Supporting Service Excellence and Continuous Quality Improvement through Evaluation

EVIDENCE BASED PRACTICE – EVALUATION GRANT
FINAL REPORT

Evaluation of Access for Children in Short-term, Out-of-Home Care by Type of Access at CAS-Toronto

Prepared for: Gavin Shaw,
Ministry of Children and Youth Services

Project Team: Connie Cheung, Olivia Lu, Deborah Goodman, Kristen Lwin,
Child Welfare Institute,
Corrie Tuyl, *Director, North Branch,*
Access Evaluation Workgroup,
Children's Aid Society of Toronto
30 Isabella St., Toronto, ON M4Y 1N1

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1.0 GRANT BACKGROUND

An essential component of care that is provided by the Children's Aid Society of Toronto (CAST) is the provision of Access visits for children and their families. Access visits provide biological parents/caregivers and family members with the opportunity to visit with their children who have been placed in out-of-home care. Within the broader offering of Access visits within a child welfare setting is the divide between children/youth in short-term, non—permanent CAS care (less than 2 years) vs. children/youth in long-term, permanent care (greater than 2 years). The focus of this examination is exploring Access services to children/youth in short-term care.

CAST currently offers three main types of Access for children in short-term care (<2 years):

1) ***In-Office (IO):*** In-office access is not a program but a range of access forms. IO can include access visits that range from a "meet & greet" between the family, child and worker to an access visit that is semi-supervised to an access visit that is fully supervised by CAS staff. IO access tends to have moderate levels of intervention by Case Worker(s).

2) ***Child Access Program (CAP)*****:** CAP is also a range of access forms and not a formal access program. CAP offers a low level of intervention by CAP coordinator/volunteer.

3) ***Therapeutic Access Program (TAP):*** TAP is an access program that is fully supervised by TAP coordinator/staff. TAP offers a high level of intense intervention between staff and parents; the duration of visits tends to be longer than the other Access forms. TAP visits occur in a home-like office setting. TAP has a structured intervention focus (e.g. parent engagement/learning component, TAP goal is a clear permanency plan). A primary intervention focus is earlier permanency planning decisions for the child.

The range of access programming varies by type. With IO and CAP it can range from low to moderate staff intervention and usually includes some form of documentation related to the visit between the child and their parent. IO may have a teaching component. TAP is at the other end of the continuum with structured interventions (parent engagement/learning), clear time lines, the documented TAP Access Plans have stated goals, and progress is reviewed at regular time periods and a primary goal is earlier permanency planning decisions for the child.

From 2000-2007, the number of access visits has increased at CAST despite a decline in the number of children placed in out-of-home care (this decrease is evident across the province). The trend to greater frequency of Access visit use during service delivery highlights the importance for us to understand the impact of Access on families and their children. Of particular interest is the influence of Access on specific service outcomes such as successful and safe reunification of the children back into their homes and assessment of child and family functioning. While CAST has independently examined Access by type, much of this exploratory work is limited to understanding the demographic composition of families who utilize these programs. What remains relatively unclear is if and how Access may influence various family, child and service outcomes.

Although goals may vary across Access programs, the current study was interested in examining the relation between different types of Access and outcomes such as child reunification, child safety, parent-child interactions and client engagement and satisfaction.

This study represents an exploratory investigation into these initial outcomes and the hope is future evaluation initiatives will build upon this study's learning.

Study Goals and Objectives:

- To expand our understanding of Access for children/youth in short-term care
- To explore the impact of Access on various service delivery outcomes within the context of the different access services.
- To gain some preliminary insights into program effectiveness of Access by examining various worker, family and child outcomes.
- To examine the following outcomes:
  - Program implementation
  - Child's reunification with family
  - Maintaining/strengthening parent-child relationships
  - Child risk/improving child safety
  - Client engagement and satisfaction with Access service

A mixed-method approach was employed through utilizing focus groups, file reviews, and caregiver questionnaires.

- Focus groups were used to examine 1) program implementation and 2) client engagement and satisfaction.
- File reviews were used to examine the rate of reunification across Access programs
- Caregiver questionnaires were used to track parent/caregiver-child relationships and child risk/child safety over time.

Study Note: IO, CAP and TAP represent very different access programs that service a wide range of families and children. Not only are there significant differences in program characteristics (e.g., different program goals), but how service is delivered varies. Therefore, the goal of the current project is not to compare outcomes between programs. Rather, the intent of this exploratory examination is to review each program independently. This approach provides a more in depth understanding of each access program and fosters greater methodological consistency, which aids in identifying common trends and themes across programs.

1.1 Recruitment Complication

The body of literature regarding Access visits in a mandated setting is not well developed. More specifically, research involving children and families involved with child welfare and who use Access programs, is a relatively unexplored area of study. In addition to ongoing program measurement practices, since 2004, CAST has made important gains in knowledge development regarding access through a number of large-scale case surveys (e.g. 3000 cases) that provided detailed descriptive analyses on use and type, and through longitudinal program evaluation of the TAP program.

This study represents another important step in knowledge advancement through the collection of data directly from the families. The reality however for many families who attend Access visits is they are often experiencing high crisis, change and adjustment. Thus, the research team encountered many recruitment challenges that were not originally anticipated. This was particularly so with IO Access, where apprehension of the child had just occurred; many families were not open to study participation. Also, there were logistical barriers around planning, and coordination of longitudinal data collection with families. Thus, the research team made a decision to omit some aspects of direct data collection from families receiving IO but IO file reviews were included.

2.0 RESEARCH QUESTIONS: Access Types by Children In Short-term Care

The current evaluation framework employs a mixed-method approach and combines varies types of data collection strategies such as file reviews, focus groups, caregiver questionnaires and in-depth interviews. The research questions addressed by the current study include the following:

2.1 What are the factors that impact program implementation?

Program implementation was examined through in-depth interviews with CAP and TAP program coordinators and volunteers. The goal was to gain some understanding into important factors that facilitated or hindered the implementation of different Access programs within the agency. More importantly, agency-level influences were also considered to gain insights into how policies and procedures within CAST may contribute to program success specific to each program.

2.2 What are the similarities and differences in 'child reunification' by Access types?

Through completing file reviews on IO, CAP and TAP cases, the proportion of children who were reunified home was examined. This is not a common analysis of access in the practice or in the literature. While one part of our learning was assessing if the likelihood of reunification was associated with certain Access placement, family- and child-specific characteristics, the other part of the learning was the best practice in that analysis. Should reunification be assessed ACROSS Access types? In other words – should the Access types be grouped together? Or given the variance in goals, objectives and methods by Access types, should reunification only be compared WITHIN types? In short, only examine reunification of CAST -TAP against other TAP programs, and only measure IO against other IO programs? Given the differences in Access types, we anticipated the rates to differ based on different program goals across Access type.

Study Note: Case by case, child reunification may not be a desired outcome. Future studies on access using aggregate data need to separate out cases where reunification is NOT the goal.

2.3 What is important in maintaining/strengthening the parent-child relationships?

The extent to which CAP and TAP services were related to changes in parent/caregiver-child relationships was examined through data collected through the caregiver questionnaire at multiple time-points. The goal of this analysis was to understand how important aspects of the parent/caregiver-child relationships may have changed since receiving CAP or TAP services.

2.4 Is child risk and child safety impacted by Access?

Although changing child outcomes may not be the primary focus of Access, nevertheless, the research team was interested in examining possible shifts in child risk and safety. Child risk and safety was examined by data gathered through file reviews. Specifically, the goal was to understand the level of child risk and safety subsequent to receiving CAP, TAP, or IO services. The research team was also interested in examining potential family and/or child-specific factors that were associated with higher/lower levels of child risk and safety.

2.5 What is the level of caregiver engagement and satisfaction with Access Service?

Caregiver engagement and satisfaction was assessed through the caregiver questionnaire and interviews. The goal was to gain some insights into caregiver engagement and satisfaction to identify processes that can improve the quality of services offered to families and children.

3.0 STUDY METHODOLOGY

In the following sections, methodology related to file reviews, caregiver questionnaires and worker interviews and focus groups will be discussed.

3.1 Retrospective, Longitudinal Case Reviews by Access Type (*n*=80): IO, CAP & TAP

Retrospective file reviews, examining the following areas was conducted (refer to Appendix A):

- *Demographic information*
- *Information concerning parents/caregivers (e.g. demographic information, mental health status, risk and protective factors)*
- *Information concerning children (e.g. demographic information, mental health status, risk and protective factors)*
- *Admission and access characteristics*

A total of 80 case files from 2008 of families who received CAP and TAP services across different branches were randomly selected and reviewed with a standardized tool and by an independent reviewer.

❖ TAP (*n*=35), ❖ CAP (*n*=25) ❖ IO access (*n*=20)

The goal of the file review was to capture the extent to which children/youth showed individual variability across two areas:

1) Rate of reunification, 2) Reduction of child risk.

More importantly, the aim was to identify which characteristics (i.e., parent/caregiver, child and admission/access factors) were related to lower levels of risk.

3.2 Caregiver Questionnaires (n=11): CAP & TAP

Significant challenges were encountered in collecting caregiver data.

Caregiver questionnaires were administered to families who participated in TAP or CAP (refer to Appendix B). While many families were asked to participate only a total of 11 families from CAP (*n*=7) and TAP (*n*=4) consented and completed the survey and were included in the sample. Two families had sibling data as multiple children from the same family participated in these programs. Therefore, data were collected for each child. The challenges in gathering Time 1 data adversely impacted data collection across multiple time points (Time 2, *n*=3 and Time 3, *n*=1).

Methodologically, caregivers were asked to complete the caregiver questionnaire in a quiet room during their access visits with their children. This usually occurred at the beginning of the visit. If a caregiver had difficulty reading or understanding the survey questions, then Access coordinators, volunteers or interpreters would aid in interpreting the questions.

3.3 Worker Interviews and Focus Groups (n= 9): CAP & TAP

Insights from CAP and TAP Access program staff were gathered via interviews and focus groups (refer to Appendix C). Views from all coordinators involved with CAP (*n*=6) were gathered through a focus group while experiences from a CAP volunteer (*n*=1) were explored through a long interview. TAP coordinators (*n*=2) were interviewed separately about their experiences and insights about the program.

