guber et al. (2001) noted that family therapy tends to motivate substance users to enter treatment. The authors also said it is important to have family involvement in the recovery process. Families that are involved in recovery are more likely to be supportive and less likely to sabotage healing. A supportive family will also encourage the user to seek out support from self-help groups and recognize factors that may interfere with recovery. Involving family in the recovery process is helpful because the whole family can learn about substance use and its effects on the user. Family involvement can also play a role in preventing relapse because when all members are aware of the relapse warning signs, they can support efforts to remain abstinent, and help the individual achieve some control over the recovery process.

Participation in the recovery of substance use can give the family an opportunity to heal from any pains they may feel as a result of the individual's history of AOD use. For the children, exposure to developmental child care services greatly improves their development. In addition,

parents who enroll their children in a child care program are three times more likely to finish their substance misuse treatment then those who do not (Dore & Doris, 1998).

Jones et al. (1992) argued that services should include transportation to programs, assistance in finding child care, respite care, the provision of in-home services, and help for families to make connections to parenting programs. Families should be assisted in connecting with long-term community resources that will enable them to continue their recovery process. Recommendations for an AOD program should include cross-system case planning and management teams, common substance abuse screening and assessment protocols, comprehensive risk assessment instruments, and good data collection methods.

Dore et al. (1998) noted that the emphasis in many child welfare agencies today focuses on family preservation versus placement. The authors said that because more children are staying in their homes, it is important that families receive education on substance use, assistance getting mental health services, parent skill training, outreach services, after-care services, counseling, family planning information, data on health and nutrition, and developmental follow-up for the children. Additional services should include aiding the families to find adequate housing, assisting parents in attaining job training, helping parents to get set up to achieve an education, and/or assisting parents to find adequate income supports.

A relapse prevention plan is needed to sustain the recovery process (Guber et al., 2001). Staff need to focus on the enhancement of the children's well-being, the conduction of accurate assessments, and the provision of assistance in order to get families through their transition

(Kovalesky, 2001). Programs should help substance-using parents recover from their use, provide assistance to deal with negative life experiences, and educate parents on how to provide a safe home for their children. Substance abuse recovery is difficult because of the need to alter the environment and the small amount of resources available to help in such a change (Dore et al., 1998). As stated earlier, sobriety requires a lot of support and resources; a goal of the parents should be to gain increasing levels of responsibility in order to deal with their problems for a substance free life. The benefits of a relapse prevention program are many (Guber et al., 2001). Child welfare agencies can get into homes and directly observe how families live and how substance use affects the children. Additionally, the services offered to the family can help them improve their home situation while attending to the individual family's needs.

As the Branch plans to evaluate the SMI the literature review now turns to a discussion of the role of evaluation in human service organizations. There is some focus on process and outcome evaluations with more emphasis on evaluability assessment. As well, the following literature addresses the utilization of evaluation research, as well as aspects of internal evaluations and data collection.

Program Evaluation

Process and Outcome Evaluations

Process and outcome evaluations are common types of program evaluations, and the type of evaluation an organization uses depends on what that organization wants to learn (Rossi, Freeman, & Lipsey, 1999). A process evaluation is a form of evaluation that focuses on a program's approach to client service delivery as well as how management handles day-to-day

operations. The focus in a process evaluation is on how services are delivered to clients and what administrative mechanisms exist within the program to support these services. Process evaluations can occur before, during, or after outcome evaluations. More specifically, a process evaluation looks at the activities and characteristics that describe how a program operates. Client service delivery and administrative support systems used to sustain the service delivery are the focus of the research in a process evaluation. Monitoring and measuring communication flow, decision-making protocols, staff workload, client records, supports, training, and worker-client activities may be addressed in process evaluations. Thus, there is a careful examination of how things are done in order to gain an understanding of why or how it is effective. The intent is ultimately to improve service delivery for clients by identifying changes that can enhance a program's effectiveness (Unrau, Gabor, & Grinnell, 2001).

Outcome evaluation focuses on which program outcomes are being achieved. The goal for outcome evaluation is to demonstrate the degree and nature of change for clients after they receive services from an agency. In order to achieve what is expected for clients, an outline of how the program is to be implemented should be available. This outline also helps keep administrators and workers focused on the program's mandate and the anticipated outcomes. The reason for using an outcome evaluation is to see if the program's services are benefiting the clients being served. Results from outcome evaluations reveal whether or not specific program objectives are being achieved. The results of outcome evaluations are explicit to the target population that used a specific program, over a particular time frame, at a precise time. The results determine if a program is working, although they do not determine why it is working.

Additionally, the results of outcome evaluations show measures of success, and demonstrate the relative effectiveness of a program (Unrau et al., 2001).

Overview of Evaluability Assessment

Given the decision by WCFS to provide specialized services to parents with substance abuse issues it is important to ensure that the program is being delivered as intended. The stated intent is to conduct an evaluation of the Initiative before the pilot project has been completed (WCFS, 2003). As the focus of this practicum is on evaluability assessment (EA) I focus my literature review here on this topic.

Work on EA written by Unrau et al. (2001) indicated that this type of evaluation is used to determine a program's readiness for evaluation as well as how successfully findings can be achieved from the evaluation. Rutman (1984) noted that the key question to answer when doing an EA is the extent to which the purpose of the intended evaluation will be met given the program's characteristics, available research methodology, costs, as well as constraints on the desired research methods.

In an article on EA written by Rutman (1984), the author gave two reasons for doing this type of evaluation: to determine the program's structure and to examine the feasibility of implementing certain methodology for the evaluation. The EA establishes how well the program is defined before it is evaluated. This description of how the program is being implemented is used as a prelude for decisions about the details of the intended evaluation. Failure to recognize problems of program implementation can result in an evaluation that tests the effectiveness of the program

but cannot determine if an unfavorable finding is the result of poor implementation or a true lack of effectiveness. An EA then, examines whether or not there are problems in program design and delivery. If there are any problems, recommendations can focus on understanding implementation issues and not just measuring program effectiveness. The feasibility of conducting the evaluation is determined by establishing the manager's purpose for doing the evaluation, which helps to provide the basis for identifying required methodologies. Methodologies include a description of the types of data collection procedures to be used, data on sampling, details on the timing of measurement, information on the use of control groups, and discussion of the types of data analysis that may be used. An evaluability assessment helps establish the extent to which methodological requirements can be applied within an agency budget as well as any political, ethical, or administrative constraints.

According to Rutman (1984), there are six steps to developing an evaluability assessment. The first step is to develop a document's model of the program by reviewing agency brochures, proposals, legislation, annual reports, and manuals. In this step the evaluator sets out all the program components, outputs, objectives, and effects. Program outputs refer to the type of services that are being delivered. Objectives are the formally stated ends that the resources are aimed at achieving. Effects can be defined here as unintended results of the program.

The second step in the EA is to develop a managers' model. This model is designed by interviewing management personnel to collect information regarding their understanding of the program. The evaluator develops a model for each manager interviewed whereby the manager describes his or her perspective on the components, objectives, and effects of the program. At

this stage the evaluator should determine the differences between the two models in relation to the formal objectives and activities of the program. These differences will help the evaluator design fieldwork which will confirm or raise questions about the managers' model.

This leads into the third step of EA, which involves going into the field to determine what is actually occurring in the day-to-day operation of the program (Rutman, 1984). Field work is used to help the evaluator understand how the program is actually being implemented. Comparisons are made between the findings from the field and those found in the document's and managers' models. If managers had trouble explaining parts of the program, the evaluator can check to see if an intervention is being affected. At the same time the evaluator can also check to see who is being served by the program as well as the nature and seriousness of their problems. Finally, in the field, the evaluator can find out if there are any latent goals of the program and any potential unintended effects. The intent at this point is to have the evaluator become more aware of the program without drawing any conclusions about it.

Once all the data has been gathered the evaluator can then prepare an evaluable program model, which is the fourth step in EA. According to Rutman (1984), it is at this stage of EA that the evaluator should be in a position to identify which program components, objectives, and effects could be considered for the evaluation study. It is important that components are well-defined and implemented in a prescribed manner, with clearly specified objectives and effects as well as causal linkages between program activities and objectives. These three criteria are preconditions for useful evaluations of program effectiveness. The evaluable program model will determine the possibility of using certain methods of evaluation or determine if an evaluation is appropriate

when suitable methodology is found and applied at a reasonable cost. Thus, an evaluability assessment can not only provide direction for the application of an evaluation but, also provide information on any shortcomings in the program's design and delivery as well as provide a restatement of more realistic objectives.

The fifth step in EA is to decide what the key evaluation questions are and what information is needed to answer them. According to Rutman (1984), in this step management should be able to decide on what key questions they want answered in the forthcoming evaluation. Managerial perspectives on the evaluation should elicit questions and information requirements that imply decisions on how to improve the delivery of program services. Management and other program staff should suggest which corresponding key indicators of program processes, outcomes, and effects to be evaluated. They can also suggest appropriate forms of measurements that will enable research methods and measurement tools to be designed and tested.

The sixth step of an EA is to determine the feasibility of the evaluation procedures by looking at what might be done and how much it would cost (Rutman, 1984). The starting point for addressing feasibility is to weigh expected benefits with the probable results. The manager's perception of future decisions and interests in the evaluation are based on the value of the information that will be produced by the EA. This helps determine the amount of money and/or resources the manager should provide in order to get the information they are looking for.

The completion of an EA sets the stage for decisions on measurement, research design, and the feasibility of any given evaluation plan. It will answer possible questions for future evaluations

and reveal whether information is accessible, whether specified data collection procedures can be implemented, and if the data and means of collecting it will produce reliable and valid data. This step also determines if sampling is necessary and how will it be handled, when measurements should be taken in relation to clients' involvement with the program, and what type of analysis is needed to adequately deal with management's needs in future evaluations. Technical questions should be identified and assessed before they are considered feasible. This must also take into consideration constraints such as funds, political and ethical restrictions, and legal limitations to conducting evaluation (Rutman, 1984, p.38). Some examples of limitations include withholding services to clients, a shortage of funds, or looking for privileged data.

Rutman's (1984) model of EA will be the general model used in this study, but this will be supplemented by material from other authors. According to Unrau et al. (2001), EA identifies shortcomings of planning and management processes that provide direction for a program. These authors claim that both goals and objectives are necessary to the understanding and explanation of the intent of a program. Cohen, Hall, and Cohodes (1985) also said that evaluators must have clear goals and objectives to answer not only what is being asked but also to promote better management for organizing and directing resources. Chamber, Wedel, and Rodwell (1992) stated that clear goals and objectives help determine whether an agency is prepared for an evaluation. These authors suggested that goals and objective are determined through the program's mission statement. Without a mission, or goals and objectives, programs cannot be evaluated. The evaluator must work hard to determine the goals and objectives in order to establish criteria for measuring the effectiveness or ineffectiveness of a program.

Another important issue to note is with respect to the stakeholders. As stated by Unrau et al. (2001), it is important to let all stakeholders know what the EA is addressing and that some things may be impossible to evaluate because of the current state of a program. Evaluators need to establish reasons for doing the evaluation so stakeholders' understand why the evaluation will help them. The incentive for the evaluation should be described in a manner that is non-threatening. This can be done by providing stakeholders with information pertaining to the key elements of the evaluation and how it will benefit the organization. Stakeholders should be informed that evaluation is necessary in social service programs because these programs are in a constant state of development. As well, informants should be told that agencies need to know what has changed within their system in order to keep up with their environment. The EA gives the program a direction and structure for growth and helps staff regain any lost focus which may have occurred because of changes in needs or other factors.

Utilization of Evaluation Research

Evaluations are performed in order to help policy makers make their points clear and direct as well as to determine if the program is being implemented as intended. They are a form of research that provides policy-makers with data on how to make decisions which will further enhance programs. Evaluation is a form of research, and according to Davies (2003), there is a distinction between research and policy-making that can often lead to tensions between the two processes. A researcher is likely to use all the data available in an effort to create balanced recommendations. This can often complicate issues however and further complicate potential actions to address problems. Policy-makers often need to simplify data so they can take action on such information. A related point is that while research produces a lot of information policy-

makers try to limit the amount of data they have because it can make the process of decision-making difficult. A last difference is that policy-making tends to be done in the short term because of the need to make and implement decisions for programs, while research takes a longer period of time and is not bound by the same time constraints.

Davies (2003) noted that these differences help to explain why some research directly influences policy makers but other evaluation research does not; factors such as timing and political interests are also influential in utilization. Even though not all the research collected will be used, good quality research and results that are clearly described are likely to be more influential than poorly-written work. The more conclusive and straight forward the findings, the more influence they are likely to have on policy-makers. When policy-making is centralized, it is more easily implemented since the audience is easier to target. Lastly, when key policy-makers are involved throughout the course of the research, findings are more likely to be implemented. Therefore, by having policy-makers involved in the research opens up opportunities for dialogue and understanding of what is being discovered as it is identified. In the next section, a brief overview of some of the advantages and disadvantages of internal evaluation are examined. This issue is addressed because of the likelihood that the evaluation of the Substance Misuse Initiative will be conducted by staff inside of the organization.

Internal Evaluations

Evaluations are used to help improve programs and make them more effective by providing information for decision-making. They can directly influence change leading to improvement and follow-through on specific recommendations. There are several ways that an evaluator can

increase the utilization of the results from an evaluation. One way this is done is by getting staff involved at the beginning of the evaluation so they are less resistant to the evaluation (Morell, 2000; Patton, 1990). According to Unrau et al. (2001), when developing a good evaluation the appropriate data-collection methods must be used and should fit the design of the organization that is being evaluated. The authors also noted that gaps in the delivery of services can be viewed as unmet benchmarks in service delivery. Tracking of the unmet benchmarks can lead to a tracking of quality standards, which give stakeholders information about the practices of a program that are consistent with the program's original beliefs as well as those that are not consistent.

While it is important to ensure that the above-noted fundamentals of evaluation are adhered to, there are a number of unique issues to consider when doing internal evaluations. Work done by Sonnichsen (2000) noted that internal evaluators not only evaluate programs within their own organizations but are often a part of the decision-making process in those organizations. Internal evaluators are expected to contribute more than just data and analysis; they must engage in a consultative role within their organizations, make recommendations, assist in decision-making, and act as advocates for change and improvement. In effect, internal evaluators are the teachers in a learning organization because they are the foundation for organizational learning, they detect and solve problems, and they act as a self-correcting mechanism by starting debate and reflection among organizational staff for alternative solutions to the agencies' problems.

Cummings et al. (1988) noted several benefits to conducting internal evaluations. First, internal evaluators have direct knowledge of their organization's policies, philosophies, procedures,

personnel, and management. In addition, internal evaluators have direct insight on service-delivery and routines that may be used to assist in the development of evaluation methods so that methods closely fit with the reality of the agency. Close relations with the staff of an organization increase the chances of the evaluator developing positive working relations with workers, thus reducing staffs' anxiety about the evaluation. Conversely, internal evaluations have their drawbacks. One limitation is that internal evaluators may be more likely than external evaluators to the issue of introducing their own values and thus skewing the outcomes of the research. As well, internal evaluators may be less able to challenge organizational or program decision-makers because of the position they hold within the agency. Finally, results from internal evaluations are often viewed as less credible than results from externally conducted evaluations.

Data Collection

According to Unrau et al. (2001), findings from data must be useful for decision-making in order to guide program policies, procedures, and practices. It is important when revealing findings that the evaluator assure the organization that every program falls short of perfection and the purpose of doing an evaluation is to provide better services by identifying the strengths and limitations of a particular program. In some cases, in order to establish an organizational plan for the data, effective information systems will be developed to assist the evaluation process. It is important to ensure that evaluations meet case-level decision-making needs that are designed to take advantage of, and build on, existing approaches to data collection. Program level data should take into consideration the decision-making responsibilities of administrators and stakeholders as well as technical requirements of the system.

When collecting data it is important to assess all relevant data-collection sources. One key source of data collection is key stakeholders, which include clients, staff, collaterals to the program, and administration. Another data source is "existing data", which is found in documents or artifacts that contain relevant information and that help answer evaluation questions. Existing data sources come from documents such as client records, social histories, program logic models, previous evaluations, census information, and published literature.

Summary

The literature review has examined material relevant to both substance abuse and program evaluation because the focus of the practicum was on the EA of a substance misuse program. The review began by focusing on the reasoning behind why people may use substances. Historical views on substance abuse, which are often still held, contend that it is a disease caused by frequent and dependent use of a chemical. The biopsychosocial-spiritual model of substance abuse represents a new way of understanding this issue. This model indicates that abuse of substances can possibly be developed in numerous and differing ways. Successful treatment relies upon the receival of accurate assessments and a successful matching of individuals with the appropriate treatment.

Substance abuse is seen as capable of occupying a wide range of dependence levels: from no use to dependence with no use (where an individual is not using the substance but they still feel an overpowering need to consume the AOD) to casual use, occasional use, and regular use. When drugs are taken enough times they move a person into cravings and dependence. Unfortunately, while taking drugs alters the functioning of the body so does its abstinence.

The most common drugs taken in North America are alcohol, cocaine, methamphetamines, and solvents. Each drug has a different effect on the person who uses it and effects each person differently. What is problematic in the field of child welfare is the fact that substance use often leads to poor attachments between parents and their children and delays in the child's development. Substance use also makes people irritable, impatient, and less likely to properly care for their child on a regular basis. This leaves many children with their basic needs unmet.

There are six stages of change that lead up to recovery from substance abuse. Specific techniques are used in order for people to move through the stages of change. In some cases, substance users are not successful in recovery because they do not complete treatment. In other cases, substance abusers do not need treatment to overcome their abuse issues. When assisting people with substance abuse issues, it is important to understand the stage of change a person is in and to use the most effective intervention for each stage. The stages of change are pre-contemplative, contemplative, preparation, action, maintenance, and termination. People do not follow a linear progression through the stages of change and often relapse to earlier ones before a successful elimination of use occurs. Recovery from substance abuse is long and cyclical. Of crucial importance is to match each person being treated with the correct treatment interventions according to the stage of change they are in.

The harm reduction approach is now commonly used to help substance abusers reduce the risk of their use. In this approach, the effects of the substance use are assessed to determine if they are harmful or helpful to the drug user and society without focusing on whether the behavior is ethically right or wrong. A harm reduction plan is developed between the parent, substance abuse

counselor, and worker, with strategies to signal the parent when s/he is feeling the triggers to consume substances as well as ways to minimize use. Motivation is a critical component and tool in assisting someone to achieve change and should be used in a non-threatening way that seeks to create little confrontation. Providing feedback on the effects of substance use, ensuring the person takes responsibility for change, giving advice on how to make change, and showing empathy tends to help the person in their decisions to change. Important factors to remember when working with AOD abusers are that they may have been physically or sexually abused as children and therefore use the substance as a way to cope. Parents who abuse substances are often isolated, engage with other AOD users, and become involved in violent relationships with other substance abusers.

Families that experience substance abuse often develop specific roles to help each member of the family cope with the situation, each of which are unhealthy for the family members. Programs that work with families who are dealing with substance abuse issues need to recognize the difficult times these families face and provide services that specifically bring them to recovery.

The second section of the literature review began with a brief discussion of process and outcome types of evaluation. A process evaluation focuses on a programs approach to client service delivery and examines how management handles day-to-day operations. Outcome evaluation focuses on what program outcomes are being achieved. The chapter then reviewed how to conduct an EA by identifying a six step model that was followed for this practicum. The steps of an EA include the development of a document's model, the formation of a managers' model, and a summary of feedback from the field. From these models comes the formation of an evaluable

program model, the development of evaluation questions, and an analysis of feasibility to further evaluate the program. There was a brief discussion on utilization of evaluation results and how to assist policy makers in making the best use of data to enhance programs.

Next, there was a brief review of internal evaluations because WCFS intends to evaluate the SMI with an in-house evaluation. Benefit of doing an internal evaluation were outlined and contrasted to limitations for this style of evaluation. Data collection was the final subject of the literature reviewed. Two sources of data collection include key stakeholders and existing data. The following chapter will address the methodology to be used for the evaluability assessment of the SMI by taking into consideration the literature that has been reviewed.

CHAPTER 3

PRACTICUM INTERVENTION

This chapter of the report outlines how the evaluability assessment (EA) was conducted. Implementation activities followed the format prescribed by Rutman (1984), but there was also some attention given to activities suggested by other authors. The purpose of the EA was to determine if the program in question was being implemented in a manner that permitted an evaluation with intended methodologies. A brief explanation of how the EA was conducted follows. First documents were reviewed to determine how the Substance Misuse Initiative (SMI) was originally designed. Managers were then interviewed to gather their perspectives on the implementation of the program. Interviews were then conducted with relevant informants, as well case files were reviewed to gain an understanding of how the program was actually being delivered. Information from these data sources were then analyzed and used for the development of proposed evaluation questions and a tentative evaluation plan for the Initiative. The chapter ends by summarizing the practicum.

Design of the Evaluability Assessment

According to Unrau et al. (2001), when choosing an evaluation design it is important to consider the purpose of the evaluative effort as well as how the data obtained will be used. In relation to the SMI, an EA was conducted by working closely with management and quality assurance staff at WCFS as well as the student's advisor. The step-by-step guide outlined in Rutman (1984) was followed. Some suggestions made by other authors who address EA were incorporated to supplement the primary model used in this practicum. As suggested by Rutman (1984), the assessment started by reviewing documents on the program so the evaluator could understand the

purpose of the SMI through its objectives, outputs, and the logic of the program. Interviews were then conducted with managers and then relevant informants from the field. The interviews as well as six case file reviews were done for the EA to clarify how the SMI operates, its size, scope, and purpose, as well, the environment in which the program functions. Activities carried out by the program as well as its goals, objectives, impacts, effects, and unintended consequences, were considered. Measurement systems, including existing information that was collected and used to summarize the design of the Initiative, was addressed in the EA. All the data gathered in the documents, interviews, and case file reviews was analyzed, summarized and used to develop proposed evaluation questions and a tentative evaluation plan for the SMI.

Ethical, political, and practical issues were addressed during the EA. Policies and procedures set by the Branch were adhered to, ensuing the unique values and/or beliefs of the program. This means that ethically, the EA did not put people at risk, or harm them in any way. Politically and practically, the EA followed procedures used by Winnipeg Child and Family Services (WCFS) including standards, guidelines, and policies that the Branch has set. Standards, guidelines, and policies were adhered in the EA by focusing to the principles of the Child Welfare Act. Examples of some of these principles are: the best interests of children are a fundamental responsibility of society, the family is the basic unit of society and its well-being should be supported and preserved, as well as the family is the basic source of care, nurture and acculturation of children (Government of Manitoba: Department of Family Services [GMDFS], 2003). Taking in to consideration these principles helped to ensure the EA was useful and would guide the development of the Branch's forthcoming evaluation.

An important aspect to consider when doing any evaluation is to understand who the participants are and how many will participate in the study (Abbey-Livingston & Abbey, 1982). It was important to capture different perspectives so a variety of stakeholders were interviewed about the Initiative. Four managers were interviewed to ensure the evaluator understood the mission and background of the program as well as the key points the evaluator was expected to learn from the EA. Other key stakeholders who were interviewed for the EA included 11 front-line workers, six supervisors, and three external agency personnel that are affected by the program. These stakeholders were important because they are the providers of the services to substance abusing families and have a huge impact on acceptance and appreciation of the services from the SMI. A more detailed outline of each stage of the EA follows.

Description and Rationale of the Substance Misuse Initiative

Document's Model

As outlined in Rutman (1984), there are six steps to doing an EA. The first of these steps is the development of a document's model, which is a description of the program. This step gave the evaluator an understanding of the purpose of the program, its components and outputs, and how these components are interrelated at the program planning stage. The process of developing the model began by describing the program components, outputs, objectives, and effects. Components are the elements of a program that provide a framework for the evaluation. Outputs refer to the type of services delivered by the program. Objectives are the formally stated ends to whose achievement the program's resources are directed. The effects are the unintended consequences of the program that can be either desirable or undesirable (Rutman, 1984, p.32). A program model was developed outlining the goals, objectives, intervention/activities, and

impacts/effects of the SMI. A review of written material from WCFS was completed, which helped develop the document's model. Documents that were reviewed included the Service Enhancement at Intake Task Team report, the Families who Misuse Substances Initiative Program Rational and Description, the Families Returning for Service study, the Work Plan for the Initiative, as well as the programs flow chart.

Managers' Model

The second step in conducting an EA is the development of the managers' model (Rutman, 1984). This model was developed for the SMI by interviewing four manager, that were considered key stakeholders, in order to determine their understanding of the program and how it is being delivered. After speaking with one quality assurance staff (personal communication, September 24, 2003), it was discovered that WCFS had made some changes to the original model for the SMI. Thus, the interviews that were conducted with the managers were also done to clarify the new model and the changes that were made. A comparison of the document's and managers' models was then done to determine their similarities and differences so field interview questions could be established.

Feedback from the Field

The third step in the EA is for the evaluator to go into the field and learn what is actually taking place in the day-to-day running of the program (Rutman, 1984). For the SMI, this was done by carrying out interviews and doing case file reviews. The primary source of field learning was based on conducting twenty interviews with key stakeholders. A copy of the questions that were explored is attached (see Appendix 4).

