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Move the Services and the Resources – Not the Youth: Evaluating the Differential After-Hours Response to At-Risk Teens

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PART ONE: GRANT INFORMATION

Project Title	Move the Services and the Resources – Not the Youth: Evaluating the Differential After-Hours Response to At-Risk Teens
File Number	Grant #111
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Reporting Period	March 2008 – March 2011
Executive Summary	**Study Findings** 1. *DR-EAHS (intervention) associated with better youth outcomes* • Youth who received DR-EAHS (intervention) were more likely to stay at home compared to SAU-EAHS (comparison) [EAHS reports] • Receiving DR-EAHS was associated with less vulnerability factors compared to SAU-EAHS youth one (1) year later [File reviews] 2. *Families satisfied with EAHS and DR-EAHS services* • Families from both EAHS and DR-EAHS reported similar levels of satisfaction with the services they received [Client Satisfaction Questionnaire] • There was a general shift towards more positive attitudes, more satisfaction and more perceived impact of program with families who stayed involved with their CAS [Client Satisfaction Questionnaire] **Project Recommendations:** 1. Improve both EAHS AND DR-EAHS referral processes 2. Educate all CAS workers/supervisors about EAHS and DR-EAHS 3. Increase community services/supports for youth and their families **Project Next Steps:** As a result of the study findings… ❖ CAST explored the feasibility, costs and sustainability of establishing a *Parent Help Line*; 2011 analysis found no current Toronto service platform or sustainable revenue source at this time [ON HOLD] ❖ Throughout 2010-2011 a need, feasibility, service delivery review was done related to a youth outreach service. In Spring 2011, the four Toronto CASs and East Metro Youth Services agreed to provide a specialized Youth Outreach Program. Funding for the 2-year pilot was obtained via a corporate funder through the Children's Aid Foundation. This 2011-2013 pilot aims to work with 30-35 hard to engage, hard to serve youth (ages 12-15) to improve their access to services, engagement skills, reduce risk and decrease re-placements and transiency [IN PROGRESS]

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Research Activities

1.0 EMERGENCY AFTER HOURS SERVICES (EAHS)

Emergency After-hours Services (EAHS) provided by children's aid societies (CAS) are there to assist families and their children during instances of crisis that occur after regular business hours. Combined, the four Toronto CAS's EAHS respond to 15 to 20 calls a week from at-risk, vulnerable teens and their families. This translates into providing after-hours services to approximately 1,000 service calls a year from youth and their families.

Of all cases referred to EAHS, approximately 80% of them are open and closed at the Intake level within 30 days. Historically, teens account for the largest proportion of EAHS admissions; most often their entry to care is crisis related, and once in care, it is often difficult to return these youth home due to the severity of the intersection of behavioural, mental health and family issues. The outcomes for these youth are often poor (e.g., frequent placement changes, poor school attendance/attainment, mental health issues).

In response to this trend, a Differential Response – Emergency After-hours Service (DR-EAHS) program was developed as a joint initiative between four Toronto children's aid societies (e.g. Children's Aid Society of Toronto (CAST); Catholic Children's Aid Society of Toronto (CCAS); Jewish Family and Child Services (JFCS); and Native Child and Family Services of Toronto (NCFST) and Oolagen Community Services (Oolagen), a children's mental health agency situated in Toronto's. The two interventions under study were: the child welfare "service as usual" (SAU) EAHS model which was compared to the differential response option, an intense, specialized EAHS service provided by a mental health worker (DR-EAHS).

The four-step DR-EAHS model is based on:

1) Focused engagement with youth and their family,
2) Comprehensive assessment during EAHS
3) Timely support,
4) Effective service.

Study Question:

- **To evaluate the effectiveness of this new specialized, differential response, emergency-after-hour service for teens (DR-EAHS) compared to service as usual (SAU) EAHS regarding youth /case outcomes.**

DR-EAHS Goals:

- To reduce the number of youth who enter into care via EAHS.
- To improve youth outcomes by facilitating greater family engagement, and higher client service satisfaction
- To increase collaboration among service providers and caregivers.

2.0 RESEARCH METHODOLOGY

2.1 Participants ~ Sample

This was a three-year, longitudinal study. The evaluation of the direct service (SAU-EAHS and DR-EAHS) occurred from April 14, 2009 to August 14, 2010 (16-months). After the DR-EAHS ended in Aug. 2010 the study continued to track cases longitudinally for one year.

Over the study period, 180 study cases across the four Toronto CAS's were identified. Of those, 149 cases received traditional services (83%) and 31 cases received DR-EAHS (17%). Of those 180 cases, nearly one-in-five were closed at Intake and 75%-80% were transferred to Ongoing. The final sample size is much lower than originally estimated in the proposal. The anticipated sample for DR-EAHS was 180-280 youth and their families, and for SAU-EAHS it was 320-420 youth and their families. This was based on previous years' EAHS data that noted across all eligibility codes, teens constitute the largest proportion of EAHS admissions. This number includes re-placements of teens already in care. Based on overall agency and provincial case transfer data it was anticipated that approximately 20% - 30% of these EAHS-Intake cases would be transferred to Ongoing.

While provincially child-in-care numbers are in decline since 2007, and this may have had some influence on the smaller in-care sample size, the major factor that contributed to the study's overall smaller sample size is a more narrow definition of cases used in the study: only significant parent/youth conflict. This was decided based on discussions between the four CAS agencies and Oolagen, the children's mental health agency's. There were two primary reasons for the focus just on parent/teen conflict cases. One, Oolagen's identified area of expertise – parent/youth conflict and youth with presenting mental health issues; and two, the complicating service and legal issues of a children's mental health being the lead (not child welfare), in a case where abuse (e.g. physical, sexual) or domestic violence was the primary referral reason. Another factor that contributed to a smaller DR-EAHS cohort was the shorter hours of operation. Initially in the planning stage, the DR-EAHS intervention was to parallel the hours of the SAU-EAHS. However, for both for financial and service reasons, DR-EAHS was limited to 7pm to midnight during the week and one day on the weekend. While the final sample was smaller than initially proposed it was an adequate size to conduct analyses.

2.1.1 Treatment Group (DR-EAHS) (n=31)

The DR-EAHS segment of the study involved 31 teens between the ages of 10-15 years. Teens and their families were recruited from one of the four Toronto's CAS's. Across the four agencies, the DR-EAHS cohort breakdown by CAS was: CAST =18 (58%), CCAS = 12 (39%), and JCFS = 1 (3%). No participants in the DR-EAHS were referred by NCFST. The DR-EAHS is intended to have greater focus on engagement and intense, individualized service delivery aimed at both youth and parent. DR-EAHS study eligibility criteria included the following case characteristics.

Teens and their families were eligible to participate in the study if:

- The case was referred to one of the Toronto CAS's EAHS & a youth (age 10-15) was the primary reason/focus for the EAHS referral;
- The primary reason for service was *significant parent-teen conflict;*
- The referred youth may be at risk for entry into care;
- The DR-EAHS Teen Service was in *operation* (offered between 19:00 hrs to 23:00 hrs, Monday to Friday and on Sunday's from 17:00hrs to 23:00 hrs) and *available* (e.g. if a youth/family was receiving the DR-EAHS Teen service and another appropriate referral was received but could not wait, the second referral would receive the SAU-EAHS
- The family consented to receive the DR-EAHS Teen Service (families choice to select/not select it).

The DR-EAHS service was provided by one of Oolagen children's mental health staff within a narrative therapy framework (refer to section 2.2). The specialized DR-EAHS was offered between 7pm-11pm weekdays with specified coverage time on weekends. The DR-EAHS was designed to provide immediate and intensive service to teens and their families, including early contact and engagement, comprehensive assessment, as well as timely support and service in order to prevent admission and maintain the family unit. See Table 1 for agency breakdown.

2.1.2 Comparison Group (SAU-EAHS) (n=149)

Teens (age 10-15) referred to one of the Toronto CAS's via EAHS where the issue was parent/child conflict but the DR-EAHS (treatment group) was not available or parents did not consent to the DR-EAHS service were provided the traditional "service as usual" EAHS, also known as the comparison group (*N*=149). While the traditional EAHS is similar to the DR-EAHS in that there is immediate service and/or response to referrals made by the community based on severity of the allegations and/or crises, with SAU-EAHS the service is emergency focused. See Table 1.

Table 1: Breakdown of All Emergency-after-hours Reports from April 2008 – August 2009

Table 1: Type of Emergency-After-Hours Service (EAHS)	**Population (N=180)**	**Sample**			
		CAST	**CCAS**	**JFCS**	**NCFST**
EAHS – Service as Usual **(SAU-EAHS)**	149 (83%)	91 (61%)	39 (26%)	15 (10%)	4 (3%)
Differential Reponses Teen EAHS **(DR-EAHS)**	31 (17%)	18 (58%)	12 (39%)	1 (3%)	0 (0%)
TOTAL	**180 (100%)**	**109 (61%)**	**51 (28%)**	**16 (9%)**	**4 (2%)**

NOTE: CAST refers to Children's Aid Society of Toronto; CCAS refers to Catholic Children's Aid Society; JFCS refers to Jewish Family and Child Services; NCFST refers to Native Child and Family Services of Toronto

2.1.3 Total Sample: DR-EAHS & SAU-EAHS (N= 180)

Across the 180 families there was the potential to have at least 360 participants: one caregiver and one teen for each case. That said, some cases only served the parent/caregiver, some served just the teen, and some served both the teen and their parent/caregiver. Breakdown by the two EAHS services finds differences. See Table 2.

- SAU-EAHS - 60% only parents/caregivers served, 5% only teens, and 35% were both parents/caregivers and teens
- DR-EAHS - 36% only parents/caregivers were served, 3% only teens, and 61% both.