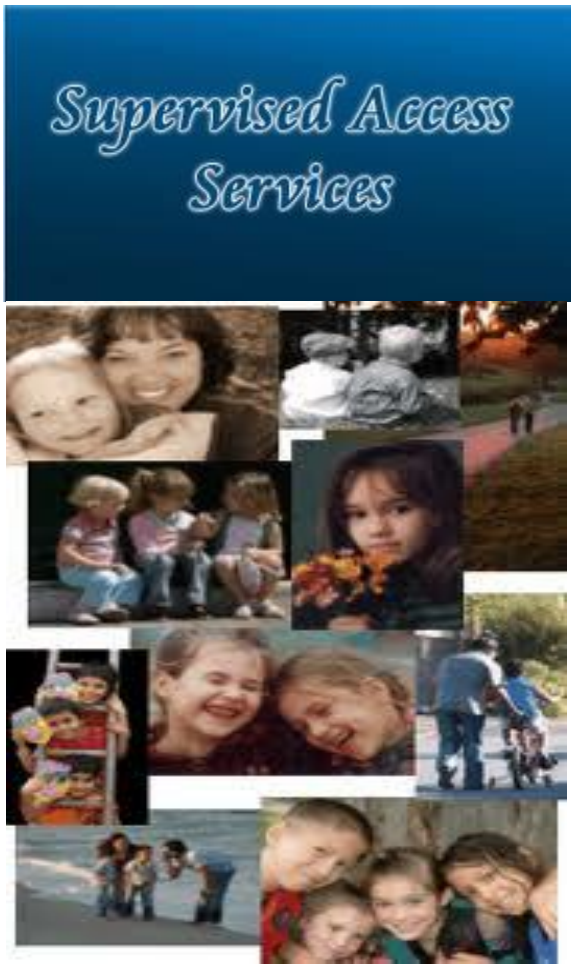
3.4 Caregiver Interviews (n=10): CAP & TAP

Significant challenges were encountered in collecting caregiver data.

Caregiver interviews were conducted to gain insights into families' experiences with Access (refer to Appendix D). Concepts related to caregiver satisfaction and caregiver/parent-child relationships were examined.

Despite significant efforts, only a total of ten caregivers/parents across TAP (*n*=5) and CAP (*n*=5) participated in interviews or provided feedback. Some of these parents/caregivers also completed the caregiver questionnaire.

Parents/caregivers provided feedback individually either prior to an access visit with their child or after completing the caregiver questionnaire. Interviews were conducted in a quiet room and generally lasted for approximately 10 minutes. A series of standardized questions were used to guide the interview when required.



4.0 PROGRAM IMPLEMENTATION

Program implementation was examined through in-depth interviews with CAP and TAP program coordinators and volunteers. A total of six CAP workers and two TAP workers participated in in-depth interviews or focus groups. One CAP volunteer also participated in an in-depth interview.

Three key areas were explored:

1) Impact of agency factors on program implementation,
2) Necessary ingredients for improved parent-child relationships,
3) Worker satisfaction with access programs.

4.1 Impact of Agency Factors on Program Implementation

Across both programs, CAP and TAP workers spoke about the critical importance of having support from senior management regarding Access services. Both CAP and TAP staff spoke about how important is to them that management appreciates, understands and values their Access program. They viewed the support as essential as decisions about budget, program implementation and growth are made by senior management.

A barrier to implementation noted by staff for both CAP and TAP is the limited flexibility in the adjustment of the staff complement related to fluctuations in service volumes. These comments were in reference to the gradual expansion of CAP and TAP services over time juxtaposed against the positions originally allocated and assigned to each program.

Analysis of the themes from the interview data finds similarities regarding both CAP and TAP programs offering Access services (colour-coded pink). There are important differences too. These are noted via CAP alone (colour-coded blue) and TAP alone (colour-code green). These themes note the unique perspectives on how agency factors may influence program implementation and fidelity. As such results will be discussed separately where the themes differ.

4.1.1 CAP Worker Interviews (n=6)

The CAP staffs' views on the factors they perceive influence program implementation and fidelity, CAP workers are noted in the three themes below:

THEME 1: Agency Resources and Support Are Key to Program Excellence (CAP)

1. *Provision of resources* (e.g., remote email access, computers). These help by a) improving service delivery and communication between different stakeholders involved with Access (e.g., easier and quicker communication between Access staff and workers; and b) resources help foster and improve communication with families (e.g. need to keep Access areas clean).

2. *Agency policies for standardized documentation.* The weekly and monthly reports of demographics and statistics help identify characteristics of families/children receiving services to define service needs and gaps. Standardization also provides the necessary framework to help the program expand through advocacy and strategic planning.

THEME 2: Importance of Communication (CAP)

CAP workers identified communication as a main factor in impacting agency-level processes that have the potential to foster or hinder program implementation and fidelity. These include the following themes:

1. **Communication between CAP Staff, Mgt and Sr. Mgt is Important:** CAP is a program that is situated off-site from the Agency offices and is offered during office and non-office hours (e.g. evenings, weekends). For staff, this set up creates a visible separation and a lack of fluidity or connection in the aspect of direct management communication, where most communication to staff is via the onsite supervisor, who then communicates with the Project Coordinator, who then links to Sr. Management. Staff underscored the critical importance of having frequent and direct communication with Management and Sr. Management regarding the specific needs of CAP families.

2. **Communication between CAP Staff and Program Coordinators is Key:** Staff relayed that CAP excellence rests on strong connections and communication between CAP staff and the CAP coordinator and current referral information about case situations (e.g. important changes to the family's situation, cancellations with appointments). Many CAP workers recommended the creation of a standardized 2-way communication tool to be used between case staff and CAP staff to ensure all stakeholders have the most up-to-date information.

3. **Communication between Access, Case workers and Families is Vital:** Access services can be affected by worker/family communication. Examples include families spending their access time on wanting to discuss worker/family issues with CAP staff, which takes away from the goal of Access. In short, some parents/caregivers are more likely to be distracted by their relationship with their worker, which may influence the way they interact with their kids.

"*Open communication between all involved with the family is important. If not, too much time is taken for problem solving"*

THEME 3: Volunteer Retention & Training (CAP)

A less dominant theme centered on the topic of the use of volunteers in CAP. Volunteers are an important service element for CAP and their inclusion brings strengths and challenges. Issues regarding retention, level of commitment and the impact of those factors on program fidelity were noted. Standardized training for volunteers was suggested.

4.1.2 TAP Worker Interviews (n=2)

Similarly, TAP workers identified resources and support from the agency and Senior Management as a major factor related to agency-level factors that may enhance or hinder program implementation and fidelity.

THEME 1: Agency Resources and Support Are Key to Program Excellence (TAP)

1. Organizational resources required to promote best practices related to TAP are provided and supported by Senior Management (e.g., support from supervisors and directors to frontline staff; TAP is well advertised within teams and highly accessible to workers; buy-in for TAP at all levels of management and front-line).

2. Access policies are developed as the program develops. Therefore, they are more responsive to the needs of families and children.

3. There is a level of clinical freedom where front-line practitioners are able to explore clinical components of their work. There is the flexibility to work outside the box when needed. Similarly, across both programs, there is a support for program evaluation and research to ensure program effectiveness.

4.2 Area 2: Necessary Ingredients for Improved Parent-child Relationships

CAP and TAP workers were asked to identify what they feel were necessary family and child factors that helped improve parent-child relationships. With respect to family factors, both CAP and TAP workers identified three key themes:

THEME 1: The ABC Parent: Attitude, Behaviour & Commitment to the Process (CAP & TAP)

CAP and TAP workers believed that in terms of necessary ingredients for improved child functioning, parents/caregivers required some ability for insight regarding *what* and *why* change needs to occur. The staff's experience on what are the ingredients in improved parent-child relationships include an amalgam of:

- Insight
- A willingness to work with staff
- Capacity to learn new concepts and strategies
- A level of respect, openness and comfort (e.g., being comfortable enough to ask questions) with the process
- Understanding of what is expected of them.

A secondary element noted regarding "success" is the family's ability to collaborate and cooperate between caregivers/ family members, and the family's overall ability adhere to the rules and expectations related to the Access service. Accumulated experience across CAP and TAP notes the families that are unable to do so, do not use Access effectively and may not be ready for the program.

"....there needs to be interest to change, being motivated to change...."

A primary goal of Access is not to change child behaviour per se. However, we posit that by fostering more positive interactions between parents/caregivers and their children, child adjustment can be indirectly affected. Therefore, to gain some insight into this possibility the Access program that focuses on this element is TAP, so for the purpose of the study, TAP staff were asked to identify some child-specific factors that may be related to higher levels of positive adjustment. Three themes emerged:

THEME 1: Support to Child during Transitions (TAP)

When children are adequately supported during the times of transition (from home to care, from care to home, during access visits), children are more likely to demonstrate better adjustment. Specifically, better adjustment in children is associated with:

- Having an understanding for *why* they are in care; *why* they are at TAP
- Support from foster caregivers when they go home
- Having support from biological parents/caregivers

"If children are aware of why they are there they have an easier time in the program. The program sometimes needs to process these issues."

"If parents are negative, it's hard for the child to want to be here."

THEME 2: Good Collaboration between Foster Family, Family of Origin, and TAP (TAP)

When collaboration between the foster family, family of origin and TAP is good this is related with better outcomes. TAP experience also finds if there is continuity in the parenting between Access visits and the foster home, then children demonstrate better adjustment. Similarly, better adjustment is associated with foster parents who are able to support the child around previous parenting experiences. Finally, better child adjustment is also related to how well the coordination occurs between all the stakeholders involved with the child's care.

THEME 3: Child-specific Factors (TAP)

TAP workers noted that although children are very resilient, workers did identify a few characteristics that were associated with better program outcome:

- More maturity
- Older children
- Higher level of functioning
- No mental health issues (e.g., no attachment issues)

Lastly, CAP and TAP workers were asked to identify program factors they felt enhanced or hindered program implementation.

THEME 1: The Setting (CAP & TAP)

Workers across both CAP and TAP underscored the importance of providing families with a warm, family-like setting in order to enhance the success of the program. Aspects of the Access environment that were identified by workers that helped facilitate success included an environment that:

- Does not feel like an office…it feels more like a "home"
- Was colourful and child-focused
- Allowed families to do the things they normally do at home (e.g., cook, clean)
- Is clean

While both programs make significant efforts to infuse the above "success" elements in the Access program, there were some suggested areas for improvement.