A brief review outlines the relevance of conducting and how to do interviews. As stated by Unrau et al., (2001) interviews are often informal and are useful for finding information about a topic by giving the evaluator the opportunity to probe for more data when necessary. Interviews can potentially be difficult because they require the interviewee to provide the specific feedback that is being sought (Unrau et al., 2001). According to Wengraf (2001), prior to doing an interview the interviewer should have a general theory of facts that were used to formulate the interview questions. The interviewer should allow participants to show their feeling and emotions in order to gain a better understanding of what is being said. Interviewers should also be aware of their own feelings and attitudes about the topic being examined so that personal feelings and beliefs can be controlled during the sessions (Hindle, 2000). The author also added that good listening skills and showing respect to participants are important skills to have when interviewing. Work on interview practices done by Schweinitz and Schweinitz (1962) indicated that interviewers must respond and probe for more information without setting up bias during the session.

The interview should begin with simple questions that the interviewee can easily respond to, thereby creating a relaxed setting and allowing the participant to feel more comfortable. The interviewer must know how to effectively end each session while taking into consideration whether the purpose of the session has been achieved. At the end of the session, the participant should be asked if they have any questions as well as be thanked for their participation (Padgett, 1998). The above data was taken into consideration and applied to the interviews for the EA of the Initiative.

In addition to the interviews, six case file reviews were done to gather information on families that received services from the program. Case file reviews are done to gather data on past behaviors of subjects as well as demographic information on families (Abbey-Livingston et al., 1982; Padgett, 1998). For the EA of the SMI file information was restricted to what was put in the file. The purpose of the file review was to gain a perspective of the families history, the services they received, and outcomes that were achieved.

Evaluable Program Model

Once all the data was collected, it was then summarized and used to establish an evaluable program model. This is the fourth step in the EA. Program components, objectives, and effects were identified and considered for the evaluation study. The evaluable program model determined if certain evaluation methods were possible or if an evaluation was appropriate when suitable methodology were applied. Lastly, the evaluable program model provided information on any limitations in the SMI, as well as changes to the program that would be necessary in order for it to be further evaluated.

Key Evaluation Questions

The fifth step in the EA was to determine what the key questions could be for the upcoming evaluation. Answers to the key evaluation questions could provide management with further information on how their program is being implemented and what, if any, additional changes need to be made. The questions for the proposed evaluation of the SMI arose from efforts to clarify how the program is being implemented as well as service quality and outcomes for families. From the managerial perspective, the EA elicited some findings that implied possible

decisions on how to improve the program's delivery of services. Findings, although limited, also addressed the program's progress, outcomes, and its effects. A final aspect of the EA ensured that tentative measurable tools were designed so that research methods intended for future evaluations could be applied. Draft interview guides and a draft file review, both of which require further modification depending on the future scope and nature of the future evaluation, were developed along with a tentative evaluation plan. This was done to provide the Branch with a general plan they could follow when and if they further evaluate the Initiative.

Analysis of Evaluation Procedures

The sixth step in the EA dealt with analyzing the feasibility of implementing various evaluation procedures. An EA is incomplete without an examination of the feasibility of carrying out an evaluation (Rutman, 1984). This was done by asking managers' what they expected from a further evaluation. The EA provided WCFS with information regarding the use of various measurement and research designs, how accessible data is, and what type of data collection methods could be implemented. As stated above, this was done in a proposed evaluation plan for the SMI. Data on feasibility reflected resource considerations and any ethical considerations that should be considered in the evaluation of the SMI.

Summary of the Practicum Activities

The main focus of the practicum at WCFS was to develop an evaluability assessment for the SMI. This was done by working alongside and getting assistance in the development of the EA from the one staff member in quality assurance. Valerie Barnby, who is a quality assurance review project coordinator at WCFS, supervised the student during the placement at the Branch

to ensure that Branch boundaries and expectations were understood and followed. Brad McKenzie, professor at the University of Manitoba, Faculty of Social Work, provided policy and administrative supervision from a social work perspective in order to enhance the student's learning experience.

CHAPTER 4

EVALUABILITY ASSESSMENT

To begin the evaluability assessment (EA), Branch documents were reviewed to gather insight on the original design for the Substance Misuse Initiative (SMI). Interviews were then conducted with management to gather their personal thoughts on the project. Data collected to this point provided a clear understanding of what is expected of the program's services. With this information, interview guides were developed and then interviews conducted with relevant informants who either worked on the SMI or were involved with its development. Case file reviews were also completed as a means of understanding family histories, the services they received and any outcomes from the services that were offered.

Document's Model

Background Information on the SMI

In April 2002, the Interim Management Board of Directors at Winnipeg Child and Family Services (WCFS) developed a plan to reduce Branch expenditures. The majority of savings were to come from Child Maintenance (i.e., the costs associated with paying for placement of children). To achieve these cost savings, the Board, in collaboration with senior management, developed four "Task Teams" to devise strategies that would reduce the costs associated with children coming into care and to further enhance Branch service. These strategies were to be developed within existing funding parameters and involved a focusing, rather than a restructuring, of service. Each task team was led by a quality assurance coordinator and was made up of staff, supervisors, and management from across existing Branch programs. The four task teams consist of:

1) Support to Foster Parents
2) Service Enhancement to Intake (later called the Intake Task Team)
3) Service Enhancement to Family Service
4) Process Mapping (Short Term Emergency Placement)

Each team developed a number of recommendations that were presented to the "Days Care Committee." This committee was made up of members from the Program and Planning Committee of the board, senior management, and quality assurance staff. The Days Care Committee selected "initiatives" for immediate implementation based on the potential of the initiatives to have an impact on reducing Days Care and enhancing service. The initiatives that were selected for implementation were as follows:

1) Response to Families Experiencing Parent-Teen Conflict at Intake
2) Specialized Response to Families Who are Abusing Substances at Intake
3) Service Enhancement for Family Services-Family Reunification
4) Short Term Emergency Placement Committee
5) Supports to Foster Parents

Each of these initiatives followed a different path in its development and the timing of implementation. For the purpose of this practicum report, the focus will be on work done by the Intake Task Team and the Specialized Response to Families Who are Abusing Substances at Intake (later known as the Substance Misuse Initiative).

As stated previously, the intent of the Intake Task Team was to develop strategies that would reduce the number of, and associated costs for, children entering care as well as to enhance service at the intake level. Three key documents are relevant to these strategies: the Statement of Work for the Intake Task Team, the Families Returning for Service Study, and the Intake Task Team Final Report. The Statement of Work outlined the purpose, objectives, and plan that the Intake Task Team followed to arrive at their recommendations. Of importance in this document

were the references to the Families Returning for Service Study (Winnipeg Child and Family Services [WCFS], 2002). This study was completed by the quality assurance staff prior to the formation of the task team and shaped their recommendations.

The Families Returning for Service study examined files that were opened including files of families who returned for service at the intake units at the Branch during a fifteen-month period. In that time frame, it was found that 24% of families received service more than once. Not all families returned due to recurring maltreatment in that some may have returned because they were seeking preventative assistance with a new crisis. However, the most common presenting issues for the families that returned for service were physical abuse and alcohol abuse followed by lack of supervision and/or neglect.

The study found that most families who were referred to an intake worker received an assessment and/or investigation service. Most files were closed within a few weeks and only 20% were transferred on to the family service program for additional service. Substance abuse was among one of the major concerns for families that were referred for further service. As stated above, substance abuse was one of the two most prevalent issues for families that returned for service. This was a significant finding and reflected both the issue of substance abuse in child welfare and the limitations of the system to respond to this growing and complex problem. The study noted that other jurisdictions were facing similar challenges. The model outlined in the MCFD (2001) described some innovative models of service delivery that had been developed to address these challenges. The Intake Task Team produced a final report along with

recommendations for the Initiative by taking into consideration some of the findings from the Families Returning for Service Study.

Development of the Implementation Plan and Work Plan for the SMI

On July 25, 2002, the SMI entered the planning stage which led to a detailed plan for how the program was to be implemented. An Implementation Planning Team was established consisting of Branch staff from across programs and external collaterals who had expertise in the area of substance use. The implementation plan specified how clients would be served by the SMI, the program intent, required staffing resources, the role for staff and related responsibilities, the lines of authority, the processes for referring clients, the training needs, and a detailed evaluation plan.

A work plan was developed and finalized in November 2002. This plan outlined tasks that needed to be completed before the SMI could be implemented. These tasks included the development of a program vision and purpose/model, a description of the activities and staff roles and responsibilities for the Initiative, as well as an outline for the role of the Substance Abuse Response at Intake Team (SARIT) Steering Committee. The work plan also documented the program's need to devise a method for identifying and referring families, the need to determine how files would be transferred and closed, and the need to indicate how the assessment process could be implemented for each family. The work plan also noted that the implementation team had to identify reporting requirements, determine how to budget items related to the project, and decide how to develop a risk management plan. A complete explanation of how these procedures were implemented is described later.

A procedure for project workers to screen for substance misuse at the intake level of service was an additional component that had to be clarified before implementation. Determining staffs' roles, identifying workers' training needs, determining what support requirements were needed in relation to consultation and team meetings, and figuring out the work location for staff were all highlighted in the work plan. The plan outlined the need to establish who would collect and enter information on the database as well as the processes for establishing auxiliary workers status. It was noted that the planning committee had to determine how to address union issues and how to develop a budget for training and other requirements. The team needed to determine how to establish regular ongoing communication between SMI staff, key community stakeholders, and the Days Care Committee. The work plan also outlined the need to devise an evaluation plan that focused on measuring outcomes and described how to increase collaboration with external treatment service providers. A full description of the implementation plan is outlined later in the description of the document's model.

During the planning phase the North-West and Central intake unit supervisors tracked the number of families with substance abuse issues that were referred to them in September 2002. This was done to gain an understanding of the potential volume of service for the SMI. Results from the data collection revealed that 66% of all cases opened by the intake units had families with substance abuse issues. Of those files, 45% were families whose substance abuse was of low to medium concern where the presenting issue was resolved at intake and the file was subsequently closed.

The SMI was developed based on the Families Returning for Service study, Intake data, and the literature review. Current with the development of the Initiative, and because of the findings from the Families Returning for Service study, there developed a growing recognition across WCFS of the need for staff to be trained in working with families affected by substance abuse issues. In February 2003, a two-day training on substance use was provided to all Branch staff. This training included presentations from a variety of substance abuse treatment providers. Later, an additional training program was developed for workers involved directly with the SMI consisting of four days of specialized education.

Program Description

The SMI was developed as a one-year pilot project. In June of 2003, the Intake Task Team Final Report was completed. This document outlined the SMI program rationale and description. The report noted that the Initiative would use a holistic approach based on an understanding that parental substance abuse is caused by a complex interplay of individual, interpersonal, and environmental factors. The intent of the Initiative was to engage with families by offering a new service that shifted away from the "caution and warn" and referral to outside agencies for assistance. Screening tools for assessing risk factors associated with substance use were designed to help workers develop a clearer understanding of a family's needs. The reason for this was to try to have workers develop relationships with each family and for them the establish an in-depth understanding of the families situation. This understanding of the family's needs was to be based on an understanding of the parent's stage of change and level of involvement with the substance. This understanding was intended to ensure an appropriate match between families, substance abuse service providers, and other community resources. Along with this match was to be the

development of a harm reduction plan that ensured the basic safety of the children and reduced parental substance abuse.

SMI Philosophy

Many families that come to the attention of WCFS are recognized as people who have faced a number of life-challenges such as poverty and racism. As families come in contact with the Branch, the opportunity arises to engage with them in a discussion about their needs that go beyond the investigation of child welfare concerns to a focus on substance abuse. Guiding principles, identified in the MCFD (2001), were developed out of the belief that families struggle with many challenges which lead them to the use of substances as a coping mechanism. Working with low to medium risk families in regards to parental substance abuse and the detrimental effects it has on their children is deemed important. If WCFS did not offer this service, it was felt that an opportunity to make positive changes in the lives of these families might be missed. Families might repeatedly come to the attention of the child welfare system and these children might end up in care. The six guiding principles established for the SMI are:

- Substance use itself does not constitute child abuse or neglect; child protection concerns arise from the impact of the parent's substance use on the child;
- Parents with substance use issues are entitled to be treated with the same respect, understanding, and compassion as other parents whose personal difficulties interfere with or lessen their ability to provide safe and effective parenting;
- The harm reduction approach to substance use, which focuses on reducing the impact of parent's substance use on him/her self and others, is the preferred approach to reducing the risk to the child as long as the safety of the child can be ensured within the harm reduction plan;
- Children's needs will be best met by developing a partnership with their parents to develop a plan that reduces the risk to the child and enhances child and parent well being;
- Service provided must be culturally sensitive to meet the needs of the culturally diverse population of families that we serve; and
- We can support both the well being of the child and the parent by building collaborative working relationships with community substance abuse service providers.

Rationale for the Development of the SMI

The rationale for the program is based on the premise that substance abuse is a significant issue impacting the field of child welfare. The purpose of the SMI is to shift thinking at the Branch to focus not only on the child but on the entire family. It was believed this could happen by training staff to partner with the family in order to develop harm reduction plans. This type of service would require a change in how the Branch delivers service to families, who up until now received what is know as a "caution and warn" service or referral to outside resources.

Parental use of substances occurs in many families whose children are at low to medium risk of harm. These families cycle through the system which eventually results in child placement. Long waiting periods for treatment of substance abuse leaves many families without the assistance they need, demonstrating the need for a shift in how these families are served. The SMI aims to provide a focused, coordinated program that combines elements found to be effective with families who have substance abuse issues. The plan is to engage with and motivate families with substance abuse issues to effectively partner with WCFS and develop a plan that reduces harm to children and parents. Staff who work on the SMI are to support and help sustain parental motivation until either change occurs or they are connected to an appropriate service provider. Another intent of the SMI is the development of collaborative working relationships with treatment service providers (Winnipeg Child and Family Services [WCFS], 2003).

Structure and Funding of the SMI

The organizational structure of the SMI includes fourteen "intake workers," (all intake staff from the Central and North-West units at WCFS), four "family preservation workers," two

"community based early intervention staff," and two "family support workers." A Steering Committee was developed to oversee the implementation of the SMI. All staff were trained on the harm reduction approach, the stages of change, the levels of involvement, and skill building in motivational interviewing. Depending on their needs, families are to receive services from the program for up to sixty days. After thirty days a review of the families goals and their progress is expected. Ongoing consultation is critical in assisting workers to integrate their knowledge and skills as well, consideration is to be given to having an on-site substance abuse service provider for staff to use for consultation about substance abuse.

Description of the Clients

The target group of the SMI consists of families who come to the attention of intake staff because of substance abuse that results in child protection concerns. These family files are normally closed at intake because the concerns of child maltreatment are low to medium risk. It is believed that many of the families are in the pre-contemplative or contemplative stage of change. Families include those whose children are at low to medium risk of entering Branch care or whose children have briefly entered care for parental substance abuse issues. Only families who live in WCFS Central and North-West units' geographic catchment areas are considered for the project.

Goals and Objectives for the SMI

There are nine goals outlined in the documents for the SMI. These goals are:

1. To increase service quality for families;
2. To increase the number of parents with substance abuse issues who engage in substance abuse rehabilitation/support services;
3. To increase collaborative activities between Initiative staff and substance abuse service providers and other community service providers;

4. To increase cross Branch program collaboration;
5. To decrease the number of children that enter Branch care as a result of parental substance abuse;
6. To decrease the length of time children are in Branch care;
7. To decrease the number of families with substance misuse issues who return for Branch service;
8. To increase workers knowledge with respect to current approaches in the substance abuse field and to increase the skill level in the areas of substance abuse screening, assessment and intervention skills; and
9. To increase workers job satisfaction.

There are six objectives outlined in the documents for the SMI. These objectives link to the achievement of the programs goals and are as follows:

1. To develop a cross program team of Branch service workers who can respond to families who are misusing substances at intake;
2. To provide specialized training for Initiative staff to deal with harm reduction, stages of change, and motivational interviewing;
3. To complete a substance abuse screening/assessment with each family referred to the Initiative using the B.C. Practice Guidelines Questions for Parents;
4. If parents are willing to work with Initiative staff, complete a comprehensive assessment and harm reduction plan with parents;
5. If parents are unwilling to work with Initiative staff, complete a contract with each family regarding their plan to reduce harm prior to file closure; and
6. Initiative staff will establish communication with the substance abuse service provider in order to share information, collaborate on harm reduction plan, etc.

Referral Process

Taking into consideration data from MCFD (2001), the implementation team discussed the process of referring files. Concerns were raised regarding the long periods of time that could lapse between a family's file being referred to an auxiliary worker and the actual services offered. It was felt that family preservation staff could intervene and provide the needed services during non-service time.

The referral process was made into a flow chart (see Appendix 3). Families come to the attention of intake staff who assess the case. When the worker feels a case can be closed and the family

shows signs of substance misuse, it is referred to one of two auxiliary units on the SMI. Low risk cases go to community based early intervention staff and medium risk cases go to family preservation workers. The two auxiliary units work with the family for up to sixty days. If major concerns arise in the case during service it is collaboratively reviewed with the auxiliary staff and intake workers and a decision is made about whether the case should go to a family service unit for further service. When a file is ready for closure, the auxiliary worker writes up a closing summary and sends the file back to intake for final closing.

Activities Offered Through the SMI

This section of the model will highlight activities for the SMI (for a full description refer to Appendix 4). Staff are expected to engage in a variety of activities that extend across the programs. These services include identifying the parent's stage of change, using motivational interviewing, contracting with families, the development of harm reduction plans, and making referrals to substance abuse service providers. Additional tasks include integrated case management, the provision of concrete services, educating parents about substance abuse, promoting collaboration among stakeholders, and advocating for families. Case recording and tracking outcomes are other activities to be undertaken by the SMI staff. Including the above activities, intake staff are to assess parental substance use as a risk factor. Findings from this assessment are recorded in a substance use screening form that is sent to auxiliary staff. Auxiliary workers are expected, along with the above-mentioned activities, to provide follow-up services to SMI families. Community based early intervention workers are expected to complete the above-noted activities and develop community maps with families. Family support workers are expected to assist auxiliary staff with their activities and provide short-term respite services.

The Implementation Committee (now the Steering Committee) oversees the implementation of the SMI and develops training opportunities for staff involved in the program. This group is involved in collaboration and advocates for clients who receive services from the Initiative. The committee is intended to provide input for the evaluation of the project, to track family outcomes, and to coordinate the overall implementation of the SMI. Eventually, the Steering Committee is expected to plan informational support groups for parents.

Implementation of Services

The Crisis Response Unit (CRU) is expected to initiate service for a family by completing a summary of the family situation. The file is to be directed to one of two intake units where the families begin receiving service. The intake supervisor assigns the case to an intake worker, who then assesses the family and identifies if substance abuse is problematic. Intake staff are expected to administer the screening questions and determine the impact the substance use has on their parenting.

The intent of the SMI is to engage with substance using parents concerning harm reduction by using a screening tool for assessing the risk to the children. Screening guidelines were established to help SMI workers assess a parent's level of involvement and match them with the appropriate treatment. A questionnaire, adapted from MCFD (2001), was developed to assess parental substance use. This questionnaire addresses how the substance use impacts social functioning, the effects of substance use on parental well-being, the effects of substance use on child care, and the parent's commitment to recovery. An additional intent of the questionnaire is to help workers determine the parent's level of involvement with substances using an open,

respectful, and non-judgmental approach. With the information gathered, workers are expected to complete a risk assessment to establish the stage of change a parent is in and to determine the parent's abilities to answer the questions as fully and openly as possible.

Information gathered from the first section of the questionnaire is summarized and recorded by intake workers on a family tracking form, which is then forwarded to the family preservation or community based early intervention program as appropriate. Each family referred for service has a substance misuse screening form filled out by intake staff that outlines family demographics and any substance misuse data that has been gathered. A hard copy of the referral summary and screening form are placed in the family file. After the intake worker has completed his or her work the file remains open in the name of the unit supervisor, which is noted on the Child and Family Services Information System (CFSIS). Although the case is referred to either the family preservation team or community based early intervention team the physical file remains at intake administration. Consultation between the intake worker and their unit supervisor determines which auxiliary unit receives the case. Once auxiliary staff accept the case, the name of that worker is added to the file as an auxiliary. Additional documentation is then typed and attached in CFSIS by auxiliary administration.

When the intake worker, in consultation with his or her supervisor, decides a family is appropriate for the SMI, the family is informed about the services they could receive. A script was designed for intake staff to introduce the SMI to families: " Our Branch has developed some new services to help families that may be struggling with the use of drugs and/or alcohol. This is a trial project, and the services are limited. If space is available, would you be interested in

receiving this service?" If families accept service, intake workers were to respond by saying: "If space is available and your family is selected to receive service, you will be contacted by a service worker within 10 days. If you are not selected you will receive a letter notifying that there was no space available." If families refuse services, intake staff were to respond by saying something like the following: "You may still be offered service because of the concerns we have discussed. If you are offered service, a service worker will contact you within 10 days. If you are not selected for service, you will receive a letter from the Branch notifying you that there was no space available."

Administrative support staff for each intake unit hold the physical file. A copy of the screening tool and tracking form are sent to the correct auxiliary service supervisor who then assigns the case to an accompanying worker. If families do not receive services because staff are unavailable, a letter and informational booklet about community substance abuse services is to be sent out informing them that their file has been closed. Intake administration workers are to attach a carbon copy of the letter to the file. If the file is in the hands of the intake supervisor, intake administrative staff are to attach a standard closing statement in CFSIS.

Prior to the Initiative, when the case was low to medium risk of child protection concerns the intake staff at WCFS offered a "caution and warn" service to families with referrals to outside agencies. The SMI attempts to offer a different type of service that will be directly and immediately accessible to families whose children are at low to medium risk due to parental substance use. Screening tools are used to assess risk to the family and to provide a clear image of the family and their needs. Parents' readiness to change is assessed so the family can be

matched to the appropriate community resources. In cases where the parents' substance use is considered a significant risk factor, the harm reduction model is used to reduce parental substance use. As stated above, the harm reduction plan is used as a three-party agreement that provides a framework for sharing necessary data between the parent, the substance abuse service provider and the social worker. The plan emphasizes the safety of the children, enhances collaboration, and integrates planning and service delivery. A harm reduction plan provides a framework for collaboration, integrated planning and service delivery for the family. As well, the plan can be used for open communication, information sharing, clarifying mandates, setting realistic limitations, empowering parents to participate in the process, establishes a clear bottom line for the safety and well-being of the children, and addresses a plan for possible relapses in recovery.

As stated earlier, workers are to use motivational interviewing strategies to assist parents in making changes to reduce harm to their family. Tip sheets have been developed for workers to educate parents on alcohol, gambling, and ensuring the safety of the children. Information, from literature, was used to help the implementation team develop the tip sheets which are felt to be effective for educating pre-contemplative individuals.

Caseloads for SMI staff are dependent on the intensity of the services required by the family. Files intended for family preservation are cases that are low to medium risk for child maltreatment; these are defined as families with children who were previously in care, cases with numerous file openings and/or families that demonstrate child maltreatment because of parental substance abuse. Community based early intervention staff receive cases that are at lower risk of

child maltreatment; these include files that are a first-time opening at the Branch, and situations where the children have never been in care. Family support workers add data and work alongside the SMI staff.

Collaboration, based on MCFD (2001), includes integrated case management from the staff on the SMI and the expertise of a substance abuse counselor. The counselor is used for consultation, advice, and/or information on parental substance use; consultation is also used for assessing substance use and for developing a harm reduction plan for the family. A substance abuse specialist from AFM is made available to assist SMI staff with substance abuse and risk assessments, to target interventions, and to provide a direct link to an external substance abuse treatment resource.

At the end of service, the auxiliary worker is to complete a closing summary as well as the remainder of the tracking form. A summary of the worker's contact with the family is to include the family's level of functioning in relation to historical and current substance use, the issues that impact the parent's level of involvement, and the parent's stage of change and its impact on the children. Conclusions and outcomes for the family are to be recorded including data outlining how the family has responded to the services they received.

The auxiliary worker's administrative support person is to enter the completed tracking form and closing summary into the database. Auxiliary administration are to retain a hard copy of the information for future use in situations where the family returns for service. All data is to be added to the closing summary as well as the tracking form on the Branches computer system

called CFSIS. A signed-off hard copy of the data to be added to physical family file is to be sent back to intake administration for inclusion in the file. Intake administration are to process the closing in CFSIS as well as the physical file.

Managers' Model

Interviews were conducted with four managers at the Branch who worked on the Substance Misuse Initiative (SMI). This was done to gain a managerial perspective on the development and implementation of the program. Information obtained in the interviews helped determine which aspects of the program can be evaluated and whether the goals and objectives are still appropriate. Data from the interviews was also used to elaborate on the evaluation plan for the SMI by ensuring that relevant information is available. Factors that affected the evaluability of the program were identified and discussed with management. At the beginning of the interview managers were made aware that the findings would be used in the development of an evaluable program model and the completion of a written report on the SMI. During the interviews, it was discovered that there have been changes made during the course of the program's implementation that differ from the design outlined in the document's model. To avoid repetition of the document's model, the summary of the managers' model is restricted to an identification of the differences that have occurred in the implementation of the model as well as major highlights of these interviews.

