Final Report

Self-Managed Care

EVALUATING PARTNERSHIP, SOCIAL NETWORKS AND COMMUNITY CAPACITY BUILDING IN THE PROVISION OF RESPITE SERVICES

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Funded by the Centre of Excellence for Child Welfare and Health Canada[1]

[1] The views expressed herein do not necessarily represent the official policies of Health Canada. Les vues exprimées ici ne représentent pas nécessairement la position officielle de Santé Canada.

ACKNOWLEDGEMENTS

The researchers would like to acknowledge and thank all of the research participants. This includes the families who agreed to participate and share their stories, as well the staff who provided their perspectives on the Self-Managed Care program. To all of you, your effort and willingness to participate were greatly appreciated. The researchers would also like to thank the research assistants, Andria Mudry and Darcey Bell for their excellent work, and Shelley Tordon for her administrative support. The researchers are also grateful for the input and support from the Local Advisory Committee: Brian Ridd, Marlyn Bennett, Angie Balan and Glenda Edwards.

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INTRODUCTION PURPOSE AND OVERVIEW

The Self Managed Care (SMC) program was formally developed in 2001 at Winnipeg Child and Family Services as an alternative form of respite service. This particular form of respite provision allows parents involved with the child welfare system to manage and control respite funds provided by the organization, including the selection of, and direct compensation to, the care provider.

The concept of 'self-managed' care has existed for several years and in different forms. It has been conceived as a set of principles designed to provide adults with disabilities a more significant and independent role in their own care, or the parents of children with disabilities to support caregiving activities through respite services (for example the government of Manitoba Children's Special Services[1]). Self Managed Care has subsequently impacted many fields, including care for senior citizens, hospital outpatients and more recently, child welfare.

The SMC model of respite services provides funds to families involved with a child welfare organization to obtain respite services. The program allows parents who require respite services to select and directly compensate care providers with funds provided by the organization. Parents take an active role in determining the services they need and are responsible for identifying a care provider, scheduling respite hours and budgeting the allotted funds. Parents are encouraged to identify care providers within the family's existing social network or to develop a care provider resource in their community. One goal of SMC is to improve the family environment and increase the likelihood of positive outcomes for parents and children. An important role for the organization is to act as a support to families, and to guide families to work towards solutions sustainable over time. By providing parents with respite funds that they can manage at their

[1] Now under the division 'Services for Persons with Disabilities' in the Department of Family Services and Housing.

discretion, the SMC program is believed to empower parents through: a sense of partnership in their relationship with the organization, control over decisions concerning their child's care provider and having a stake in the financial aspect of service delivery. As well, potential community benefits of the program include the development of social networks through the identification and hiring of a care provider and the actual provision of respite services. These networks may develop into long-term community-based relationships, and the relationship between the care provider and the family may remain after the formalized organization involvement is terminated.

The SMC program is an innovative approach to the provision of respite services in child welfare. This program demonstrates the potential to develop and enhance a family's existing support system using a collaborative, empowering approach to service provision that integrates aspects of community capacity building. This could ultimately lead to greater client satisfaction with the services provided and a reduced dependency on the organization for continued respite service.

Self managed care is not without risks however and some service providers have expressed concern regarding the amount of control given to the client in terms of selecting an appropriate care provider, reimbursing the care provider, and the absence of a requirement to conduct criminal record and abuse registry checks.

LITERATURE REVIEW

A review of child welfare literature suggests that the Self Managed Care Program is a unique service in child welfare organizations. Examples of self managed respite were found solely in the field of services to children and adults with special needs. Consequently the following review provides a brief overview of issues related to child welfare planning and services which are specifically relevant to the SMC program.

Child welfare literature over the last 20 years contains numerous calls for reform, driven largely from the shortcomings of the 'traditional' child welfare service delivery model. Increases in the rates of child maltreatment and moreover, the number of children in nation's alternate care systems have led to re-examination of child welfare approaches (Chaffin, Bonner, Hill, 2001). Concerns exist that the current child protection system is fundamentally flawed as its primary emphasis is on reporting and investigation in contrast to the prevention of initial or further harm to children (DePanfilis, Zuravin, 2002; Barter, 1999, Farrow, 1997).