- ❖ *Have some outdoor space for families to use during visits*
- ❖ *More user friendly facilities (e.g., washrooms that are easily accessible, having an oven, laundry facilities)*
- ❖ *Provision of parking and transportation*

THEME 2: Stability, Reputation & Continuity of the Access Program (CAP & TAP)

Workers' perception of why families trust the program is because of the stability, consistency and quality of service, and the continuity of the access service over time. Specific to TAP, the standardized plan, goal setting with concrete objectives is perceived as helping the family document their progress.

4.3 Area 3: Worker Satisfaction with the Access Program

Workers were asked to identify aspects of their Access program that they *"enjoyed working with the most"* and those that they *"enjoyed the least".* Not surprisingly, worker satisfaction is associated with being able to make a positive difference in the life of a child and their family and dissatisfaction is related to feeling ineffective and understaffed.

Positive Elements:	Difficult Elements
• Working with families on their strengths; seeing them in their daily routines	• Observing parents struggle and not being able to meet program expectations
• Delight of the children to see their parents	• Effects of inconsistency (e.g., different caregivers/parents coming for visits, visitation schedules changing because of parent or worker needs) on children
• Simultaneously working with parent/caregiver and child	• Effects of poor communication and collaboration between parents/caregivers, workers, Access workers and/or agency
• Aiding in the reunification of families	• Not able to answer parent's questions
• Effects of good collaboration between Agency and Access workers, parents/ caregivers, and foster parents in the care of the child	• Staffing challenges

5.0 CHILD REUNIFICATION

To explore if there is a relationship between a child who is in short-term care and participating in one of the Access programs and the outcome, *child reunification*, file reviews were completed on 80 randomly selected case files. The sample breakdown: In-office (IO; *n*=20, 25%), Child Access Program (CAP; *n*=25, 31%), and Therapeutic Access Program (TAP: *n*=35, 44%). The presence of reunification was tracked and coded for 12 months after receiving one of the Access services.

The goal of the analysis was to explore the feasibility of this as an outcome area and to gain a better understanding of the long-term effectiveness of Access on child reunification with family. To that point, it must be noted that child reunification may not necessarily be a desired outcome across all Access programs. At a broader level, reunification of the child with their family is one of a number of possible goals during child welfare service. To this end, our first objective was to simply describe the proportion of children across each type of Access and those that were reunified with their families. The second objective was to examine where trends differed across the Access program types.

5.1 Family and Child Demographics

To understand the experiences and context of families and children, important demographic factors were examined.

Age of Child:

Across all Access types, the ages of the 80 children ranged between age one to 16 years of age (M_{age}=6.70, *SD*=4.78); the average age across all three programs was 6.70 years of age.

- IO (M_{age}=7.35, *SD*=4.83); the average age was 7.35 years of age.
- CAP program (M_{age}=9.63, *SD*=4.83) the average age was 9.63 years of age.
- TAP (M_{age}=4.25, *SD*=3.33); the average age was 4.25 years of age.

Gender of Child:

Of the 80 files, 75 noted gender of the child and five had missing data. The overall breakdown across all Access Programs found gender equally split: 37 girls (49%) and 38 boys (51%). When examined by program, differences were noted, which may a sampling factor or a program factor. This is flagged as an area for future study.

- IO Program (n=19/20); nine girls (47%) and 10 boys (53%)
- CAP Program (n=21/25); eight girls (38%) and 13 boys (62%)
- TAP Program (n=35/35); 20 girls (57%) and 15 boys (43%)

Family Structure:

The preponderance of the 78 of 80 families in this sample with data on this variable were:

- Single-parent families (n=60, 77%)
- Two-parent families (n=18, 23%).

5.1.1 Prior Risk Experienced by Parents/Caregivers

To understand the context in which families lived prior to their contact with a CAST Access Program, the risk factors experienced by parents/caregivers were examined through the file review by whether six risk factors were evident in one or both parents at the time of referral: *mental health issues, substance abuse, prenatal substance abuse, criminal history, developmental delay* and *health issues.* Other risk factors can be included in subsequent analysis. For example, across all programs, of the 80 families,

Previous partner violence:

- 33 of 80 (41%) families experienced some form of IPV
  - IO: 10 of 20 (50%) experienced some form of IPV
  - CAP: 9 of 25 (36%) experienced some form of IPV
  - TAP: 20 of 35 (57%) experienced some form of IPV

Significant group differences between the three Access program regarding IPV, were not found.

Amount of Risk Prior to Access Service:

The amount of risk biological parents/caregivers experienced prior to receiving Access services was explored (refer to Table 1 for a summary). As is evident when viewing Table 1 all three Access programs have a significant proportion of families that experience one or more risk factors. Across all three Access Programs, 15% or more of the families appear to have three of six risk factors: *mental health issues, substance abuse* and *criminal history.* The TAP Program appears to have families with a profile of even more added risk: *prenatal substance abuse* and *developmental delay.*

- Orange: 15%-24% of families experience the risk factor
- Blue: 25% -34% of families experience the risk factor
- Yellow: 35% - 50% of families experience the risk factor
- Pink: 51%+ of families experience the risk factor

Table 1: Biological Parents/Caregiver's Experience of Risk Factors Prior to Receiving Access Services

Access Group N=80	Mental Health Issues	Substance Abuse	Prenatal Substance Abuse	Criminal History	Developmental Delay	Health Issues
In-office (*n*=20, 25%)	NO (*n*=6) **YES (*n*=12)** Missing (*n*=2)	NO (*n*=9) **YES (*n*=10)** Missing (*n*=1)	NO (*n*=14) YES (*n*=1) Missing (*n*=5)	NO (*n*=11) **YES (*n*=7)** Missing (*n*=2)	NO (*n*=15) YES (*n*=2) Missing (*n*=3)	NO (*n*=17) YES (*n*=1) Missing (*n*=2)
CAP (*n*=25, 31%)	NO (*n*=14) **YES (*n*=8)** Missing (*n*=3)	NO (*n*=16) **YES (*n*=5)** Missing (*n*=4)	NO (*n*=17) YES (*n*=0) Missing (*n*=8)	NO (*n*=17) **YES (*n*=5)** Missing (*n*=3)	NO (*n*=20) YES (*n*=1) Missing (*n*=4)	NO (*n*=21) YES (*n*=1) Missing (*n*=3)
TAP (*n*=35, 44%)	NO (*n*=14) **YES (*n*=20)** Missing (*n*=1)	NO (*n*=18) **YES (*n*=16)** Missing (*n*=1)	NO (*n*=26) **YES (*n*=5)** Missing (*n*=4)	NO (*n*=23) **YES (*n*=10)** Missing (*n*=2)	NO (*n*=26) **YES (*n*=6)** Missing (*n*=3)	NO (*n*=27) YES (*n*=4) Missing (*n*=4)

Risk Factor Across Access Programs:
Interestingly, although there were no significant differences in biological parents/caregiver's previous experience with *criminal history, developmental delay* and *health issues* across the three Access programs, parents/caregivers involved with CAP were marginally less likely to experience previous problems with *mental health*, $\chi^2(2)$=4.75, p=.09 and *substance abuse* $\chi^2(2)$=5.48, p=.06 relative to IO and TAP. Future research should focus on better understanding the reasons for the variances.

An aggregate measure of the *cumulative risk* experienced by caregivers prior to receiving one of the Access services was also examined. Across the entire sample (n=80):

- ❖ No Previous Risk = 25% of caregivers did not experience any forms of previous risk
- ❖ Previous Risk = 75% of caregivers did experience 1 or more forms of prior risk
  - 1 Risk Type = 35%
  - 2 Risk Types = 26%
  - 3 or more = 14% (refer to Figure 1).

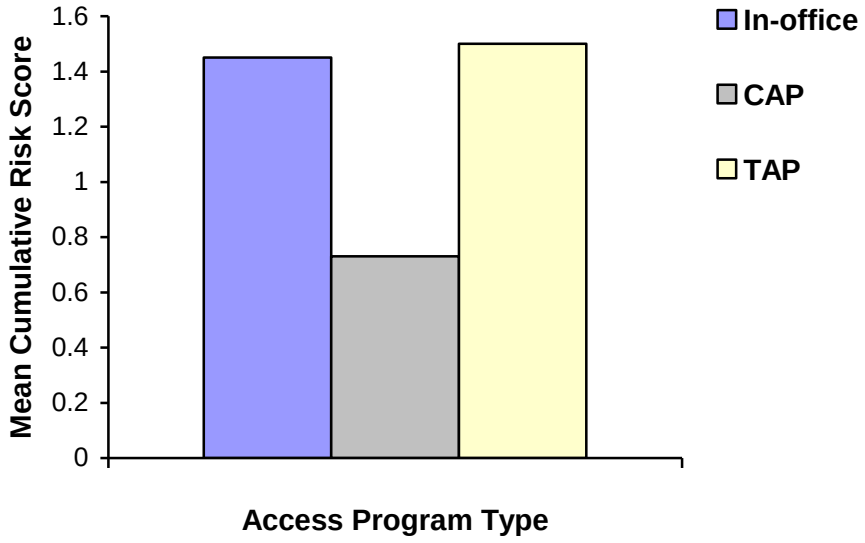


Figure 1: Mean cumulative risk experienced by biological parents/caregivers prior to receiving Access services

Differences re Parental Risk Across Access Programs:
The amount of *previous risk* experienced by biological parents/caregivers within the different programs was significantly different, $F(2,77)=5.35$, p=.01. Specifically, relative to both IO (M_{risk}=1.45, SD=1.00). and TAP (M_{risk}=1.54, SD=1.04), parents/caregivers involved with CAP (M_{risk}=0.76, SD=.78) experienced significantly less previous risk (see Figure 1).

This suggests that biological parents/caregivers involved with CAP sample entered into the program with somewhat "less risk". Taken together, these results suggest that depending on which program parents/caregivers were involved with, the amount and type of previous risk families experienced may be different. This trend may be reflective of a more restrictive referral criteria seen in TAP, relative to CAP. Therefore, it is important to examine outcomes of families separately.

5.1.2 Child Risk

Children's exposure to risk and vulnerability was examined in each of the 80 cases. The first step of analysis examined the children's maltreatment history (e.g. prior referrals, verification); Step 2 looked at multiple forms of maltreatment. Finally, each child's history regarding the following "risk" factors was reviewed against: *developmental delay, physical health concerns, mental health concerns, school difficulties, negative peer associations,* and *positive natal toxicology.*

Step 1: Maltreatment History

Physical Harm: 78% DV/ Emotional Harm: 60% Sexual Harm 1%

When examined across three Access Program types, there is no evidence to suggest that the types of harm children experienced were significantly different across programs.