This suggests that the SAU-EAHS is more of a "parent-help line" and the DR EAHS more of a parent-teen telephone service.

Table 2: Breakdown of Involvement in EAHS

Table 2: Involvement in EAHS	**Who Was Involved in the After-Hours Service?**						**TOTAL**	
	Only the parent		**Only the teen**		**Both the parent and teen**			
SAU - EAHS	90	(60%)	7	(5%)	52	(35%)	149	(83%)
DR- EAHS	11	(36%)	1	(3%)	19	(61%)	31	(17%)
TOTAL	**101**		**8**		**71**	**(100%)**	**180**	**(100%)**

2.2 Intervention: Narrative Therapy

Youth and family participants in the DR-EAHS treatment group were referred to and received service from an Oolagen teen specialist worker. The Oolagen staff provided immediate and intensive service to the teen and their family within the framework of "narrative therapy" model.

Narrative Therapy Framework

Narrative therapy involves a process of *deconstruction* and *meaning-making* which are achieved through questioning and collaboration with the client. Often, families who are referred to the DR-EAHS program have experienced crisis and the family member, guardian, or the teen themselves are requesting the youth be placed in-care.

As such, the nature and setup of the DR-EAHS model is to facilitate engaged conversation in order to deconstruct the crisis. This occurs after all immediate safety concerns have been addressed by Children Aid Society (CAS) EAHS staff. Therefore, Oolagen teen specialist workers have the opportunity to diffuse the crisis and facilitate more reflective conversations rather than strictly to the more traditional EAHS model of crisis response. The aim of the DR-EAHS model of service is to utilize these engaged conversations as a way to centre the knowledge and preferences of the people whose lives will be the most affected.

DR-EAHS narrative therapy was provided as a phone service. Although there are recognizable differences in the process of counselling by telephone rather than face-to-face, the use and value of telephone counselling has grown. For instance, counselling by telephone is seen as a more flexible, accessible and cost-effective approach (White, 1997) and offers a confidential method to provide support.

2.2.1 Assumptions of Narrative Therapy and the Guided Conversation Via Telephone

- Expert: *It posits people are the expert in their own lives. This assumption is extremely valuable in finding solutions to crisis situations that are viable and helpful for the people involved.*

- Curiosity: *Narrative Therapy, based on a poststructuralist way of thinking, has the therapist seeking to understand the meaning that a person ascribes to their life experiences by taking a 'not knowing the answer to the questions' position. This ensures the therapist is a collaborator and influential but not central to the process. The focus is not the absolute truth but rather the meaning as derived by the client. This helps facilitate conversations move from what is known and familiar to what is possible to know.*

- Language: *The meaning and details of the language used by those who consult with therapists needs to be understood and not interpreted. By drawing out the client's meaning attached to the language used, the therapist can gain a sense of what language is transformative for the client. The aim is for the client and therapist to develop a shared language that opens up new meanings and possibilities. Being aware of transformative language can facilitate the emergence and consolidation of new meanings and new opportunities for the client.*

2.2.2 Method of Service Delivery

The dominant service method for both types of after-hours services was the phone. Of the SAU-EAHS cohort 81% (n=120) of the EAHS workers vs. 90% (n=28) of the DR Teen EAHS workers intervened on the parent-teen conflict cases via telephone contact only.

Alternative to the EAHS phone service is a home or community face-to-face visit between the family and CAS. More specifically, most face visits occur within the community setting not the home setting. In this study population approximately 14% (n=21) of SAU- EAHS workers vs. 10% (n=3) DR-EAHS workers visited the families in crisis within the community. While visits to the home occurred in 5% (n=8) of the SAU-EAHS cases, none of the DR-EAHS cases resulted in a home visit.

When visits occurred within the family's home or within the community, most often the SAU-EAHS were accompanied by police 72% (n=21) whereas in 28% (n=8) of the situations the CAS EAHS worker on their own to visit the family. The response approach for the DR-EAHS workers has a small sample size, which limits conclusions (n=3); either went with police (n=1; 33%), by themselves (n=1; 33%) or both the police and EAHS worker (n=1; 33%).

For a more detailed description of method of service delivery, refer to Appendix A.

2.3 Measures

The current study employed a mix-methods design to evaluate perceptions, experiences and outcomes of teens, caregivers, staff and other key stakeholders involved with the DR-EAHS program.

Both qualitative and quantitative methodologies were used and included:

A: Emergency After Hours Response Report

B: Pre and Post Surveys assessing engagement, satisfaction and outcomes

C: File reviews

D: Semi-structured interviews and focus groups with various stakeholders

A multi-method data collection strategy was employed:

A: Emergency After-Hours Response (EAHS) Reports (n=180)
All 149 SAU-EAHS reports and 31 DR-EAHS reports were collected to obtain brief details on service and service requests, referral, family, and outcomes; along with identifying the presenting concerns, interventions provided and recommendations for the family. All data obtained were aggregated. A standardized template was used to collect the data (see Appendix B).

B: Pre/Post/Post Surveys – Engagement, Satisfaction and Outcomes
* Time 1 (n=100%): All youth and caregivers were invited in the first 30 days of service to voluntarily participate in a brief 10-minute telephone interview. We asked about their experiences with the service and the EAHS worker; their satisfaction with the service and what outcomes they believe occurred (refer to Appendix C). No identifying information was collected. Youth and caregivers were initially contacted 10 to 20 days post the initial EAHS service.

* Time 2 (82%) : If the family continued to receive service from CAS 90 days or 3 months post Intake service they were asked to complete the same tool at three months post initial EAHS – but only if the case was still open.

* Time 3 (75%): Again, if the family continued to receive CAS service 270 days or nine months after the initial EAHS service the family/youth was asked to complete the follow-up survey but only if the case was still open. For the families that remained open at Time 2 and Time 3 we posit that with these families and teens the respective CAS is dealing with more complex issues relative to those whose case was closed at Intake and did not stay involved with CAS.

No monetary compensation was provided to client participants who completed the telephone surveys

C: File reviews (n=179)
All 179 of 180 families that participated in this research had their file reviewed one year after receiving the index EAHS (one case was a sealed file). Data collected in the standardized file review (see Appendix E) included # re-openings, # subsequent after-hours contacts, follow-up to the index EAHS service, youth risk / protective factors, youth placement stability, caregiver risk/ protective factors, and # collaterals involved.

D: Semi-Structured Interviews/Focus Group (n=41)
All youth, caregivers, SAU-EAHS and DR-EAHS staff, and DR-EAHS supervisors were invited to voluntarily participate in a semi-structured interview on their perceptions of the after-hours services, perceptions of the worker's approach, perceptions of workers experience with teens, perceptions of barriers, impressions of changes due to the intervention and suggestions for improvements (refer to Appendix D for a sample of questions). Along with EAHS staff and supervisors, CAS Intake Day Staff who had experienced at least one case served by EAHS *and* one case served by DR-EAHS was also invited to participate. An honorarium was provided to youth ($30), caregiver ($30), EAHS worker ($40), DR-EAHS worker ($40) and DR-EAHS supervisor ($40) for their time. EAHS supervisors and CAS Day Staff did not receive an honorarium as the interviews/focus group occurred during regular, paid work hours.

3.0 FINDINGS

Given the breadth of the longitudinal data collected and the page limitations associated with this report, a general overview of the findings is presented. Additional information is available from the research team upon request.

3.1 A: Emergency After-Hours Service - Response Reports (EAHS-RR)

The Emergency After-Hours Service Response Report (EAHS-RR) tracked and monitored important demographic information pertaining to each case and associated outcomes. Comparing these statistics across groups provides some insights into the effectiveness of the DR-EAHS program. A summary of youth outcomes is provided below:

Table 3: Breakdown EAHS Involvement at Time 1 (Post EAHS ~ Pre Intake)

Table 3: Youth Outcomes Post EAHS & Pre Intake	**POPULATION (N=180)**	**SAMPLE**	
		Traditional SAU-EAHS (n=149)	**Specialized CMH DR-EAHS (n=31)**
REMAINED IN THE COMMUNITY		**96 (65%)**	**29 (94%)**
Teen remains in the home	93 (52%)	71 (48%)	22 (71%)
Teen to stay with kin	20 (11%)	16 (11%)	4 (13%)
Teen to stay in community	12 (7%)	9 (6%)	3 (10%)
PLACED IN CARE / CUSTODY		**26 (17%)**	**1 (3%)**
Teen placed in care	24 (13%)	23 (15%)	1 (3%)
Teen placed in hospital	2 (0.5%)	2 (1.3%)	0 (0%)
Teen placed in custody	1 (0.5%)	1 (0.7%)	0 (0%)
AWOL / OTHER		**27 (18%)**	**1 (3%)**
Other (unknown results)	16 (9%)	15 (10%)	1 (3%)
Teen missing	12 (7%)	12 (8%)	0 (0%)
TOTAL	**180 (100%)**	**149 (100%)**	**31 (100%)**

Across the three key areas (community, in-care, other) the outcomes favour the youth that received DR-EAHS. To examine whether statistical differences existed between the two samples, a chi-square analysis was conducted to answer the study question:

*** QUESTION 1: DIFFERENCE IN YOUTH OUTCOMES BETWEEN DR-EAHS & SAU-EAHS?**

Are the number of youth who stayed in the community (i.e. at home, with a kin provider or community) versus those who were removed from the community (i.e. placed into care, placed in a hospital, placed into custody) statistically different ($p<.05$) across treatment (DR-EAHS) and comparison (SAU-EAHS) groups?