Friedman (1994) notes that the decline in the well-being of children, adolescents and their families in many life domains is increasingly documented. The author states that the prevalence of problems is so great that systems can no longer wait until after problems become severe to serve children and families. Although there is a need to provide support and services within the family's community, local communities often are not adequately involved in service planning and systems are not designed in a culturally competent manner that enhances the capacity of families and communities to address their own needs (Friedman, 1994). Similarly Barter (1999) states that despite advancements made in child welfare, there is sufficient evidence that contemporary public child welfare systems remain concerned with social control, that little or no attention is given to prevention and early intervention, that alternate care continues to be

fraught with problems, that resources are not available to support families and that child welfare practices are confined to deal with symptoms as opposed to root causes (p. 56).

One of the criticisms of many of the system designed to assist children and families is that too many resources are expended in expensive out-of- home placements, many of which could be avoided if resources were diverted to systems of care with a wide range of home-based and family support services (Friedman, 1994, p. 42). Friedman (1994) suggests that the challenge becomes one of shifting system from those that have emphasized expensive out-of-home placements to those with great emphasis on prevention, family support and community-based services and systems of care.

Child welfare literature in both Canada and the U.S.A. emphasize the need to find more effective ways of providing support to families that become involved with the child welfare system. Common themes emerge in the literature on how the system could be reformed. These themes include: 1) an increased collaboration with other community resources; 2) an emphasis on working in partnership with families; 3) greater community involvement; and 4) an increased emphasis on early intervention and prevention services.

Increased Collaboration

Child welfare organizations have recognized for some time the need to "work together" with other organizations that are designed to support children and families. However there is often a "tension" between the mandated and non-mandated parts of the social service system. Child welfare organizations continue to face challenges in their efforts to engage other systems and other systems have felt frustrated with child welfare.

Friedman (1997) notes that many services are geared to address specific problems, but children and families frequently experience multiple problems and require comprehensive and flexible support services. As well, service systems are highly fragmented and lack the flexibility to serve child and families adequately;

this is partly due to large numbers of categorically funded activities. Given this reality Friedman (1997) suggests that increased funding flexibility is critical in addressing the needs of children and families. By creating multi-organization pool of funds many states have enhanced fiscal flexibility, and fiscal incentives. Instead of competing for resources or "shifting costs" to other agencies, they work together (Freidman, 1997, p. 43).

Partnership with Parents

In order to work in partnership with parents, parents must be seen as having something to offer in their role as parents. Barter (1999) notes that parents must be considered collaborative partners with many strengths and capabilities, rather than simply people with problems. Partnership can be seen in some respects as the extension of 'parental responsibility' (Sheppard, 2001). Partnership can become a means by which the parent is able to carry out at least part of their role as parent, even where they do not have the conventional responsibility of the day to day care of the child (Sheppard, 2001, p. 33). Each partner is seen as having something to contribute, power is shared, decisions are made jointly, roles are not only respected but also backed by legal and moral. Sheppard states that it is through the partnership between parent and social worker that parents can be empowered: ‘For the parent, the opportunity to exercise choice becomes greater, in that partnership provides the context in which their wishes might be expressed in a way that would not otherwise be possible’ (Sheppard, 2001, p. 34).

Farrow (1997) argues that partnerships between parents and social workers are mutually beneficial and states that parents should be included as informed partners in all aspects of the work. Children cannot be kept safe unless parents own this task. He believes that parents and their interests are integral to creating the partnership otherwise involvement is seen as an imposition on parents. Common outcomes should be defined and act as the "glue" for new partnerships and provides a language upon which everyone agrees (Farrow, 1997, p. 25).

Social Network and Community Development

Cameron and Vanderwoerd (1997) posit that positive social support empowers people through increasing self-esteem, independence and autonomy. Positive social supports are considered a means to help people deal with stressors and the authors argue that social supports are associated with lower levels of child maltreatment. The authors describe four types of social support: 1) concrete support; 2) educational support; 3) emotional support; and 4) social integration (Cameron & Vanderwoerd, 1997). A key role for social workers during assessment and intervention phases is to explore a person's social networks, both formal and informal.