Step 2: Multiple Maltreatment Forms

A cumulative score of the total types of maltreatment children experienced and/or were at risk of experiencing was created from the analysis of the data.

Across the sample, children in the three Access Programs experienced an average of 1.4 types of maltreatment (*SD*=.76). However, there was also no evidence to suggest that children's exposure to different types of abuse were different across program types. This suggests that the types of abuse children experienced were similar across program types.

Step 3: Amount of Risk (refer to Table 2 for a summary).

Finally, similar to the analysis conducted with the parents, the risk factors of the children by Access Program, were detailed. Across all three Access Programs, 15% or more of the children appear to exhibit five of six risk factors in the areas of: *developmental delay, physical health issues, mental health concerns, school difficulties and negative peer associations.*

- Orange: 15%-24% of children/youth experience the risk factor
- Blue: 25% -34% of children/youth experience the risk factor
- Yellow: 35% - 50% of children/youth experience the risk factor
- Pink: 51%+ of children/youth experience the risk factor

Table 2: Children's Exposure to Risk across Access Programs

Access Group	Developmental Delay	Physical Health Concerns	Mental Health Concerns	School Difficulties	Negative Peer Associations	Positive Toxicology at Birth
In-office (*n*=20, 25%)	NO (*n*=14) **YES (*n*=5)** Missing (*n*=1)	NO (*n*=15) **YES (*n*=5)**	NO (*n*=19) YES (*n*=1)	NO (*n*=17) **YES (*n*=3)**	NO (*n*=17) **YES (*n*=3)**	NO (*n*=19) YES (*n*=1)
CAP (*n*=25, 31%)	NO (*n*=18) **YES (*n*=7)**	NO (*n*=19) **YES (*n*=6)**	NO (*n*=15) **YES (*n*=10)**	NO (*n*=15) **YES (*n*=9)** Missing (*n*=1)	NO (*n*=23) YES (*n*=0) Missing (*n*=2)	NO (*n*=23) YES (*n*=2)
TAP (*n*=35, 44%)	NO (*n*=18) **YES (*n*=15)** Missing (*n*=2)	NO (*n*=22) **YES (*n*=12)** Missing (*n*=1)	NO (*n*=28) **YES (*n*=5)** Missing (*n*=2)	NO (*n*=26) **YES (*n*=6)** Missing (*n*=3)	NO (*n*=31) YES (*n*=1) Missing (*n*=3)	NO (*n*=27) YES (*n*=4) Missing (*n*=4)

With the exception of mental health concerns, there were no significant group differences across program types in the types of risk children experienced. However, relative to both IO and TAP, children in the CAP program were more likely to experience and/or suspected of having a mental health concern, $\chi^2(4)$=10.97, p=.02.

Step 4: Amount of Cumulative Risk
The children's exposure to cumulative risk was examined.

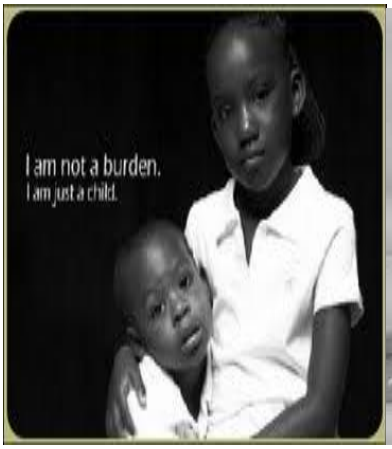
An aggregate measure of total risk was constructed. Across the sample, mean cumulative risk score ranged between 1 to 6 (M_{score}=1.35, SD=1.39). No group differences were found across the three Access programs in the amount of risk factors children were exposed to suggesting the overall weighted risk profile of these children is similar across the Access Programs.

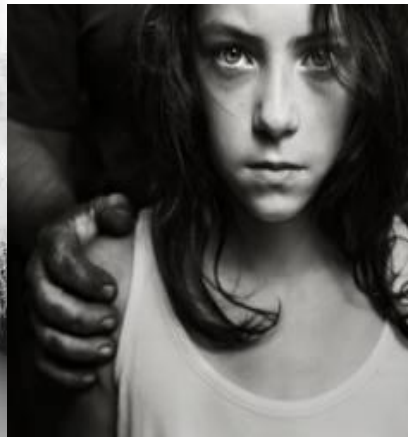
Summary

In summary, there is evidence to suggest that although families and children served across different Access programs are similar with regards to the overall risk profiles of the families and children prior to Access services. That said, the analysis suggests some important differences between the three Access Programs do exist. Specifically:

- Caregivers involved with CAP experienced significantly less previous risk (especially mental health issues) when compared to those involved with IO and TAP
- Children involved with CAP were more likely to experience mental health issues

This suggests that although caregivers involved with CAP may experience less risk, children involved with CAP demonstrate more risk issues relative to children involved with IO and TAP. This highlights the possibility that there may be a selection effect which selects parents with less vulnerability to certain programs (i.e., CAP). For this reason, outcomes related to each program type will be examined separately.



5.2 Child Reunification

The proportion of children who were reunified with their family of origin was examined separately by each Access program type. Of the 80 files that were reviewed, overall reunification occurred in 34 or a little more than forty percent (42.5%). Analysis by Access Program finds the following rate of reunification (refer to Figure 2).

IO:	6 of 20	= 30%
CAP	14 of 25	= 56%
TAP	14 of 35	= 40%

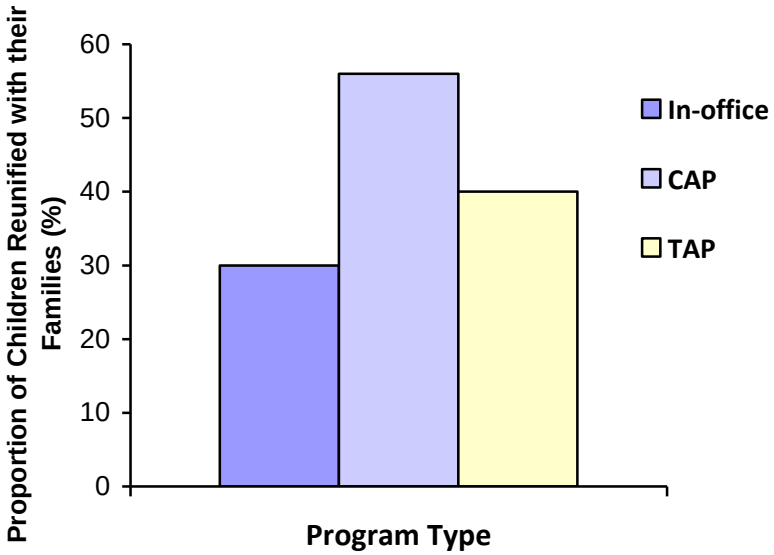


Figure 2: Proportion of children who were reunified with their parents across different Access programs

The intent of the study was not to compare reunification across Access Programs because the intent of the program and as is noted in previous analysis, the composition of families and children across each program does differ somewhat.

Perhaps a more important concept to explore and understand is given the similarity of the familiy and child profiles regarding risk factors *why* some children are more likely to be reunified with their families than others?. Therefore, in the following sections, associations between the likelihood of being reunified and family, child and Access visit characteristics will be examined.

5.2.1 Family Characteristics

Family characteristics that may be related to the likelihood of reunification were examined independently across different Access programs. Significance (*) was set at p<.05. Specifically, we examined:

- ❖ Family composition,
- ❖ Family size
- ❖ Previous amount of parent/caregiver risk.

Family Characteristics Related to Reunification?

IO	NO
CAP	NO
TAP	*YES for Family Composition & Previous Amount of Caregiver Risk

Although these three family characteristic variables were not related to the likelihood of reunification in IO and CAP programs, a) *family composition* and b) *cumulative caregiver risk* was significantly correlated with child reunification for TAP.

a) Family Type Related to Reunification?

Single Parent:	NO
Two-Parent:	*YES – more likely to reunify

Two-parent households were more likely to be reunified with their children, r=.39, p=.02 when compared to single-parent households.

b) Cumulative Parent Risk Related to Reunification?

Less Cumulative Risk	NO
More Cumulative Risk	* YES – less likely to reunify

Moreover, caregivers who experience *more previous risk* were also less likely to experience reunification with their children, r=.42, p=.01. This suggests that family characteristics may be related to child reunification for TAP.

5.2.2 Child-specific Characteristics

The relationship between *child-specific characteristics* and *child reunification* was examined. Specifically, we focused on *a) the experience of and/or risk of physical, emotion and sexual harm, b) cumulative child risk* and *c) the extent to which children experienced or were at risk of experiencing different types of abuse/maltreatment.*

Maltreatment History

Analysis suggests that children who participated in CAP were significantly less likely to be reunified if they have *experienced or at risk of experiencing physical abuse*, r=.45, p=.03 but marginally more likely to experience reunification if they have *experienced or at risk of experiencing emotional abuse*, r=-.34, p=.09. There were no significant correlations for IO or TAP.

Amount of Risk:

In CAP, the *amount of risk* experienced by children may be associated with child reunification. Specifically, those with higher levels of risk were marginally less likely to experience reunification, *r=.38*, p=.06. Similar associations across IO and TAP were not observed.

5.2.3 Access Placement Characteristics

Lastly we examined whether the Access placement characteristics were related to child reunification. Specifically we explored:

- Access visit supervision,
- Court involvement with access,
- Purpose of access
- Changes to access experienced by caregiver.

Access Visit Supervision

No significant correlations were noted for *access supervision* for any of the three Access Programs.

Court Involvement:

Generally, families with Access visits from any of the programs where there was *court involvement* were *less likely* to experience reunification. More specifically for IO program, the correlation between *court involvement* and *child reunification* for IO was marginally significant, r=.46, p=.06; no significance was found with CAP and TAP.

Purpose of Access:

For CAP, child reunification was marginally associated with *purpose of access* where reunification was more likely to occur when the purpose of access visits was to maintain caregiver-child relationship, r=-.19, p=.09; but no significance was found with IO and TAP.

Changes to access experienced by caregiver.

No significant correlations were noted for *changes to access experienced by caregiver* for any of the three Access Programs.

Summary

It appears that although the proportion of *child reunification* is different across programs, as an outcome, *child reunification* may be associated with different family child characteristics than program characteristics alone. Although these associations vary across programs, nevertheless, these amalgam of these factors may be important to understand when efforts are made to improve services and outcomes for children and youth served by Access Programs.

There are several limitations to be mindful of when interpreting these results.