Design of the SMI

Management from the Branch indicated that they felt the overall development and implementation of the SMI was consistent with that outlined in the documents. They described

the rationale for the project as it is outlined in the documents; that is, children are often placed in care when staff intervened with families that are in disarray. It was noted that the four programs providing intervention (i.e., family preservation, community based early intervention, intake units and family support), remained the same. Feedback from collateral agencies as well as across the SMI program was still said to be important to ensure the effectiveness of the program. However, changes to the structure of the Initiative included the expansion of the Steering Committee and the development of a Screening Committee. No details were provided regarding the expansion of the Steering Committee. The Screening Committee was developed to examine and assign cases that are sent to the auxiliary units attached to the SMI.

Staffing for the SMI was allocated to the program as described in the document's model. Substance misuse training was provided to all the program workers, educating them on the new ways to address the issue. This reconfiguration of staff offers more resources to families who are dealing with substance abuse and establishes a starting point for a team approach to service delivery. The SMI provides families with a choice of services and offers a continuum of assistance for its clients. With the implementation of the SMI, $5000 was allocated for consultation from external agencies; half of the money is intended for AFM consultancy and the other half for either NAC consultancy, or another aboriginal substance abuse service provider.

Management described the profile of intended SMI clients as they are depicted in the document's model. The client group who are referred to the project were described as low to medium risk families who are dealing with substance abuse issues. A number of the families served by the Initiative are recognized as single mothers of aboriginal decent. All families with a substance

abuse issue whose file would have been closed at intake are to be referred to the program. However, at the time of the interview two managers were unsure if this was currently occurring. Managers believed that clients referred to the SMI were in the pre-contemplative stage of change and, as one person noted, not ready to look at issues related to their substance use.

At the onset of the interviews there was a consensus from management that the goals of the Initiative were the same as those outlined in the document's model (see Appendix 1). In general, management agreed with the goals but there were concerns about the seventh goal (to decrease the number of families who return for service). There was concern that the activities offered in the SMI will not meet this goal as it reads. In order to effectively evaluate this goal, it is suggested that the Branch review the intent of the goal to see if it is appropriate for the program so an evaluation could effectively evaluate its achievement. The original intent of the goal was to reduce the number of families who return to the Branch because the children are in need of alternative care due to their parent's substance use. It could be considered a positive thing for families to return for service because the family would get further assistance to deal with their substance abuse. Thus, the statement with respect to families returning for service should be reviewed and may only need rewording. There is also uncertainty whether the ninth goal, relating to employee job satisfaction, can be met. When the Initiative was first developed, it was found that intake staff needed better tools to be more effective when working with families with substance abuse issues. Thus, it was thought that increased job satisfaction would result from staff having the right tools to serve families. At the time of the interviews, managers were unsure if providing staff with these tools would lead to increased job satisfaction.

All four managers agreed that what is stated on the flow chart is generally similar to what is being implemented (see Appendix 3). One manager mentioned that the flow chart is a general guide that will be added to as the SMI is delivered. It is believed that the flow chart is thorough, even though it may be complicated to read. The intent of the referral process is to have an immediate response within a 72-hour time frame; this is deemed important when working with families who have substance abuse issues.

Managers mentioned an addition that had been made to the referral process (see Appendix 5). One person from either family preservation or community based early intervention is to join intake workers in their initial meetings with families. This change was made in an attempt to reduce the layers of intervention for families; initially, there were three layers of Branch involvement before a client saw auxiliary staff. It was said that clients were repeating their story to several workers and by the time they met the person who would deliver ongoing service, they had become disengaged.

A change to the referral process eliminated the need for intake staff and their supervisor to determine which auxiliary unit received the case (see Appendix 5). The new referral process is to have all SMI cases now sent from the intake units to the family preservation supervisor. The file is then taken by the supervisor to weekly Screening Committee meetings for review. On the Screening Committee are the two auxiliary supervisors, the family support coordinator, and the SMI leader. A consultative approach is used at the Screening Committee to collectively decide which of the auxiliary units will provide service to the family.

An additional change in the referral process involves the kind of information intake workers give to clients about the program. In the original process, intake staff informed parents that their file had been closed but that auxiliary staff would be visiting them as a voluntary service so there would then be no obligation to meet with the auxiliary worker. The new approach involves intake staff telling clients that they have completed a portion of their journey with the Branch, but there are still concerns with their situation. As well, management suggested that perhaps intake workers could provide relevant information to parents about their substance abuse so their children would not end up in care. They could then encourage the family to work with auxiliary staff in order to get through their life crisis and establish a plan for a healthier family lifestyle.

There is agreement that SMI staff are expected to perform the activities as summarized in the document's model. These activities include advocacy, counseling, motivational interviewing, identifying stage of change, and developing a harm reduction plan. Other activities for the SMI staff include making referrals to substance abuse services, integrating case management functions among all Initiative staff attached to a case, providing concrete supports and child care, as well as educating parents on their substance use. Collaboration, doing follow-up service, tracking work done with the family, and contracting with parents are additional responsibilities for SMI staff. For a complete report of the activities for Initiative workers please see Appendix 4.

Management felt that assessing and understanding families' needs are important activities for all program staff. They added that information gathered by staff helps them create treatment plans for families. Counseling parents on their stressors and helping them with basic things such as finding adequate housing and child care are also important. These activities are noted as being

essential because concrete issues are found to impact parents, cause them to become overwhelmed, and subsequently abuse substances. Thus, the various levels of the staffs' skills and abilities within the SMI offers a wide range of service to help substance-abusing families.

In-home respite services were important activities that required adjustment. The two in-home support workers came from Level Two positions, which did not fit the respite role. Level Two-support work focuses on educating parents and connecting them to community resources, rather than respite services. This has been adjusted and, at the time of the interviews, two aboriginal respite workers were being recruited as part of the family support services.

The overall implementation of the SMI remains similar to that described in the document's model. In one manager's opinion, the Branch has done interesting work with this project and other Initiatives being implemented. It is felt that the SMI leader and the program unit supervisors best understand the Initiative and make all final implementation decisions. Managers felt that a significant aspect of the SMI is that all staff remain invested in the success of the project. It was said that one way this can be achieved if all the SMI staff work as a team. At the time of the interviews, the program was still in the developmental stages of implementation, so it was possible that families were not being served as intended. In addition, some cases will need to be transferred to family service units when safety-related concerns for children are missed. Auxiliary staff are expected to make direct referrals to family service programs through the intake units. When files are transferred, auxiliary workers are expected to continue to follow the case for the remainder of the 60 days along with the family service worker by conducting more intrusive interventions as necessary.

Further Recommendations for the SMI

During the interviews with management there were discussions about some changes in relation to referral to the program. One of the changes that was contemplated was the expansion of the SMI to include the Crisis Response Unit (CRU), which would have changed the referral process for the Initiative. If they expansion had occurred it would have meant that clients would see night duty staff, CRU would assess their situation, and directly refer the family to auxiliary staff. This change would have eliminated some of the intake workers' involvement, cut out some layering of workers, and sped up the referral process. A second change that was considered was to have the other two intake units at the Branch also assess and refer cases to auxiliary staff. A third idea was to have three family service units, already identified within WCFS, to make direct referrals to the auxiliary workers. For this latter expansion to occur, staff in the family service units would have had to be trained on the new approaches to working with families with substance abuse issues. The addition of the CRU, as well as the other two intake units, and three family service units to the program was considered because of an uncertainty that all families intended for the Initiative were being referred. In the end the expansion of referrals to the program did not occur.

There was some concern expressed by management that not all of the activities related to the program were being fully implemented by the intake workers. This may have been because the intake staff did not see themselves as part of the Initiative. Managers noted that intake staff are key to the initial service and referral because most families will only see them. The implementation of the intake workers' activities needs to be reviewed to determine any issues to be addressed and to make the necessary changes. Issues faced by the intake staff included case managing SMI families and knowing which families to refer to auxiliary staff in the program.

Concern was also expressed that the SMI is not meeting the needs of aboriginal clients because the Initiative takes on the Addiction Foundation of Manitoba's approach to substance abuse, which does not have an aboriginal focus. Thus, as the program exists, issues that are important to aboriginal clients may not be fully addressed in the program. An aboriginal agency is being targeted as a source of consultation for SMI staff to learn more about the distinctive needs of aboriginal people who are dealing with substance abuse issues. The intent is to learn the unique ways that aboriginal treatment agencies assist their clients so that SMI workers can also implement those strategies. The lack of aboriginal perspectives in the Initiative were identified as something to be further considered in order to ensure that the service needs of aboriginal people are being met. The Steering Committee is currently reviewing this issue and options that might be pursued in order to resolve this matter.

It was noted by management that other issues have emerged during the implementation of the Initiative. One problem is that auxiliary staff are having difficulty connecting with families. This has to be addressed so that workers do not have to actually pursue families and be concerned that they are not helping them. While this is true, one person felt that perhaps in meeting with auxiliary staff a seed had been planted for resistant families that in the future could possibly influence them. An additional implementation issue identified relates to the child protection mandate of WCFS. If a case that receives SMI services has safety related concerns it is not clear who is responsible for handling these concerns or what everyone's role is in dealing with these matters. This issue needs to be clarified by the Steering Committee so there can be agreement and clarity on the role of the different staff with the Initiative.

Challenges in implementing the SMI are fully discussed below but first a note will be made in relation to the child welfare mandate. At the time of the interviews the Steering Committee was sorting out what to do in situations where auxiliary staff, who spent a large amount of time introducing themselves as being a voluntary service, shift to a child-protection role when safety issues arise. The concern is that this shift in service will leave clients extremely confused.

Challenges and Benefits of the SMI

Several challenges, more specifically related to implementing the SMI, were identified in the interviews. A reorganization of the Branch eliminated job security for anyone hired past December 2000. As well, some staff are concerned about their job security because WCFS is joining one of six access centers. These centers are developed to bring community services such as child welfare, employment and income assistance, and health programs into the same building so services are more easily accessible to families.

The SMI originally planned to begin in late spring of 2003, but because of managerial changes, implementation slowed down and a full launch of the program did not occur until later that fall. Additional concerns noted are related to the Aboriginal Justice Inquiry–Child Welfare Initiative (AJI-CWI). This concern relates to how the Joint Intake Response Unit (JIRU) will impact intake units once the four authorities are running. The lack of stability at WCFS most likely creates a demoralizing effect on some members of staff. With so many changes in the Branch, it is often unsettling for staff, especially when trying to implement a new Initiative. For example, workers who were initially prepared to work for the SMI lost momentum when things were delayed.

A further challenge to implementing the SMI results from a change in membership on the Steering Committee. Original members left the committee for a variety of reasons and new ones came to take their place. Another issue relates to auxiliary staff; workers who were initially designated from the various units left their positions and it then took time to find replacements. When the Steering Committee members and front line staff positions were filled, it then took time to train everyone, resulting in a slowing down of the implementation process.

Some managers felt that the lack of momentum and the fact that the SMI serves low risk clients had created some hesitancy from intake staff to accept the value of the project. One manager stated that intake workers do not think clients are interested in the services so it took a while to get intake staff to understand the benefits of the program. Intake workers are justifiably concerned that if the Branch tries to take on too much, staff will spread themselves too thin and expend efforts on low risk families at the expense of higher risk clients. The concern from some intake staff relates to the larger concern that there are not enough workers to both work for the SMI and meet the needs of high-risk cases. The challenge was to get intake staff to understand that the program is a way of broadening service instead of waiting for a crisis to occur before helping families. Auxiliary staff are also having difficulty finding families who are motivated to change. Many of the families that staff are meeting with do not feel that there is a problem, thus, their motivation to change is low and they are not working very hard to address identified problems.

There were many benefits mentioned about the services offered from the implementation of the SMI. Results from the interviews with managers suggested that there is a great deal of support

for the Branch to proceed with the Initiative. One manager referred to the SMI as "leading edge work" with child welfare clients. This person added that the program established a multidisciplinary team to focus on the issue of substance abuse, which was viewed as positive. Increased collaboration with external agencies was, overall, very important for the Branch. One manager added that the project brought community based early intervention workers closer to the major work of WCFS.

Another advantage of the SMI mentioned by interviewees was that the staff have enhanced their skills and confidence in the area of substance abuse because of the training they received. Clients benefit from the Initiative because of the extension of services to those who would have otherwise had their files closed. The SMI approach is more respectful and "less black and white" than previous approaches employed by WCFS in their work with clients.

Feedback from the Field

Feedback was gathered from the field to gain an understanding from supervisors, front-line staff, and external stakeholders about the implementation of the Substance Misuse Initiative (SMI). Seventeen interviews were conducted with various staff from Winnipeg Child and Family Services (WCFS) who had been involved with the program. Three stakeholders from outside agencies were also interviewed to gain their perspectives on the Initiative because they also had connections with the Branch and the program. The assessment gathered data on peoples' thoughts about collaboration, as well as their thoughts concerning how to measure the success of the project. During the interviews, it was explained to each person that data was being collected to determine how the program is currently being delivered, which aspects of the project can be

evaluated, and to confirm that relevant information will be available for an evaluation. Six files were reviewed to assess whether they would be a viable source of data for an evaluation. The above-mentioned information was gathered to help determine which tools to use and what data would be needed to conduct an evaluation of the SMI. The data was also collected to determine whether the previous models were in fact being implemented as they had been designed and conceptualized by management. Content that is summarized in this section is twofold; first, the highlights of the interviews and file reviews are presented, and second, any discrepancies between the document's and managers' models are discussed.

Twenty-four interviews were conducted for the EA using the interview guide reproduced in Appendix 6. These interviews included three collateral agency workers, as well as both supervisors and two staff each from the family preservation and community based early intervention units. The two supervisors from the intake units as well as eight intake staff were interviewed along with the family support supervisor, family support coordinator, and one family support staff. The reason for interviewing this collection of people was to get an understanding of the SMI from all relevant informant groups. Questions were asked of the participants in order to gain their understanding of the services offered through the SMI, to obtain people's thoughts on the training they have received, to learn about people's understanding of the program, to gather everyone's interpretations of whether the program is realistic, and to learn about ideas that staff have on how to assess the services that are offered in the project.

The second source of field information came from case file reviews, which were done in order to determine what information is recorded by workers about family history and outcomes. For the

EA of the SMI, file reviews were done to gather general data on demographic information, family history, interventions used, and outcomes for families who received services. A "yes/no" questionnaire was developed from the Branch's stand-alone tracking form, screening form, and closing summary form (see Appendix 7). A review of the forms developed for the SMI was undertaken to determine if relevant data was being recorded to enable the ongoing evaluation of results and processes. An additional purpose for doing the file reviews was to elicit feedback for WCFS on any needed adjustments to the SMI tracking form.

The evaluator devised a plan of copying, indexing, and transcribing data. Wengraf (2001) stresses that it is important for evaluators to work slowly through this stage in order to better manage the abundance of information and memories. The evaluator should answer initial questions by reviewing the information collected. This is because new questions may come out during data analysis, whereupon the evaluator must re-analyze the data (Bloom, Fisher & Orme, 1999). Data from the EA for the SMI was analyzed qualitatively by producing comments along the side of a paper simultaneous to it being transcribed in order to build an understanding of the information as well as record the evaluator's reflections. Numbers were written beside data to code information as it was summarized for the final evaluation report.

Design of the SMI

It is important to note that changes to the SMI were occurring at the time these interviews were conducted, and some of these changes produced confusion and questions in the minds of staff. However, as issues arose, measures were taken by the Branch to address them. Before discussing these challenges in more detail, I will summarize whether respondents felt the field model was

congruent with the document's model and managers' expectations. The focus will then shift to feedback on the SMI and some recommendations for the program.

As described in the document's model, stakeholders said that the SMI was developed because of the cycling of families through the system and, in many cases, children were entering care because of parental substance use. The structure of the Initiative was described fairly consistently with what the documents and managers outlined. Many of the intake workers who were interviewed referred to auxiliary staff as the SMI and did not acknowledge that they too are a part of the Initiative.

In addition to what is stated in the document's model and managers' model, clients were described as having low self-esteem, being less educated, often shy, and frequently isolated from others. Family members were portrayed as low income, living in poor housing, and with few supports in their lives. Most clients were described as individuals of aboriginal descent who would likely prefer an aboriginal worker. It was said that parents are self-medicating with substances as a way of dealing with their world, which is often perceived in negative terms.

There seems to be some understanding from supervisors and staff who work on the SMI about its goals and objectives (see Appendix 1). People had a clear concept of the goals to improve service quality, to reduce recidivism at intake, and to reduce both the number of days and the number of children that enter care. Many people agreed with and felt that the goals for the Initiative are appropriate; however, a few staff voiced some skepticism with two goals of the SMI. These issues will be reviewed further, but one concern that people mentioned in relation to

the goals is uncertainty that all clients are being targeted. Upon analysis of the goals, and with the feedback from the field, management were considering if there should be a revision to the seventh goal, which is to reduce the number of families who return to the Branch for service. Management also stated that they were considering whether or not to revise the ninth goal, which is to increase employee job satisfaction.

In general, SMI supervisors and staff described the referral process as it is summarized in the managers' model (see Appendix 5). The managers' model made mention of the Crisis Response Unit (CRU) directly referring families to the auxiliary programs. As stated earlier, it was confirmed that CRU will not directly refer families for further service. In order to refer families, CRU needs to carry cases and, thus, perform the role of case managers, which is not a part of their normal responsibilities. The referral process remains focused with families experiencing their first contact with the Branch at the CRU. When the CRU feels there are valid concerns, one of two intake units further assess the situation in relation to the parents' substance use. From there, and when appropriate, the family is referred to either the family preservation unit or the community based early intervention program via the Screening Committee. Uncertainty among service staff about the referral process is discussed in more detail later. One issue raised is that intake workers are unsure which families to refer for further services and whether the families they do refer are appropriate. Another concern relates to an auxiliary worker accompanying intake staff on initial visits to families. Staff said it would be overwhelming for families to have two workers at the initial meeting.

Staff reported consistently between their actual work activities and those outlined in the document's model and managers' model (see Appendix 4). SMI workers described doing motivational interviewing, identifying the stages of change, and making referrals to substance abuse agencies. Family preservation workers, family support personnel, and community based early intervention staff said that they spend a lot of time helping families with concrete issues such as finding adequate housing and establishing proper health care.

The implementation of the SMI was generally occurring as outlined in the document's model but many of the issues identified by managers were still being sorted out. Internally, staff identified some difficulties in working collaboratively with other units. There was mention of confusion about staff roles and responsibilities as well as systemic issues at the Branch. These issues and others will be discussed in detail later in the report.

At the time of the interviews, nine staff from the SMI had completed the four days of substance abuse training. Seven workers had yet to finish the last two days of training while one person had not attended any of the training. Overall, staff regarded the training on substance abuse as beneficial; workers said it provided them with a framework to apply to their work, although it lacked an aboriginal perspective. While two of the staff did not feel they needed further information on substance abuse, most workers identified additional consultation needs. These needs ranged from wanting more data on specific drugs and how they impact people, as well as acquiring ideas on how to cope with clients not following through with meetings. Staff also wanted information regarding the street life of substance users and how to work with pre-

contemplative clients. At the time of the interviews, consultation with AFM was just beginning and these training issues were beginning to be addressed.

The document's model refers to collaboration as an important component of the SMI. When staff were asked what collaboration meant, a variety of definitions were identified. The most common definition was that collaboration meant "working together". Another dimension of collaboration referred to how often people got together and how well things flow between staff. Other aspects of collaboration were understanding and supporting each other's roles and responsibilities, and a "sharing of responsibility". Collaboration was also said to be a sharing resources, being on a first-name basis with people, or having more than one person working on a case. The manner in which staff members speak about and value what others bring to the process was also considered collaboration. Another aspect of collaboration was WCFS workers learning the language used at treatment agencies and how these agencies work with substance using families. While none of the explanations of collaboration noted earlier are inappropriate, they illustrate the multidimensional nature of this construct and demonstrate how different interpretations may affect opinions about whether or not a desirable level of collaboration is being achieved.

As stated earlier, Initiative workers are beginning to collaborate with many agencies including both substance abuse service providers and other community resource programs. Substance abuse agencies that were identified as potential collaterals include the Addictions Foundation of Manitoba (AFM), the Native Addictions Council (NAC), the Behavioral Health Foundation, the Nor'west Mentor program, Peguis All Care, and Sagkeeng. Additional collaterals referred to in the course of the interviews include Mamawi, the Manitoba Metis Federation, the Main Street

Project, the Salvation Army, schools, Women's Advocacy, clothing closets, and churches. Manitoba Housing, Employment and Income Assistance, Marymound, New Directions, Aboriginal Health and Wellness, and the Department of Corrections were also identified as relevant collaterals. The frequency and level of collaboration between WCFS and these agencies was described as being in the learning stages and, therefore, weak.

Implementation Issues

While there appears to be clarity in the document's model and managers' model regarding the implementation of the SMI there was some uncertainty in the field regarding implementation. Four major issues were identified by the SMI staff as having an impact on the initial implementation of the program. Some of these issues are similar to those mentioned in the managers' model. Some new problems were noted which related more specifically to the front-line staff. These issues were associated with the referral process, internal collaboration, external collaboration, and the challenges associated with engaging with families who have substance abuse issues. The following data outlines the issues as they were reported. This will lead into reviews of how the challenges were addressed as well as their related outcomes. An analysis of people's beliefs about the Initiative, its implementation, and related issues will follow.

1. Referral Process and Criteria

The first implementation issue relates to the referral process and criteria used for referrals. As the program was being delivered, a number of changes were made to the way cases were referred to the SMI. For example, structural changes to the intake program resulted in an expanded role by the Crisis Response Unit (CRU). This unit provides short term, call out, and emergency services

to families within twenty four hours of a call to the Branch. When the SMI was initially developed, CRU did not screen out families before they went to intake, which they now do.

Another issue related to the referral process was the lack of clarity concerning referral criteria. In particular, many intake workers who were interviewed said they were unsure if the families they referred were appropriate or if they should refer both voluntary and involuntary clients. Some staff also felt that by focusing on low-risk cases, higher risk families were not being helped even though they have a greater need for service.

An additional challenge associated with the referral process is the intake workers' role as case manager. Originally, the intake supervisors held this responsibility once their workers assessed a family with substance abuse issues and referred them to auxiliary staff. This was modified when it became apparent that the families served by the program often require the services of a case manager (i.e., apprehension or transfer to family service).

A change that was considered as a means to resolve issues with the referral process was for joint initial meetings that includes both an intake staff and an auxiliary worker. This was proposed as a way of reducing the time and number of contacts a family experiences before they receive auxiliary service. It was also meant as a way of improving the timeliness of service so that intervention could be offered at the time of crisis; a critical move when dealing with substance abusing parents. A schedule was developed which ensured that an auxiliary worker is available any time during the day to be contacted by intake staff to accompany them on fields. This system was not utilized and in fact workers had mixed feelings about the strategy. In the interviews

many people stated that this was unnecessary and that having two staff members meeting a family at once was overwhelming for clients who may be intimidated by WCFS involvement. Management agreed that the joint intake meetings were not necessary but could be used as needed. Table 1 outlines the issues that were identified in relation to the referral process.

Table 1: Referral Process and Criteria

Issue	How the Issue was Addressed	Outcome
1.Structural changes to the Intake program resulted in an expanded role for the Crisis Response Unit (CRU).	• Consideration was given to have CRU as an outreach service. • The addition of a CRU supervisor on the Steering Committee was made. • CRU staff and supervisors were trained on the new model of dealing with substance abuse so they can use the same language as the SMI team.	Resolved Resolved Resolved
2.Lack of clarity around referral criteria.	• A document was developed outlining the referral process. • More regular meetings are being arranged with and without management and SMI staff.	Underway Underway
3.Focusing on low risk cases means higher risk families are not being helped when it is felt they have a greater need for service.	The SMI started with lower risk families. The Steering Committee reviewed a request to serve higher risk families in attempt to increase the number of referrals but decided to remain with the initial target group of low to medium risk families.	Resolved
4. Role of the Intake workers.	Initially the role of case manager was the intake supervisors responsibility. Intake staff have since been given this role. This creates additional workload for intake staff increasing their responsibility for a family they have little involvement with. A document was developed outlining how intake staff will be kept up to date on families. Every 20, 40 and 60 days auxiliary staff are to send reports to intake workers outlining the families current situation and progress.	Under Process

2. Internal Collaboration: Staff Roles and Responsibilities

One of the unique features of the SMI is the reconfiguration of existing resources resulting in collaboration to provide service to families with substance abuse issues. Internal collaboration is identified as an important goal of the Initiative. One objective that relates to this goal is for all staff involved with the program to receive the same training. This enables a common language and theoretical framework across various staff groups involved in providing service through the Initiative. Three family service units were also targeted to receive this training even though they are not directly involved with the program. This was done because these units would eventually be receiving families who were served by the SMI. Although the training was a positive strategy toward increased collaboration, staff and managers who were interviewed identified some challenges with internal collaboration. These challenges relate to how to develop more cohesive cooperation across programs.