Farrow (1997) maps out seven steps for building community partnership which includes working in partnership with parents, providing services that respond to the families' unique needs, community development, particularly active involvement in child protection services governance and delivery (Farrow, 1997). Throughout these steps there is an emphasis on engaging the informal helping network of the family. Farrow (1997) notes that communities that are experimenting with ways to engage informal networks are finding them to be a significant resource in meeting families' needs. The failure to consider the neighborhood and social network of the family as part of an assessment and intervention plan places them at greater risk for child maltreatment. The ultimate goal of a community focus is a partnership that includes a diversity of people as well as formal and informal groups and agencies.

Another study reviewed 30 human service agencies to gain an understanding of how linkages were made with the community in each organization (Froland, et al., 1981). Interventions ranged from micro level personal network development, to the macro level of community empowerment. The linking efforts pursued by staff and informal helpers were influenced by a number of factors including the types of problems, the type of client population, the stability of the neighborhood, the legal or political climate encountered by the

organization, the organization's organizational base, and the personalities of the staff and informal helpers (Froland, et al., 1981, p. 56).

Volunteer linking is one way to promote community integration that involves the use of nonprofessional resource persons in the community. These individuals, usually people with similar experience to the client, are selectively recruited and paid to provide training to organization clients in a skill area needed for a particular client group. Other examples of volunteer linking include the use of a "lay therapist" approach in home-based interventions for clients identified as having problems with child abuse (Froland, 1981, p.71). The challenges associated with the volunteer linking approach involve creating successful matches, particularly when the aim is to develop sustained relationships.

The Neighborhood Parenting Support Project (Fuchs, 1995) was an experimental four-year research and demonstration research project involving two inner city, high-risk, multi-cultural neighborhoods in Winnipeg. Parents from these neighborhoods reported high levels of stress both from the demands from parenting as well as from the community. High rates of crime was identified as a concern as were gangs of young children and teenagers vandalizing the neighborhood, and drunken persons roving through the neighborhoods, worries about their children going to and from school, and dissatisfaction with recreation and education facilities and programs for their children.

The project hypothesis was that child maltreatment risk could be reduced at both the neighborhood level and at the parent level if social support for parenting could be strengthened. Indications of social support are formal service use, personal network diversity, parenting support network size, and neighborhood child care norms (Fuchs, 1995, p.117). A social network method was developed to assist parents to make changes for the purpose of increasing support in their networks and thereby reducing their level of risk to child maltreatment in the high-risk neighborhoods:

> Network change activities were directed at weakening ties with stressful persons or agencies; clearing stress from a particular network link by

mediation brokerage or other activities; strengthening ties with persons or agencies who could provide stronger or better support; and connecting the parent with other persons for the purposes of network construction (Fuchs, 1995, p.118).

Key reported findings of the study include:

- Informal helping and support can be strengthened by social network intervention
- The formal systems can be meshed with the informal systems
- The risk of child maltreatment in a community can be reduced by social network intervention

The author concludes that failure to assess and work with the social support structure of the parent and the neighborhood places children and families at risk of child maltreatment (Fuchs, 1995, p.121).

A more recent development in the involvement of community members in the provision of respite in child welfare is evident in a child protection organization in Jacksonville, Florida. In an attempt to encourage families, friends, and neighbors as well as other non-familial community resources to play an active role in keeping individual children safe, the services worker offers the parent the option of arranging follow-up contact with a person in the community whom the parent trusts, such as a minister, a relative or a friend. If this person agrees to become consistently involved in the plan of action, for example, by stopping by the house three times a week to ensure that the parent does not become isolated and over stressed, the CPS worker, the parent, and the third party sign a brief agreement to this effect. Having now entered into dozens of these "Community Support Agreements", workers in Jacksonville find that they extend their resources to help families immensely, with no extra cost (Farrow, 1997, p.36).