- First, it is appear that certain families are more likely to be assigned into certain Access programs. Therefore, results may simply be reflective of demographic differences between families, as well as differences between service plans. Also, even though random sampling was done this is an exploratory study.

- Second, it appears that Access programs focus service to children from different developmental stages. As noted in the analysis of mean ages, younger children migrate to TAP and older children to CAP. Particularly with the younger age groups (i.e., TAP), it may be more difficult to identify and classify child difficulties. This analysis provides an initial, exploratory examination of *child reunification* and possible factors that may be related to better outcomes in children and youth.

6.0 Maintaining/Strengthening Parent-child Relationships

Another objective of this study was to examine the extent to which participation in Access Programs *maintained or strengthened the parent-child relationship*. To examine this premise we drew on two sources of information: 1) Caregiver Questionnaire and 2) Parent Interviews. Because of difficulties noted with recruitment for IO access only results for CAP and TAP will be discussed.

6.1 Caregiver Questionnaire

On the Caregiver Questionnaire, caregivers were asked to respond to six (6) questions that assessed their beliefs concerning the impact of the program on their relationship with their child. Items included "My relationship with my child has/will improve as a result of access" and "Access visits will help/have helped me maintain/strengthen my bond/connection to my child". Possible responses ranged on an ordinal scale from 1 (strong disagree) to 5 (strongly agree); the maximum score was 30 (very high satisfaction).

Internal consistency between items was high (α=.91) and an aggregate score was created by summing across all items. *Higher scores* reflected more positive caregiver attitude towards the impact of the program on their relationship with their child. Across all participants, scores ranged between 1 to 30 with a mean score of 20 (*SD*=9.05). Refer to Figure 3.

- CAP Program: scores ranged between 10 to 30 with a mean score of 19 (*SD*=9.05)
- TAP Program: scores ranged between 20 to 30 with a means score of 25 (*SD*=3.74.

Overall, two-thirds or more of the parents indicated they were satisfied with the CAP and TAP Access Programs. Not surprisingly, satisfaction was generally rated higher by parents in the more intensive, therapeutic TAP program.

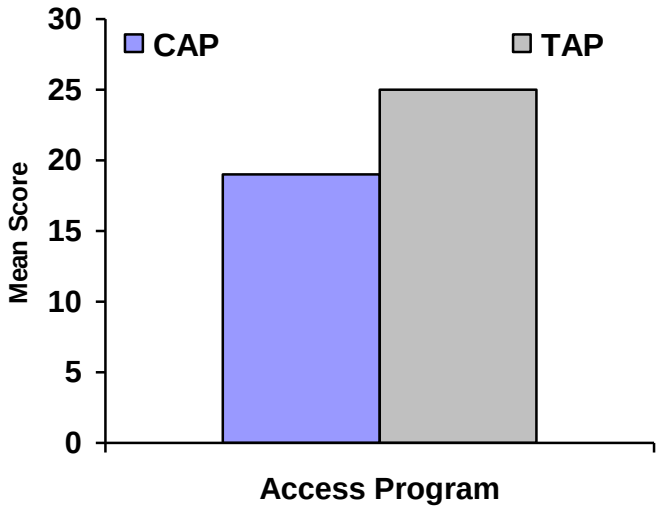


Figure 3: Caregiver belief concerning the impact of the program on their relationship with their Child

6.2 Parent Interviews

To qualify data from the caregiver questionnaire, we also asked caregivers to describe their relationship with their children since starting the program. Two main themes emerged from these conversations with caregivers involved with CAP and TAP.

THEME 1: ACCESS Improved Parenting Skills ~ Improved Child Interactions (CAP & TAP)

Parents/caregivers stated that they felt the purpose of the TAP was to help them develop their parenting skills. Parents said they felt as though their interactions with their child had "improved" since acquiring new and correct parenting skills from the workers of the program. Similarly, for families who are new to CAP, many stated that they are hopefully that Access will help improve their relationship with their child.

"It kind of influenced how I interact with my child. Compared to back at home, I would have to tell him to do things a million times.. he does it right away now."

"[It] taught me how to be a better parent. How some things are acceptable and some things aren't. It made me feel like a bad parent in the first place; no one wants their kid taken away. I guess it's helped me to understand my child better; to understand his cues. It's been helpful - I guess so."

"Program is good because it feels like you are at home; [you] don't feel like you are being watched; [it] helps you do everything; [you] don't feel like you're being watched if you're not doing something right, they make sure you are going to do it right. They will come in and show you; they are very informative; They give you parenting books - very helpful."

THEME 2: ACCESS Worsened Relationship with Child (CAP & TAP)

A few parents/caregivers felt their relationship with their child had worsened through the Access experience. Their comments were about 'restricted freedom when interacting with their child' and feeling 'CAS involvement was making it increasingly difficult for their child to be reunified with them.'

"It has made it [our relationship] worse because I barely see him. We always had a close relationship before they took him. We can't do what we used to … like go out go for walks, go to the doctor. I have little to no say in what goes on in his life. Tough not knowing."

"My relationship with my kids has suffered and I am close to giving up because no one listens to me or treats me without bias."

6.3 Summary

Not surprisingly the reviews were mixed. Families' comments support the earlier data from workers on the characteristics of families that make "success" more or less likely. Families who open themselves up to learning, participating and engaging in the program, generally have very positive comments about the impact of the Access service on them as parents, and on their relationship with their child. For the parents that struggle with understanding "why" they need to be there, "why" they need to comply with the rules, and "why" the situation is not working – they are generally dissatisfied and view the service from that lens. Given the small sample size, it is important to be mindful that these results are preliminary. Future research, including a larger sample may consider exploring how caregiver beliefs change over time. More importantly, understanding the processes that can explain why caregiver beliefs are different can be important for quality and continued improvements in service.

7.0 REDUCING CHILD RISK/IMPROVING CHILD SAFETY

Although the primary goal of Access is not to influence child outcomes, it is possible that by fostering more positive interactions between parents/caregivers and their children, child adjustment can be indirectly affected. Particularly since *child safety* is a central concern of child welfare services. Examining how *child risk* / *child safety* may be influenced by Access service can contribute to our understanding of how services may be effective in this domain. As such, change in *child risk* and *child safety* was examined by data gathered through file reviews. Specifically, the goal was to understand the level of *child risk* and *child safety* subsequent to receiving CAP, TAP, or IO services.

7.1 Access Programs: Descriptive

Across all programs, risk scores at time of admission into care ranged on a four-point scale between low (1), somewhat low (2), somewhat high (3), to very high (4). Scores at admission and discharge were examined.

Admission: Analysis of child risk scores for the 80 Access cases finds the mean score of 2.98 (*SD*=.61), or closest to "somewhat high"

Discharge: Risk scores at time of discharge ranged between low (1) to very high (4) with a mean score of 1.44 (*SD*=1.36; refer to Table 3) or between "low" and "somewhat low".

Table 3: Risk scores at time of admission and discharge across different Access programs

Access Program	Risk Scores at Time of Admission (T1)	Risk Scores at Time of Discharge (T2)
In-office (*n*=20, 25%)	Range: 2-4, M_{score}**=3.00**, *SD*=.63	Range: 2-4, M_{score}**=2.85,** *SD*=.80
CAP (*n*=25, 31%)	Range: 2-4, M_{score}**=2.76**, *SD*=.70	Range: 2-4, M_{score}**=1.77,** *SD*=.44
TAP (*n*=35, 44%)	Range: 2-4, M_{score}**=3.13**, *SD*=.50	Range: 2-4, M_{score}**=2.50,** *SD*=.91

To examine how risk may have changed over time, a difference score was created by subtracting risk scores at discharge from risk scores at time of admission. A negative score suggests an increase in risk vs. a positive score suggests a decrease in risk. Analysis by Access Program:

IO Access n = 20
- 10 of 20 (50%) = *no change* in risk scores at T1 to T2;
- 6 of 20 (30%) = *increase in risk scores* between T1 and T2;
- 4 of 20 children (20%) = *decrease in risk scores* between T1 and T2.

CAP n = 25
- 7 of 25 (28%) = *no change* in risk scores at T1 to T2;
- 3 of 25 (12%) = *increase in risk scores* between T1 and T2;
- 15 of 25 (60%) = *decrease in risk scores* between T1 and T2.

TAP n = 35
- 12 of 35 (34%) = *no change* in risk scores at T1 to T2;
- 3 of 35 (9%) = *increase in risk scores* between T1 and T2;
- 20 of 35 (57%) = *decrease in risk scores* between T1 and T2.

7.2 Change of Risk over Time

We then examined whether shifts in risk scores across time was statistically significant. That is, were changes in scores reflective of a real phenomenon or a finding of chance? Mean scores across the two time points were compared with paired t-tests.

Analysis found:
IO Risk scores change between T1 and T2 are not statistically significant
CAP Risk scores between T1 and T2 are statistically significant
TAP Risk scores between T1 and T2 are statistically significant

In short, for CAP and TAP, risk scores measured prior to discharge were more likely to be significantly lower (decrease in risk) than scores measured prior to admission (refer to Figure 4).

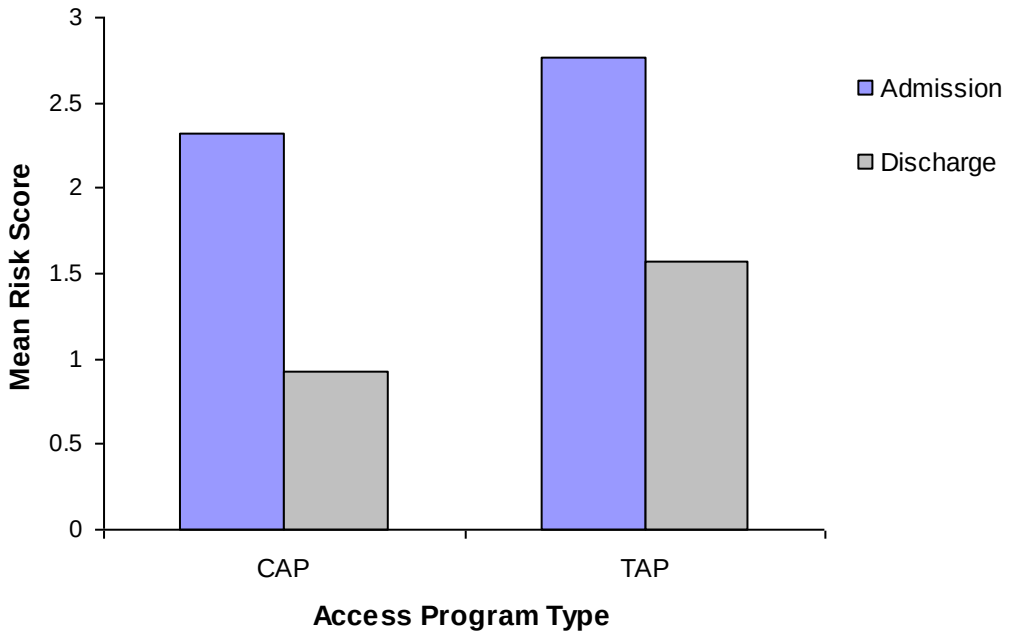


Figure 4: Mean risk score at time of admission and discharge across Access program type

Additional analyses find some evidence to suggest that differential risk scores are significantly related to family composition. Specifically for IO and CAP, where children prior to entering care were living in two-parent families, were *more likely* to demonstrate a decline in risk scores. No other significant associations were found for other family, child and Access visit characteristics. Future study in this area is recommended.