Problems associated with collaboration include the following: workers feeling uncertain about their roles and responsibilities; staff feeling disconnected from other aspects of the program; and the confusion regarding the different mandates for the various units involved with the project. Some staff were confused about their job description, which for some was a result of changes that were made to their role. An example of this is the role of intake workers as case managers. The Initiative was initially designed to limit the roles and responsibilities of the intake worker because of both workload and concerns regarding responsibility for cases with which they may have little involvement. In the end, this resulted in greater confusion and the intake worker has since been designated the case manager.

A strategy was developed in order to address the concerns of the intake worker regarding their role as case managers. This was done because intake workers were concerned about their role as case managers, noting they felt uninformed about families once they went to auxiliary units and asked for regular feedback on families that they have referred to auxiliary staff. In response to this, a guideline was developed that describes how auxiliary workers will keep intake staff up-to-date on the cases. Essentially, a report from the auxiliary workers is to be sent to intake staff every twenty, forty and sixty days of service with a family in order to update the intake workers on the case. The information is a summary of client contact that the auxiliary worker has had with the family, any child safety issues, and any action that has been taken to address them prior to file closure. In addition, when emergency issues arise the intake staff are to be notified immediately and a consultative approach between the auxiliary staff and intake personnel is to be used to resolve the matter.

The second issue, as noted by management and service staff, is a concern that the SMI will not achieve all of its goals. One person referred to the goals as being too broad, while others were unsure if they were all being implemented. Intake staff believed that the cycling of families is normal and questioned the need for a goal to reduce families returning for service. As stated earlier, management has agreed to review the goals to ensure that they are all still appropriate.

The third issue noted by SMI workers concerns the systemic issues within the Branch which make it difficult to implement the Initiative. It was stated that each unit involved with the program has its own policies and mandate that the Branch has to follow. Staff felt that it was difficult to do a harm reduction plan within a child welfare mandate. Asking a mother to reduce

her alcohol intake, for example, may be helpful for her, but the continued consumption may still be enough to uphold concerns for her child's well-being. It was determined that many of these issues are unavoidable and the SMI team will have to be creative in order to work around them.

Another confusion that arose relates to the use of support workers. When the SMI was initially developed, the family support needs of clients were unknown. It was felt that the best resource for families would be education on child care issues. Early on in the program it was discovered that the family support workers were underutilized. Auxiliary staff noted that they found it difficult to put additional resources into place when many families were not engaging in service. In addition, because referrals to the program were low, it followed that there were few referrals to the family support staff.

A respite worker from the family support program was added to the Initiative in an effort to match resources with the needs of families. Although the respite worker has been in place for some time respite services and the services of the other family support worker continue to be low. Attempts have been made to ensure that auxiliary staff utilize the family support resources to their fullest potential. At the time of referral, for example, auxiliary staff have been asked to consider what role family support can have in the case. The family support resources can also be used when a case is being prepared for transfer to family services. Table 2 shows the issues related to internal collaboration.

Table 2: Internal Collaboration: Staff Roles and Responsibilities

Issue	How the Issue was Addressed	Outcome
1. Workers are uncertain about their roles and responsibilities as well as what will happen when the AJI-CWI begins.	• Ongoing meetings are arranged for management and staff to discuss roles and responsibilities. • A document was developed by the project coordinator and finalized with the assistance of the Program Manager of intake and family intervention as well as four SMI supervisors. The case manager role was established and clarity was provided relating to intake workers and auxiliary staff roles and responsibilities. An agreement was reached outlining auxiliary staff expectations. OUTCOME: 1. The development of the written protocol every 20, 40, and 60 days. 2. A schedule has been developed for the four SMI supervisors to meet monthly. Scheduled meetings are to begin in September 2004. Initiative staff meetings will be considered and planned for by the four supervisors.	Ongoing Ongoing Under Process Underway
2. Recording policy is unclear.	• Improved communication among SMI staff. • Joint intake and auxiliary staff doing initial meetings with clients • 20, 40, and 60 day updates from auxiliary staff to intake workers regarding families.	Under Process
3. Concern that the SMI will not achieve all of its goals more specifically concerning job satisfaction and families returning for service.	• At the time of the EA it was determined that the goals of the SMI need revision, which will be done by the Steering Committee	Underway
4. Early on it was discovered that the family support program is not being used when it should and it is underutilized.	• It was discovered that the needs of the families regarding family support services relate mainly to respite, so an aboriginal family support worker respite worker has been added to the Initiative. • At the Screening Committee, efforts are being made to determine when family support services would be beneficial to the family as a way to get them involved more quickly. • When a family is being transferred to family service, the family support worker remains involved as a part of the transition.	Resolved It remains an ongoing challenge to have auxiliary and intake staff lead with a support worker early in the intervention process

3. External Collaboration and Other Influences

Supervisors, service staff, and personnel from outside organizations that were involved with the SMI identified issues with collaboration between the SMI staff and external agencies. The restructuring of Manitoba's child welfare system, and more specifically the development of the Aboriginal Justice Inquiry-Child Welfare Initiative (AJI-CWI), created significant uncertainty for external agencies. The AJI-CWI is a new province-wide project that will result in the delivery of child welfare services under the auspices of four different authorities. Unless each authority recognizes the value of the SMI, they may not utilize it and, thus, its service could end.

When asked, staff mentioned concerns regarding the minimal level of external collaboration established thus far. One concern was in respect to the different mandates of WCFS and substance abuse treatment facilities. Different mandates for these organizations often resulted in incompatible ways to assist families. The other concern is in regards to the lack of aboriginal focus in the SMI because of setbacks in establishing collaborative efforts with a treatment facility that addresses the unique needs and history of aboriginal people. At the time of the interviews, collaboration with an aboriginal treatment agency was still being developed.

The first issue raised by staff regarding external collaboration concerns past relations among the various organizations. During the interviews a comment was made regarding the amount of power that WCFS has over families making it hard for other agencies to refer and share information with the Branch. It was also stated that the negative view created by previous actions of WCFS, particularly among aboriginal agencies, has made it difficult to establish collaborative working relationships. A related issue is confidentiality in that agencies are reluctant to share

information about a family or individual. At the time of the interviews external collaboration was beginning to be established. Respondents felt that external collaboration would be enhanced as the program continues to develop.

The second issue raised during interviews revealed that many staff members felt the difference in agency mandates between WCFS and substance abuse service providers made it hard to collaborate. The Branch was established to protect children, while substance abuse treatment facilities were developed to assist people with substance abuse issues. To be able to assist a substance-abuser a facility must focus on the need of the individual. WCFS, on the other hand, is concerned with the well-being of children, which means that the needs of parents may be secondary to ensuring the safely of the children.

The third issue in relation to external collaboration concerns the project's perceived lack of aboriginal perspective. Various respondents who were interviewed noted that most families served by the Initiative are First Nations and Metis, while the majority of staff are not aboriginal. Many of the SMI staff are Caucasian, thus, they are unaware of many of the aboriginal cultural practices. Learning the customs of aboriginal people could further enhance services to the aboriginal families who practice their cultural traditions. The focus of the Initiative has been adapted from the Addictions Foundation of Manitoba (AFM), and the B.C. Practice Guidelines, which do not pay particular attention to the historical and cultural issues affecting aboriginal families. Although the Native Addictions Council is deemed an important agency for the SMI to collaborate with, at the time of the interviews this association was proving to be difficult. As

noted earlier, work is being done to try and establish stronger relations with an aboriginal agency. An outline of the issues related to external collaboration can be reviewed in Table 3.

Table 3: External Collaboration and Other Influences

Issue	How the Issue was Addressed	Outcome
1. External agencies are not clear about the restructuring of Manitoba's child welfare system, creating uncertainty about the program. This relates to the development of the Aboriginal Justice Inquiry-Child Welfare Initiative AJI-CWI.	AFM mid and senior management met with representatives from the Steering Committee where upon the Branch informed them of the developments in the child welfare field at this time.	Underway Service staff have been made aware of changes to the child welfare system through meetings and written feedback
2. Other organizations do not focus on and/or understand child welfare although WCFS is mandated for this.	Information sharing, joint meetings, and written correspondence was shared across systems.	Underway Exploring further joint training experiences
3. Confidentiality also makes it difficult for agencies to share information about a family or individual.	Thought is being given to how this can be resolved.	Ongoing
4. The need for culturally appropriate practice in relation to overcoming substance abuse. A high percentage of the families that receive services from the SMI are aboriginal	• The coordinator and an auxiliary supervisor met with NAC personnel to inform them of the SMI. An increase in aboriginal respite/child care supports was recognized as missing in the Initiative. Recent hires have resulted in more direct involvement of our aboriginal staff with aboriginal clientele. • Consideration is being given to developing a "Coming to Terms" group for pre-contemplative clients struggling with substance abuse • Thought is being given to include some of the aboriginal cultural teachings in group programming	Under Process Under Process Under Process

4. The Challenge of Engaging Families

The inherent challenge of engaging with parents about substance abuse is the fourth implementation issue that is identified in this EA. Problems ranged from connecting with families, dealing with concrete stressors, working with low risk pre-contemplative clients, the length of service time, and uncertainty that the program is serving the right population. New approaches to overcome these issues include a group being developed in collaboration with AFM and two family preservation workers, as well as a flexible approach allowing auxiliary staff to join intake personnel on initial visits with families.

In designing the SMI, services are to be delivered for two months in order to offer intense, short-term assistance. Some staff have previously had difficulty closing files and suggested that if a family needs service, this should be extended for a longer period of time. However, management has confirmed that the length of service will remain at the sixty day cut-off. When necessary staff may refer families to a family service unit. This was done so the SMI does not drastically change from the original design of providing an intense service to families.

Staff expressed some discouragement regarding their interactions with low to medium risk, pre-contemplative clients. The issue here concerns the difficulty of engaging with clients when child welfare concerns are minimal or when there is a shift in focus. As stated above, some staff mentioned that focusing on concrete stressors leaves little time to discuss substance abuse concerns. It is felt that these tangible issues impact families greatly and make it hard for them to deal with their substance abuse. Management felt the focus should remain on harm reduction and support work, and not solely on child protection issues. What makes this difficult is that some

families terminate their involvement with SMI staff when the focus shifts to substance misuse. As stated earlier, consultation with AFM has begun, which will provide staff with resources and information that could help them to better assist and get connected with families.

As mentioned earlier, some workers had concerns the SMI was not targeting the right population. A suggestion was made to have the program serve higher-risk families. People felt this would increase the number of referrals and would likely result in more engagement. Conversely, some staff felt that if SMI expands it would change the focus of the Initiative. A couple of workers recommended the program resolve the implementation issues that now exist and then expand services. While consideration was given towards expanding the project, a final decision was made by management to maintain the original plan and serve only those initially targeted. For a full review of the issues related to engagement see Table 4.

Table 4: The Challenge of Engaging Families

Issue	How the Issue was Addressed	Outcome
1.Connecting with families.	• Groups are currently being developed to provide additional services to pre-contemplative clients. • Joint meetings with families at Intake is a cross program strategy designed for quicker interventions	Underway Resolved
2. Dealing with concrete stressors resulting in little work being done regarding substance use.	More regular staff meetings have been established to address these concerns.	Under Process
3. Working with low risk pre-contemplative clients	AFM consultancy training is focused on training staff on how to move clients through the stages of change.	Resolved
4. Auxiliary service intervention and recording timeliness plus the movement of intake staff to a case-managing role.	• A decision was made to have the service time remain at the original length of sixty days with reports being provided to intake staff every 20, 40 and 60 days. • A roles and responsibilities document was developed with senior mangers and mid managers involved with the SMI.	Resolved Under Process
5.Lack of staff's ability to impose their involvement when child welfare concerns are minimal or when they have to shift their focus when these concerns arose.	A higher number of regular meetings are established to assist the staff with their concerns, provide further training, and continue workers skill development.	Under Process
6. Uncertainty that the program is serving the right population.	A decision was reached at the Steering Committee to continue to serve low/medium risk families because of the original design and the need to give staff time to develop collaborative working relationships.	Resolved

Summary of the File Review

File reviews were done to determine what data is being recorded regarding family demographics, what services are offered to families, and what outcomes have been achieved. The purpose of the file review was to determine the consistency with which information is recorded and whether the formation will yield useful data for a complete evaluation of the program. A complete summary of the file review is included in Appendix 8.

Reviews were done on the closed files of families who had received service from the SMI. At the time of the reviews there were only six closed files to examine. The files contained a clear description of the demographic information of each family. All six families had had their file opened with the Branch more than once. Reasons for file openings ranged from parents leaving children unattended, to children viewing pornography, to inappropriate care giving. Five out of six of the cases included an explanation of the parenting issues. Half of the files documented the parent's stage of change as assessed by the intake worker. At closure, the parent's stage of change was documented in only two of the six files. Face-to-face meetings with a substance abuse service provider was not recorded in any of the files. Two of the files recorded the interventions used with the family which included substance abuse screening and assessment, the development of a harm reduction plan, education, and counseling. The other four files noted that parents refused service; thus, interventions were not possible. None of the files documented if family goals/objectives were reached satisfactorily or if the risk to children was reduced.

Two files did not have a screening form attached to them. Files that did include the screening form were complete, but only one of the four files had a record of the responsible tip sheets

being used. In order to avoid repetition, information gathered from the screening form was the same as the file review data. In the closing summaries, half of the files described the contacts which had occurred during service delivery. These contacts mainly included phone calls and letters being sent to the homes. In two cases, there was mention of face-to face contact but the contact was brief and involved the activities noted earlier. A description of both historical and current issues that had impacted the family were documented in three of the files. These issues included alcohol use, child abandonment, and the use of inappropriate caregivers. None of the files described how substance use impacted a parent's ability to care for his or her children.

The file review revealed what information is kept on file for SMI families. The review was done to determine if the files would be a good source of data for the evaluation of the program. Of particular interest, the reviews revealed that the Initiative serves a high number of pre-contemplative, single mother, aboriginal families. This reinforces the need for an aboriginal perspective to be integrated into the program.

An analysis of the file review concludes that more data will need to be recorded in order to evaluate the program and conduct a full comparison of the families that received services with those that did not. If data is kept of the clients responses to the twenty questions, as was originally intended, then a comparative study could be undertaken. This could look at families who were served, where people were at prior to service, what interventions they received, and what changes occurred.

Outcomes for Families

Based on an analysis of the interviews, a variety of different outcomes for families who received service from the SMI were identified. Workers stated that some parents made some progression through the stages of change. Staff noted that a few families increased their support network and became aware of and used resources in the community. In a couple of cases workers felt that parents were abstaining from their substance use while other situations presented parents as better caregivers. Staff noted that a few mothers followed through with harm reduction plans that had been established for them. Workers mentioned that in some situations children were apprehended and the file was transferred to a family service unit for further service. A couple of families were reported to have returned for additional service. In these cases the workers said they picked up with the family where things had been left off by re-addressing material that was discussed in the past. On two occasions a letter explaining the service of the SMI was sent to families who called and requested services; these resulted in active cases.

In situations where families had made changes, staff noted that these changes likely resulted because of the families involvement with the SMI. It was also stated that outcomes were dependent on a client's willingness to change prior to being involved with the program. When workers were asked why they felt there had not been change in some families, most said that it was because the families had not engaged with auxiliary staff. These families were described as resistant to help and as denying their substance use.

Staff Recommendations

For years, when Winnipeg Child and Family Services (WCFS) became involved with families, intake workers were not expected to spend much time looking at the life situations which had led up to the client's substance abuse. Originally, the focus had been on providing a "caution and warm" service as well as referring clients to outside resources. More complete assessments, which may have helped families address substance misuse issues contributing to child welfare concerns, were likely not done because they had not been a part of the Branch's intended service. The SMI, which relates to findings in the literature mentioned earlier, is the Branch's attempt to utilize a coordinated, client-focused approach in order to deal with substance abuse by using both the harm reduction model and motivational interviewing techniques. An important component of the program is collaboration among staff and substance abuse service providers in the community. Collaboration is necessary because of the Initiative's focus on establishing a healthier home life for all family members.

Many people interviewed believed that the SMI is a practical way for the Branch to address the present needs of families. Program staff acknowledged and supported the principles of the SMI and felt that it is being delivered in a timely manner. Many respondents had a positive opinion of the program and noted that it is beneficial to target a group of people who otherwise would not receive service. Training and consultancy with AFM was said to be useful for SMI staff. The training gave staff who worked on the Initiative more expertise, skills, and abilities in relation to working with substance abusing families. External stakeholders noted that the SMI is an innovative way to work with families, not only in relation to their substance use, but also in dealing with the concrete stresses in their lives. When comparing the outline for the SMI to

available literature, it was believed that the program has the capacity to both address the basic needs of families and focus on prevention. This focus on prevention is viewed positively by staff and management involved with the Initiative because the focus provides a new and effective way of seeing families and providing assistance before a crisis occurs.

One manager believed that a strong sanction from management is important to ensure the success of the project. More regular meetings were deemed necessary for SMI staff in order to clarify their roles and activities, to ensure consistency in service delivery, to address differing views, and to avoid the risk of a drift in service.

Many intake workers interviewed were opposed to case-managing SMI families while auxiliary staff provide service. These staff were concerned about the additional workload case-management would create as well as taking responsibility for a family with whom they would have little involvement. Some intake workers were unclear about the referral criteria as well as their role with cases. Given the role that intake staff have in identifying and referring families their understanding and support of the referral criteria and process is considered important. At the time of the interviews, it was believed that the lack of clarity concerning referral criteria and the fact that intake staff did not want to case-manage might have impacted on the low number of referrals. Lower than expected referrals did affect workload for auxiliary staff and family support workers. It is hoped that with greater clarity around referral criteria, process, and roles more families will be referred for service.

Frustration was evident for some intake staff who believed they could do a lot of the educational work with resistant families rather then referring them on to an auxiliary unit. Anxiety also existed for some workers who had difficulty establishing relations with staff on the SMI and felt that the team was not working together very effectively. During the interviews it was confirmed that some progress had been made with respect to these concerns and some people believed that in time things would improve further.

Discomfort with changes in staff roles and responsibilities is often a part of the implementation process in developing a new program. Nevertheless, these changes have contributed to staff confusion in terms of their own roles and responsibilities, as well as the roles and responsibilities of others. In awareness of this, there was an understanding among management that they have the added responsibility of regularly updating and informing staff of changes in job expectations.

Some staff recommended that regular meetings for all SMI workers would improve internal collaboration. Staff said that the meetings could be used to clarify and discuss each worker's role as well as their concerns about individual cases. The documents note that regular meetings are an essential means of clarifying staff duties and of ensuring that staff conduct their jobs as intended. At the time of the interviews, it was said that irregular meetings were occurring among auxiliary staff and family support workers.

When asked, staff from outside agencies were unsure just how successful WCFS has been in promoting the SMI to other organizations in the community. They were also uncertain about how much their own employees know about the project. It was suggested that the Branch make more

effort to inform other organizations about the Initiative. Stakeholders felt this effort would ensure that outside agencies were educated on the SMI and that this would help improve collaboration with external service providers. It was also recommended that Initiative staff continue to learn about the role of substance abuse agencies as a means of better preparing families for treatment. In this way, education could be a mutual partnership between the Branch and substance abuse service providers. The SMI documents and literature that was reviewed reinforce the importance of educational exchange between external agencies and WCFS as a means to enhance collaboration. At the time of the interviews it was established that consultation with AFM had begun, and this had helped to increase everyone's knowledge. Staff said that the consultation provided them with ongoing education regarding substance abuse, which helping them conduct their jobs more effectively. Some people suggested that additional training for external agencies regarding child welfare issues could help them understand the mandate of the Branch.

A strategy to promote increased collaboration was suggested by one respondent. This idea was to implement a co-facilitated group run by both SMI staff and a substance abuse counselor. It was believed that pre-work could be done with parents in the groups that would help them move along the stages of change which would benefit them when they enter treatment. Increased understanding would be promoted by having the two organizations work together to implement the groups and thereby incorporate their different interests. One SMI staff added that s/he wanted to facilitate groups using "Wolves" –an aboriginal perspective for dealing with substance abuse- as a twelve-step program. At the time of the interviews it was said that some SMI staff were preparing to deliver groups but, as noted earlier, work still needs to be done to incorporate aspects of the aboriginal culture.

Positive Aspects of the Program

Before discussing the evaluable program model a brief summary will be provided outlining the benefits of the SMI as viewed by the evaluator. This Initiative deals with an extremely sensitive issue that is serving a challenging and often highly disadvantaged group of families. It is felt that this program is an important project that should be maintained because it attempts to meet the needs of families before things become totally unmanageable.

Considerable effort along with a variety of strategies are being implemented to try and engage these families, many of whom are resistant to addressing their substance misuse issues. However, these efforts are important in trying to establish an effective early intervention model of service, a strategy which in the long term is likely to lead to improved outcomes. As stated in the literature, parents who are dealing with substance abuse often do not want to, nor do they intend to harm their children. Thus, it is important to establish a more proactive service model.

Collaboration among the Branch and substance abuse agencies as well as between the SMI staff is viewed as an important aspect of the SMI. No one person or agency can provide all the services that are needed to help any family. But, WCFS working internally as a team and externally along side treatment facilities can only enhance the services that a family receives.

CHAPTER 5

A PROPOSED EVALUATION PLAN

Evaluable Program Model

The evaluable program model for this study emerges from information that that was presented in the document's model, the managers' model, and feedback from the field. To avoid repetition refer to these earlier sections of the report for a clear outline of the design and implementation of the Initiative. Program components, as well as the project's goals and objectives, were identified and defined in order to determine their evaluability. Any causal links between the components, program goals, and objectives were described. The data that was collected was used to arrive at an evaluation plan and evaluation questions for the SMI. A discussion of the evaluation issues that were recognized in the study will be presented next. The report will now turn to identifying which goals and objectives can be assessed and how this can be done. Some goals are not evaluable at this time, and the report will identify what needs to be addressed before these goals can be evaluated.

Most people interviewed had a positive opinion of the Initiative. Some felt that the Initiative promoted a realization that substance use is not simply about a person using substances, but also about a person experiencing consequences from that use. Interviewees felt that the program represented WCFS in a positive manner, provided the Branch with an opportunity to get to families earlier, and bridged services across the Branch and with external agencies.

Evaluation Issues

A brief analysis of the feasibility of conducting an evaluation of the SMI is presented in this section. A review of the goals and objectives of the SMI will help to establish which ones can be evaluated as they exist and which ones require revision. For instance, in order to determine if the goal of collaboration has been established the evaluation could focus on the key issues related to collaboration and how they impacted service results for families. Questions could relate to the level of family satisfaction with the program, if there were changes in the family situation, and if fewer children entered Branch care and stayed in care for shorter periods of time because of the interventions that were offered. Incorporating these aspects in to the evaluation could show if the program was beneficial to both families and the Branch.

Evaluation of the Program Goals

There are nine goals for the Initiative, seven of which could be measured in an evaluation as they are stated. Two goals for the program should be reviewed by management to identify if they can realistically be attained, or if they require modification. A review of the goals could also determine if any additional goals could be considered. An example of an additional goal could be to determine how well the services of the SMI meet the needs of aboriginal families. Ensuring that service staff understand and carry out their jobs as efficiently and effectively as possible will support the achievement of the goals and increase the feasibility of an evaluation intended to measure them. An outcome component as well as a process aspect to the evaluation could test which goals have been met and how successful the SMI has been at achieving them. It should be noted that measuring the goals of the SMI requires an outcome component of the evaluation, which is consistent with the Branch's focus on whether the Initiative makes a difference.

The first goal is to increase service quality for families. In order for this goal to be measured management should determine exactly what service quality means. Currently, there is no established meaning for service quality so some suggestions of how to overcome this issue are discussed later in the report. With this understanding an evaluation could then measure how successful the Branch was at achieving this goal.

The second goal is to increase the number of parents with substance abuse issues who engage in substance abuse rehabilitation/support services. The existing Tracking Form does have the capacity to gather information on whether the family was referred to addiction treatment service but depending on the case circumstances, it may or may/not be possible to determine whether the parent actually "engaged" in the service to which they were referred. It is acknowledged that the Branch is making efforts to ensure that the twenty questions, from the B.C. Practice Guidelines, designed for the SMI are completely answered in order for this to occur. These twenty questions incorporate a section about a parent's commitment to recovery and explore treatment options.

The next two goals relate to collaboration and are considered together in relation to their evaluability. The third goal is to increase collaborative activities between Initiative staff and substance abuse service providers as well as other community service providers. The fourth goal is to increase cross Branch program collaboration. As stated earlier, if there is a clear definition of what collaboration means then an evaluation could assess whether or not this is achieved. Interviewing staff from the SMI as well as personnel from outside agencies could be done to establish if these goals are achieved.