Many families who become involved in the child welfare system experience larger societal problems such as poverty, crime and drug and alcohol abuse, and these issues are not easily addressed on a case by case basis. Given

that these are societal problems a societal or community based solution is required in order to resolve them:

> Community building suggests focusing on the strengths and capabilities of all citizens. Child and families in need of support are viewed as essential resources with whom child welfare professionals and systems should be engaging in collaborative partnerships to work toward the collective good of the whole community. (Barter, 1999, p. 60)

Barter (1999) identifies the following shifts in thinking that are necessary to move toward a community building approach to child welfare delivery:

- Viewing the community as primary client, including all citizens
- Empowering parents: seeing them as critical resources
- Employing generalist workers and integrating family, individual and community practice
- Using foster care as a family service resource
- Linking services to social justice issues of inequality, discrimination and poverty
- Collaborative partnerships between child welfare agencies, families and community
- Early intervention and outreach through community based resource centers
- Viewing children with rights as individuals. (p. 66)

This brief literature review suggests that the underlying tenets of a Self Managed Care approach to respite; client empowerment, working in partnership with families and the development of community, is supported by the child welfare literature. However the implementation of SMC respite programs is rare in the child welfare field.[2]

[2] In addition to reviewing the literature, the researcher attempted to contact other child welfare organizations in Canada regarding the use of a Self Managed Care approach to respite. Of the contacts that were made, none indicated using a similar practice however a representative from Alberta indicated that they encourage parents to find their own respite provider in most situations, although this person is not compensated directly by the parent. A representative from Ontario indicated that foster parents are encouraged to find and compensate their own respite providers.

STATEMENT OF RESEARCH QUESTIONS

The research goal was to evaluate the Self Managed Care (SMC) program. The research evaluation objectives included elements of both formative and summative evaluations and examined the processes and outcomes of the SMC program. There were seven principal research questions guiding the research:

1. Are the program goals achieved?

2. Are services adequate in meeting the needs of the participating families?

3. Are the service users satisfied with the program?

4. Are the staff satisfied with the program?

5. What are the cost benefits of the program?

6. How is identified risk contained or managed within the program?

7. How does the SMC program compare with Traditional Respite (TR) in service eligibility, delivery, outcomes, costs and risks?

METHODOLOGY

This was an exploratory study with the aim to evaluate the SMC program based predominantly on service users and staff's perceptions of the program. The research design employed a mixed method approach, including both quantitative and qualitative data although it relied predominantly on qualitative data.

ETHICAL APPROVAL

Ethical approval for this project was obtained from the Research Ethics Committee at the University of Manitoba. Additionally, all participants in the research completed informed consent forms prior to participating in the data collection process.

DATA COLLECTION AND RESEARCH INSTRUMENTS

There were five components to the data collection process:

1) SMC service users' perceptions of SMC
2) Supervisors' perceptions of SMC
3) Key informant perceptions' of SMC
4) Traditional respite service users' perceptions of traditional respite
5) File reviews of accounting and family file data (obtained through CFSIS)

As part of the pre-data gathering phase, meetings occurred with individuals and groups internal and external to the organization. These included the organization's legal council, a representative from Children's Special Services, key family service supervisors, and the Family Support Coordinators. The purpose of these meetings were twofold; 1) to learn more about SMC and how it is currently being operationalized in the organization thereby informing the research design; and 2) to use the opportunity to inform staff about the research

project. As well, a Local Advisory Committee was formed at the beginning of the project to provide input and feedback to the researchers throughout all phases of the project. Representatives of this Committee included an organization staff person, closely involved with SMC, a representative from the Child and Family Support Branch, and a representative from the First Nation Child and Family Caring Society of Canada, First Nations Research Site.