*** ANSWER**:
YES. The number of youth who stayed in the community (remained at home or stayed with kin or found lodgings with a friend) was significantly different across groups (,$\chi^2(3)=10.57$, $p=.01$) with findings favouring the treatment group (DR-EAHS).

* Youth who received DR-EAHS were more likely to stay in the community relative to those who received the traditional SAU-EAHS.
* Of the 31 youth who received DR-EAHS, 94% remained in the community and only 3% were removed from the home vs. the 149 youth who received SAU-EAHS, where 65% remained in the community and 17% were removed from their home (i.e., placed in CAS care, hospital or custody).
* SAU-EAHS youth were more likely to be reported missing vs. the treatment group (DR-EAHS).
Refer to Figure 1 on page 11 for a summary of results.

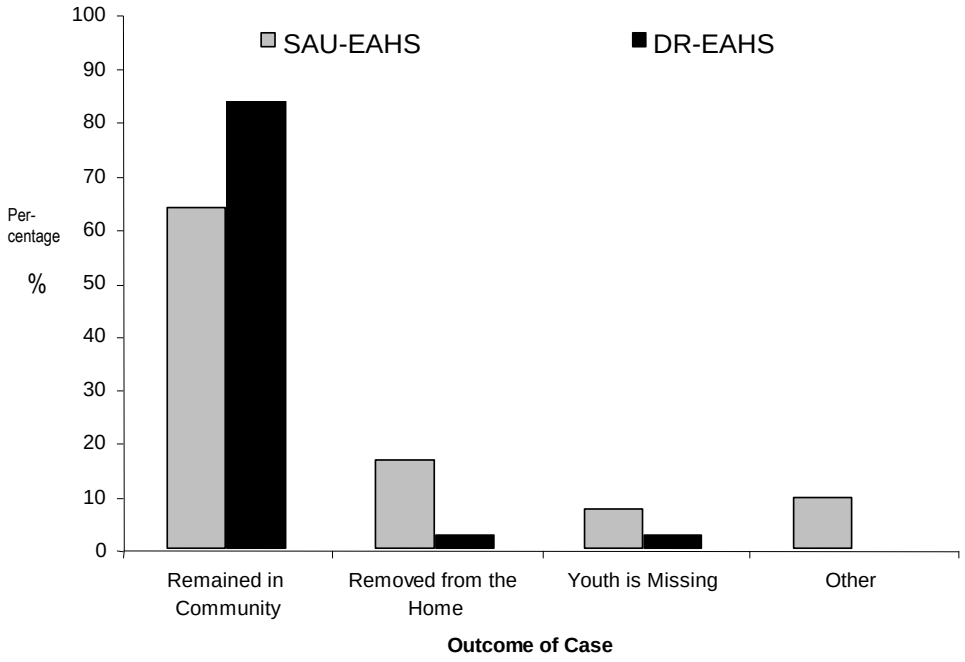


Figure 1: Outcomes related to youth who were serviced by SAU- EAHS vs. DR-EAHS

Data pertaining to referral and service details, demographic characteristics of children and families (e.g., age, gender) and case characteristics were collected. However, given the limited scope of the current report, these details are in prior reports or available from the research team upon request.

3.2 B: Client Satisfaction & Outcomes: Telephone Interviews

Study methodology also included conducting brief standardized phone interviews with families/youth to examine perceived service satisfaction and outcomes. The aim was to gain insight into how satisfied clients were with the EAHS service and explore if differences existed between SAU-EAHS and the DR-EAHS programs.

While attempts were made to contact all study families and their youth at the Time 1, 2 and 3 data collection points there were significant challenges in obtaining this data. The result is the sample size for Time 1,2,3 data collection point is small (see chart page 12). The problems encountered in collecting the longitudinal data were not anticipated. This methodology has been successfully used at the end point of CAS service with a number of other studies (e.g. Family Support, Pregnancy & After Care). While technically this study was collecting data at the end-point of the EAHS segment of service, it was also the start of the formal Intake service and families did not yet know the outcome.

In sum, families were reluctant to participate at Time 1, 2 and 3; they were even more hesitant to give permission for their youth to be contacted. This is important learning for future studies regarding understanding families' concerns and reluctance to participate in research at this sensitive intersection or point for them in the CAS service.

The 55 families that remained involved with their CAS agency after Time1 were contacted for Time2 and Time3 follow-up; this resulted in 11 families (8=SAU-EAHS; 3=DR-EAHS) that provided follow-up data.

Table 4: Client Satisfaction Survey: Completion Rate

Table 4: Client Satisfaction Surveys: Completion Chart	**ALL**	**Traditional SAU-EAHS**		**Treatment DR-EAHS**	
		Family	***Youth***	***Family***	***Youth***
	N=180	**N=149**		**N=31**	
Time 1 10-20 days post initial EAHS service	55	46	(5)	9	(0)
Only Families Involved with CAS after Time 1	**N=55**				
Time 2 3 months post initial EAHS service	8	6	(2)	2	(0)
Time 3 9 months post initial EAHS service	3	2	(0)	1	(0)

Quantitative Analysis

The Time 1 phone survey required parents or youth to rate various statements about:

- Their attitudes towards their CAS,
- Their satisfaction with the EAHS service they received
- The perceived impact of the EAHS program

Responses were on a 5-point Likert scale that ranged from 1 *("much worse" or "strongly disagree")* to 5 *("much improved" or "strongly agree").*

Since all corresponding items (i.e., those that measure attitude, satisfaction with service and perceived impact) all measured the same underlying concept, the three mean scores that assessed attitude, satisfaction with service and perceived impact, were created.

A summary of results are presented below in Table 5:

Table 5: Time 1: Mean Scores	**Attitude Towards CAS (mean score)**	**Satisfaction with Services Provided (mean score)**	**Perceived Impact of Services (mean score)**
SAU-EAHS n=46	3.55	3.59	3.30
DR-EAHS n=9	3.22	2.91	3.11

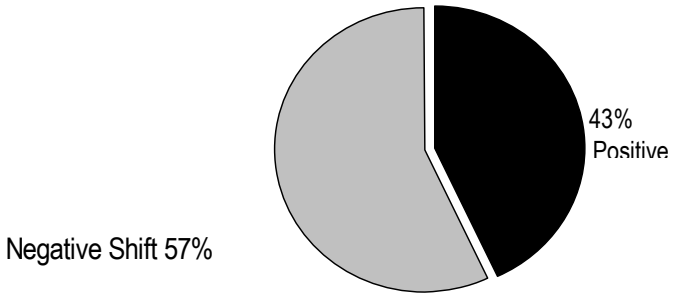
Analysis of mean Time 1 score differences (independent t-test) across the two EAHS groups (SAU and DR) was undertaken where significance was set at $p<.05$. Significant differences were NOT found across the two interventions.

Therefore, there is no evidence to suggest that youth and families who used SAU-EAHS or the DR-EAHS differed in attitudes, satisfaction with services provided or perceived impact of services.

Change in Attitude, Satisfaction and Perceived Impact of Services

Change in *attitude, satisfaction* and *perceived impact of services* across time was also examined. Given the relatively small number of families (n=11) that provided Time 2/3 data only change between Time 1 and Time 2 was examined. Since no differences of significance were noted across the two interventions at Time 1, the Time 2 and Time 3 SAU-EAHS and DR-EAHS data were collapsed and examined together. An *attitude, satisfaction* and *perceived impact* differential score (score at Time 1 – score at Time 2) was created for each family. However, since only 7 of 11 provided *attitude* data, 9 of 11 gave *satisfaction* data and 4 of 11 families provided *perceived impact* data at Time 1 and Time 2, current results are exploratory.

With respect to ***attitude*** scores, 3 out of the 7 families reported a shift towards more positive attitudes at Time 2 (refer to Figure 2). The remaining 4 families reported a shift towards more negative attitudes at Time 2. Of note, the family that reported the largest positive shift at Time 2 received the DR-EAHS intervention. See Figure 2- *shift in ATTITUDES from Time 1 to Time 2.*



With respect to ***satisfaction*** scores, 5 out of the 9 families reported a shift towards more positive attitudes at Time 2 (refer to Figure 3). There was no change in one family's satisfaction score whereas the remaining 3 families reported less satisfaction at Time 2. Similarly, the family who reported the largest increase in satisfaction at Time 2 received the DR-EAHS intervention.

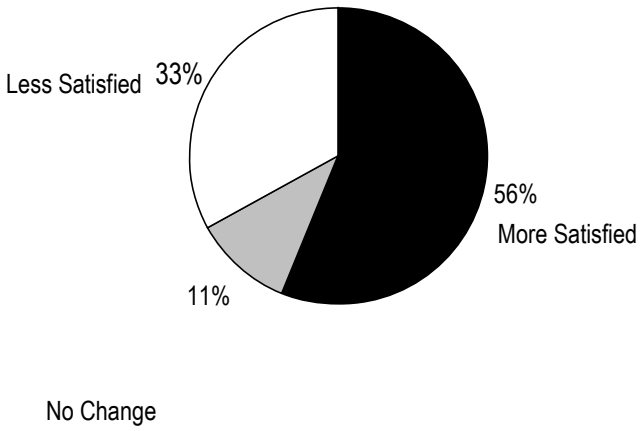


Figure 3: Proportion of families who reported shift in SATISFACTION from Time1 to Time 2.

Lastly, with respect to ***perceived impact*** scores the data and related findings need to be treated with considerable caution as only four families reported on this element.

Of the four families that provided data, three reported a shift towards more perceived positive impact of services (refer to Figure 4), with only one family reporting more negative impact of services at Time 2.