7.3 Summary

Taken together, results suggest that there may be a general downward trend in children's exposure to risk after receiving CAP and TAP services. Although we are unable to attribute these changes to participation in Access per se, these results are encouraging as it suggests that children are showing significant improvements since coming into care. However, what remains unclear is why risk scores are changing. Future research may consider examining possible processes that can explain this trend. Nevertheless, current results represent a significant first step in understanding how Access programs may influence children's exposure to risk.

8.0 CLIENT ENGAGEMENT AND SATISFACTION WITH ACCESS SERVICE

The final study objective was to broaden understanding regarding client engagement and satisfaction with Access services (i.e., CAP and TAP). To this end, we again drew on data from the Caregiver Questionnaire to examine caregiver engagement and data from the in-depth interviews to examine caregiver satisfaction. Results are summarized in the sections below:

8.1 Caregiver Engagement (CAP & TAP)

8.1.1 Caregiver Engagement at the Start of the Program

Caregiver engagement was assessed through the Caregiver Questionnaire/Survey through 19 items each on a 5-point Likert scale. Items assessed different aspects of engagement such as *"I believe my family will get the help we really need from CAS Toronto", "What CAS want me to do is the same as what I want"* and *"I feel like I can trust CAS to be fair and to see my side of things".* Negative items were reverse coded so that higher scores reflected more caregiver engagement. An aggregate score of caregiver engagement was created by summing across the 19 items with the highest score being a 95.

Of the 11 families, engagement scores were available for 10 families (5 from CAP and 5 from TAP). However, only data from 9 families were included in the analysis as one family did not provide responses on this section of the questionnaire.

CAP & TAP: Aggregate scores ranged between10 to 85 with the average score = **58.27** (M_{score}=**58.27**, *SD*=21.46).
CAP: Aggregate score was **56.0** (M_{score}=56.00, *SD*=27.01)
TAP: Aggregate score was **60.20** (M_{score}=60.20, *SD*=19.01)

Overall, the satisfaction scores were comparable across the two Access programs and suggest that the families were generally satisfied.

8.1.2 Change in Caregiver Engagement

For three families we collected longitudinal data (approximately three months apart). Two families were able to provide data on two time points and one family was able to provide data on three time times. Although the sample size is very low, which severely curtails analysis, we provide both the process and findings as an illustration of a methodology to replicate in future studies.

To examine how engagement levels possibly changed over time, differential scores were constructed by subtracting engagement scores collected at Time 2 from scores collected at Time 2. A positive differential score suggests that engagement levels were higher at Time 1 whereas a negative score would suggest higher engagement at Time 2. When examining data collected at Time 2 (approximately 3 months after Time 1 data was collected), caregiver engagement appeared to stay relatively stable. With the exception of one family where their engagement improved (with a differential score of 45), the remaining two families did not demonstrate any significant shifts in engagement (i.e., a differential score of +/- 3). Moreover, when examined over three time points (data from one family), patterns reflected a similar trend. These results suggest that engagement levels commenced at a high level and stayed relatively stable across time.

Again, when interpreting these results it is important to be mindful of the limited number of families included in the analysis. At best, these trends are exploratory, highlighting the importance for us to examine change in caregiver engagement more thoroughly in the future.

8.2 Caregiver Satisfaction

To help us qualify our data on *caregiver engagement*, we used caregiver interviews to understand caregiver satisfaction/dissatisfaction with CAP and TAP services. Specifically, we were interested in understanding some challenges and barriers to services. A total of ten caregivers/parents across TAP (*n*=5) and CAP (*n*=5) participated and caregivers provided feedback separately prior to Access visits. For caregivers involved with CAP, they also provided data for the caregiver questionnaire.

Feedback from caregivers involved with CAP revealed two common themes related to caregiver satisfaction:

THEME 1: Importance of the Worker-Client Relationship (CAP)

Caregivers involved with CAP discussed the importance of having a positive relationship with their caseworker. Parents/caregivers who shared a positive relationship with their worker were hopeful that their worker would be able to help them work out difficulties they experienced with other family members and strengthen her relationship with their child. Other caregivers expressed the possibility for workers to help them reunify with their children.

The corollary were a few parents/caregivers who did not experience a positive relationship with their worker. They were less satisfied, did not perceive the worker-client relationship as positive or responsive, and were generally "unhappy" with the service.

THEME 2: Importance of Addressing Cultural and Language Barriers (CAP)

The importance of cultural, language and communication barriers within the Access service was underscored by parents. With cultural barriers parents feel their cultural practices are neither understood nor accepted. Parents articulated their worry about the gap between their views and the CAP staff and how the differences might impact their case. They worried when there the issue was a language barrier; caregivers spoke about feeling frustrated and not heard. And they worried when miscommunication issues arose, which often resulted in scheduling difficulties (e.g., missed/cancelled visits), discrepancies during court).

Similarly, caregivers involved with TAP also identified some common themes related to client satisfaction. These include:

THEME 1: Opportunity Costs Associated with Timing of Program (TAP)

Parents/caregivers of the TAP relayed they were satisfied overall with the program and happy with their gains. For some, the advancements are juxtaposed against the burden and inconvenience regarding the time of the scheduled visits. Specifically, weekday mornings. For some, they are in a very difficult position: see their child and work towards reunification or give up their employment and suffer financially. A certain cohort of parents want and need after-work hour visits for working parents.

"That is something that can be changed- the timing. For parents that are working there should be a session from 5-8 for parents who are working because I can't take jobs. I don't mind coming to see her it's a godsend, but I need to be working because my bills are piling up but I need to see her."

"Just a night visit program for working parents would be good and helpful."

THEME 2: Satisfaction with Extended Duration of Visits (TAP)

A few parents had participated in several Access programs. This group of parents talked about how important TAP's extended duration of the visit was to them. They liked the longer visit (e.g., 4 hour visit) compared to the one-hour visits in other Access programs. The longer visiting time gave them more opportunity to interact with their child.

"I get to spend a lot more time with my kids than I would spend at IO, from 1.5 hours to now its 3 or 4 hours. It's better for me if I can be around them everyday. So since I can see them longer, the experience has been good."

"Brought us closer together. I go to sleep just cause I know I need to get up to come see her. Because more hours, at the IO we had less than an hour."

THEME 3: Importance of More Constructive Feedback from Workers (TAP)

Some parents/caregivers talked about wanting more constructive feedback from TAP staff regarding their progress with their children. They want feedback on themselves – not just their child and for TAP staff to model appropriate behaviours for caregivers.

8.3 Summary

In summary, results for Caregiver Engagement and Satisfaction are somewhat mixed. Analysis of the initial engagement data indicate overall engagement starts high and remains relatively stable throughout the Access service. While a high engagement score at the start may contain the range of the gain, some gain is expected and anticipated if Access is successful in promoting caregiver engagement. The fact that the scores did not increase suggests this is an area for further study. Is it an instrument issue? Do high engagement scores at the start of service limit developmental engagement? Does the type of engagement shift and the quality of that change is not detected with the current methodology? Future research will be required to examine area this further.

These findings highlight the importance of understanding why these trends may occur. Particularly since caregiver engagement may be an integral component of program success, an important next step is to understand program mechanisms that may promote higher engagement from caregivers. Perhaps there can be more emphasis across Access programs in promoting and facilitating higher caregiver engagement.

Discussions with caregivers also suggest that while most are satisfied with services, some are others who are not. The reasons range depending on the case: program is not working for the parent/ parent is not working for the program, language / cultural barriers, challenges in the worker-parent relationship, conflicts with employment/other duties. Parents very much like the extended visiting hours and support they receive from Access staff. And they appreciate the gains they do make and how that impacts them and their relationship with their child. Unequivocally, access is an important service for many reasons.

9.0 SUMMARY

The study objective was to examine the following areas related to Access at the Children's Aid Society of Toronto:

1. Program Implementation
2. Child Reunification
3. Maintaining/Strengthening Parent-child Relationships
4. Reducing Child Risk/Improve Child Safety
5. Caregiver Engagement and Satisfaction

Utilizing a mix-methods approach, data were collected through worker interviews, focus groups, caregiver questionnaires/surveys, interviews with caregivers and standardized file reviews. Key findings are summarized in Table 4.

Table 4: Key Findings of Project

Research Area	Data Method	Sample Size	Key Findings
Program Implementation and Fidelity	• Worker interviews • Worker focus groups (qualitative)	• 8 workers • 1 volunteer (CAP & TAP only)	• Management support and resources are perceived as important to ensuring program excellence • Positive program processes and outcomes are link to worker's job satisfaction • Unique challenges are associated with each program
Access ~ Child Reunification	• File Reviews (quantitative)	80 files • IO (n=20) • CAP (*n*=25) • TAP (*n*=35)	Preliminary analyses suggest that *child reunification* may be associated with different family, child and visit characteristics including: • *Family composition* • *Cumulative caregiver risk* • *Children's experience of abuse* • *Cumulative child risk* • *Court involvement with Access* • *Purpose of Access*
Access ~ Maintaining/ Strengthening Parent-child Relationships	• Caregiver Survey • Caregiver Interviews (qualitative)	Survey n= 11 Interviews: 10 (CAP & TAP only)	Preliminary analysis suggests: • Dominant theme: Most caregivers' perceive Access has had a positive impact on self and child relationship • Minor theme: A few caregivers perceive Access as restrictive in their parenting and feel it has adversely impacted their relationship with their child
Access ~ Reducing Child Risk / Improve Child Safety	• File Reviews (quantitative)	80 files • IO (n=20) • CAP (*n*=25) • TAP (*n*=35)	• General downward trend in *children's exposure to risk* after receiving Access services
Access ~ Caregiver Engagement and Satisfaction	• Caregiver Survey • Caregiver Interviews (qualitative)	Survey n= 11 Interviews n= 10 (CAP & TAP only)	• For caregiver's who engage, *engagement* commences at a high level and remains stable • Caregivers are generally satisfied with the service, extended visiting hours and support from Access • Barriers to program satisfaction include negative worker-parent relationships, miscommunication and insensitivity to culturally specific parenting practices

10.0 BARRIERS TO DATA COLLECTION, LESSONS LEARNED, AND DIRECTIONS FOR FUTURE RESEARCH

In the following sections, barriers to data collection, lessons learned, and directions for future research will be discussed.