Formal data collection methods included the use of surveys, in-depth interviews, a focus group and file reviews. There were eight research instruments employed in the data collection process:

1) The SMC service user qualitative interview guide (Appendix B)
2) The service user social network map (Appendix C)
3) The service user survey (Appendix D)
4) The SMC service user qualitative post-test interview guide (Appendix E)
5) The SMC focus group interview schedule (Appendix F)
6) The SMC stakeholder interview schedule (Appendix G)
7) The TR service user qualitative interview guide (Appendix H)
8) The File Review Form (Appendix I)

SAMPLING SITES

Two units were targeted as primary sample sites due to their status as the organization's SMC pilot units. Prior to the data collection phase of the project the researchers attended the two pilot units' team meetings and met with the social work teams to discuss SMC and explain the purpose of the research and the sampling process. Due to time and resource constraints, and in order to obtain a higher number of respondents, further sites were added based on the unit's recorded participation with SMC.

SAMPLING METHODS

Service users as well as staff participants were selected based on non-random sampling methods. A combination of purposive, self-selection and convenience sampling methods were used due to time and resource constraints.

1. Participants: Service Users

Participating service users from both the SMC and TR programs were interviewed regarding their perceptions of, and experiences with, respite services. In addition, all service users completed a questionnaire concerning their social network identifying key social supports in their communities.

Families were eligible to participate in the research if they were identified as SMC recipients (based on accounting information). Identified SMC service users were approached by their social worker and informed of the project. Those who opted to participate signed a form giving consent to the researchers to contact them. The social worker returned this signed form to her unit supervisor who then forwarded it on to the researchers. At that time a research assistant contacted the family and arranged for a meeting time to complete a survey and an interview with the parent. Clients in two parent families self-selected which of the parents would participate and in all cases the mothers were the respondents. Following a limited response rate from one pilot unit, a call was put forth to other units with clients receiving SMC services, to approach and inform clients about the project, and to forward a signed consent form signifying their interest to participate. Data collection concerning SMC service users ended after repeated requests to unit supervisors for family consents resulted in no further names submitted. This resulted in a total of 10 SMC service user mothers participating in the project. Additionally, six of the ten SMC service users were asked to participate in a post-test after a six-month interval to assess changes in their connection to their community. Only three participants chose to participate.

Service users who were currently receiving traditional respite services were identified by the unit's Family Support Tracking Spreadsheet. These families were approached by their social worker to obtain their consent to participate and were included in the research on a first come, first serve basis. As the primary focus of the research was to evaluate the SMC program and not traditional respite services, only a small group of traditional respite users (six) was included.

Table 1

Sample: Service User Participants

Participants	n
SMC	10
Traditional	6

2. Participants: Staff

All organization unit supervisors who had used SMC on at least one occasion since its implementation were invited to participate in a focus group regarding the SMC Project. Key supervisory/management staff known for their involvement in the development of the SMC program were approached and invited to participate individual interview. This resulted in one focus group with five supervisors and four key informant interviews.

Table 2

Sample: Staff Participants

Participants	n
Supervisors	5
Key Stakeholders	4

3. File Reviews

Demographic information and monetary expenditure data were drawn from 102 accounting records. This represented all SMC cases since the formal accounting tracking system was developed. A file review instrument was developed to gather additional information on the 102 families from the Child and Family Service Information System (CFSIS) (See Appendix I). For the purposes of the research goal, the accounting records presented certain limitations. For example, the "service user name" used with the accounting system often did not have sufficient detail to allow for it to be positively identified in CFSIS. In fact only 40 families were able to be matched with CFSIS information. Findings based on the accounting data is presented in the first findings section.

LIMITATIONS OF THE RESEARCH

Unfortunately, the goal of interviewing 15 SMC service users from the two pilot sites was not realized and a smaller interview sample size was obtained: only ten SMC service users were interviewed. Nevertheless the interviews provided a depth and breadth of data. The smaller than expected sample size was possibly in part due to the researchers' reliance on supervisors and front-line social workers in obtaining service user consents to be contacted forms. Given their other workload demands, obtaining consents from clients was likely not a priority. Additionally there were fewer participants from the identified pilot units than expected which resulted in a greater number of participants from several units. There is a potential that there is some bias within the service user sample. For example, service user participants were selected based on the social worker's and supervisor's judgment. However data specific to service user perceptions provides an initial understanding of some service users' perceptions of, and experiences with the program.