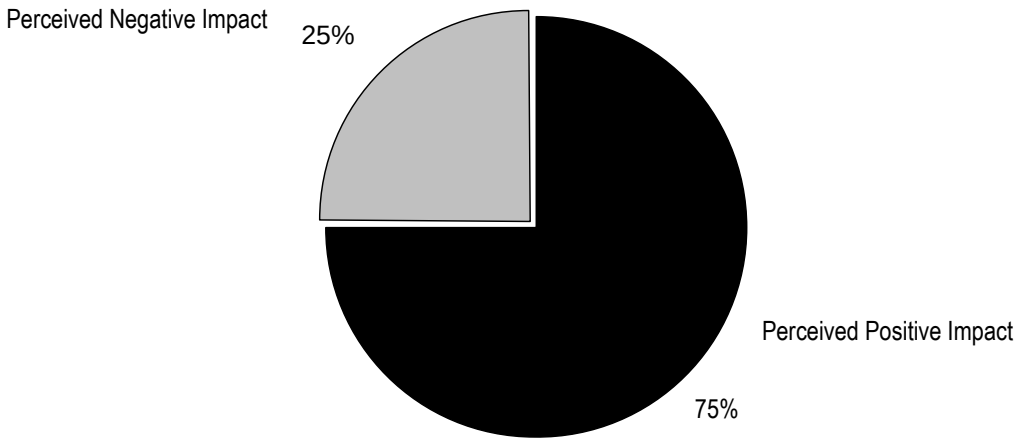


Figure 4: Proportion of families who reported shift in PERCEIVED IMPACT OF SERVICES from Time 1 to Time 2.

While the quantitative data provide some indication of the families/youth varied experience with EAHS, their comments are most illuminating on what was or was not helpful at the time the decision was made to call CAS for assistance.

Qualitative Analysis

As part of the Time 2/Time 3 Satisfaction Survey youth and/or families were asked more qualitative questions:

- *What was most helpful about the DR-EAHS?*
- *What was least helpful about the DR-EAHS?*

For the six families that provided feedback on their satisfaction with EAHS it was an "either/or" experience – either EAHS worked for the family or it didn't. The more positive themes are color-coded in green vs. the more negative themes are color-coded in yellow. See Table 6.

Table 6: Themes	**Families n =6**	**Teens**
Time 1 (10-20 days post EAHS)	**Listened & Heard (n=3)** "Person on the other end listened. They allowed me to talk, even repeat myself. They were very kind." "EAHS worker talked to me as if she was in my shoes."	***Note: There were no teen comments obtained during this time period.*
	All Talk. No Action. (n=4) *"They don't do anything. I don't know what they do."* *"Don't know why it is called EAHS. If in crisis you call after-hours and they are barking at me. Not helpful."* ***Increase Response Time (n=2)*** *"When I called it was 4 or 5 hours until I received a call-back. I think that I had to wait for the next shift to take over."*	
Time 2 (3 months post index EAHS)	**Discussion of Crisis / Situation Helpful (*n*=8)** "It was a most excellent person that I have worked with during the after-hours. I don't believe that the teen worker we spoke with worked for CAS, but they were really helpful. They were very good dealing with a crisis; they knew how to take care of the situation; they were understanding and cooperative. As parents, we felt understood." "She seems to know exactly what to say and know the questions to ask to calm down the situation."	**Listened & Heard (*n*=1)** "I liked the one-on-one. It was nice to here both sides of the story." ***Note: Only 3 youth provided feedback; two said "I don't know" to questions on 'most helpful' and 'least helpful' re-EAHS. One teen provided feedback on what they liked about EAHS service. Thus, data from the teens is treated with caution.*
	Approach Not Helpful (n=5) *"[EAHS] wasn't able to help. I wanted CAS to remove my teen. They wanted to talk to teen. Not much good that did."* *"Limited in what they can do. An extended service would be better. For example, they could come to the site as it can feel that you are trapped on the phone."* ***Lack of Confidentiality (n=2)*** *"There needs to be more confidentiality. I mean, if you call and have to leave your number, that isn't very confidential."*	
Time 3 (9 months post index EAHS)	**Decreased Conflict/Crisis (*n*=2)** "[EAHS] stopped the arguing – separated the argument" "It wasn't a quick fix"	**Helpful** "Helped overall….." ***Note: One teen completed survey, but did not give detailed responses*

Summary of Qualitative Interviews

As is evident with the themes, of the families that consented to be interviewed on the EAHS intervention their experience was mixed and not necessarily related to the outcome but more to the process.

- *Positive Experience ~ High Satisfaction:* When the family felt heard and advice was useful or suggestions were perceived as helpful – satisfaction and perceived positive impact of the service was good.

- *Negative Experience ~ Low Satisfaction*: When the service was viewed as non-responsive, non-engaging and non-helpful – the experiences were more negative.

Lessons Learned

Considerable effort and time went into trying to engage these families and youth in the interview process. Families were called on an average of three times. As noted previously, it was exceedingly difficult to engage the families and nearly impossible to engage the youth. Our analysis of why there was a significant lack of engagement identified reasons that were both anticipated, and while not necessarily unanticipated, they were under-acknowledged in the degree of adverse impact they had on family engagement.

Anticipated reasons include those related to the family's current crisis with their youth. For example, with some youth the EAHS service initiated an entry into care and the associated legal proceedings. Additionally, we recognize there is a general wariness by youth and families in participating in evaluation on a mandated service such as child welfare. We tried to address this through written and verbal communication with families that was non-threatening, sensitive and engaging.

Under-acknowledged elements included the fact that child welfare is still in the early stages of learning how best to engage clients in the evaluation process. The study's methodology was informed by previous studies that included client satisfaction. Much of CAST's evaluation work in this area to date that has been successful (e.g. Family Support, Annual Society Phone Survey, Pregnancy and After Care Program) has involved conducting client satisfaction at the END of the service. We now posit the reluctance of family's to participate in this evaluation may stem from trying to engage them in the VERY EARLY stages of service.

Additionally, we believe the absence of an embedded culture of evaluation in child welfare is a factor. Unlike the health sector with hospitals designated as "teaching hospitals" (e.g. Hospital for Sick Children), child welfare to date has no such designation or culture that may prepare or help inform a client when they are asked to participate in evaluation. Part of the work of each CAS as well as the field as a whole, is to develop that culture of evaluation with and for clients.

If a more fulsome and engaged evaluation of EAHS is to occur in child welfare, learning about how best to engage, include and sustain clients throughout the process must occur if the evaluation initiative is to be successful. Work by Kieran McKeown (2000) underscores not only the four key factors that influence outcomes but the relative weight of those elements: *client characteristics is 40%, worker/client relationship is 30%; client hopefulness is 15%* and finally, *the intervention itself is only 15%.* In other words, achievement of high client satisfaction as an outcome measure entails a number of elements that needs to be understood in how they influence the client experience.

3.3 C: File Reviews

File reviews were conducted one year after they received the EAHS: SAU- EAHS (n=149) and DR-EAHS (n=31). The purpose of the file review was to examine the long-term impacts of the services across four Toronto-based CASs. Files were reviewed using a standardized template (see Appendix E) that identified specific protective and vulnerable factors of youth and caregivers who received EAHS and DR-EAHS. Analysis summarized the mean number of protective/resilience factors (e.g., easy-going temperament, supportive siblings) as well as vulnerability/risk factors (e.g., physical illness, drug issues) of the youth and primary caregivers by EAHS type at the 1-year follow-up period. See Table 7.

- *Protective Factor Scores:* Across both groups there is little difference in the mean *protective factor* scores for youth (DR-EAHS = 5.65 vs. SAU-EAHS = 5.78) and parent/caregivers (DR-EAHS = 3.32 vs. SAU-EAHS = 3.80).

- *Vulnerability Factor Scores:* There are differences in the vulnerability mean scores between the groups for youth (DR-EAHS = 7.42 vs. SAU-EAHS = 6.44) and for parent/caregivers (DR-EAHS = 3.55 vs. SAU-EAHS = 2.70), with the DR-EAHS cohort showing higher vulnerability scores.

As noted in the sample description, the DR-EAHS cohort had some elements of difference compared to the SAU-EAHS group (i.e. higher % of families requesting youth be removed).

Table 7: Protective vs. Vulnerability Factors	**YOUTH**		**PRIMARY CAREGIVER/PARENT**	
	Total Vulnerability Factors	**Total Protective Factors**	**Total Vulnerability**	**Total Protection**
SAU-EAHS n=149	6.44	5.78	2.70	3.80
DR-EAHS n=31	7.42	5.65	3.55	3.32

NOTE: Higher scores in vulnerability suggest an adverse situation; higher protective scores suggest greater resilience.

*** QUESTION 2: DIFFERENCES IN VULNERABILITY & PROTECTIVE FACTORS?**

Are the parent/caregiver *vulnerability* and *protective* factors statistically different ($p<.05$) across the two groups: DR-EAHS vs. SAU-EAHS? The answer will help us understand whether the family backgrounds are different or similar between the two interventions.

ANSWER:
Protective Factors: NO. There was no statistical difference in the mean scores across the two interventions.

Vulnerability Factors: YES. The parents/caregivers who participated in the DR-EAHS had significantly more difficulties and vulnerabilities compared to those parents/caregivers in the SAU-EAHS. It is possible the youth in the DR-EAHS families come from more difficult backgrounds
Refer to page 18 for further analysis.

Since *vulnerability* and *protective* measures were assessed on all 180 cases one-year after the receiving EAHS service then examining whether receiving SAU-EAHS or DR-EAHS predicted the extent to which the youth were exposed to vulnerability or protective measure can help us understand the associations between these programs and long-term youth outcomes. However, because baseline measures of protection and vulnerability was not assessed, causality cannot be inferred and results remain exploratory.