10.1 Barriers to Data Collection

Research involving vulnerable populations is difficult to implement due to challenges related to participant recruitment. Particularly when vulnerable families are experiencing crisis (e.g., during the early stages of Access, having a child entering into care because of safety concerns), participant engagement becomes increasingly more difficult. As such, some unanticipated challenges related to data collection were experienced.

10.1.1. Family Crisis

The most difficult barrier to overcome was the state of crisis some families experienced when involved with Access. Especially for IO Access, many families were in a state of current crisis since the apprehension was recent. The result - caregivers were not open to study participation. Moreover, several members of the research group questioned the ethical practice of engaging participants during times of such crisis and the quality of data these families could actually provide. As such, a decision was made to remove families involved with IO Access from certain aspects of data collection (e.g., caregiver questionnaire, interviews).

10.1.2 Different Age Groups

A significant challenge in recruiting eligible participants is the constraint related to age groups. Since certain Access Programs (e.g. TAP) were more likely to service young infants, some of the outcomes measures were not applicable (e.g., the Strengths and Difficulties Scale is only valid for children 4 year and older). Therefore, to ensure valid and reliable results only very few families from TAP were eligible to participate. Consequently, it was difficult to collect longitudinal data for this sample.

10.1.3 Support from Frontline Workers

Although this project was fully supported by Senior Management, frontline staff had limited input during the planning and development of the evaluation plan. As such, coupled with staffing issues and workload demands there were some challenges in engaging workers during the data collection phase of the project. Future projects may consider involving all stakeholders during the planning and implementation of program evaluation.

10.2 Lessons Learned

Several important lessons have emerged from our experiences in evaluating the different types of Access. These include, but are not limited to:

- The need to be sensitive, respectful and understanding as the evaluation is focused on collecting data at a highly sensitive and difficult time in the family and child's life. These are highly vulnerable study participants. Part of the secondary effects of this study is to learn more about how to reasonably and feasibly mitigate risk that may be experienced by the children, their family's, the workers, and other stakeholders. One of the stakeholder groups is the research team, where in the course of interviewing traumatized families there is the risk the researcher experiences vicarious trauma.

- The need to consider *special considerations.* This is specific to our learning around different challenges in recruitment across the different access types and the length of time these challenges add.

- The need to achieve a fair, reasonable and realistic balance between rigorous research and good clinical practice and service.

10.3 Directions for Future Research

Results from the current study provide a comprehensive description of the families and children who are involved with Access at CAST. Drawing on multiple informants, the current analysis provides an in-depth understanding of family's context, program satisfaction and challenges with program implementation and fidelity. A significant achievement of this study is the ability for the Access Programs to describe the clientele, to now have more comprehensive information about factors and trends that potentially impact outcomes, to be able to articulate how Access programs are implemented, to have highlighted some of the common challenges across programs and unique barriers within each program related to Access service delivery, and of great importance, to have included the direct client recipients (i.e. parents) in broadening our understanding of the effects of Access on themselves and their relationship with their child. A future study may expand knowledge further by including the child/youth voice as a key stakeholder group in the service.

What remains less clear at the conclusion of this study is why some of these trends exist? And why they may change over time? By understanding the mechanisms that can explain change, improvements to service delivery can be made. Similarly the causal association between Access and family and child outcomes remains unclear. Although the current study attempted to examine this interaction, lessons related to participant engagement highlights the importance of developing an evaluation plan with these challenges in mind.

In sum, the current study provides us with a necessary foundation to further explore the impact of Access on the quality of services provided by CAST. Directors for future research may consider examining processes that can explain trends and individual differences in family and child outcomes.

APPENDIX A: STANDARDIZED FILE REVIEW TOOL

1.0 ADMINISTRATIVE DETAILS

Date Tool Completed: _____ **Tool Completed By:** _____

ID Code: _____

Family File Name: **File Number:**
Child File Name: **Child's File Number:**

Current Case Status: □ Active (Open) □ Closed → If closed - date of closing _____

Case Type (Opened): □ New □ Reopened **If reopenings occurred - # of CAST System Openings** _____ **FS most recent opening date:** _____

BSU (at time of closure or most recent opening): _____

Primary Access Program Utilized Since 2008 Admission to Care:

O In-Office Access (IO) O Child Access Program (CAP) O Therapeutic Access Program (TAP) O Mixed _____

Age of Primary Child: _____**year(s) of age.**

O 0-4 years of age O 5-9 years of age O 10-15 years of age O >16 years of age

Child's Status during Index Period- In Care? (Jan '08-Dec '08): O Yes O No **Child previously in care:** O Yes O No If yes: _____# previous admission

Child Admitted From (e.g. PCP): _____ **Relationship to Child:** _____

Date(s) of Admission(s): _____.

Child's Current Status (at time of file review): In Care : O Yes O No

Child's File Status (at time of file review): O Open O Closed

Reunification (to <u>original caregiver</u> (e.g. CG1) Status of Child/Youth during Index Period: O Reunified O Not Reunified

2.0 FILE CHARACTERISTICS

File Characteristics	
Intake Eligibility Code	
Most Recent/Closing Eligibility Code	
Initial Family Risk Assessment Level (At opening)	□ Low □ Moderate □ High □ Very High
Family Risk Assessment Level (Current/Closing)	□ Low □ Moderate □ High □ Very High
Family composition	□ Single parent/guardian household □ Two-parent guardian/household □ Unknown
Total number of children in family	_____ Total # of children _____ # of children < 5 years _____ # of children >5.1-16 years
Domestic Violence Concerns	○ Yes ○ No ○ CND/Unknown

2.1 –Type of Allegations Verified

(Initial Protection Investigation re: file opening during the 2008 admission period)

File Characteristics		
Original Protection Concerns Verified	○ Yes ○ No	
Type	**Harm**	**Risk of Harm**
Physical	○	○
Sexual	○	○
Emotional	○	○

○ **Other** _____

3.0 Parents/Caregivers Information

CG1 (Primary Caregiver)	Details	CG2	Details
Relationship to Child	□ Mother – biological □ Father-biological □ Grandmother/grandfather-maternal □ Grandmother/grandfather-paternal □ Mother –step □ Father-step □ Aunt □ Uncle □ Other:	**Relationship to Child**	□ Mother – biological □ Father-biological □ Grandmother/grandfather-maternal □ Grandmother/grandfather-paternal □ Mother –step □ Father-step □ Aunt □ Uncle □ Other:
DOB		**DOB**	
Age		**Age**	
Gender	□ Male □ Female	**Gender**	□ Male □ Female
Racial Grouping		**Racial Grouping**	
Citizenship Status	○ Canadian ○ Other _____ ○ Missing Information	**Citizenship Status**	○ Canadian ○ Other _____ ○ Missing Information
Relationship Status	○ Single ○ Married ○ Divorced ○ Widowed ○ Common-law ○Separated ○ Missing Information	**Relationship Status**	○ Single ○ Married ○ Divorced ○ Widowed ○ Common-law ○ Separated ○ Missing Information
Diagnosed mental illness	○ Yes ○ No ○ CND/Unknown	**Diagnosed mental illness**	○ Yes ○ No ○ CND/Unknown
Suspected mental illness	○ Yes ○ No ○ CND	**Suspected mental illness**	○ Yes ○ No ○ CND
Substance Abuse issues	○ Yes ○ No ○ CND	**Substance Abuse issues**	○ Yes ○ No ○ CND
Pre-natal substance or alcohol use	○ Yes ○ No ○ NA ○ CND	**Pre-natal substance or alcohol use**	○ Yes ○ No ○ NA ○ CND
Criminal history	○ Yes ○ No ○ CND	**Criminal history**	○ Yes ○ No ○ CND
Developmental Delay/issues	○ Yes ○ No ○ CND	**Developmental Delays/issues**	○ Yes ○ No ○ CND
Health Issues	○ Yes ○ No ○ CND	**Health Issues**	○ Yes ○ No ○ CND

4.0 Primary Child/Youth

Please answer applicable questions with Yes = Y; No =N; and UK = Unknown

Variable	Child 1 (Primary Child)
Child's File # (if in care status)	
DOB	
Age	
Racial Grouping	
Reason for Admission (most current)	
Gender	□ Male □ Female
Most Current/Closing Placement Setting	O Foster Care O Residential/Group Home O Kinship Care O with Family_____ O Other _____
Most Current/Closing Legal status	□ **Child in the community** □ Supervision order with parents □ Supervision order with kin/kith □ Voluntarily working with Society □ File Closed (N/A) □ **Child in Care** □ TCA □ Society ward □ Crown ward
Positive Toxicology at Birth	□ Yes; Details _____ □ No □ CND
Developmental Delay (e.g learning difficulties, speech, etc).	□ Yes ; Details _____ □ No □ CND
Health Issues or Physical Illness (i.e. leukemia, severe asthma, cerebral palsy)	□ Yes; Details _____ □ No □ CND
Mental Health Diagnosis	□ Yes; Details _____

Variable	Child 1 (Primary Child)
(i.e. ADHD, ODD, Eating Disorder)	☐ No ☐ CND
Mental Health Issues Suspected	☐ Yes; Details _____ ☐ No ☐ CND
Negative Peer Association (e.g., gang involvement)	☐ Yes; Details _____ ☐ No ☐ CND
Preschool/School Difficulties	☐ Yes; Details _____ ☐ No ☐ N/A ☐ CND
Drug Issues (i.e., marijuana, cocaine)	☐ Yes ☐ No ☐ N/A ☐ CND
Criminal history	☐ Yes ☐ No ☐ N/A ☐ CND

5 (a) Admission & Access Characteristics. Please complete for the primary child that entered care **between Jan 08 - Dec 08:**