Obtaining a post-test sample proved to be a challenge as most of the participating service users were not 'new' to the system and were not necessarily new to receiving respite services. As well, many of the SMC service users identified a key issue as having medical needs, whether for their children or themselves. This group of service users did not identify social 'connectedness' as a goal of receiving self-managed care, rather the flexibility and consistency of services were prioritized. For these reasons, it is unlikely that any changes would be noted between the pretest and the post-test. Three of the families declined to be interviewed for the post-test phase as they stated that there were no changes from the first interview. As a result, the pre-post data on social networks is limited.

Another limitation of the research was the minimal involvement of front line workers as a source of information about SMC. At the onset of the research, management of the organization expressed that the project should not burden staff with additional responsibilities, given heavy workloads. As a result, the researchers relied on two brief team meetings with the pilot project service units to explain about the research, to determine social workers' involvement and experience with SMC. During those meetings very few workers presented as having had experience with SMC. This resulted in staff data that does not include front-line social workers' perspectives and experiences with SMC.

Due to the exploratory nature of the research and the small sample size, the use of complex inferential statistical analysis is not warranted. However descriptive statistics are included in the findings. The purpose of the research was not to make predictions or generalizations based on the sample about the larger population but rather to evaluate the SMC program using a richness of data stemming from qualitative interviews.

RESULTS: ANALYSIS AND INTERPRETATION

Results are presented in four 'findings' sections. Section I presents findings primarily based on quantitative data collected from accounting records and file reviews and is limited to socio-demographic information. Sections II, III and IV reflect the analysis of the qualitative interview and focus group data. As previously noted the intent was to collect a depth of data related to staff and service user perceptions of, and experiences with, SMC. The semi-structured interview questions provided certain pre-set categories for data analysis and presentation; however data analysis also included categorizing responses or comments based on new, emerging themes reflecting a majority of perspectives or experiences, as well unique or unusual responses. Where relevant, staff and service user responses are presented under thematic categories in order to highlight similarities and differences in perceptions of SMC respite. Section II presents findings related to program eligibility requirements and the relationship between the SMC care provider, the family and the social worker. Section III presents data on staff's and service users' perceptions of the benefits of SMC, whereas Section IV presents identified challenges of the SMC program.

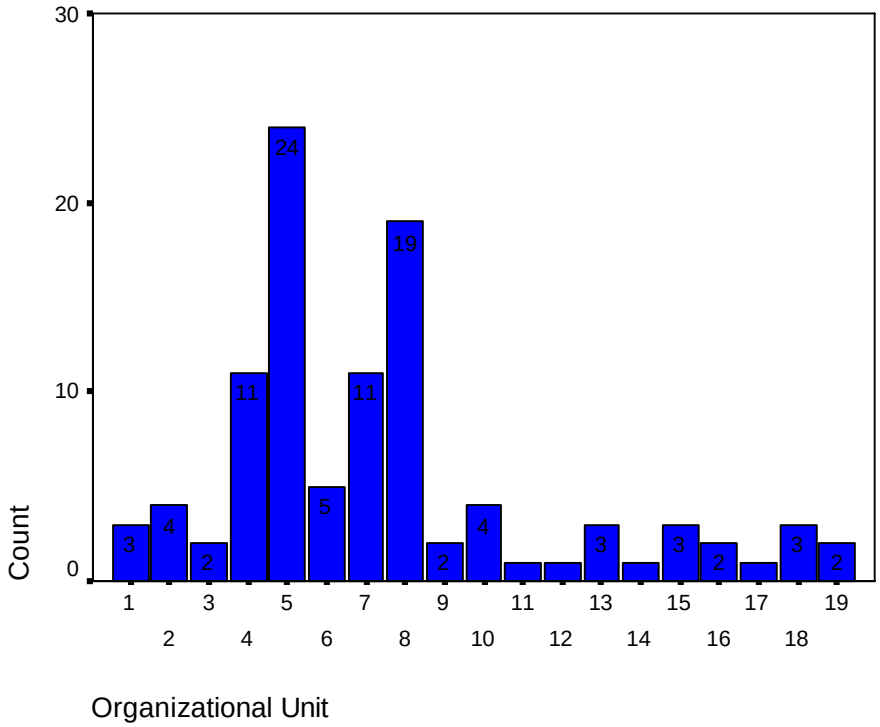
SECTION I. FINDINGS: GENERAL INFORMATION