Hierarchical regression analysis was used to examine this association. Since the experience of being removed from the home can also be related to the level of protection and vulnerability experienced by youth, the effect of this experience was accounted for before examining the effects of service (i.e., SAU-EAHS vs. DR-EAHS).

*** QUESTION 3: ARE THERE LONG-TERM EFFECTS IN BEING REMOVED FROM THE HOME?**

Does being removed from the home effect later vulnerability or protective factors in the youth? Does being removed from the home explain differences in youth vulnerability scores?

*** ANSWER**:
Protective Factors: NO. The hierarchicial regression model suggests there are not associations between being *removed from the home* and *later protective* factors in the youth.

Vulnerability Factors: YES. The hierarchicial regression model suggests there is an association between being *removed from the home* and *higher levels of later vulnerability.*

~ The inclusion of *being removed from the home* into the model explained approximately 8% of the differences in the youth's vulnerability scores.

*** QUESTION 4: DOES THE TYPE OF SERVICE HAVE LONG-TERM EFFECTS?**

Does the EAHS type effect later vulnerability or protective factors in the youth?

*** ANSWER**:
After controlling for the experience of being *removed from the home*, the type of service (DR-EAHS or SAU-EAHS) was entered into the same regression model.

Results suggested that youth who received *traditional SAU-EAHS* were more likely to *experience higher levels of vulnerability one-year later* when compared to those who received DR-EAHS. In other words, youth who received *DR-EAHS* showed *lower levels of vulnerability one-year* later relative to their peers who received SAU-EAHS.

~ The inclusion of *type of service* into the model explained approximately 5% of the differences in the youth's vulnerability scores.

3.3.1 Summary of Analysis of File Reviews:

Summary of the analysis of the 180 file reviews one-year after the EAHS service suggests that,

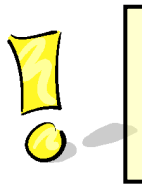
- Families who received DR-EAHS may come from more difficult backgrounds with higher levels of vulnerabilities.
- Youth who are removed from their homes and receive EAHS are more likely to experience higher levels of vulnerability one-year after the initial EAHS service relative to those youth who received the EAHS service but remained in the community.
- Youth who received traditional SAU-EAHS were more likely to show higher levels of vulnerability 1-year after service relative to their peers who received DR-EAHS.
- Findings do not suggest the experience of being removed from the home or the type of service affects protective factors 1-year after receiving services.

3.4 D: Semi-structured Interviews and Focus Groups

To more fully understand the perceptions of those involved in the EAHS services, the research team at the Child Welfare Institute, CAS-Toronto conducted 41 in-depth, semi-structured interviews/ focus group with those that:

- *Received the EAHS service* (youth and parent/s caregivers, n = 16)
- *Provided the EAHS service* (DR & SAU EAHS staff/supervisors and CAS day staff assigned the SAU or DR-EAHS case, n =25).

The majority of the 41 interviews took place over the telephone (n=34, 83%), while other interviews were conducted via email (n=2, n=5%), or in a focus group/in-person (n=5, 12%). The interviews took place between October 2008 to March 2010 and were 30 minutes to 60 minutes in length. There were four main themes. They are presented both visually and sequentially in order of the most dominant themes to least dominant. See Table 8 for a summary of participants.



A standardized thematic, discourse analysis process was used to review and analyze the patterns of similarity in responses across the data from the 41 respondents. Stakeholders were divided into four groups:
1) Youth/Families, 2) EAHS workers, 3) EAHS supervisors, and 4) CAS day staff.

Table 8: Summary of participants in semi-structured interviews/focus groups

Table 8: Participant Category	Breakdown of Participants	Type of After-Hours Service		N =41	%
		SAU-EAHS	DR-EAHS		
Teens	Teens who entered care	0	0	0	
	Teens who *did not* enter care	1	0	1	**2.5%**
N=1	**TOTAL Interviews with Teens**	**1**	**0**	**1**	
Parents / Caregivers	Parents- teens entered care	2	0	2	
	Parents-teens *did not* enter care	11	2	13	**36.5%**
N=15	**TOTAL Parent Interviews**	**13**	**2**	**15**	
EAHS/ CAS Staff	EAHS workers	7	N/A	7	
	DR Teen EAHS workers	N/A	6	6	
	CAS day staff	4		4	**61.0%**
N=25	EAHS supervisors	7	N/A	7	
	DR Teen EAHS supervisor	N/A	1	1	
	TOTAL Interviews with Staff	**18**	**7**	**25**	
TOTAL		**32**	**9**	**41**	
%		**78%**	**22%**		**100%**

Table 9: Summary of staff breakdown in semi-structured interviews/focus groups

Table 9: Staff Participation	Breakdown of Participants	Type of After-Hours Service		N =41	%
		SAU-EAHS	DR-EAHS		
EAHS/ CAS Staff	EAHS workers	7	N/A	14	
	EAHS supervisors	7	N/A	(34%)	
					61.0%
N=25	DR Teen workers	N/A	6	7	
	DR Teen EAHS Supervisor	N/A	1	(17%)	
	CAS day staff	4		4 (10%)	
	TOTAL Interviews with Staff	**18**	**7**	**25**	

3.4.1 General Themes Emerging from Semi-structured Interviews and Focus Groups

THEME 1: After-Hours Intervention

SAU-EAHS Provides Emergency Response Not Service

While the EAHS acronym indicates that it is a "service", analysis of stakeholder views, both CAS staff and parents, suggest EAHS is more of an emergency response, not a service. The parents want a service, and an immediate one. EAHS response to "hold the situation" over the weekend. This leaves a large gap between parental expectations and service delivery

"Families call for 'service', but EAHS is a 'response.' For example, when I'm sick I will go to the hospital. I might think that I'm really sick, but based on the hospital standards, it isn't that bad. The Society prioritizes the cases to determine what needs to be done." [SAU staff]

SAU-EAHS and DR-EAHS Have Different Mandates

EAHS workers and the DR-EAHS workers note they approach the same situations through different lenses. The different response is due to the variance in responsibilities, expectations and mandate between the two services.

"We provide services that are <u>not</u> through the child welfare lens. It is different from the risk-focused approach. Where the EAHS workers can be focused on risk, we can look at the family through a different lens, including a strengths-based approach." [DR-EAHS staff]

DR-EAHS Has The "Luxury of Time" …SAU-EAHS Does Not

EAHS workers have many responsibilities and duties which restrict the amount of time available to spend on each case to counsel, to mediate with families.

"EAHS workers/supervisors have to juggle multiple calls. Pagers are going off, one [EAHS worker] on your cell phone, another holding on your landline, everyone is trying to be as quick as possible because you don't know who has the bigger crisis." [SAU-EAHS supervisor]

"We have the luxury of having the time and can let the family members vent a bit, whereas my perception is that SAU workers can't afford that luxury."*[DR-EAHS staff]*

Mixed Perceptions of 'Telephone Support' vs. In-Person'Support

While there is a perception amongst staff that EAHS services may be more beneficial and effective during parent-teen conflicts if the worker attends in-person to assess and de-escalate the crisis there is also recognition of the benefits associated with providing services over the phone.

"When we went into it, we thought that there would be more face-to-face…been a bit of surprise about how well the telephone service worked… Maybe the anonymity of it helps people to talk to someone and get the information and off they go." [DR-EAHS staff]

THEME 2: Families' Expectations

EAHS Families' Expectations & 'Wants'

When families are in contact with a CAS-EAHS service they have a number of "wants". First and foremost they **want to be listened to**; second, they **want workers to try to understand their family's situation**; third, they **want the worker to normalize the process** for them; and finally, they **want action** to their crises and/or situation (i.e., remove the teen).

"They expect intervention and action to be taken. They usually have created ideas of what the solution is – like an increase in services for the family or a tangible solution for temporarily removing their youth or something that will ensure that the relationship will be different. Whether it is a program that the youth would attend or one that they attend with the teen. They are thirsty for service or intervention." [SAU-EAHS staff]

THEME 3: Recommendations for Improving SAU-EAHS & DR-EAHS

Improve SAU-EAHS AND DR-EAHS Referral Processes

There is concern from families with both EAHS services that they are not being able to directly connect with an EAHS or DR-EAHS worker. Currently, there is a delayed process of going through other individuals before direct contact with a designated worker is obtained.

"Getting the worker first. Not having someone wait and call you back. Have direct contact with the worker, instead of calling back."[Parent]

Educate all CAS workers/supervisors about EAHS and DR-EAHS

A staff theme suggests that CAS staff require more knowledge about the EAHS program objectives for both SAU-EAHS and DR-EAHS. Greater efforts need to be made in accurately educating and promoting the EAHS and DR-EAHS, including referrals processes, and limitations to the after-hours.

"Decisions that are made by day staff are not communicated properly [to EAHS]." [CAS day staff]

THEME 4: Recommendations for Youth/Families Needing EAHS

Needed: Temporary Youth Respite Care Home / Crash Bed

All respondent groups flagged the need for a community youth resource that would provide a temporary but safe respite care/crash bed. It was suggested that it NOT be linked to child welfare. Such a resource could provide: a) "time-out" to parents and teens, b) offer a place of safety to the teen during periods of high conflict, and c) offer specialized services in intensive, customized interventions to parent-teen conflicts. Given the poor outcomes noted for youth that enter care adding a "crash-bed/respite care home" concept appears to be a much needed addition to after-hour services for Toronto parents and teens.

"More resources. More knowledge. More workers that don't label you. More resources to get help." [Parent]

Needed: Increase Youth Community Services/Supports

More services within the community would be advantageous. Participants have a recommendation: more services and recreational activities for teens all of the time (day or night).