The next two goals relate to decreasing costs to the Branch. Thus, the fifth goal is to decrease the number of children that enter Branch care as a result of parental substance abuse and the sixth goal is to decrease the length of time children are in Branch care. Both of these goals could begin to be measured as they are stated by reviewing family files and determining how many SMI families children entered care and for how long. The statistics could be compared to information that was gathered in the Families Returning for Service study to see if they were any decreases in numbers and length of stay for children in care. As well, an assessment could be made of all the files that were reviewed over the four years of the evaluation to determine if there was a decrease in the number of children that entered care as well as the length of time they were in care.

The seventh goal is to decrease the number of families with substance misuse issues who return for Branch service. During the course of the EA it was established that this goal should be reviewed because it may not be a negative thing for some families to return for services. Before this goal could be measured a final decision should be made about how a return for service should be interpreted.

The eighth goal is to increase workers' knowledge with respect to current approaches in the substance abuse field and to increase the skill level in the areas of substance abuse screening, assessment and intervention skills. This goal could be measured by determining what services were offered to families and if those services lead to positive outcomes for families.

The ninth goal is to increase workers' job satisfaction. There was concern raised during the EA that this goal may not be attainable. Management stated that they would be reviewing this goal to

determine how to measure workers' job satisfaction or whether to reword the goal so that it fits with the intent of the program. One reason for this is because it would be difficult to measure an increase in job satisfaction. As well, it is unclear if one should reasonably expect the Initiative to lead to increased job satisfaction as there are so many other factors that can affect this. Lastly, it is questionable that the SMI be designed to have this as a short-term goal as it currently reads.

In relation to the objectives of the Initiative these relate to the implementation of the program and link to the achievement of the SMI goals. It makes sense to evaluate the objectives of the program because they can establish if implementation issues were resolved and whether service activities are likely to lead to goal attainment. A process component for the evaluation could determine whether or not objectives have been achieved. Generally the objectives, as stated, are evaluable and appear to be designed to lead to the realization of the goals.

Evaluation of the Program Objectives

The first objective is to develop a cross program team of Branch service workers who can respond to families who are misusing substances at intake. The program has established four different units at the Branch who currently work on the SMI. This objective could be evaluated by assessing if and how well the staff who work on the Initiative are working together to assist families that the program serves.

The second objective is to provide specialized training for Initiative staff to deal with harm reduction, stages of change, and motivational interviewing. A majority of the staff who are involved with the Initiative have received the training in relation to substance abuse as well as

the current models that are being implemented to assist substance abusing families. As identified in the EA, this objective has, to a considerable extent, already been achieved. One could assess this issue further with the staff who did not complete the training, and it is possible to further examine whether additional training is required.

The next three objectives deal with work that is being done with families who receive the SMI services; thus they are addressed together in relation to their feasibility of measurement in an evaluation. The third objective is to complete a substance abuse screening/assessment with each family referred to the Initiative using the B.C. Practice Guidelines Questions for Parents. The fourth objective is to complete a comprehensive assessment and harm reduction plan with parents who are willing to work with Initiative staff. The fifth objective is to complete a contract with each family regarding their plan to reduce harm prior to file closure if parents are unwilling to work with Initiative staff. An evaluation of these objectives could be done by measuring whether or not workers are implementing these strategies/techniques and applying them in the work they do with families.

The sixth objective is for SMI staff to establish communication with the substance abuse service provider in order to share information, collaborate on harm reduction plan. During the EA it was established that collaboration was not that strong with outside agencies. Asking staff who work on the SMI as well as personnel from outside agencies if they have built better collaborative working relations with each other could assess this objective. In turn, by achieving this objective and the other five that were just mentioned the evaluation could then turn its focus to the goals of the program.

Program Model

A program model was developed and highlights some aspects that might be considered both in monitoring whether implementation is progressing as well as program outcomes. For example the model shows the activities, outputs, outcomes and impacts of the SMI that were considered for the proposed evaluation. This is illustrated in the program model see Table 5.

Table 5: Program Model for the SMI

Activities	• Assess Parental Substance Use as a Risk Factor • Addiction Screening of Parent • Identification of 'Stage of Change' • Motivational Interviewing • Contracting with families • Development of a Harm Reduction Plan/Agreement • Referral to Addiction Services • Provision of concrete supports • Child care/ respite • Community Mapping • Education • Counseling • Advocacy • Collaboration • Follow-up Services • Case Recording • Tracking of outcomes • Informational Support Groups • Coordination
Outputs	• A cross program team of Branch service workers who can respond to families who are misusing substances at intake is developed. • Specialized training for Initiative staff to deal with harm reduction, stages of change and motivational interviewing occurs. • A substance abuse screening/assessment with each family referred to the Initiative is developed. • For parents willing to work with Initiative staff, a comprehensive assessment and harm reduction plan with parents is developed. • Parents that are unwilling to work with Initiative staff have a contract completed regarding the parents plan to reduce harm prior to file closure. • Initiative staff will establish communication with the substance abuse service provider in order to share information and collaborate on harm reduction plans. • Increased workers knowledge with respect to current approaches in the substance abuse field and to increase the skill level in the areas of substance abuse screening, assessment and intervention skills. • Increased service quality for families.
Outcomes	• Increased number of parents with substance abuse issues who engage in substance abuse rehabilitation/support services. • Increased collaborative activities between Initiative staff and substance abuse service providers and other community service providers. • Increased cross Branch program collaboration. • Decreased length of time children are in Branch care. • Decreased number of families with substance misuse issues who return for Branch service.
Impacts	• Families become healthier. • Improved child well-being.

Acknowledgement of which goals and objectives can be successfully measured allows for inclusion of them in to an evaluation plan. In addition, the incorporation of the program model helps to establish a link between the program activities, outputs, outcomes, and the programs intended impact. The following section of this report will address a proposed evaluation plan taking in to considerations the issues and abilities of the program to be evaluated. In addition, if data collection is to include file information, a more consistent reporting format needs to be established, particularly in relation to content areas that will be reviewed for evaluation purposes. Currently, family demographic information is complete, but a summary of the services offered and identification of the stage of change upon service completion is still needed. Similarly, notification of collaborative activities that occur throughout the course of service delivery, as well as more thorough family histories, are needed in the closing summaries in order to evaluate if change has occurred. While such changes would necessitate some modifications to the tracking form, it could potentially facilitate a more comprehensive evaluation of the program.

Proposed Evaluation Plan

Outline of the Evaluation

The type of evaluation described in the SMI documents focused on tracking program outcomes. A number of methods were proposed, some of which have been incorporated into the evaluation plan proposed here.

The Initiative was originally developed as a one-year pilot project. Assuming that the program continues to operate, an evaluation plan is proposed which incorporates data collection each year over a four-year time frame. While the direct financial cost of any internally implemented

evaluation should be low, the time and effort required to complete it could be significant. Since only one employee works in the quality assurance unit at the Branch, additional resources would need to be allocated to complete the evaluation. Perhaps a future graduate student could assist in the implementation of the evaluation.

The program model, depicted earlier in Table 5, illustrates the activities, outputs, expected outcomes, and impacts of the program. The proposed evaluation is intended to examine program activities, outputs, and outcomes. This proposed evaluation plan is a tentative proposal and is subject to revision based on the needs of management at the Branch. The draft model to evaluate the SMI, as outlined below, includes the following:

- Discussion of a proposed evaluation design;
- Data collection procedures and sources for the data collection; and
- Ethical considerations.

Proposed Evaluation Design

The proposed design incorporates an evaluation that would include two components that would be measured over a four-year time frame. The first component of the evaluation could examine objectives of the Initiative where attention is also given to measuring how the implementation issues identified in this report are being addressed. The second component of the evaluation could focus on gathering data pertaining to the goals of the program; as such the focus would be on service quality and outcome.

As noted above, the first component of the evaluation could address program objectives as well as implementation issues. These areas require an emphasis on concepts mainly from a process evaluation; however, some questions relate to outcomes are included. Incorporating the process

style of evaluation into the evaluation plan could help determine if the needs of clients are being met; as well additional information on program operations could be generated. Feedback from staff and clients could offer the Branch information regarding the execution of the program as well as such aspects as the resolution of implementation issues, identified in this report. It is my assessment that the evaluation should first assess the achievement of program objectives because they are linked to goal statements, and if these are being achieved it makes it more likely that stated goals will be realized. For instance, the objective of providing specialized training for all Initiative staff in order to deal with harm reduction, stages of change, and motivational interviewing, should lead to an increase in workers' knowledge with respect to current approaches in the substance abuse field. The following program objectives can be assessed in the implementation component of the evaluation:

- To develop a cross program team of Branch service workers who can respond to families who are misusing substances at intake;
- To provide specialized training for Initiative staff to deal with harm reduction, stages of change, and motivational interviewing;
- To complete a substance abuse screening/assessment with each family referred to the Initiative using the B.C. Practice Guidelines Questions for Parents;
- If parents are willing to work with Initiative staff, complete a comprehensive assessment and harm reduction plan with parents;
- If parents are unwilling to work with Initiative staff, complete a contract with each family regarding their plan to reduce harm prior to file closure; and
- Initiative staff will establish communication with the substance abuse service provider in order to share information, collaborate on harm reduction plan, etc.

Outcome style evaluations measure the results of a program, aim to demonstrate the degree and nature of change for clients after they receive service, and help to measure where program staff and clients are headed as they work together. Outcome evaluation methods could assist WCFS in finding out if the Initiative led to change in a client's life and if these outcomes were positive. This information would provide data further for the first component of program implementation. Two goals, related to program implementation, which are more outcome oriented are:

- To increase workers' knowledge with respect to current approaches in the substance abuse field; and
- To increase the number of parents with substance abuse issues who engage in substance abuse rehabilitation/support services.

In the first year of the evaluation information could be collected focusing on the first component of the evaluation. Data could be gathered through interviews and a tracking form as described later in Table 6. Examples of process oriented evaluation questions for the first component of the evaluation are:

1. Was a cross-program team of Branch service workers developed that can properly respond to families who are misusing substances at intake?
2. Did Initiative workers receive training that would help them to conduct their job?
3. Have substance abuse screenings/assessments been completed by workers for each family referred for service?
4. Was a substance abuse comprehensive assessment and harm reduction plan developed for families who received service helpful in reducing harm at the time of file closure?
5. Was the contract developed with parents unwilling to work with Initiative staff able to reduce harm prior to file closure?
6. Did Initiative staff collaborate with other substance abuse service providers in the community in order to make plans for families?
7. Was there an increase in workers awareness' of their role with the Initiative?
8. Are procedure of the referral criteria and source clear and understood by all staff?
9. What were the experiences of family's while working with SMI staff?
10. What activities were operationalized to engage with families?
11. What is the level of engagement with SMI families?
12. Was an aboriginal component added to the program for aboriginal families who prefer a service based on their culture?

Examples of outcome oriented evaluation questions for the first component of the evaluation could be:

1. Are workers more knowledgeable about the current approaches in the field of substance abuse?
2. Is there an increase in the number of parents with substance abuse issues who engage in rehabilitation/support services?

Part one of the evaluation framework for the SMI is outlined in Table 6.

Table 6: Part One of the Evaluation Framework for the SMI

Evaluation Component and Questions	Data Collection Methods	Data Source
A. Implementation of the program		
1. Was a cross-program team of Branch service workers developed that can properly respond to families who are misusing substances at intake?	Interviews	• Managers • Service staff • Supervisors • Clients • External stakeholders
2. Did Initiative workers receive training that would help them to conduct their job?	Interviews	• Managers • Service staff • Supervisors • Clients • External stakeholders
3. Have substance abuse screenings/assessments been developed by workers for each family referred for service?	File Reviews Interviews	• Service staff • Supervisors • Clients • Tracking form
4. Was the substance abuse comprehensive assessment and harm reduction plan developed for families who received service helpful in reducing harm at the time of file closure?	File Reviews Interviews	• Tracking form • Managers • Service staff • Supervisors • External stakeholders
5. Was the contract developed with parents unwilling to work with Initiative staff able to reduce harm prior to file closure?	File Reviews Interviews	• Tracking Form • Managers • Service staff • Supervisors • External stakeholders
6. Did Initiative staff collaborate with other substance abuse service providers in the community in order to make plans for families?	Interviews	• Managers • Service staff • Supervisors
7. Were workers more knowledgeable about the current approaches in the field of substance abuse?	Interviews	• External stakeholders • Service staff • Supervisors
8. Was there an increase in workers' awareness of their role with the Initiative?	Interviews	• Managers • Service staff • Supervisors
9. Are procedures of the referral criteria and source clear and understood by all staff?	Interviews	• Managers • Service staff
10. What were the experiences of families while working with SMI staff?	Interviews	• Service staff • Clients
11. What activities were operationalized to engage with families?	Interviews	• Clients • Service staff

12. What is the level of engagement with SMI families?	Interviews	• Clients • Service staff
13. Was there an increase in the number of parents with substance abuse issues who engage in substance abuse rehabilitation/support services?	Interviews File Reviews	• Tracking form • Service staff • Supervisors • Clients • External Stakeholders
14. Was an aboriginal component added to the program for aboriginal families who prefer a service based on their culture?	Interviews File Reviews	• Tracking form • Service staff • Supervisors • Clients • External Stakeholders

The second component of the evaluation could begin collecting data in the first year of the evaluation but include further data collection for an additional three years. Thus, a longer-term of data collection would be necessary for this component of the evaluation. This component could incorporate both process evaluation questions as well as outcome evaluation questions. The focus of the second component of the evaluation could be on service quality and outcomes. Again, data could be generated from interviews, and the tracking form as described later. A sub-component of the service quality and outcome component of the evaluation could focus on the achievement of the following two goals, namely:

- To decrease the number of children that enter Branch care as a result of parental substance abuse; and
- To decrease the length of time children are in Branch care.

An additional sub-component of the evaluation could focus on the results pertaining to services offered in the Initiative. These goals of the program, which are somewhat more process oriented, that could be measured in this sub-component are:

- To increase service quality for families;
- To increase collaborative activities between Initiative staff and substance abuse service providers and other community service providers; and
- To increase cross Branch program collaboration.

A comparison group could be used to help establish whether or not it was the program that lead to change. Data relating to service quality and outcome could be compared to the statistics that were gathered from the two intake supervisors in relation to families that came to the attention of the intake units prior to the implementation of the SMI. Data from these statistics could be compared with information that is gathered from families who received services from the program. Suggested process evaluation questions that could be used for the comparisons include the following:

1. What contributed to the outcomes families experienced?
2. Were Branch standards met in relation to the services offered by the SMI?
3. Did the SMI provide the appropriate services to the families who received service?

Outcome evaluation questions for the second component of the evaluation could show how the program impacts both the Branch and SMI families. Possible outcome evaluation questions could be:

1. Were the SMI services beneficial to families?
2. Were families satisfied with the services they received from the SMI?
3. Was there an increase in collaborative activities between Initiative staff, substance abuse service providers, and other community service providers?
4. Was there an increase in cross-Branch program collaboration?
5. Was there a decrease in the number of children that entered Branch care as a result of parental substance abuse?
6. Was there a decrease in the length of time children were in Branch care?
7. What effects did the program have on families?

Table 7 outlines Part two of the evaluation framework for the SMI.

Table 7: Part Two of the Evaluation Framework for the SMI

Evaluation Component and Questions	Data Collection Methods	Data Source
B. Service Quality and Outcome		
Service Quality		
1. What contributed to the outcomes families experienced?	Interviews	• Service staff • Supervisors • Clients • External Stakeholders
2. Were Branch standards met in relation to the services offered by the SMI?	File Reviews Interviews	• Tracking form • Managers
3. Did the SMI provide the appropriate services to the families who received service?	Interviews File Reviews	• Tracking form • Service staff • Supervisors • External Stakeholders • Clients
Service Outcome		
1. Were the SMI services beneficial to families?	Interviews File Reviews	• Tracking form • Service staff • Supervisors • External Stakeholders • Clients
2. Were families satisfied with the services they received from the SMI?	Interviews	• Clients
3. Was there an increase in collaborative activities between Initiative staff, substance abuse service providers, and other community service providers?	File Reviews Interviews	• Tracking form • Service staff • Supervisors • External Stakeholders
4. Was there an increase in cross-Branch program collaboration?	File Reviews Interviews	• Tracking form • Service staff • Supervisors • External Stakeholders
5. Was there a decrease in the number of children that entered Branch care as a result of parental substance abuse?	Interviews File Reviews	• Tracking form • Service staff • Supervisors • Clients
6. Was there a decrease in the length of time children were in Branch care?	Interviews File Reviews	• Tracking form • Service staff • Supervisors • Clients
7. What effects did the program have on families?	File Reviews Interviews	• Tracking form • Service staff • Supervisors • External Stakeholders

The evaluation could begin by gathering data in order to determine if implementation issues are resolved and if the objectives of the program are achieved. The evaluation could then focus on service quality and outcomes in order to show trends in outcomes for the program and families. In addition, data relating to service quality and outcomes could be collected and used for comparison in the evaluation. One reason for assessing service quality is to establish if the Branch and families are better off because of the services offered from the program and provide some useful information on the benefits of the Initiative. The evaluation could assess if the services meet families needs and/or the standards set by the Branch when the program was first designed. This could be done as long as the standards set by the Branch relate to the ability of the SMI staff to connect people to relevant community services, if families concrete needs have been met, and if clients are satisfied with the program.

Data Collection and Analysis

In order to collect data for the first component of the evaluation a post-test only design could be used for interviewing key informants in order to gather their perspectives on service delivery, to determine if services were beneficial, and to find out whether or not implementation issues were resolved. In the first year of the evaluation fifty clients could be questioned after they received or were offered services from the program. Half of the interviews could be done with families who received SMI services while the other half of the client interviews could be done with families who did not receive service. Families could be questioned about the services they received, whether services were beneficial to them, why they accepted or declined the services, and if they felt the services they received from the programs were beneficial (see Appendix 9 for a review of the draft interview guide).

The program coordinator of the SMI could be interviewed in order to learn if implementation issues had been resolved. A copy of a draft interview guide that could be used for this purpose is included in Appendix 10. All five supervisors working on the SMI, as well as thirteen service providers, could be interviewed to find out if collaboration took place, if assessments were beneficial, if implementation issues were resolved, and if staff were more aware of substance abuse issues (see Appendix 11 for a full outline). It is suggested that up to ten external stakeholders representing substance abuse agencies could be interviewed in regards to collaboration and how beneficial SMI services are to clients. These interviewees could be determined by asking the service staff for a list of key informants from external agencies. Appendix 12 provides a review of the draft interview guide that could be used for external stakeholders in relation to the first component of the evaluation.

Concerning the service quality and outcome component, the evaluation could measure outcomes, as earlier described, and how the SMI operates in relation to improving family situations and improving children's well-being. This could be done by conducting further interviews with key informants and asking them about the services offered by the SMI and how they impacted the families. In the second, third and forth year of the evaluation an additional fifty clients each year could be interviewed, half of whom being families who received SMI service and half who did not. Families could then be asked to report their opinions on the services they had received, if they had entered treatment facilities, and if their children entered care. Families could also be questioned about what they felt had led to the outcomes, if any, they had achieved as well as their level of satisfaction with the program. Questions could focus on how helpful services were, if services met the families needs, and if clients felt understood by SMI staff. Further questions

could address the families involvement with the harm reduction plan, whether staff had advocated for the family, if clients felt more informed about substance use, and if the home situation had improved. A draft interview guide for the second component interviews with clients can be reviewed in Appendix 14.

A draft interview guide has been designed for use with service staff and supervisors that could be used in relation to the second component of the evaluation. The guide could be used with all five SMI supervisors and thirteen service staff in order to discover outcomes for families and the program (see Appendix 15). A majority of the interviews could be done with the service staff to determine how many parents entered treatment, the number of children who entered care, and the length of time they were in care. Additionally, service staff could be asked about service outcomes and collaboration. Interviews could also be conducted with ten relevant external stakeholders (see Appendix 16 for a review of the draft interview guide for these key informants). These interviews could potentially reveal if there was an increase in collaboration among program staff and substance abuse service providers, as well as reveal their thoughts on the effectiveness of the program.

Possible comparison groups for the evaluation are identified later in this section. In each year of data collection a non-equivalent comparison group pretest-posttest design could be used to review and compare data from 100 SMI client files using a revised tracking form (see Appendix 13). Data for the completion of the tracking form could be found in family files. Information from the file reviews would measure the implementation of services in order to complete the first component of the evaluation. This form could help determine on a client-by-client basis whether

parents entered treatment, if and for how long children enter Branch care, as well as the level of collaboration that has been established. In addition, the file reviews could also provide data that could be used for comparison in relation to the second component of the evaluation. This would be done as a means of measuring program trends.

Data collected from the client files could identify family demographics, reasoning behind why the file was opened, the family's previous contact with the Branch, and services that were offered. The tracking form could also reveal the parent's stage of change at the beginning of service and again at the end, whether risk to the children was reduced by the end of service, and what follow-up services were provided. As noted above, data from the tracking form could also show trends in family outcomes over the four years of data collection. This would help demonstrate if the program increased the number of parents who entered treatment, if fewer children entered care, and if children were in care for shorter periods of time.

Information from family files who received SMI services could be compared with data on families who did not receive service. A comparison group is used to strengthen the findings from the research and assess whether it is the program that produces any noticeable changes. In particular, a special sample could be established to look at families who are of aboriginal descent in order to support or dispel the need for services to be delivered in a more culturally-appropriate manner. There is a high number of families who are aboriginal being serviced by the SMI. Management has asked that the evaluation measure the service quality and outcomes of the SMI for aboriginal families who are being served by non-aboriginal staff. The reason for this is because the SMI currently does not provide extensive treatment based on the aboriginal culture.

Implementation of the Aboriginal Justice Inquiry-Child Welfare Initiative will result in cases being transferred to the new authorities who will then decide what services to implement. If the evaluation reveals that aboriginal families had positive outcomes from their interactions with the Initiative then they may be more likely to implement the program.

As expected, an analysis and comparison of all the data collected in the evaluation could provide WCFS with the important information they want regarding the implementation and outcome of the Initiative. While there are limitations to this evaluation, the proposed plan attempts to address these limitations within recognized restrictions on resources. Limitations include the length of time allotted to complete the evaluation and the need for additional assistance for its completion. An additional constraint to the evaluation is the need to interview clients who are often difficult to engage with but who would provide important feedback for the evaluation. To an extent, this limitation could be overcome by ensuring that all data is kept confidential and will not impact the services clients receive. A significant amount of time would be required to complete the evaluation. For instance, the tracking form is designed in such a way that it collects data on a client-by-client basis. The database is set up to track individual findings on families. This data may need to be analyzed and compared manually in order to show how services have impacted the well-being of families and children unless a statistical package or a qualitative analysis program can be utilized. If more funding is allocated to the program, perhaps thought could be given to having a computer programmer modify the tracking form so it would take less time to enter data and complete the data analysis component associated with the file reviews. If these issues are overcome, measures for most of the goals and objectives of the SMI could be established.

Internal and External Validity

A comparison group should be used in order to enhance both internal validity and external validity. The use of a comparison group allows one to determine whether any changes that might have been observed in the evaluation could be attributed to the program and not some other external factor. Thus, internal validity is concerned with alternative explanations for what may have impacted client change. The higher the internal validity the more likely the program caused change. In relation to the SMI there are some alternative reasons for client outcomes. One explanation could be that a crisis in the home helped the parents' realize they had to end their substance use. As well, families could receive services from an outside agency, which assisted them in any changes they made. Family members may also learn to help themselves and make changes without the assistance of a service provider.

External validity is increased in this evaluation by using a large enough sample size that allows for generalization of the findings from the study to other key informants attached to the SMI. In addition, external validity can be strengthened in the evaluation of the SMI by ensuring that the sample chosen for the study is representative of the population from which it is drawn. Informants who are chosen for the evaluation should be randomly chosen and equally represent the group for which they are being interviewed. Cases for file review should be randomly chosen and represent all families who came in contact with the Initiative.

Results of an evaluation can be impacted by threats to internal and external validity, leading to alternative explanations for change. A comparison group can address threats to internal and external validity in different ways. The following two comparison groups could be considered

for the evaluation. Both of the groups would strengthen findings from the evaluation with each comparison group controlling different threats to internal and external validity.

One comparison group could be families with substance abuse issues from the South and North-East areas of the city where the program is not offered. This group could be used as a comparison to families who receive SMI services. Clients from the South and North-East areas of the city should be similar to those who received services on demographic variables. These families should have come to the attention of WCFS because of substance misuse issues and subsequently had their file closed because of low-level child protection concerns. Advantages to using this group are these clients would be similar to families that received SMI service. As well, these families should be easy to track because the intake staff would have noted their concerns in relation to substance abuse; however, because there was low-level child protection concerns the file would likely have been closed.

There is one disadvantage to using these families as a comparison group. Files for these clients may not contain all the necessary data needed to complete the file review component of the evaluation. Making sure that the staff at the Branch document all the necessary data needed for the evaluation can control this issue.

A second comparison group could be established from family in the Central and North-East areas of Winnipeg where parents did not receive SMI services. Files could be identified through the use of a tracking system already established at the Branch. These families should be similar to the SMI families in that they are deemed eligible for the program but did not receive service

because the program was full. One advantage to using this group is that these clients live in the same geographical area as the families who received the services from the program. In addition, these families could explain why they refused services from the program because many would have been offered but declined service. This could provide some further insight into the needs of substance abusing families as well as ways to enhance engagement.