***** If child was discharged from care and reunified with original caregiver(s) (e.g. CG1/PCP) - please also complete Section 6

ADMISSION CHARACTERISTICS							
Admission # Re/Admission/ Date (dd.mm.yy)	**Reason for Admission**	**Type of In-Care Placement (check all that apply)**	**Family Risk Level at Admission to Care**	**Family Risk Level at Admission to Care**	**If discharged from care - reason ?**	**Reunified with original caregiver at time of discharge from care?**	**Family Risk Assessment at Discharge from Care**
		○ Kinship Care ○ Foster Home ○ Group Home	□ Low □ Moderate □ High □ Very High	○ Yes ○ No Date of Discharge? _____ dd/mm/yy		○ Yes ○ No If yes, date of Reunification? _____ dd/mm/yy If no, who was child reunified with_____ (relationship)	□ Low □ Moderate □ High □ Very High □ N/A

5 (b) Access Details

Access Arrangement	**Access Safety Issues**	**Purpose(s) of Access Listed**
○ Court Ordered ○ Voluntary	○ Yes ○ No Details if Yes ____	

5 (c) Access Arrangements

	Attended Access?	**Type of Access**	**Initial Frequency of Access Arrangements (per week).**	**Supervision**	**Level of Supervision**	**Any changes in access during period reviewed?**
CG1	○ Yes ○ No	○ IO ○TAP ○CAP ○Other		○ Yes ○ No ○ Partial	○ Fully Supervised ○Semi-Supervised ○Unsupervised/Meet & Greet	○ Yes _____ ○ No
CG2	○ Yes ○ No	○ IO ○TAP ○CAP		○ Yes ○ No ○ Partial	○ Fully Supervised ○Semi-Supervised ○Unsupervised/Meet & Greet	○ Yes _____ ○ No

5.1 READMISSIONS TO CARE FROM PLACEMENT SINCE DISCHARGE

- ☐ Yes If yes - # of readmissions _____
- ☐ No
- ☐ N/A

5.2 CHANGES IN PLACEMENT SINCE DISCHARGE

- ☐ Yes If yes - # of placements (i.e caregiver/guardian) _____ If yes - who was the child transferred to _____
- ☐ No
- ☐ N/A

6.0 CHILD REUNIFIED WITH ORIGINAL CAREGIVER (PCP)

What services implemented to assist with reunification transition?	□ Increased visitation □ Decrease in level of supervision □ Family Support Worker □ Community Services ; □ Other Supports implemented; □ Other; □ Not applicable - child not reunified with original primary caregiver
List of Collaterals Involved	Please provide details _____
Placement Stability- any readmissions to care during period (Jan - Dec 2010)?	○ Yes If yes, # _____ ○ No Date of Readmission(s) _____

APPENDIX B: CAREGIVER QUESTIONNAIRE ABOUT ACCESS

Hi, thank you for consenting to participate in this study. We are interested in your feelings about your involvement with the Children's Aid Society (CAS) of Toronto's Access Program.

There are no right or wrong answers to any of our questions. Please answer as honestly and openly as you can. Your answers will be kept absolutely confidential.

Here are some ways families may feel about having CAS in their lives. Some are positive and some are negative. You may have both positive and negative feelings at the same time. Please read (listen) the following statements carefully. Then, thinking about how you feel right now about your recent involvement with the access services at CAS Toronto. Please indicate how much you agree or disagree with each. Thank you!

Frequency of access with child in care? O 2x/week O 1X/week O Biweekly O Monthly O Other? _____

Age of Child in care: _____

PART 1. Engagement Questionnaire

	Please circle only one response on the scale for each question	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know/ NA
1	I believe my family will get the help we really need from CAS Toronto	SA	A	N	D	SD	DK/NA
2	I realize I need some help to make sure my kids have what they need	SA	A	N	D	SD	DK/NA
3	I was fine before CAS got involved. The problem is theirs, not mine	SA	A	N	D	SD	DK/NA
4	I really want to make use of the services (help) CAS is providing me concerning access	SA	A	N	D	SD	DK/NA
5	It's hard for me to work with the access staff I've been assigned	SA	A	N	D	SD	DK/NA
6	Anything I say they're going to turn it around to make me look bad	SA	A	N	D	SD	DK/NA
7	There's a good reason why CAS is involved with my family	SA	A	N	D	SD	DK/NA
8	Working with CAS access staff has given me more hope about how my life is going to go in the future	SA	A	N	D	SD	DK/NA
9	I think my access worker(s) and I respect each other	SA	A	N	D	SD	DK/NA
10	I'm not just going through the motions. I'm really involved in working with CAS access staff	SA	A	N	D	SD	DK/NA
11	My worker and I agree about what's best for my child/youth	SA	A	N	D	SD	DK/NA
12	I feel like I can trust CAS to be fair and to see my side of things	SA	A	N	D	SD	DK/NA
13	I think things will get better form my child because CAS is involved	SA	A	N	D	SD	DK/NA
14	What CAS want me to do is the same as what I want	SA	A	N	D	SD	DK/NA
15	There were definitely some problems in my family that CAS saw	SA	A	N	D	SD	DK/NA
16	My worker(s) doesn't understand where I'm coming from at all	SA	A	N	D	SD	DK/NA
17	CAS is helping me take care of some problems in our lives	SA	A	N	D	SD	DK/NA
18	I believe CAS access offered is helping my family get stronger	SA	A	N	D	SD	DK/NA
19	CAS is not out to get me	SA	A	N	D	SD	DK/NA

Part 2. Caregivers' Perceptions of Access Ability to Maintain/Strengthen Child/Family Bond

As a result of receiving services from CAS-Toronto's CAP Access Program….

		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Don't Know/ NA
1	My relationship with my child has/will improve as a result of access	SA	A	N	D	SD	DK/NA
2	I have a better understanding of my child's needs	SA	A	N	D	SD	DK/NA
3	Access visits have helped to improve my parenting skills and abilities	SA	A	N	D	SD	DK/NA
4	Access visits will help/have helped me maintain/strengthen my bond/connection to my child	SA	A	N	D	SD	DK/NA
5	It is important to attend all access visits	SA	A	N	D	SD	DK/NA
6	The goal of access is to be reunified with my child	SA	A	N	D	SD	DK/NA

Part 3. Child Functioning. Strengths & Difficulties Questionnaire

Please answer the questions below with respect to your child/youth who has received/is receiving access.

How many children are in the family? _____

Is the child biologically related to the caregiver? YES NO

Age of child_____ Gender of Child: Male Female

		Not True	Somewhat True	Certainly True
1	Considerate of other people's feelings	NT	ST	CT
2	Restless, overactive, cannot stay still for long	NT	ST	CT
3	Often complains of headaches, stomach-aches or sickness	NT	ST	CT
4	Shares readily with other children, for example (Yr 3-10 -toys, treats; Yr 11-17-CD's, food)	NT	ST	CT
5	Often loses temper	NT	ST	CT
6	Rather solitary, prefers to play alone (Yr 3-10) /Would rather be alone with other youth (Yr 11-17)	NT	ST	CT
7	Generally well behaved, usually does what adults request	NT	ST	CT
8	Many worries or often seems worried	NT	ST	CT
9	Helpful if someone is hurt, upset or feeling ill	NT	ST	CT
10	Constantly fidgeting or squirming	NT	ST	CT
11	Has at least one good friend	NT	ST	CT
12	Often fights with other children and bullies them	NT	ST	CT
13	Often unhappy, depressed or tearful	NT	ST	CT
14	Generally liked by other children (ages 3-10)/ or youth (Yr 11-17)	NT	ST	CT
15	Easily distracted, concentration wanders	NT	ST	CT
16	Nervous or clingy in new situations, easily loses confidence (Yr 3-4). Nervous in new situations, easily loses confidence (Yr 11-17)	NT	ST	CT
17	Kind to younger children	NT	ST	CT
18	Often argumentative with adults (ages 3-4)/ Often lies or cheats (ages 4-17)	NT	ST	CT
19	Picked on/ bullied by other children (YR3-10)/ Picked on/bullied by other youth (Yr 11-17)	NT	ST	CT
20	Often offers to help others (parents, teachers, children)	NT	ST	CT
21	Thinks things out before acting	NT	ST	CT
22	Can be spiteful to others (Yr 3-4)/ Steals from home/school/elsewhere (Yr 4-17)	NT	ST	CT
23	Gets along better with adults than with other children / youth	NT	ST	CT
24	Many fears, easily scared	NT	ST	CT
25	Good attention span, sees work through to the end (Yr 3-4)/ Good attention span, sees chores or homework through to the end.	NT	ST	CT

APPENDIX C: WORKER INTERVIEW AND FOCUS GROUP QUESTIONS

Worker Interview Questions

Theme 1: Exploring possible agency factors that can impact on outcomes

- How do you think CAS-T influences the implementation and effectiveness of the access programs?

- What are some barriers at the agency level that can influence the effectiveness of access programs at CAS-T? By agency-level barriers, the agency processes and/or policies that can make it difficult for access programs to effectively assist children and their families. What are some agency-level factors that help access programs run smoothly?

Theme 2: Necessary ingredients for a successful placement

- In your opinion, what are the necessary ingredients (both family and child-specific factors) for a successful access program placement? What are some family and child factors that can impede on the success of the access program?

- What are some strategies that you've used to engage families?

- With respect to how Access is implemented and delivered, what are some aspects of the program that you feel help facilitate success (e.g., reunification of families, improved parent-child interactions?

- Similarly, what are some program changes you'd make to Access to help improve program success?

Theme 3: Satisfaction with access program

- Which aspects of Access do you enjoy working with the most?

- Which aspects of Access do you least enjoy working with?

APPENDIX D: CAREGIVER INTERVIEW GUIDING QUESTIONS

Parent/Caregiver Interview Guiding Questions

1. **The Purpose of Access**
   In your experience, what do you think is the purpose or the goal(s) of access/ visitation?

- What impact did access have on your relationship with your child?

- What impact, if any did access have in your ability to strengthen or maintain your and your families' relationship with your child?

2. **Experience with CAST Access**
   What has your experience been with the access programs at CAST?

- What worked? (i.e. What was most helpful about access for you, your child, family)?

- What didn't work (i.e. challenges or difficulties)?

3. **Recommendations for Change**
   What recommendations do you have to improve access services for parents with children in care?

- What changes would you make to agency access services?

- What could workers do to make the experience of access better for children and families?

- What could the agency do differently?