"Resources. Resources. Resources. I think there needs to be a lot of resources for young people so that they can be actively engaged in activities and they don't leave them to negative involvement, like criminal activities. After school programs, homework programs, community centres. I would like to see that." [CAS staff]

4.0 Summary of Results

There are several important observations that emerged from this project. They include:

1. ***Receiving DR-EAHS was associated with better outcomes in youth***

    - Youth who received DR-EAHS were more likely to stay at home (EAHS reports)
    - Receiving DR-EAHS was associated with less vulnerability 1-year later (file reviews)

2. ***Families were satisfied with the services they received from the SAU-EAHS and DR-EAHS programs***

    - Families from both EAHS and DR-EAHS at Time 1 generally reported similar levels of satisfaction with the services they received (Satisfaction Questionnaire).
    - Although there was a general shift towards a more *positive attitude*, *greater service satisfaction* and *more perceived positive impact of program with families who stayed* involved with their CAS (Time 2/Time 3) there were also families who reported a shift in the other direction (Satisfaction Questionnaire).
    - Shift towards *more positive attitudes, greater satisfaction and more perceived impact* of program may have occurred because the family felt listened and heard, and had the opportunity to discuss/reduce their crisis, and had access to more resources.
    - Shift towards more *negative attitudes, less satisfaction and less perceived impact* of program may have occurred because families felt that there was no action taken when EAHS was contacted, response time was slow, approach was not helpful, there was a lack of confidentiality, and frustration in not being able to connect/continue working with worker

"SAU - EAHS was designed and only has the resources to be a crisis response. [SAU-EAHS] is unable to provide the same in-depth services (beyond the immediate assessment of the risk) that CAS day staff can. The results at this time suggest that these differences in the family's expectations and EAHS services results in frustration and dissatisfaction." [SAU-EAHS staff]

As with all studies, there are limitations that need to be noted. With this study, one limitation is the sample that was used in the current study. In trying to find the balance between practice demands and research rigor, the CWI research team chose not to conduct random sampling to assign participants into treatment and comparison groups. Since baseline measures were not assessed prior to the EAHS service, it is difficult to know whether there a selection bias exists for families, especially those participating at Time2 and Time 3, who have more difficulties.

Thus, results are exploratory. Future research, utilizing random sampling will be required to examine the extent to which results are generalizable to other samples.

Knowledge Transfer and Dissemination Activities

1. Knowledge Transfer and Dissemination to Stakeholders

To date, the research team has participated in a number of knowledge transfer and dissemination activities. Knowledge transfer and dissemination involved two aspects: 1) stakeholders who were directly involved with the study, and 2) external stakeholders from the child-welfare sector.

An EAHS Advisory Committee was created to guide all research and service activities related to this project. The committee consisted of representatives from the partner CAS and CMH agencies at various levels of service and management. Informal updates to the EAHS Advisory Committee were provided every 6-8 weeks by the research team. The intent was for representatives on this committee to take information back to their teams (e.g., after-hour workers) so that knowledge can directly impact on services.

Aside from the EAHS Advisory Committee, results have been presented at various conferences and professional child-welfare journals (refer to Appendix F for a summary of knowledge dissemination outcomes).

2. Barriers to Knowledge Transfer and Dissemination

Some barriers in applying knowledge to practice include:

- Non-random sample of families into treatment and comparison groups
- Limited number of families participating at Time2 and Time 3
- Limited time and resources to engage in knowledge transfer and dissemination
- The need for expertise to translate key research findings to practice
- The need to develop a specific plan for knowledge transfer and dissemination
- The need to coordinate knowledge transfer and dissemination efforts amongst different partners

3. Lessons Learned

This project has been a fruitful collaboration between the four Toronto child welfare agencies and the children's mental health sector, more specifically the agency Oolagen. The opportunity to participate in this collaboration highlighted the following advantages, challenges and barriers to this approach:

a) The need to integrate various theories and perspectives with cross-sector collaborations:

- Child welfare assess risk/harm of youth within a strengths-based, anti-oppressive framework which differs from the narrative approached used by the DR-EAHS program
- The approach taken by child welfare tends to also be more direct as mandates are time sensitive

b) Increase knowledge of community resources:

- Cross-sector partnerships increased knowledge about the various community resources (i.e., one parent talked about being informed by DR-EAHS worker of how to access other mental health services that have a fee, but are covered by OHIP)
- Children's mental health staff and CAS EAHS staff conducted joint training and protocol review

c) Turn-over of committee members:

- The advisory committee and/or point persons from agencies have changed over the past years throughout this pilot program (i.e., retirements, termination of employment with agency).

d) An ever-changing process of growth, change and adaptation:

- The collaborative model approach is one that is not static, but evolving; research has to evolve with it

e) Engagement in the service and research components:

- Advisory committee and team are enthusiastic to incorporate service with the research so that processes became more seamless
- Example (a): initially it was going to be a one-year study, but our participant numbers were low, so funding was sought and the pilot program was extended another four (4) months
- Example (b): initially the DR Teen EAHS was available on Mondays – Fridays and Saturdays from April to September 2008. However, the preliminary findings indicated that Sunday had more cases that could fit the criteria, thus the change was made to provide the pilot service Mondays to Fridays and Sundays

f) Maximize each other's strengths:

- The team was made up of a variety of positions (front-line, supervisors, branch directors, etc.), which provided greater perspective/insight into issues or questions asked.

Research Capacity Building

Participation in this evaluation project has reinforced the importance of not only building a research culture within the agency but also extending that philosophy and expectations to our clients. Through participation in this research, CAS, EAHS and DR-EAHS staff and management have been able to gain a better understanding of the processes involved with research. Discussions about research have been found to spark engagement and interest for other research projects or activities (e.g., literature reviews, file reviews, pilot studies), direct involvement with different aspects of data collection serves to expose front-line staff and management to various stages of research (e.g., formulation of results). Thus, this collaborative effort results in skills that can be further developed through other research initiatives across all stakeholders.

Challenges and Barriers

Despite the advantages, some challenges and barriers were noted. These included:

Difficulty with participant recruitment

- Attrition during the various time points of data collection on the engagement and satisfaction survey (Time1, Time2 and Time3).
- Language and cultural background of participants may have impacted which children and families consented to participate in the research

Difficulty engaging teens in the research process

- Many parents' declined the research team's request to speak with the teen. Common reasons include:
    - Telephone survey may bring the teen back to that negative time
    - Parents knew that the teens' wouldn't participate – despite not asking them
    - Disclosed that the teen was not even involved in the after-hours service.

- When teens did participate, they frequently responded in one-word answers. When teens' didn't want to participate they often just simply terminated the interview by hanging up.

- Future research may look at more effective and sustainable methods of connecting with youth (i.e., Facebook, texting).

In light of the difficulties in engaging hard-to-serve youth, the research team has proposed a new initiative to provide creative, personalized youth-outreach mentoring support to this often challenging cohort. In partnership with the child mental-health sector, this newly funded initiative aims to facilitate better engagement from these youth in the community and to provide the necessary support for independent living.

Difficulty engaging parents in the research process

- Difficult finding convenient times for families to participate in interviews
- Scheduling of interviews had to be flexible to accommodate availability of parents

Intensive data collection

- The amount of time required to complete data collection was lengthy

Difficult in achieving the same rigour associated with experimental designs

- Balancing between service and program and research demands, it was difficult to apply a strict experimental agenda (e.g., counterbalancing, matched treatment and comparison groups)
- The research team made every effort to achieve experimental rigour without compromising the quality of services delivered to clients and safety of workers (e.g., there were safety concerns for non-protection workers attending homes of families during night duty times)

Costs

	Total for Grant Period $	2007-08 Actual Expenditure $	2008-09 Actual Expenditure $	2009-10 Actual Expenditure $	2010-11 Budget	2010-11 Actual Expenditure Q1 - Q2	2010-11 Actual Expenditure Q3	2010-11 Actual Expenditure $	Variance
Salaries, Benefits	161,251.21	13,832.00	43,231.38	68,980.35	31,187.83	25,786.86	5,400.97	31,187.83	-
Consulting Services	2,730.00	420.00	1,050.00	-	630.00	-	600	600.00	30.00[1]
Honoraria	1,322.10	-	722.10	290.00	100.00	-	0	-	100.00[2]
Specialized / Technical Services	3,960.00	330.00	1,320.00	1,320.00	990.00	660.00	330	990.00	-
Materials / Supplies	7,620.00	635.00	2,540.00	2,540.00	1,905.00	1,270.00	635	1,905.00	-
Computing/ Related	3,000.00	-	3,000.00	-	-	-	0	-	-
Travel	1,913.50	-	13.50	63.00	900.00	36.00	0	36.00	864.00[3]
Subtotal:	**181,796.81**	**15,217.00**	**51,876.98**	**73,193.85**	**35,712.83**	**27,752.86**	**6,965.97**	**34,718.83**	**994.00**
Overhead Costs (20%)	39,514.97	3,315.00	13,259.40	15,798.00	7,142.57	4,761.71	2,380.86	7,142.57	0
Total:	**221,361.78**	**18,532.00**	**65,186.38**	**88,991.85**	**42,855.40**	**32,514.57**	**9,346.83**	**41,861.40**	**994.00**

NOTE: *No interest was earned on variance funds

Justification of Costs

[1] There was slight variability in the cost of consulting services for data analysis

[2] The ***honoraria:***

- There were fewer family participants that consented to participate within the research during this time period; and while some participants initially agreed to participate, when called back - they declined. We were anticipating that there would be at least 15 more parents/ teens that could have consented, but regardless of multiple attempts to reach families there were only 7 who consented [thereby 7 participants x $30.00 = $210].
- In regards to the EAHS workers, we were anticipating that the remaining 6 workers would consent, but only 2 did [thereby 2 participants x $40.00= $80.00]. If everyone had agreed to participate there would have been the total cost of $690 [15 x $30 = $450; and 6 x $40 = $240]; but we were anticipating/ budgeting for the fact that a few participants were going to drop out. We weren't anticipating that so few would consent to participate during this recording period.