Threats to using this comparison group include the fact that these families may learn about the negative impact their substance abuse has on their family during their interactions with intake staff. Intake workers received training in relation to substance abuse, and this training may change the nature of the services they offer to families when they first come in to contact with the Branch. Another disadvantage to using this group is that families who declined service, as was established in the EA, often did so because they were resistant to help. Therefore, these clients may be less motivated to change and thus would make the groups less similar. The issue of being less motivated raises questions about the equivalency of the two samples. Being somewhat more selective of the families chosen for the evaluation could help control this issue.

Ethical Considerations

The evaluation for the SMI could contain letters of consent that all key informants fill out at the beginning of the interviews. The consent form could be used to ensure comfort and confidentiality for those participating in the evaluation. They could also help assure informants that their responses will not impact their job or the services that they receive.

CHAPTER 6

EVALUATION OF THE PRACTICUM AND PERSONAL LEARNING GOALS

In order to evaluate my practicum, I examined both my practicum goal and objectives as well as my learning goals and objectives. First, I assessed the extent to which my practicum goal and objectives had been accomplished. This was done by assuring the quality of the evaluability assessment (EA) that was conducted. Secondly, the achievement of my learning goals and objectives was reviewed. This was done by reviewing logs that were kept on my practicum, as well as gathering feedback, that was provided on an ongoing basis, from an advisory committee that was developed for the practicum, my Branch supervisor, and my practicum advisor. The Utilization Enhancement Checklist was also used in order to determine how effective the learning was and the EA that was completed.

Assessing the Achievement of Practicum Goal and Objective

The goal for my practicum was to develop a written report summarizing the EA of the Substance Misuse Initiative (SMI). In order to achieve this goal, two objectives were established to help implement this goal. The first objective was to present an EA of the SMI that conveyed relevant information which could be used in the development of an evaluation framework. The second objective was to establish relevant evaluation questions for the SMI. A separate summarized document will be presented, at a later date, to a small committee outlining the findings from the EA. A draft summary report was presented for further consideration to the Branch based on the results of the EA.

Before addressing the achievement of my practicum and learning goals, I should note that at the time of my practicum I was also a family support worker for the SMI. This resulted in a unique aspect to my learning experience because I was involved in the program as both an evaluator and a service provider. My dual role with the SMI made it crucial that I not put myself in a position of conflict regarding the EA and my employment at the Branch. Findings from my interviews had to be kept confidential from people associated with the program. I also had to be aware of my opinions on the Initiative and not include them in the final report. For the most part, I did not find it difficult to comply with these factors because management and staff from WCFS were accepting and supportive of my education. I did at times find it a challenge to withhold my thoughts on the program and not include them in the findings. Referring back to the data from the interviews and file reviews helped me keep my ideas separate and report only what was said by those interviewed.

My assessment is that the goal and objectives of the practicum have been achieved. As mentioned above, I will present a summarized report to the Branch to provide them with a clear understanding on the design of the SMI, implementation issues for the program as well as the manner in which the Branch has tried to overcome them. The report also included a proposed evaluation plan, which incorporated two components. One component focused on further assessment of implementation issues identified in the EA, and the second component is intended to evaluate service quality and outcomes. The evaluation plan is designed to measure the goals and objectives of the SMI in relation to how the program operates and outcomes of service delivery for both program staff and families.

The primary reason for the EA was to determine if the program is ready to be evaluated, specifically in relation to outcomes. While some modifications are needed, a full evaluation of the program could potentially begin in the fall of 2004. Should the Branch choose to use the design that has been developed, a full evaluation could begin by first assessing whether or not implementation issues have been resolved. The evaluation could then examine service quality and outcomes. This could provide WCFS with information on whether or not the program is a benefit to people who receive service. Additionally, the evaluation could provide data on the how the program impacts staff.

A number of meetings were held between personnel at WCFS, my practicum advisor, and myself, in order to determine the focus of my practicum. In the midst of those meetings, I learned about the process for developing an EA, as well as and how to ensure that the research is done in accordance with Branch procedures and in a respectful manner. Through conversations with my advisory committee, I discovered how important it is to find out what management wants to gain from the EA. By asking management what they wanted to learn, I was able to develop interview guides based on Branch objectives, resulting in a final product that was beneficial to the organization. This, I discovered, is a very important aspect of conducting any evaluation. By involving management in the design of the EA, it not only helped to ensure that relevant data was collected, but also increased the likelihood of its use. Upon the completion of my report I was told that the work I had done was very helpful to the Branch. Because I was a support worker for the SMI, I was able to see that many of the issues that emerged during the EA were being addressed by supervisors and management associated with the Initiative.

The time that I spent with my practicum supervisor, who worked in the quality assurance team, provided me with an appreciation for considering all of the necessary practical and ethical measures when implementing the EA. In a practical sense, I found out how important it is to get documents organized and prepared before proceeding with interviews and file reviews. It seemed to take a long time to develop the interview guides; I now realize the importance of preparing these guides because it ensures all key informants are interviewed and that all the necessary data has been gathered. I discovered that interview questions need to be written in a manner that allows for the expression of a participants' thoughts, without being biased. Developing the file review tracking form was easier than the interview guides. I discovered that in order to fill out the tracking form, data first needs to be in the files. Since this was not an evaluation, I was able to help the Branch consider what additional information should be recorded so that future monitoring or evaluations could be done more efficiently. Taking the time to complete the pre-work enabled me to accumulate a more accurate knowledge of how the program is being implemented. Not only was this useful for developing the evaluable program model but I was told it provided the Branch with data they found useful in their attempts to overcome the challenges associated with the program.

While I was conducting my interviews, a death of a baby occurred in one of the families attached to the Initiative. Personnel at the Branch asked me to put my interviews on hold because this was a difficult time for staff. I learned that, although the interviews provided me with interesting and useful data, if I continued with them I would impose on staff who were dealing with a very difficult and important issue. In an ethical sense I had always understood the importance of allowing participants the opportunity to refuse to participate in the interviews or to decline to

respond to any of the questions I was asking. My appreciation for this ethical boundary is heightened because of the unfortunate death. I realized that participants needed time to overcome their feelings and deal with these types of situations before interviews could continue.

Another ethical consideration was that of ensuring that management were comfortable with the EA. I learned that management support for the EA is helpful in convincing staff to participate and share their understanding of how the program is delivered. By having the support of management I was able to conduct interviews that generated very valuable information. Without management's support, I would have likely had a hard time getting some of the interviewees to open up and disclose the challenges they were facing in relation to the implementation of the program. I feel that management at WCFS were very open and receptive to both the EA and findings I presented during our meetings. With this understanding and lack of pretension, I was able to successfully complete the EA.

An advisory committee, developed at the beginning of my practicum experience, met three times to review my findings. This committee included my original practicum committee and the coordinator of the SMI. The committee was designed to discuss the data I collected in order to keep the Branch up-to-date on findings from the EA. As it turned out, these meetings became a time to inform management about the difficulties staff endured in relation to the delivery of the program. Because of the implementation issues a decision was made to develop a condensed report that will be presented to the Branch. This presentation will be done so relevant stakeholders can be informed about the results of the EA. I found that, by having the advisory committee, I was able to stay focused with what management wanted to learn and was able to

keep them informed on implementation issues. It was an inspiring experience to be able to participate in a process where the quality assurance team and management worked together to address issues pertaining to a new program.

I began my research for the EA by reviewing documents on the SMI. This was very useful for my understanding of why the SMI was developed. I began to appreciate the considerable amount of work that had to go into the original design of the project. This was an interesting process because the Initiative is a unique program with no prototype design. In the second stage of the EA, when I interviewed management I discovered that they believed the original design for the SMI was what was being delivered. When interviewing people in the field I found out that there was some variation with how the program was being implemented and what was originally intended. As I was doing my interviews, management made some changes to the SMI design on account of some challenges the program was experiencing. Thus, while I researched how the Initiative was being delivered, management dealt with a number of implementation issues. Conducting the EA and learning about the changes to the program as they were being considered and implemented added to my learning and work experience. This gave me the opportunity to participate in discussions regarding how to overcome some of the problems as they arose.

As I went through the steps for the EA I discovered that it does not follow a linear process. I developed my interview guide for management and conducted those interviews. While I was creating the interview guides for the field I developed the managers' model. This was a useful process because I was able to develop questions based on what I had learned from management. I was nervous conducting the first couple of interviews, but as I continued with them I became

more comfortable. Taping the sessions made it much easier for me to create an environment for discussion, rather than just questions and answers. I found that each person had a different approach and level of willingness to respond to the questions. Some people seemed to share a lot of things with me while others seemed brief with their responses. I believe that the interviews went well. I received a variety of responses and relevant feedback which were useful in helping me to understand to how the program is delivered. Management informed me that participants felt at ease and that I was very professional during the interviews; I was told that this made the interviews a positive experience for the informants.

I found that having a positive relationship with many of the workers of the SMI increased my ability to conduct productive interviews. I felt that this reduced anxiety about conducting the EA and encouraged people to honestly express themselves. Conducting the EA while simultaneously working on the project had some drawbacks. I had to be very careful not to introduce my own beliefs and thereby bias the outcomes of the research.

I found it difficult to develop the summary of the feedback from the field because of the implementation issues that were discovered. Meetings with my advisor and supervisor were helpful for me to find the best way to present my findings in a non-judgmental manner. This was a useful process leading me to incorporate suggestions that people offered as a means of overcoming the problems that were mentioned. Although I was the main person conducting the EA, I learned that I needed assistance in deciding how to report my findings.

The approach that I chose for analyzing the data was to take each transcribed interview and, while reviewing it, develop a list of codes in order to identify what was said. I discovered that this process provided me with a guide that I could use to further analyze interviews. As new data emerged I added it to the code sheet. This list of codes provided me with an outline of how to write up the report. Once each interview was coded I began to summarize the results. I learned that this is a time-consuming process. I wanted to be certain that nothing was left out, that I was not being repetitive, and that all key points were incorporated into my report.

I recall experiencing anxiety about misrepresenting what staff had intended to say. To overcome this, I decided that I needed to repeatedly revisit the transcribed interviews to confirm my understanding and to be sure that I had reported only my findings and not my interpretations. I learned that a lot of work goes into writing up the first three parts of the EA. Once the first three steps were completed, I found it easier to write up the evaluable program model because it summarized data from the earlier stages of the EA. I devised a summary of the SMI outlining what is currently being implemented as well as the issues that had been identified. At the end of the evaluable program model, I added a brief explanation of the issues that would need to be addressed if the Branch chose to implement my proposed evaluation plan.

Although the model in Rutman (1984) outlines an EA that has six steps I ended up combining the final two steps into one. The summary of the program outlined in the evaluable program model was very useful in the development of the evaluation questions, the evaluation plan, as well as how feasible it would be to conduct further evaluations. Meetings with quality assurance staff helped me determine possible actions while keeping in accordance with Branch policies and

procedures. I discovered that this was a useful way for me to provide a draft plan that could provide further data on the program in a manner that the Branch could then implement.

In consideration of the above data, I feel that as an evaluator I have done a good job in demonstrating sufficient understanding of the SMI. I was able to do this by developing my practicum report as well as a document and short a summary for the Branch outlining the results of the EA.

Assessing the Achievement of Personal Learning Goals and Objectives

There were three personal learning goals for the practicum.

- To discover how to conduct an evaluability assessment by taking on the main responsibility for its implementation;
- To gain an increased awareness concerning how substance misuse impacts child welfare; and
- To evaluate my work as a practitioner.

Objectives that helped me achieve these learning goals were:

- To develop the necessary skills to conduct an evaluability assessment;
- To work collaboratively with the quality assurance team at WCFS; and
- To conduct a further literature review of substance misuse.

There were a number of challenges in conducting the EA. One issue stemmed from the fact that the Branch experienced a number of difficulties during the implementation phase of the project. Some staff at the Branch were resistant to the program being evaluated so I had to be very clear that I was doing an EA and not a full evaluation. I was told that this eased some of the hesitation and anxiety that staff expressed regarding this issue. In the end, those informants that I interviewed seemed very open and supportive of my research and practicum, which greatly helped my data-collection and learning.

In order to determine if my first two personal learning goals were achieved I kept a log wherein I documented and reviewed my experiences during the practicum. As stated above, my first learning goal was to discover how to conduct an EA by taking on the main responsibility for its implementation. I attained my first goal by achieving two objectives: to develop skills needed to do an EA and to work collaboratively with the quality assurance team at WCFS. I successfully accomplished this goal because I completed the EA and was asked to develop a summarized version for the Branch to use for further modification to the program. As stated earlier, at the onset of my practicum I researched and spoke with my advisor and staff at WCFS to clarify how I would implement the EA. By doing this I built skills and understanding about the conduction of an EA. I also learned different methodologies that can be used for data-collection and how those findings can be analyzed.

As mentioned earlier, I learned about the practical and ethical measures that I had to take when implementing the EA. I also discovered how important it is to be organized and prepared before doing interviews and file reviews. To add to this, I found out what data I should collect and how important it is to keep management informed about the findings. Lastly, I learned that it is necessary to incorporate suggestions in order to produce the most useful final product.

My second learning goal was to gain an increased awareness of how substance misuse impacts child welfare. One objective helped me attain this goal: conducting a further literature review of substance misuse. I achieved this goal by completing a literature review on substance abuse and how it impacts the child welfare system. Through conversations with relevant people I also gained more insight on the issue of substance abuse in the field of child welfare.

In the literature review I learned that substance use can be hereditary but that environment can also play a large role. The SMI is a unique Initiative with only one other program like it in Canada. Although this other program has been designed it has yet to be implemented. This could explain why there have been so many difficulties getting the program underway. I learned that time and patience are important characteristics for staff to have when dealing with such a delicate issue. I now know that people who abuse substances often come from unsupportive environments, have low incomes, and often do not realize that they have a problem. Dealing with concrete issues makes work with SMI families challenging for staff, especially when their focus has to change to that of child protection. In the field of child welfare, the well-being of the child must always come first. Substance abusers often need a lot of support with their recovery, which can mean they are not always able to provide for their children without help.

While implementing the EA I discovered that the issue of substance abuse and its impact on children is not easy to remedy. Substance abuse is considered a challenging issue to deal with and is recognized as having a huge impact in the field of child welfare. I found that doing preventative work with families can lessen the harm to children and improve the entire family's lifestyle.

Originally, this program was intended to be a voluntary service for families that presented as low to medium risk of child welfare concerns. In the course of working with these families, staff noted that many of them were resistant to change and became even more so when their worker had to take on a child welfare role. Interestingly, although substance abuse impacts child welfare greatly, the approach to dealing with this sensitive issue focuses on the user, whereas child

welfare focuses on the children. These two foci create a struggle in relation to what is in the best interest of each family member. It became apparent that not only do child protection workers need to learn about substance abuse, but substance abuse service providers also need to be educated on child welfare. If the two organizations better understand each other then it is more likely they will work more collaboratively. While it appears that this process had begun, it will nevertheless take a long time to mature into a truly collaborative working relationship.

Additional learning came from the recognition that mainly aboriginal families are being served by the SMI, but the program has been designed from a more generic perspective on substance abuse. Many of the families SMI staff work with are aboriginal and could further benefit from treatment for their substance use from a program that incorporates their unique cultural perspectives. The Aboriginal Justice Inquiry-Child Welfare Initiative is intended to provide more culturally appropriate services for aboriginal people. If the new child welfare authorities decide to implement the SMI it could be a further benefit to aboriginal people especially if the aboriginal treatment agencies are working collaboratively with the child welfare system. Management at WCFS feel that this program could be a valuable resource to these authorities and want to show that funding for the program would be beneficial. The importance and usefulness of the SMI could increase the likelihood of its adoption as an ongoing program. One of the most important things I discovered about substance abuse is that it is a significant issue in the field of child welfare and something needs to be done to address it. While the SMI is experiencing some challenges, it is nevertheless appreciated and necessary as a means of protecting children over their lifespan.

My third learning goal was to evaluate my work as a practitioner. I assessed the attainment of this learning goal with the Utilization Enhancement Checklist, which is used to assess ones effectiveness as an evaluator. The checklist was used to self-evaluate my work at the end of the practicum (please see Appendix 2 for a copy of the checklist). The checklist consists of five categories, including ten items each, which I went through to evaluate my practicum. The five categories reviewed include: determining the evaluator's roles, understanding the organizational context, planning the evaluation, conducting the evaluation, and communicating the evaluative information. Some of the items did not relate to my work tasks and are therefore not included. Thus, only the items that I evaluated are listed.

Section A of the checklist is used to determine the evaluator's role. Activities that relate and which I successfully achieved include my ability to address the program goals, my personal commitment to completing the evaluation, and my publicly advocated personal values and opinions about the program. Additional components I accomplished for this section of the checklist were outlining my educational activities, as noted above, establishing congruence between my personal role and audience expectation with the EA, as well as establishing credibility and trust with the program manager, Branch personnel, and SMI staff.

Section B of the checklist focuses on understanding the organizational context. Tasks that I achieved here included obtaining and studying the organizational chart. I also identified names of key people within and outside of the organization attached to the SMI, established who the key decision-makers are, and identified the potential users of the evaluation information. To a minimal extent, I learned about the policy-making process at the Branch and learned how some

of the decisions and policies were made as a result of the EA. I discovered which staff I needed to speak to while developing and conducting the EA. I accomplished these task by having discussions with my practicum supervisor.

Section C of the checklist addresses planning of the evaluation. By speaking with my practicum supervisor I was able to clearly understand my role in the EA, set up meetings with the quality assurance staff and management to discuss the findings, and determine the sources of resistance to the results of the EA. I designed a report that outlines the findings in a manner that provides the Branch with needed information. To a minimal extent, I participated in some mutual problem solving with decision makers. By successfully completing these activities in a manner that was useful to WCFS I was able to accomplish these tasks.

Section D of the checklist focuses on conducting the evaluation. While conducting the EA I was sure to get affirmation on the process I used so it fit with Branch policy. While interviewing each informant, I was clear about what an EA is and what I was gathering data on. I involved key personnel in the purposes, issues, and general evaluation strategies. I made myself available to program staff during the EA to learn and share perspectives on the information gathered. I collected information from multiple sources for the EA and made sure that data-collection instruments and procedures were understandable and relevant. I gathered only needed data for the EA and adapted the EA plan in order to meet changing information needs. All of these activities were preformed with the advice and guidance of my advisory committee.

Section E of checklist measures communication of the evaluative information. As I noted above, there were meetings held with my advisory committee during which time I shared findings from the EA. My practicum supervisor and practicum advisor assisted me in the interpretation of the data and communicated the major findings when appropriate. Rough drafts of the EA were provided to management in order to get their preliminary thoughts before making a final report that will be presented in the future to relevant Branch staff. I developed a detailed report of the EA that management can use as needed, as well as a summarized synopsis of the EA for necessary personnel to more easily review. By completing these activities in the checklist I feel that I conducted an effective EA and therefore have achieved this learning goal.

Summary

In conclusion, the implementation of the EA provided me with a broad level of knowledge in relation to this form of evaluation. I was able to successfully go through the steps of developing the EA, providing me with a report that the Branch deemed useful for them as a means of improving the program and for advocating to the government for further funds. At the end of the practicum, I feel that I have a good understanding of how to carry out an EA, and the many issues related to substance abuse and the field of child welfare. Working with my practicum supervisor, who is the only staff member on the quality assurance team, allowed me to appreciate the amount of work that she has to perform in evaluation of programs, as well as related work. By assisting her, I gained insight on how to conduct the EA in accordance with Branch procedures. My literature review gave me with the knowledge I needed to defend my findings and present a report that was acceptable to the Branch. It was a arduous process that taught me to be patient and thorough.

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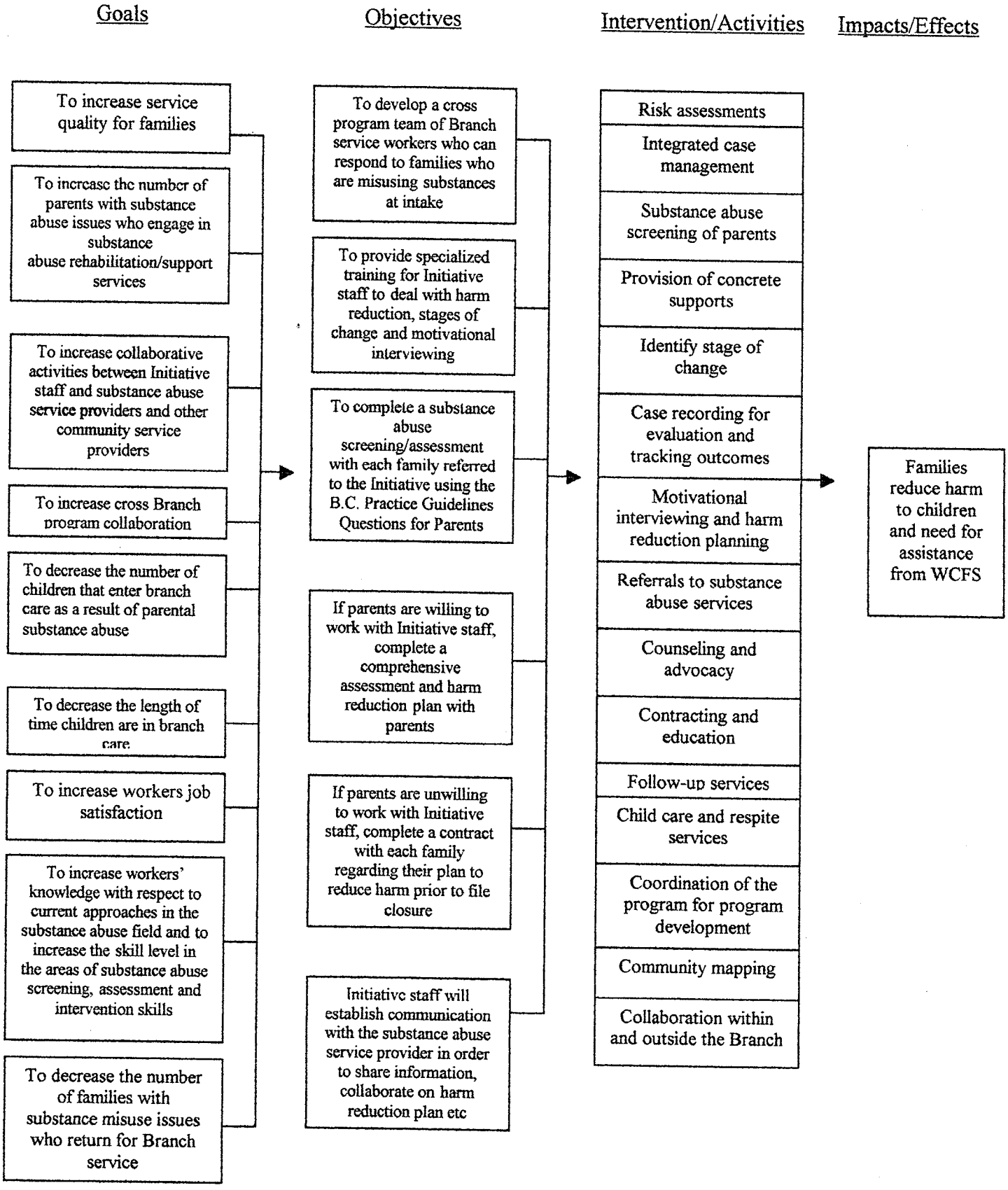
Appendix 1

Program Model

Program Model for the SMI



Appendix 2

Utilization Enhancement Checklist

Utilization Enhancement Checklist

Directions: There are fifty items below, which focus on self-analysis, understanding the organizational context, planning and evaluation process, and communication. You may wish to rephrase some of the items to fit your particular situation or to add items. The checklist can serve as a guideline as you conduct an evaluation or as a self-examination after you complete an evaluation. To serve these multiple purposes, all items are written in the present tense.

A. Determining the Evaluator's Role

1. Assess level of personal congruence with the program's general goals and consider withdrawing if the incongruity may result in unnecessary conflicts.
2. Determine extent of personal commitment to the importance of conducting an evaluation of this program.
3. Analyze degree to which personal value and opinions about the program are publicly advocated by the evaluator.
4. Determine appropriate share of responsibility for utilization.
5. Specify activities related to educational roles as well as a data-gathering, information-providing role.
6. Make sure that consulting skills, time references, and personnel are available to conduct a utilization-focused evaluation.
7. Ensure that sufficient technical skills, time resources, and personnel are available to conduct a utilization-focused evaluation.
8. Establish congruence between personal role perception (Data-gathering, consultant, expert, recommended, change agent) and audience expectations.
9. Determine willingness to spend time with program staff in activities that are not directly related to the evaluation (for instance, informal lunches).
10. Establish a sense of credibility and trust with the program director, staff and other audiences.