[3] The ***travel expenses***:

- Initially they were anticipated to be higher during this recording period because we were going to be doing the bulk of the the file reviews which were to be located at each of the 4 agencies' branch sites - CAS-Toronto branches (Scarborough, Etobicoke, North and Central), CCAS, JC&FS (Toronto Branch & Thornhill) and NC&FST. However, the majority of the data collection occurred over the agencies electronic system or hard copies were brought by the agencies to a centralized office. This drastically decreased the number of travel expenses. The RA walked to and from CCAS from the home CAST office at Isabella and did not take the TTC) - thus travel expenses were lower.

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Appendix A
Method of Service Delivery

STEP 1: Contact with the CAS is made by the referral source (i.e., family, teen, community, police)

STEP 2: EAHS worker is paged and contacts referral source.

When the referral source contacts CAS, they are greeted by a telephone service that takes down the basic contact information.

STEP 3: EAHS worker assesses the presenting concerns / crises

EAHS workers assess the presenting concerns/crisis. Overall, 90% of EAHS workers connected with clients within 15 minutes; regardless of the time of the after-hours shift (n=105 out of 117; 32 EAHS Reports didn't have time recorded within the document).

STEP 4: EAHS worker provides an intervention (i.e., telephone conversations, face-to-face, referral to resources) or if eligible, family is referred to DR-EAHS worker

EAHS interventions resulted in various outcomes (i.e., a detailed report is forward to CAS day staff for follow-up, other supports are brought in during the evening, child/teen comes into care)

If the case fits the pilot project's study criterion, the EAHS worker and duty supervisor referred the case to the DR-EAHS worker, who in turn provided immediate and intensive service to the teen and their family. DR-EAHS workers were available for in-person service between 7:00 pm to 10:00 pm; and via telephone service between 7:00 pm to 11:00 pm.

Appendix B
Emergency After-Hours Response (EAHS) Reports

1. REFERRING CAS	☐ *CAS-Toronto*	☐ CCAS	☐ JFCS	☐ *NCFST*	**DATE:**	dd/mm/yy	☐ Family ☐ Resource [JFCS only]
2. TEEN-EAHS SERVICE DETAILS			**Teen Worker Service Method**	☐ ***Phone contact only***		***If Teen Worker Visited***	☐ *Teen worker only*
Teen Worker Name							
EAHS Worker Name				☐ **Phone & visit**	☐ at home		☐ *Teen worker & CAS*
CAS Supervisor Name					☐ in community		☐ *Teen worker, police, CAS*

3. REFERRAL DETAILS	**24hr**	**CONTACTS**	**# CONTACTS**	**IDENTIFIED TEEN [age 12 –15]**				
Time Teen worker receives call		EAHS Supervisor		**Name**				
Time Teen worker contacted client		EAHS worker		**Age**		**DOB**		
Time Teen worker completed service		Community		**Gender**	☐ Male ☐ Female			
Referral Source	☐ Family ☐ Teen ☐ Caregiver ☐ Police ☐ Community ☐ Other….			**Known to CAS**	☐ Yes ☐ No ☐ Unknown			
				Teen Phone #				
*Referral Reference # **[if available]***	CAST		CCAS		JFCS		NCFS	

4. FAMILY DETAILS	**FILE NAME [first/ surname]**	**PHONE (Home/Work)**	**ADDRESS/WHEREABOUTS**
Mother			
Father			
Step-Parent/Collateral			
Total # Children in Family	____ # under 12 yrs ____ # over 12 t o 16 yrs ____ # over 16 to 18 yrs		**TOTAL:**

5. REFERRAL DETAILS			
The Family's Service Request: Primary [select one]	☐ provide teen counselling ☐ relocate youth ☐ provide family counselling ☐ place youth in care ☐ Other _____	**Youth's Service Request: Primary** [select one]	☐ provide teen counselling ☐ relocate youth ☐ provide family counselling ☐ place youth in care ☐ Other _____
Case Type: Primary	☐ Parent/teen conflict-community ☐ Parent/teen conflict –resource ☐ Other _____		
6. OUTCOME DETAILS			
Immediate Case Outcome	☐ provided teen counselling - teen remains at home ☐ provide teen/ family counselling -teen remains at home ☐ provide teen/ family counselling -teen to stay with kin community ☐ provide teen/ family counselling -teen to stay in community ☐ provide teen/ family counselling -teen placed in care ☐ provide teen/ family counselling -teen placed in CMH / Hospital ☐ provide teen/ family counselling -teen placed in custody ☐ Other _____		
Case Follow-up *[check all that apply]*	☐ EAHS service ☐ CAS Day Staff ☐ Community Service Referral ☐ Other _____		
7. NOTES	**Presenting Concerns**:		
EAHS Teen Worker Assessment/ Case notes	**Intervention Provided:** **Recommendations**:		

Appendix C
Satisfaction Telephone Questionnaire

To Be completed by Researcher Prior to Phone Call			
O Date Tool Administered _____			
O Time 1 (AHS service)	**O Time 2 (3 months post-AHS)**	**O Time 3 (9 months post AHS)**	
O Toronto CAS	**O Catholic**	**O JFCS**	**O NCFST**
O Regular AHS	**O DR-AHS**	**O Phone only**	**O Visit**
O Youth completed	**O Family completed**		
NON-IDENTIFYING CASE CODE: _____			

Researcher Phone Script: Your evaluation of the _____Children's Aid Society After Hours Service is very important as your feedback allows us to continue to evaluate our service and improve its quality. There are no right or wrong answers. All your responses are non-identifying, are kept confidential and results are only used for evaluation purposes.

Please select only one response on the scale for each question		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Not Applicable
1	AHS Service clearly explained their service	SA	A	N	D	SD	*NA*
2	AHS treated me with courtesy and respect	SA	A	N	D	SD	*NA*
3	AHS spent enough time with me /my family	SA	A	N	D	SD	*NA*
4	I felt listened to and treated fairly	SA	A	N	D	SD	*NA*
5	AHS worker was knowledgeable about teens	SA	A	N	D	SD	*NA*
6	AHS involved me in decisions about my family	SA	A	N	D	SD	*NA*
7	I was kept informed about what was happening	SA	A	N	D	SD	*NA*
8	AHS gave me other community resources to use	SA	A	N	D	SD	*NA*
9	I had confidence in the AHS service	SA	A	N	D	SD	*NA*
10	AHS interventions helped the specific issues that brought me to AHS	SA	A	N	D	SD	*NA*
11	I am satisfied with the AHS service	SA	A	N	D	SD	*NA*

As a result of receiving the AHS service,		Much Improved	Improved	Same	Worse	Much Worse	Not Applicable
12	My / my teen's safety is	M I	I	S	W	MW	*NA*
13	My /my family's safety is	M I	I	S	W	MW	*NA*
14	The crisis/situation is	M I	I	S	W	MW	*NA*
15	My knowledge of what services can assist me is	M I	I	S	W	MW	*NA*
16	My /my family's ability to get help is	M I	I	S	W	MW	*NA*
17	My / my family's stress level is	M I	I	S	W	MW	*NA*
18	What was most helpful about the AHS service?						
19	What was least helpful about the AHS service?						

20	Additional Comments

Appendix D
Sample of Semi-Structured Interview Questions

Protocol Used with Families Receiving Emergency After-hours Services

1. **Perception of After-Hours Service**

    - **Tell us your thoughts about the After-Hours Service you received?**
        i. What were you expecting of the AHS service?
        ii. What did you think would happen?

2. **Perceptions of the worker's approach**

    - **Tell us about your experience with the approach the worker took?**
        i. What was most helpful about the worker's approach?
        ii. What was least helpful about the worker's approach?

3. **Perceptions of worker experience with teens**

    - **Tell us what you think about the worker's expertise with teens?**
        i. Did you feel the worker was knowledgeable about teens?
        ii. Did you feel the worker was experienced in working with teens and their families?

4. **Perceptions of barriers**

    - **Tell us about what factors act as barriers to the AHS?**
        i. What are barriers you experienced with AHS?
        ii. How could these barriers be removed?

5. **Impressions of changes due to the intervention**

    - **Tell us about whether you / your situation changed as a result of AHS?**
        i. Did the AHS intervention help improve your situation?
        ii. Has the AHS service influenced your attitude towards CAS in general?

6. **Suggestions for improvement**

    - **Tell us about changes that you would like to see implemented with AHS?**
        i. What changes would you like to see in regards to service to teens and their families?
        ii. What changes would you like to see at an agency level?
        iii. What changes would you like to see at a community level?
        iv. What changes would you like to see at a policy level?