B. Understanding the Organizational Context

1. Obtain and study the organizational chart
2. Identify the names of key people within and outside the organization.
3. Identify the decision-makers and potential users of evaluation information within and outside the organization.
4. Understand the policy-making process of the organization.
5. Determine which decisions and policies are made a result of the evaluation.
6. Know when decisions are made.
7. Determine which staff and other users should be consulted as the evaluation is planned and conducted.
8. Determine whether the sponsor of the evaluation is committed to the evaluation activity and uses evaluative information.
9. Determine the information sources and channels within the organization.
10. Trace the path and impact of previous evaluations in the same setting and determine how this affects the evaluation.

C. Planning the Evaluation.

1. Make sure there is clear understanding of the evaluation role (that is formative or summative).
2. Set up specific sessions in which the evaluation plan and its implementations are discussed with key persons.
3. Assess the implications of decisions based on the evaluation that affect personnel.
4. Assess the political implications of decisions based on the evaluation that affect personnel.
5. Determine the likely sources of resistance to negative evaluation results.
6. Determine the likely sources of resistance to positive evaluation results.
7. Determine the freedom to provide evaluative information to various audiences.
8. Determine strategies for dealing with potential conflict and tension between program director/staff and evaluator.
9. Design an evaluation plan that will have technical credibility and provide needed information.
10. Establish a mutual problem-solving approach with the program personnel and decision-makers.

D. Conducting the Evaluation

1. Make sure that everyone understands the purpose of the evaluation.
2. Involve key personnel in determining the purposes, issues, and general evaluation strategies.
3. Involve representatives of potentially affected groups in making decisions about instrumentation and data sources.
4. Be accessible to program staff during the evaluation to learn of and share perspectives from which each is interpreting the information.
5. Collect data from multiple sources.
6. Make sure the data collection instruments and procedures are understandable and relevant.
7. Have informal as well as formal meetings with key persons.
8. Maintain a mutual problem-solving relationship with staff and administrators throughout the evaluation.
9. Collect information needed, but only that.
10. Adapt the evaluation plan to meet changing information needs.

E. Communicating the Evaluative Information

1. Ask periodic informal reports or presentations.
2. Ask program staff, especially those most affected, to assist in interpreting the findings.
3. Communicate major findings when available and considered appropriate; do not wait for the formal report deadlines.
4. Share rough drafts or preliminary thoughts with key persons before making a final presentation.
5. Write different reports for different audiences.

6. Make presentations understandable and easy to follow.
7. Link presentation to key issues and decisions.
8. Make sure that all audiences receive the evaluative information in sufficient time prior to key decision-making events.
9. Keep written reports brief.
10. Use several media (slides, charts) when making formal presentations.

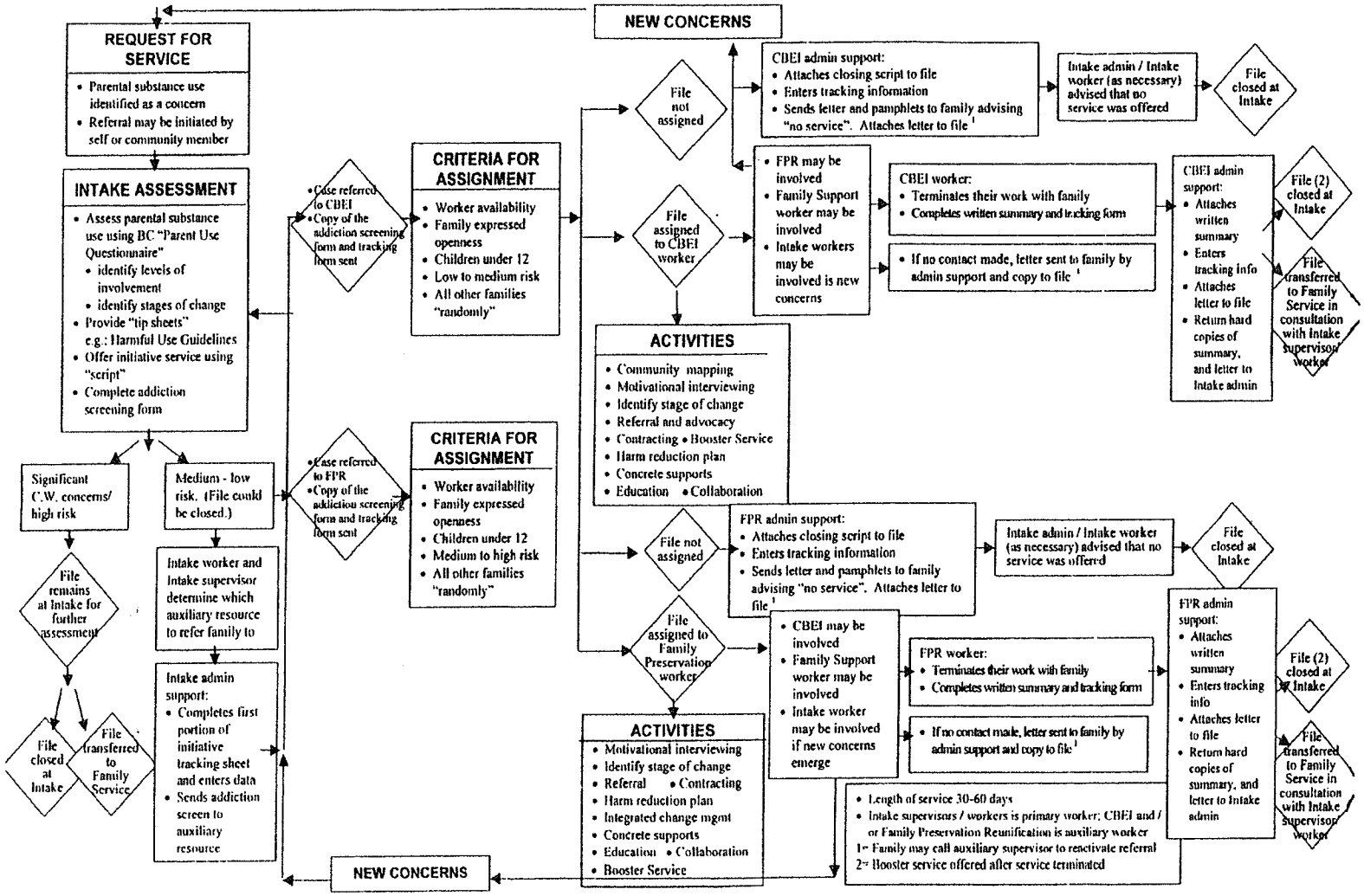
Score Interpretation: Here are some rough guidelines for interpreting the results of you analysis. Allow two points for each question answered positively.

25 or less	Don't expect much to happen as a result of you efforts. Most likely your information will be ignored or gathers dust on a shelf somewhere.
26–50	You may be called back later to do another evaluation, but don't count on it. Perhaps you might get a publication for your efforts, but the world won't change.
51-75	Somebody may actually do something different as a result of the evaluation, especially if it already reinforces what he or she was already thinking.
76-100	Be careful! You may be so effective that someone may have you earmarked to be an administrator, even though you have no desire to be one.

Appendix 3

Original Flow Chart

Families Who Misuse Substances Initiative



Appendix 4

Activities

Activities

Workers attached to the Initiative may perform many of the same activities. As indicated by the criteria for referral described above, although the activities preformed are similar, families will receive service from specific Initiative workers based on the assessed risk of child maltreatment, and other criteria. The following table depicts the activities that will be offered by Initiative staff:

PROGRAM ACTIVITIES	INTAKE	FAMILY PRES. REUNIF.	COMM UNITY	FAMILY SUPPORT	STEER-COMITT.
Assess Parental Substance Use as a Risk Factor	X				
Addiction Screening of Parent	X				
Identification of 'Stage of Change'-using the Stages of Change model, initiative workers will identify the parents' stage of change with respect to addressing substance use issues. This will assist the worker in determining the most appropriate intervention.	X	X	X	X	
Motivational Interviewing- Use of motivational interviewing techniques to assist families to be more 'ready' for change. Current research supports the effectiveness of brief interventions with people who have substance use problems by using a motivational interviewing approach.	X	X	X	X	
Contracting-Use of contracting as a motivational strategy. The contract would be used primarily with families who were refusing service from initiative worker and where the worker wants to document the parents denial of a concern or the plan the a parent has agreed to for future reference if case reopens.	X	X	X		
Development of a Harm Reduction Plan/Agreement-Usually completed in collaboration with an addictions counselor and parent. Specifies concerns, triggers, strategies for reducing harm and relapses, and reporting.	X	X	X		
Referral to Addiction Services- Referral based on an assessment of parent's readiness, and their service preference.	X	X	X		
Integrated Case Management- Joint planning, development, implementation, and monitoring of the service plan with addiction treatment service provider and/or initiative auxiliary worker. Initiative workers will have at least one face to face meeting with the parent and the addiction service provider to establish a case plan.	X	X	X		
Provision of concrete supports- Support and liaison with community groups to provide concrete supports e.g. housing, food, transportation etc.	X	X	X	X	
Child care/ respite-Provision of short-term child care/respite to families.				X	
Community Mapping- Community workers to assist families to identify the resources in their			X		

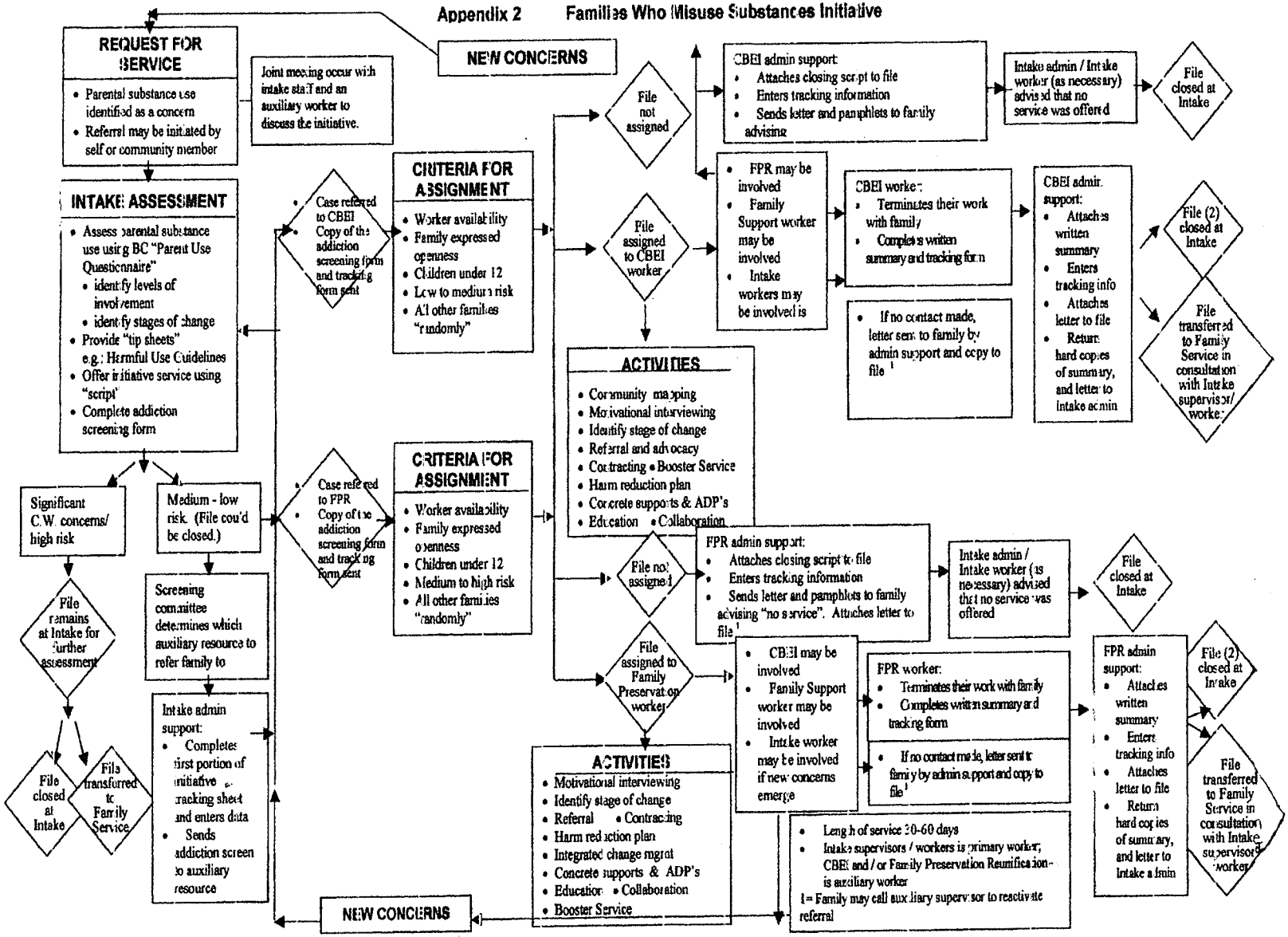
community by 'mapping' the location of services in their neighborhood.					
Education- Provision of information to parents regarding risks of alcohol and drug use and its effects on the child, patterns of usage, available addiction resources, feedback regarding levels of involvement. Education of system collaterals regarding the initiative	X	X	X	X	X
Collaboration-Collaboration with addiction service providers to develop a common harm reduction plan for parents, promote information sharing, case planning, and to clarify roles and responsibilities. Collaboration to identify effective referral processes, consultation etc.	X	X	X	X	X
Counseling- Identify underlying issues resulting in substance use, assistance to develop alternative coping mechanisms to reduce harm and prevent/ deal with relapse.	X	X	X	X	
Advocacy- Identify service gaps based on family need and advocate for their development, support family to obtain needed services. Identification of system service gaps and advocacy with community service providers to develop.	X	X	X	X	X
Follow-up Services- Provision of 'booster shots' if required by family i.e. short-term intervention to family if file is closed to stabilize and strengthen family functioning.		X	X		
Case Recording-completion of written summaries following program and initiative reporting guidelines.	X	X	X	X	
Informational Support Groups –Designed for parents to supply information regarding stages of change, range of addiction service options. Parallel group could be facilitated for children. *This activity to be planned at a later date in the initiative if there is an identified need in the target population.					X*
Evaluation- Collect and interpret information regarding implementation and client outcomes on a continuous basis. Evaluation to be used to inform initiative improvements, and to determine effectiveness of the initiative. *Evaluation support to be provided by Quality Assurance, Research and Planning Program.					X*
Tracking Outcomes- All initiative workers will record their work with families on a Response to Substance Misusing Families Tracking Sheet. Client satisfaction and comparison data to be gathered.	X	X	X	X	X
Coordination- An initiative 'coordinator' to be appointed who would chair steering committee and would have overall responsibility for the implementation of the initiative, would provide ongoing information and reporting on implementation issues and outcomes to management etc.					X
Program Development – Provision of policy and					X

procedural direction, clarification of roles, identification of issues and strategies for resolution, modification of the initiative based on implementation and outcome data.					

Appendix 5

Revised Flow Chart

Appendix 2 Families Who Misuse Substances Initiative



Appendix 6

Interview Guide For Front Line Staff at the Branch

Interview Guide For Front Line Staff at the Branch

My name is Karole Ducharme. I am a support worker for the Initiative but the reason I am here today is because I am doing an EA for the SMI as part of my MSW degree. I am doing the EA to determine how the Initiative is being implemented and to identify if it is ready to be evaluated. The findings from the EA will be used to come up with a framework for evaluating what to measure and how to measure it. The model I am using for the EA involves getting an understanding of the program from background documents, then talking to managers about their understanding of what is being delivered and then interviewing supervisors, service staff and maybe a few clients about the services being delivered. I will also be doing case file reviews to learn what data is being entered into family files so the evaluation of the Initiative can be adequately developed.

Valerie Barnby has been providing me with direction and assistance in the development of the EA so far. I have spent a lot of time reviewing documents and interviewing management, which has helped me gain a good understanding of the Initiative. I am interviewing you with respect to the third stage of the model. This requires me to get your feedback on the implementation of the Initiative. The information you give today will be developed in to a summary of the perspectives of service staff. No one will be identified in the final report but I should make you aware that some of your comments may reflect your position so complete confidentiality may not be likely. I would like to tape record the interview today. I assure you that the tape will be kept in a secure place with only myself and Val having access to it. The tape will be destroyed once my practicum and the final report are complete, which will be some time in the spring. After I have gathered all the necessary information I will be writing a report that explains each of the models

and the data I have gathered. I will give the Branch this report to help with the evaluation of the Initiative. With this being said there is no right or wrong answer to any of the questions just your thoughts about the Initiative. When I have completed the interview I can send you a copy of your responses if you would like.

Do you have any questions at this point?

Do I have your permission to ask the following questions and record your responses?

I want to begin the interview by talking about the Initiative in general to gather your thoughts on the SMI

1. What are the goals of the SMI as you understand them.
   a) Do you feel that these goals are appropriate?
   b) Are there any goals that should be changed?
2. What are the advantages of the SMI?
   (Probe with... yourself, families or the Branch)
3. What have been some of the challenges in implementing the SMI?
   (Probe with... yourself, families or the Branch)
4. To your knowledge have their been any changes in how the SMI operates?
   a) Are these changes important to you and the work that you do?

The next few questions focus on the implementation of the SMI. The reason for this is because we are trying to establish a general idea of what is occurring in order to learn what we can later evaluate.

5. Did you attend the four-day training from AFM in relation to substance misuse?
   a) What were your expectations from this training?
   b) Did the training meet your expectations?
   c) Do you feel the training was beneficial?
   d) How was the training beneficial?
6. Could you describe your job and the services you provide to families through the SMI?
   a) What percentage of the work that you do is related to the Initiative?
   b) Are you aware of any changes that the Steering Committee is planning to make in relation to the implementation of the SMI?
   c) How do you feel about the changes?
   d) Are there any changes you feel would make the SMI more effective? Please explain
7. The next set of questions relate to the process for how families get services from the SMI.
   a) Who is being served from the SMI?
   b) How are families directed through the various channels for service?
   c) On average, how long do you work with families through the SMI?
   d) What activities/services do you offer to families through the SMI?
      a. How will it be known if these services benefit the families that your unit is serving?
      b. Are these services different then the ones offered to families in the past?
      If yes, how?

e) Could you tell me what some of the outcomes were for various families your unit has worked with through the SMI?
   a. If the outcomes were positive what led to this?
   b. If positive outcomes were not realized why do you think this was the case?
   c. Are there any implications for the outcomes that relate to how services should be provided?
f) Has your unit experienced families returning for additional services once their file was closed?
   a. If yes… What was you role with these families upon re-service?
g) How will it be know if the focus of the SMI makes a difference to family situations because of the services that were offered to them?

Because one of the goals of the SMI is to increase collaboration I would like to ask you some questions about what collaboration means to you so that we can establish how it can be measured.

8. What does collaboration mean to you?
9. What should we be looking for when measuring collaboration within the Branch?
10. What should we be looking for when measuring collaboration with external agencies?
11. What agencies do you currently have working relations with?
    a) Would you say these relationships are good, bad, neither?
    b) Has collaboration changed with these agencies since the SMI started? Please explain.

One of the major goals of the evaluation will be to measure how successful the Initiative has been. The next set of questions will relate to how you see success for the SMI.

12. The next two questions concern how we should measure the success of the SMI?
    a) In order to determine if the Initiative has been a success, what should we be measuring?
    b) In your opinion, how can we measure success?
13. That is all the questions that I have for you but before we end this interview I would like to ask if you have any questions of me?

Thank you for your time and responses. I would again like to ask if you want a copy of the responses you have provided today….otherwise the interview is over.

Appendix 7

File Review Form

File Review Form

Family Information

Was the following information filled in for each family that received service from the Initiative?

CFSIS Family Number: YES _____ NO _____
File Name: YES _____ NO _____

Parents:
Legal Mother's/Guardian's Name: YES _____ NO _____
Legal Father's/Guardian's Name: YES _____ NO _____
Other Caregiver's Name: YES _____ NO _____

Family Type: YES _____ NO _____
Single Parent-Female __ Single Parent-Male __ Adoptive Family __
Two Parent __ Blended/Step Parent __ Extended Family __

Legal Mother's/Guardian's Racial Background: YES _____ NO _____
Aboriginal (includes First Nation and Metis) ___Caucasian___ Black ___
Asian __ Unknown __ Other __
Total Number of Children in the home: YES _____ NO _____
1__ 2__ 3__ +4__

Opening Information

Was the call received by --- recorded? YES _____ NO _____
After Hours ___ CRU___
Was it recorded if an immediate response was required: YES _____ NO _____
Yes___ No___
Was the date the file was opened recorded? YES _____ NO _____
____/____/____
D M Y

Was the source of referral recorded?: YES _____ NO _____
Who was the source of referral?

Ex-partner/spouse	____	Day care	____
Parent	____	Education System	____
Child/Youth	____	Justice System	____
Community Member	____	Other child welfare agency	____
Mental Health System	____	Health System	____
Extended Family Member	____	Addiction Service Provider	____
Anonymous	____	Other _____	

Was it recorded if the family call requested service? YES _____ NO _____

Previous Contacts:

Was the families previous level of involvement with the Branch documented?
YES _____ NO _____

What was the previous level of involvement?
None ____ one opening ____ two openings ____ three openings ____
more than three openings ____

Was there documentation of the families previous involvement with the Branch:
YES _____ NO _____
Was there documentation of the auxiliary worker who was involved?
YES _____ NO _____
Was there documentation of the families previous involvement with the project?
YES_____ NO_____
What was the families previous level of involvement?
None ____ one time ____ two times ____ three times ____
more than three times ____

Was there a record of the auxiliary worker? YES_____ NO_____
Who was the auxiliary worker?
First time _____
Second time _____
Third time _____
Any additional times _____

Was the data entered stating if the family had previous contact with the Initiative:
YES _____ NO _____
Was there documentation for the reasons the file was opened?
YES_____ NO_____
What was the reason for the file reopening?
Parents request? _____
Involuntary _____

Was there a documentation of the number of times children had been previously in care?
YES _____ NO _____
How many times had the children previously been in care:
None ____ One ____ Two ____ Three ____ More than three times ____

Intake Service Information:

Is the name of the intake worker on file? YES _____ NO _____
Is the reasons for the file opening on file? YES _____ NO _____
What was the reason for the file opening?

Neglect-Physical	_____	Abuse-Physical	_____
Neglect-Emotional	_____	Abuse-Emotional	_____
Neglect-Medical	_____	Abuse-Sexual	_____
Child left unattended	_____	Parent Requesting Service	_____
Inappropriate Discipline	_____	Family Violence	_____

Were the parenting issues recorded on the file? YES _____ NO _____

What were the parenting issues:

Child with special needs	_____	Parent-Mental Health issues	_____
Behavioral problems of child	_____	Parent-Substance Misuse	_____
Emotional problems of child	_____	Parent-Medical issues	_____
Difficult parent-child relations	_____	Parent-Gambling	_____
Financial problems	_____	Parent-FAS/FAE	_____

Was the outcome of the screening tool written in the file? YES _____ NO _____
Was the stage of the parents current substance use recorded? YES _____ NO _____

What was the parents current stage of substance use?

Addiction/dependence	_____	Occasional use	_____
Experimental use	_____	Abusive use	_____
No use	_____	Regular use	_____

Was the parents stage of change documented by the intake worker?
YES _____ NO _____

What was the parents stage of change?

Pre-contemplative	_____	Contemplative	_____
Preparation	_____	Action	_____
Maintenance	_____	Termination	_____

Was the date of screening documented? YES _____ NO _____
Was there a record of the auxiliary worker that the case went to?
YES _____ NO _____
Was there documentation of who the file went to? YES_____ NO_____
Who was the file referred to?
Preservation _____ Community _____ Family Services _____

Referral Information:

Was the date the lead auxiliary service commenced recorded? YES _____ NO _____
Was the date that the second auxiliary worker started service recorded?
YES _____ NO _____
Did the file indicate whether the family was willing to receive service?
YES _____ NO _____
Was it recorded if the family received services? YES _____ NO _____
If no was the closing date recorded? YES _____ NO _____
Was there a record that the family received a closing letter?
YES _____ NO _____
Was intake notified if the referral wasn't accepted? YES _____ NO _____
If the family received services was the name of the auxiliary worker recorded?
YES _____ NO _____

Auxiliary Service Information:

Was there a documentation that contact was made with the family? YES_____ NO_____

If no -was there a date for when no contact was made? YES_____ NO_____
If yes -was there a date for when contact was made? YES_____ NO_____

Was the date for the last contact with the family recorded? YES_____ NO_____
Was there a family support worker involved? YES_____ NO_____
If yes was the date the FSW involvement recorded? YES_____ NO_____
was the date the FSW involvement ended recorded? YES_____ NO_____
Was another auxiliary service involved with the family? YES_____ NO_____
Was the parent stage of change, at closure, documented by the auxiliary worker?
YES_____ NO_____

What was the parents stage of change at closure?