Appendix E
Standardized Tool Used in File Reviews

1.0 ADMINISTRATIVE DETAILS

ID: _____ **DATE TOOL COMPLETED**: _____

GROUP: ○ EAHS ○ DR Teen EAHS **RESEARCH ASSISTANT**: _____

FILE #: _____ **FAMILY NAME:** _____

WORKER SAFETY ALERT: ○ No ○ Yes If yes, please explain: _____

CAS: ○ CAST ○ CCAS ○ JFCS ○ NCFSTT

Location / Worker of File: _____

2.0 PREVIOUS CAS INVOLVEMENT				
# of Openings	**Eligibility Code**	**Open Date** (dd.mm.yy)	**Closed Date** (dd.mm.yy)	**Total Days Open**

3.0 ALL EAHS CONTACTS REGARDING FAMILY				
# of Contacts	**Eligibility Code**	**Date** (dd.mm.yy)	**Referral Source**	**Service Received**
				○ Report made ○ Contact with family ○ Placed Child
				○ Report made ○ Contact with family ○ Placed Child
				○ Report made ○ Contact with family ○ Placed Child

4.0 FOLLOW-UP TO EAHS INTERVENTION (as per research)					
Date of EAHS	(dd.mm.yy)	**Date of CAS Day Staff Follow-Up**	(dd.mm.yy)	**Total Days until Follow-Up**	
EAHS or DR Teen EAHS recommendations	○ ○ ○ ○ ○		**CAS Day Staff Used Recommendations**	○ Yes – All ○ Yes – Some ○ No – None ○ N/A	

4.1 Briefly identify what transpired <u>after</u> EAHS intervention (via case-notes):

5.0 IDENTIFIED TEEN			
Vulnerability Factors	**Details**	**Yes**	**No**
Physical Illness	(i.e. leukemia, severe asthma, cerebral palsy)	Yes	No
Mental Health Diagnosis	(i.e. ADHD, ODD, Eating Disorder)	Yes	No
Developmental Issues	(i.e. learning difficulties, developmental delay)	Yes	No
Parental Separation/Loss	(i.e. divorce, death)	Yes	No
	Previously in Care	Yes	No
Physical Abuse		Yes	No
Sexual Abuse		Yes	No
Emotional Abuse		Yes	No
Neglect		Yes	No
Negative Peer Association	(i.e. gang involvement)	Yes	No
Teen Pregnancy / Sex		Yes	No
Drug Issues	(i.e. marijuana, cocaine)	Yes	No
Poor School Attendance	(i.e. skips school)	Yes	No
AWOL	(i.e. from home)	Yes	No
Externalizing Issues	(i.e. aggression, hard-to-manage)	Yes	No
	Medication	Yes	No
Internalizing Problems	(i.e. isolation, keeps to themselves)	Yes	No
	Medication	Yes	No
Experience of Trauma	(i.e. resettlement stress)	Yes	No
Involvement in Youth Justice System	(i.e. probation)	Yes	No
	TOTAL Vulnerability Factors Identified		
Protective Factors	**Details**	**Yes**	**No**
Personal Talents	(i.e. artistic, athleticism)	Yes	No
Easy-Going Temperament	(i.e. positive attitude, humorous, empathetic)	Yes	No
Sense of Future Self	(i.e. long-term goals)	Yes	No
Problem Solving Abilities	(i.e. resourcefulness)	Yes	No
Close with PCP		Yes	No
Supportive grandparents		Yes	No
Supportive siblings		Yes	No
Supportive teachers		Yes	No
Community mentors	(i.e. therapist, foster parent)	Yes	No
Supportive peers	(i.e. best friend)	Yes	No
Involvement in Activities	(i.e. sports, band, community groups)	Yes	No
	TOTAL Protective Factors Identified		

5.1 IDENTIFIED TEEN – IF REMOVED FROM THE HOME…				
Admission Date (dd.mm.yy)	**Discharge Date (dd.mm.yy)**	**Total Days in Care**	**Type of Out-of-Home Care**	**Circumstances of Admission**
			○ Kinship ○ Foster Home ○ Group Home ○ Hospital ○ Incarceration ○ Other	
			○ Kinship ○ Foster Home ○ Group Home ○ Hospital ○ Incarceration ○ Other	
			○ Kinship ○ Foster Home ○ Group Home ○ Hospital ○ Incarceration ○ Other	
			○ Kinship ○ Foster Home ○ Group Home ○ Hospital ○ Incarceration ○ Other	

5.2 Placement stability – number of placements since the initial EAHS intervention: _____

6.0 IDENTIFIED CAREGIVER(s)							
		Mother		Father		Collateral	
Vulnerability Factors	**Details**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Physical Illness	(i.e. leukemia, severe asthma, cerebral palsy)	Yes	No	Yes	No	Yes	No
Mental Health Diagnosis	(i.e. ADHD, ODD, Eating Disorder)	Yes	No	Yes	No	Yes	No
Developmental Issues	(i.e. learning difficulties, developmental delay)	Yes	No	Yes	No	Yes	No
Parental Separation/Loss	(i.e. divorce, death)	Yes	No	Yes	No	Yes	No
	Previously in care	Yes	No	Yes	No	Yes	No
Physical Abuse		Yes	No	Yes	No	Yes	No
Sexual Abuse		Yes	No	Yes	No	Yes	No
Emotional Abuse		Yes	No	Yes	No	Yes	No
Neglect		Yes	No	Yes	No	Yes	No
Financial Complications	(i.e. lost housing, unemployed)	Yes	No	Yes	No	Yes	No
Self-Harming Behaviours	(i.e. overdose)	Yes	No	Yes	No	Yes	No
Externalizing Issues	(i.e. aggression, hard-to-manage)	Yes	No	Yes	No	Yes	No
	Medication	Yes	No	Yes	No	Yes	No
Internalizing Problems	(i.e. isolation, keeps to themselves)	Yes	No	Yes	No	Yes	No
	Medication	Yes	No	Yes	No	Yes	No
Experience of Trauma	(i.e. resettlement stress)	Yes	No	Yes	No	Yes	No
Involvement in Criminal Justice System	(i.e. incarcerated)	Yes	No	Yes	No	Yes	No
	TOTAL Vulnerability Factors Identified						
Protective Factors	**Details**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Personal Talents	(i.e. artistic, athleticism)	Yes	No	Yes	No	Yes	No
Easy-Going Temperament	(i.e. positive attitude, humorous, empathetic)	Yes	No	Yes	No	Yes	No
Sense of Future Self	(i.e. long-term goals)	Yes	No	Yes	No	Yes	No
Problem Solving Abilities	(i.e. resourcefulness)	Yes	No	Yes	No	Yes	No
Supportive grandparents		Yes	No	Yes	No	Yes	No
Supportive siblings		Yes	No	Yes	No	Yes	No
Community mentors	(i.e. therapist)	Yes	No	Yes	No	Yes	No
Supportive peers	(i.e. best friend)	Yes	No	Yes	No	Yes	No
Involvement in Activities	(i.e. sports, gym, community)	Yes	No	Yes	No	Yes	No
	TOTAL Protective Factors Identified						

6.1 IDENTIFIED CAREGIVER(s)			
Categories	**Primary Caregiver**	**Secondary Caregiver**	**Collateral / Step-Parent**
Date of Birth			
Age			
Gender	○ Female ○ Male	○ Female ○ Male	○ Female ○ Male
Racial Grouping			
Religious Affilation			
Immigration Status	○ Born in Canada ○ Landed immigrant ○ Refugee status ○ No status	○ Born in Canada ○ Landed immigrant ○ Refugee status ○ No status	○ Born in Canada ○ Landed immigrant ○ Refugee status ○ No status
Marital Status	○ Single ○ Married ○ Divorced ○ Widowed	○ Single ○ Married ○ Divorced ○ Widowed	○ Single ○ Married ○ Divorced ○ Widowed

	○ Common-law ○ Other	○ Common-law ○ Other	○ Common-law ○ Other

7.0 COLLATERALS INVOLVED FROM EAHS INTERVENTION _____ TO _____
(one year after intervention)

	Type of Worker(s)	Reason(s) for changes (*if applicable*)
CAS *TOTAL:* _____		

	Agency	Length of Service	Reasons for Termination
NON-CAS *TOTAL:* _____			

8.0 TIMELINE OF CASE ACTIVITY
(Including: date of opening, EAHS intervention(s), pre- and post-tests, admissions, Day Staff follow-up)

Appendix F
Summary of Knowledge Dissemination Outcomes

2010

Langhorne, R., Dorfman, R., Young, S., & Beatty, S. (July 2010). "*Narrative Approaches to Preventing Child Admission to Care: A single session model for working with families involved with child protection services*." Preliminary findings presented at the International Summer School of Narrative Practice: Toronto, Ontario.

Beatty, S., Goodman, D., Langhorne, R., & Malik, A. (June 2010). "*Child Welfare Emergency After-Hours & Children's Mental Health Services: Partners in a Differential Response Model to High Risk Teens: Year 1 and Year 2 Findings*." Preliminary findings presented at the Ontario Association of Children's Aid Societies' (OACAS) Putting Children First Makes a Difference: Toronto, Ontario.

Goodman, D., & Beatty, S. (January 2010). "*Move the Services and Resources – Not the Youth! Differential After-Hours Response to At-Risk Teens. Year 1 & Year 2 Preliminary Findings*." Webinar presented at Practice and Research Together (PART) Ontario: Toronto, Ontario.

Goodman, D., & Beatty, S. (April 2010). "*Move the Services and the Resources-Not the Youth: Evaluating the Differential After-Hours Response to At-Risk Teens, Preliminary Findings from Year 1 (April2008-March2009), Year 2 (April2009-March2010)*." Child Welfare Institute, Children's Aid Society of Toronto.

2009

Beatty, S., & Goodman, D. (May 2009). "*Move the Services and the Resources-Not the Youth: Evaluating the Differential After-Hours Response to At-Risk Teens. Preliminary Findings from April 2008 to March 2009.*" Child Welfare Institute, Children's Aid Society of Toronto.

2008

Beatty, S., Goodman, D. (November 2008). Research Update… Move the Services and the Resources-Not the Youth: Evaluating the Differential After-Hours Response to At-Risk Teens. *Communicate*, pp.7.