Pre-contemplative ____	Preparation ____	Maintenance ___
Contemplative ____	Action ____	Termination ___

Was the number of sessions with the family recorded? YES_____ NO_____
Was there documentation if there was a face-face meeting with an addiction service provider? YES_____ NO_____
Was there mention of the interventions used with the family? YES_____ NO_____

What interventions were used? by
Addiction Screening and Assessment YES_____ NO_____ ___
Identification of Stage of Change YES_____ NO_____ ___
Motivational interviewing YES_____ NO_____ ___
Contracting YES_____ NO_____ ___
Development of a harm reduction plan/agreement YES_____ NO_____ ___
Referral to addiction services YES_____ NO_____ ___
Integrated case management YES_____ NO_____ ___
Provision of concrete supports YES_____ NO_____ ___
Child care/respite YES_____ NO_____ ___
Community mapping YES_____ NO_____ ___
Education YES_____ NO_____ ___
Collaboration YES_____ NO_____ ___
Counseling YES_____ NO_____ ___
Advocacy YES_____ NO_____ ___
Informational support groups YES_____ NO_____ ___

Closing Summary:

Was there documentation that the file was closed at intake? YES_____ NO_____
If yes-was there documentation that further service was required after referral to auxiliary worker resource? YES_____ NO_____
Was there documentation that the file was transferred to a service unit?
YES_____ NO_____
Was there documentation of the date the file was transferred? YES_____ NO_____
Was the reason for the file closure recorded? YES_____ NO_____

What was the reason for the file closure?
Service was no longer required YES_____ NO_____
Family not selected for service YES_____ NO_____
Parents refused service YES_____ NO_____

Family moved YES_____ NO_____
Family accessed external resource YES_____ NO_____
Other child welfare agency provided services YES_____ NO_____

Was the outcome at file closure recorded? YES_____ NO_____
Was there documentation that goals/objectives were reached satisfactorily?
YES_____ NO_____
Was there documentation that the risk to children was reduced?
YES_____ NO_____
Was there documentation if parents were connected to addiction service providers?
YES_____ NO_____
Was there documentation if the children entered care during service?
YES_____ NO_____
If yes If the children were returned home YES_____ NO_____
If the children stayed in care YES_____ NO_____
Was there documentation of the parent moving to a higher stage of change?
YES_____ NO_____

Was there documentation of whether the parents asked for their children to enter care, so they could receive treatment? YES_____ NO_____
If yes was the date of entry in to care recorded? YES_____ NO_____
was the date of return from care recorded? YES_____ NO_____
Was there a record stating whether the placement was with a relative?
YES_____ NO_____
Was there a record of intake end date for service? YES_____ NO_____
Was there a record of preservation service end date? YES_____ NO_____
Was there a record of community end date? YES_____ NO_____
Was there a record of support end date? YES_____ NO_____

Follow-Up Services:

Was there a documentation of whether the family requested follow up services?
YES_____ NO_____
If yes was there a documentation of who provided the services?
YES_____ NO_____ by which unit?_____
Was the date the follow up service was provided documented?
YES_____ NO_____
Was the date the follow up service ended documented?
YES_____ NO_____

Appendix 8

File Review Data

File Review

At the time of the evaluability assessment there were six closed files that were reviewed. All six files contained the CFSIS family number and file name. Legal names of the mothers and fathers were documented in five of the six files. Family type was recorded in all but one of the files. Four of the families were single parent-females, one family was a single parent-male and one was a two-parent family. The mother's ethnic background was aboriginal in all but one of the cases. In the sixth file ethnic background was not recorded. The total number of children in the home was recorded in each of the files. Two of the families had one child, two families had two children and one family had three children in the home.

In each of the files the unit at WCFS that initially handled the child protection concern was recorded. "After Hours" handled two of the cases while CRU dealt with the other four. All of the cases required an immediate response. The date that the file was opened and the source of referral was recorded in all six files. On two occasions the source of referral came from the education system, once from the justice system, once from a community member, and once by an anonymous person. In all six of the files it was documented what the families previous level of involvement was with the Branch. In two cases it was the second time the file was opened, in one of the situations it was the family's third opening, and the other three cases had more than three file openings.

All of the files documented which auxiliary worker was involved with the family, the reason the file was opened and the number of times children had previously been in care. There was a recording of the parenting issues in five out of the six files. The intake worker documented the parent's stage of change in three of the six files. The auxiliary program that the case went to was

recorded in all of the files. Family preservation staff received five of the cases while the other file went to a community based early intervention worker. The date that the lead auxiliary service commenced was recorded in two of the six cases. Files indicated whether the family was willing to receive service in five of the six cases. In each file it was recorded if families received services. Five of the six files revealed that a connection with the family was not made. One family that did connect with the SMI received a brief intervention involving a harm reduction plan and contracting. For families that did not receive service the closing date was recorded in three of the six files. Among the five families that did not receive service, three of the files noted that the family received a closing letter.

In two of the files the intake unit was notified that auxiliary staff did not accept the referral. In cases where contact was made only one file reported the dates for contact. The date of the last contact with the family was recorded in only one of the files. There was no mention that a family support worker was involved in any of the cases. The parent's stage of change at closure was documented in two of the six files. One parent was pre-contemplative and another was in the action stage of change. The number of sessions with the family was recorded in three of the six cases. A face-to-face meeting with a substance abuse service provider was not documented in any of the files. Two of the files made mention of the interventions used with the family. Interventions included substance abuse screening and assessment, the development of a harm reduction plan, education, and counseling.

In five of the six files there was documentation of when the file was closed at intake. There was documentation that further service was required after referral to an auxiliary worker in one of the

six files. None of the files were transferred to a family service unit. Five of the six files noted the reason for the file closure. For those cases the file was closed because the parent refused service. The outcome at file closure was recorded in only one of the six files. None of the files documented if the goals/objectives were reached satisfactorily or if the risk to children was reduced. There was documentation in two of the files that parents were connected to a substance abuse service provider. None of the files documented if the parent moved to a higher stage of change. Five of the files had a record of the auxiliary service end date. There was no documentation of whether the family requested follow up services in any of the files.

Reviews of the Screening Form

Two files did not have a screening form attached to them. The four files that had a completed screening form included the date in which the form was completed and the family name but only three files indicated the file number. The first name of the primary caregiver was filled in on all of the completed forms. Two of the forms noted that the family did not have a phone while the other two files listed the families phone number. The intake workers name and the unit they worked in was filled out on the four completed forms.

Indication of the family's willingness to receive services from the Initiative as well as the auxiliary service the family was referred to was entered on the four completed forms. Only one of the forms had a record that the responsible tip sheets were used. All four completed screening forms had documentation of the substance used by the parent, which was alcohol. Each of the forms had a record of the effects that the substance use had on child care, specifically inappropriate child care and children being left alone. Parental level of involvement was

documented on all four of the forms. Two of the families were recorded as having irregular involvement with substance use, one parent had regular involvement with substances and another family was noted as having harmful involvement with substances.

The stage of change by the parent was documented on all four forms that were filled out. Three parents were pre-contemplative and one parent was in the preparation stage. All four of the forms had a record of the parent's readiness to make change regarding their substance use. Three of the parents were still actively drinking and the third was attending AA meetings. There was no record showing what kind of help the family wanted. Three of the forms revealed that the parents had no concerns and did not think they needed help. One form showed that the parent wanted assistance to make a better life for his or her family.

Closing Summary

The family name and the file number was filled out for each of the closing summaries. Five out of the six summaries had the intake supervisor, the intake unit and all the names of Initiative workers recorded. Start and end dates for the work done by all auxiliary staff was on file for three out of the six families. The date the case was completed was on file for all of the cases.

An explanation of significant contacts that occurred during service delivery was recorded in three of the six summaries. A description of the historical and current issues that impacted the family was documented in three of the summaries. Documentation of parental level of involvement with substances was included in one of the six files that were reviewed. Two out of six summaries had documentation of the stage of change the parent was in. How the substance use impacted the parent's ability to care for his or her children was not recorded in any of the

cases. Two of the summaries mentioned the services that were offered to the family. Four of the six summaries included a statement detailing the family's response to the services that were delivered. In each of those four summaries it stated that the family resisted service.

Appendix 9

Draft Interview Guide for Clients (Component One)

Draft Interview Guide for Clients (Component One)

Introduction

- Background information on the evaluation of the SMI
- Reason for conduction the evaluation
- Discussion on confidentiality and signing of the consent form

Questions:

1. When did you first receive services from the SMI?
2. What were the reasons for you being involved with the Initiative?
3. What types of services did you receive from the SMI?
4. What supports did you feel you needed from WCFS?
    a. Do you feel that you received this support?
    b. Did you feel that additional services would have enhanced your experience with the program?
    c. What services do you feel would have been more beneficial for you and your family?
5. Was a harm reduction plan established for your family?
    a. Who was involved in the development of this plan?
    b. Was the plan helpful to you and your family?
    c. If yes How was the plan helpful?
    d. If no Why was the plan not helpful?
6. Did you feel like SMI staff were understanding of your situation and provided you with the help you needed?
    a. In what ways were the services a benefit to you and your family?
    b. In what ways were the services a challenge for you and your family?
7. What are your thoughts on the services you received from the SMI?
    a. What is life like for you and your family since receiving services from the SMI?
    b. Why did you decide to accept (or decline to receive) services from the program?

Appendix 10

Draft interview Guide for Management (Component One)

Draft interview Guide for Management (Component One)

Introduction:

- Background information on the evaluation of the SMI
- Reason for conduction the evaluation
- Discussion on confidentiality and signing of the consent form

Questions:

The interview will begin by addressing the implementation of services.

1. What is your position with the SMI?
2. As you understand it what is the current referral process for the SMI?
    a. To your knowledge are staff implementing this process?
    b. If not why is this so?
3. As you understand them, what activities are being operationalized by SMI staff to engage with families?
    a. Do you feel that SMI staff are becoming more successful at engaging with families?
    b. Why or why not?
4. To your knowledge how long are services provided to SMI families?
5. To your knowledge do SMI employees develop harm reduction plans for SMI families?
    a. How is this plan developed?
    b. How is the plan beneficial to families?
    c. How is the harm reduction plan useful to the Branch?
6. To your knowledge have SMI staff increased their knowledge in relation to substance abuse because of the Initiative?
    a. Describe what was learned about substance abuse and how it impacts parenting?
    b. How does this knowledge on substance abuse effect the Branch?
    c. Do you feel that the SMI has been able to improve staffs' satisfaction with their job? How or how not?
7. Has the SMI been a positive program for the Branch?
    a. Why or why not?

The next set of questions relate to collaboration.

8. Have collaborative efforts changed among SMI staff?
    a. How has collaboration changed?
9. Have collaborative efforts changed for SMI and substance abuse service providers?
    a. How has collaboration changed with external agencies that deal with substance abuse issues?
10. How do you think collaboration could be further enhanced?

Appendix 11

Draft Interview Guide for Service Staff/ Supervisors (Component One)

Draft Interview Guide for Service Staff/ Supervisors (Component One)

Introduction:

- Background information on the evaluation of the SMI
- Reason for conduction the evaluation
- Discussion on confidentiality and signing of the consent form

Questions:

The first set of questions relate to the implementing the SMI

1. What is your position with the SMI?
2. As you understand it what is the current referral process for the SMI?
   a. How effective is this referral process for your (your staffs') job?
3. What activities are being operationalized by you (your staff) to engage with families?
   a. Do you feel that you (your staff) are becoming more successful at engaging with families?
   b. Why or why not?
4. On average how long do you (your staff) provide service to SMI families?
5. What services do you (your staff) offer to families through the SMI?
   a. Were the services offered through the SMI beneficial to families?
   b. Why or why not?
   c. Do you feel that additional services could enhance the SMI?
   d. What additional services do you feel would enhance the SMI?
6. Have you (your staff) done assessments of a families substance use?
   a. How did you (your staff) conduct this assessment?
   b. Did you feel the assessment was effective for you (your staffs') work?
   c. How was it effective for your (your staffs') work?
   d. Did you feel the assessment was effective in assisting families?
   e. How was it effective in assisting families?
   f. Do you feel the assessment could be enhanced?
   g. How could it be enhanced?
7. Have you (your staff) developed a harm reduction plan for a family?
   a. How did you (your staff) go about developing this plan?
   b. Did you feel the plan was helpful for the family?
   c. How was it useful?
   d. Was the harm reduction plan helpful to the work that you (your staff) do?
   e. How was the harm reduction plan helpful to you (your staffs') work?
8. Since working on the SMI has you knowledge increased in relation to substance abuse?
   a. Describe what you have learned about substance abuse and how it impacts parenting?
   b. How does your knowledge on substance abuse effect SMI families?
9. What are your thoughts on the SMI?
   a. Has working on the SMI been positive or not?
   b. In what way to you feel the SMI could be further enhanced to make your job more enjoyable?

The next set of questions relate to collaboration.

10. Have collaborative efforts changed for yourself among the SMI staff?
    a. How has collaboration changed?
    b. How could it be further enhanced?
11. Have collaborative efforts changed for you (your staff) among substance abuse service providers?
    a. How has collaboration changed with external agencies that deal with substance abuse issues?
    b. How could collaboration be enhanced further with substance abuse service providers?

Appendix 12

Draft Interview Guide for External Stakeholders (Component One)

Draft Interview Guide for External Stakeholders (Component One)

Introduction:

- Background information on the evaluation of the SMI
- Reason for conduction the evaluation
- Discussion on confidentiality and signing of the consent form

Questions:

1. Have you been involved with any families that received services from the SMI?
2. What are your thoughts on the understanding that SMI staff have in relation to substance abuse and how it impacts families?
3. In your opinion how did the services offered by the SMI affect families?
    a. Why do you feel this was so?
4. What are your thoughts on the SMI?
    a. Do you feel this program can be enhanced?
    b. In what ways do you feel the program could be enhanced?
    c. In what ways does this program differ from services that were offered in the past?
    d. Do you feel these services are more beneficial, less beneficial or neither?
5. Do you feel that families situations have changed since receiving services from the SMI?
    a. Why do you feel these changes occurred?

The next set of questions relates to collaborative efforts with WCFS in relation to an SMI family?

6. Have you been involved in any of the assessment for an SMI family?
    a. What was your involvement?
7. Have you been involved in any harm reduction plans for an SMI family?
    a. What was your involvement?
8. Have collaborative efforts changed for yourself among the SMI staff?
    a. How has collaboration changed?
    b. Do you feel that collaboration could be enhanced?
    c. How could collaboration be further enhanced?

Appendix 13

Draft Evaluation Tracking Form

Draft Evaluation Tracking Form

Family Information:

Family Type:

Single Parent-Female __ Single Parent-Male __ Adoptive Family __
Two Parent __ Blended/Step Parent __ Extended Family __

Legal Mother's/Guardian's Racial Background:

Aboriginal (includes First Nation and Metis) ___Caucasian___ Black ___
Asian __ Unknown __ Other __

Total Number of Children in the home:
1__ 2__ 3__ +4__

Opening Information:

Was the call received by ---?
After Hours ___ CRU___
Was it recorded if an immediate response was required: YES _____ NO _____

When was the file was opened recorded? ____/____/____
D M Y

Who was the source of referral?

Ex-partner/spouse	____	Day care	____
Parent	____	Education System	____
Child/Youth	____	Justice System	____
Community Member	____	Other child welfare agency	____
Mental Health System	____	Health System	____
Extended Family Member	____	Addiction Service Provider	____
Anonymous	____	Other	____

Was it recorded if the family call requested service? YES _____ NO _____

Previous Contacts:
What was the families previous level of involvement with the Branch?
None ____ one opening ____ two openings ____ three openings ____
More than three openings ____

What was the families previous involvement with the project:

_____
_____
_____
_____
_____
_____

How many times was the family involved with the Initiative?
None ____ one time ____ two times ____ three times ____
More than three times ____

Which auxiliary program did the family go to?

Family Preservation_____ Community Based Early Intervention_____

Who was the auxiliary worker?
First time _____
Second time _____
Third time _____
Any additional times _____

What was the reason for the file reopening?
Parents request? _____
Involuntary _____

How many times had the children previously been in care:
None ____ One ____ Two ____ Three ____ More than three times ____

Intake Service Information:
What was the reason for the file opening?

Neglect-Physical	_____	Abuse-Physical	_____
Neglect-Emotional	_____	Abuse-Emotional	_____
Neglect-Medical	_____	Abuse-Sexual	_____
Child left unattended	_____	Parent Requesting Service	_____
Inappropriate Discipline	_____	Family Violence	_____

What were the parenting issues:

Child with special needs	_____	Parent-Mental Health issues	_____
Behavioral problems of child	_____	Parent-Substance Misuse	_____
Emotional problems of child	_____	Parent-Medical issues	_____
Difficult parent-child relations	_____	Parent-Gambling	_____
Financial problems	_____	Parent-FAS/FAE	_____

What was the outcome of the screening tool?

_____
_____
_____
_____
_____

What was the parent's level of use at the onset of services?

Addiction/dependence	_____	Occasional use	_____
Experimental use	_____	Abusive use	_____
No use	_____	Regular use	_____

What was the parent's stage of change?

Pre-contemplative	_____	Contemplative	_____
Preparation	_____	Action	_____
Maintenance	_____	Termination	_____

Referral Information:

What was the date the lead auxiliary service commenced service? _____

Was the family willing to receive service?	YES _____ NO _____
If no was the closing date recorded?	YES _____ NO _____
Was there a record that the family received a closing letter?	YES _____ NO _____
Was intake notified if the referral wasn't accepted?	YES _____ NO _____

Auxiliary Service Information:

Was there contact made with the family?	YES_____ NO_____
If no -was there a date for when no contact was made?	YES_____ NO_____
If yes -was there a date for when contact was made?	YES_____ NO_____
Was the date for the last contact with the family recorded?	YES_____ NO_____
Was there a family support worker involved?	YES_____ NO_____
If yes was the date the FSW involvement recorded?	YES_____ NO_____
was the date the FSW involvement ended recorded?	YES_____ NO_____
Was another auxiliary service involved with the family?	YES_____ NO_____

What was the parent stage of change, at closure

Pre-contemplative	____	Preparation	____	Maintenance	___
Contemplative	____	Action	____	Termination	___

What was the number of sessions with the family? _____

Was there a face-face meeting with an addiction service provider? YES_____ NO_____

What occurred at this meeting?

_____

_____

_____

_____

_____

What interventions were used with the family?

Addiction Screening and Assessment	YES_____ NO_____
Identification of Stage of Change	YES_____ NO_____

Motivational interviewing YES_____ NO_____
Contracting YES_____ NO_____
Development of a harm reduction plan/agreement YES_____ NO_____
Referral to addiction services YES_____ NO_____
Integrated case management YES_____ NO_____
Provision of concrete supports YES_____ NO_____
Child care/respite YES_____ NO_____
Community mapping YES_____ NO_____
Education YES_____ NO_____
Collaboration YES_____ NO_____
Counseling YES_____ NO_____
Advocacy YES_____ NO_____
Informational support groups YES_____ NO_____

Closing Summary:

When was the file closed? _____

Was there documentation that further service was required after referral to auxiliary worker resource? YES_____ NO_____

Was there documentation that the file was transferred to a family service unit? YES_____ NO_____

Was there documentation of the date the file was transferred? YES_____ NO_____

Was the reason for the file closure recorded? YES_____ NO_____

What was the reason for the file closure?

Service was no longer required YES_____ NO_____
Family not selected for service YES_____ NO_____
Parents refused service YES_____ NO_____
Family moved YES_____ NO_____
Family accessed external resource YES_____ NO_____
Other child welfare agency provided services YES_____ NO_____

Was the outcome at file closure recorded? YES_____ NO_____

What was the outcome?

_____
_____
_____
_____
_____
_____

Was there documentation that goals/objectives were reached satisfactorily? YES_____ NO_____

Was there documentation that the risk to children was reduced? YES_____ NO_____

Was there documentation if parents were connected to addiction service providers? YES_____ NO_____

Was there documentation if the children entered care during service? YES_____ NO_____

If yes Where the children were returned home YES_____ NO_____
Did the children stayed in care YES_____ NO_____
Was there documentation of the parent moving to a higher stage of change?
YES_____ NO_____
Was there documentation of whether the parents asked for their children to enter care, so they could receive treatment? YES_____ NO_____
If yes what date did the children enter care? _____
What was the date of return from care ? _____
Did the children enter care with a relative YES_____ NO_____
What was the end date of service with intake? _____
What was the end date of auxiliary service? _____

Follow-Up Services:
Did the family request follow up services? YES_____ NO_____
Who provided the services?

_____
_____

When were follow up services provided?

_____
_____
_____

What follow up services were offered?

_____
_____
_____
_____
_____
_____

Appendix 14

Draft Interview Guide for Clients (Component Two)

Draft Interview Guide for Clients (Component Two)

Introduction

- Background information on the evaluation of the SMI
- Reason for conduction the evaluation
- Discussion on confidentiality and signing of the consent form

Questions:

1. When did you first receive services from the SMI?
   a. Did you feel these services were supportive?
   b. Did these services meet your needs?
   c. Did you feel the SMI staff understood your needs and tried to help?
2. What were the reasons for you being involved with the Initiative?
3. What types of services did you receive from the SMI?
   a. Did you develop a plan with your workers to deal with your issues?
   b. Did you feel apart of the plan that was developed for your family along with the SMI workers?
4. Did your worker spend time discussing substance use with you?
   a. Do you feel more informed about your substance use because of the information that was provided to you by your worker?
5. What supports did you feel you needed from WCFS?
   a. Do you feel that you received this support?
   b. What additional supports could have better assisted you and your family?
   c. Did SMI staff advocate for you when necessary?
6. Did you feel like staff were understanding of your situation and provided you with the help you needed?
   a. In what ways were the services a benefit to you and your family?
   b. In what ways were the services a challenge for you and your family?
   c. What are your thoughts on the services you received from the SMI?
   d. Do you feel like you got the assistance that you needed from the SMI?
   e. What services do you feel would have been more beneficial for you and your family?
7. Did your children enter care at the Branch?
   a. How long were your children in care?
8. Did you enter a treatment program with the assistance of the SMI?
   a. Did your worker from the SMI help you to get established with this program?
   b. Was this program the right one for your needs?
9. What is life like for you and your family since receiving services from the SMI?
   a. Did the services you received help improve your home situation?
   b. Were you satisfied with the services that you received from the SMI?
   c. Are you more aware of the community resources that are available for you and your family?
   d. Are your children better off because of the services that you received from the SMI?

Appendix 15

Draft Interview Guide for Service Staff/ Supervisors (Component Two)

Draft Interview Guide for Service Staff/ Supervisors (Component Two)

Introduction:

- Background information on the evaluation of the SMI
- Reason for conduction the evaluation
- Discussion on confidentiality and signing of the consent form

Questions:

The first set of questions relate to the benefits of implementing the SMI.

1. What is your position with the SMI?
2. What services do you (your staff) offer to families through the SMI?
   a. Do you feel the services offered through the SMI were beneficial to families?
   b. What additional services do you feel would enhance the SMI?
3. How many children entered care because of their parents substance use?
   a. On average how long were the children in care?
   b. Do you feel that this length of time was in anyway impacted by the services offered by the SMI?
   c. Why or why not?
4. What were some outcomes for families that received services from the SMI?
   a. Do you feel that the program was influential to these outcomes?
   b. In what way do you feel the program impacted these outcomes?
5. If the outcomes were positive what led to this?
   a. If positive outcomes were not realized why do you think this was the case?
   b. Are there any implications for the outcomes that relate to how services should be provided?
   c. What lead to the outcomes that families experienced?
6. Do you feel that the services offered by the SMI were beneficial to families?
   a. Why or why not?

The next set of questions relate to collaboration.

7. Have collaborative efforts changed for yourself with other SMI staff?
   a. How has collaboration changed?
   b. Do you feel that collaboration among the SMI could be improved?
   c. How could collaboration be improved?
8. Have collaborative efforts changed for you (your staff) with substance abuse services providers?
   a. How has collaboration changed with external agencies that deal with substance abuse issues?
   b. Do you feel that collaboration could be improved with external agencies?
   c. How could collaboration be enhanced?

Appendix 16

Draft Interview Guide for External Stakeholders (Component Two)

Draft Interview Guide for External Stakeholders (Component Two)

Introduction:

- Background information on the evaluation of the SMI
- Reason for conduction the evaluation
- Discussion on confidentiality and signing of the consent form

Questions:

1. Have you been involved with any families that received services from the SMI?
2. In your opinion how did the services offered by the SMI affect families?
    a. Why do you feel this was so?
3. What are your thoughts on the SMI?
    a. Do you feel this program can be enhanced?
    b. In what ways do you feel the program could be enhanced?
    c. In what ways does this program differ from services that were offered in the past?
    d. Do you feel these services are more beneficial, less beneficial or neither?
    e. Do you feel that families situations have changed since receiving services from the SMI?
    f. Why do you feel these changes occurred or did not occur?
4. Have you been involved with any families that also received SMI services?
    a. About how many families would you say were referred to your agency by SMI staff?
    b. What were some outcomes for SMI families?
    c. What do you think lead to these outcomes?
    d. Would you say these outcomes were good, bad, neither?
    e. What do you feel lead to the outcomes that families experienced?
    f. Do you feel that the program had an effect on the outcomes for families?
    g. In what ways did the program effect the outcomes for families?

The next set of questions relates to collaborative efforts with WCFS in relation to an SMI family?

5. Have collaborative efforts changed for yourself among the SMI staff?
    a. How has collaboration changed?
    b. Do you feel that collaboration could be further enhanced?
    c. How could collaboration be improved?