This section is divided into three sub-sections and presents general socio-demographic information on service users based on data collected primarily from organization accounting files and in some cases, family files. The section begins with information related to 102 SMC service users since the inception of the program. Information is then presented on 10 SMC interview participants. The section concludes with a brief comparison between interviewed SMC and TR participants and includes some qualitative data as it relates to perceived reasons for receiving SMC services.

1. Self Managed Care – File Records

This sub-section presents data on the 102 families who received SMC services from April 2000 to April 2003, based on financial accounting data. A total of 19 units used the SMC program since its formal inception in 2001 to April 2003. Of note, units 8 and 18 are the pilot project units. Units 5 and 7 are both rural units and have a recorded high use of the SMC program. Unit 4 is also an urban location. This data indicates that units from across a variety of the organization's programs including intake, family service and peri-natal service have used SMC to some extent or another.

Figure 1. SMC cases by unit location.



Sixty-six percent of these families resided in an urban area while 34% lived in a rural setting. Of the 102 SMC accounting files, the age of the caregiver ranged from 21.5 years to 59 years, with a mean of 35 years (SD = 9.2). The mean number of children in these families was 3.5 (SD = 1.8) with a range between one child and eight children.

The accounting data did not provide consistent information for each family in receipt of SMC services other than the total amount of money expended per family on SMC respite. As a result some information was recoded into new variables. For example, while there was a variety of information on the number of days of SMC a family received, there was no standard unit of measurement. Recorded information included the amount of respite money provided for a weekend of SMC services, as well as the amount of hours provided per month (as opposed to per week). Certain cases had the total amount of SMC respite funds allotted however no specific hours noted. As well, the number of days per family

was not necessarily consecutive. In spite of these variations a variable was created to reflect the number of days of SMC respite per family based on the accounting data provided. If for example, a family was recorded as receiving SMC for two days per week for three months, the total number of days would be coded as 24 days. This variable is a crude estimate of the number of SMC days per family.

Based on the accounting data, a total of $215,304 was expended on SMC respite since the beginning of the program (approximately three years). There was a range in the amount of SMC money provided to these families from a low of $40 to a high of $25,000 with a mean of just over $2,000 (SD = $3,970). Fifty percent of SMC families received $768 or fewer dollars. Based on the number of days recorded for each family's SMC use and the amount of money expended, an estimate of the total dollars per week was calculated. As with the total expenditure per case, the figures varied. There was a low of just under $5 per week and a high of $1,739 per week, with a mean of slightly more than $200 per week (SD = 314.31). Seventy-five percent of the families received $175 or fewer dollars per week. The amount of time a family received SMC also showed variability. For example, the minimum number of days was 1 with a high of 667 days. The mean number of days per family was 140 (SD = 171).

Table 3

SMC Case Expenditures and Days

		Case[a] Expenditures($)	Case[b] Expenditures per Week ($)	Case[c] Days
Mean		2,131	202	140
Median		768	82	60
SD		3,971	314	171
Minimum		40	5	1
Maximum		25,549	1,739	667
Percentiles	25	50	297	26
	50	82	768	60
	75	176	2,060	191

[a]n = 101, [b]n = 92, [c]n = 93

The 'total number of days' variable was collapsed into four categories: 0-27 days, 28-70 days, 71-182 days, and 183 or more days. As is evident in table 4 there is a similar distribution in each of the categories, although slightly fewer families received SMC between 71-182 days.

Table 4

SMC Days Categories

Days	n	%
0-27	25	26.9
28-70	24	25.8
71-182	20	21.5
183+	24	25.8
Total	93	100.0

Table 5 presents expenditures and total days per family by geographic location. The mean expenditures per case were lower for families residing in urban areas. Families in urban areas also had a lower average number of days.

Table 5

SMC Expenditures and Days per Family based on Location

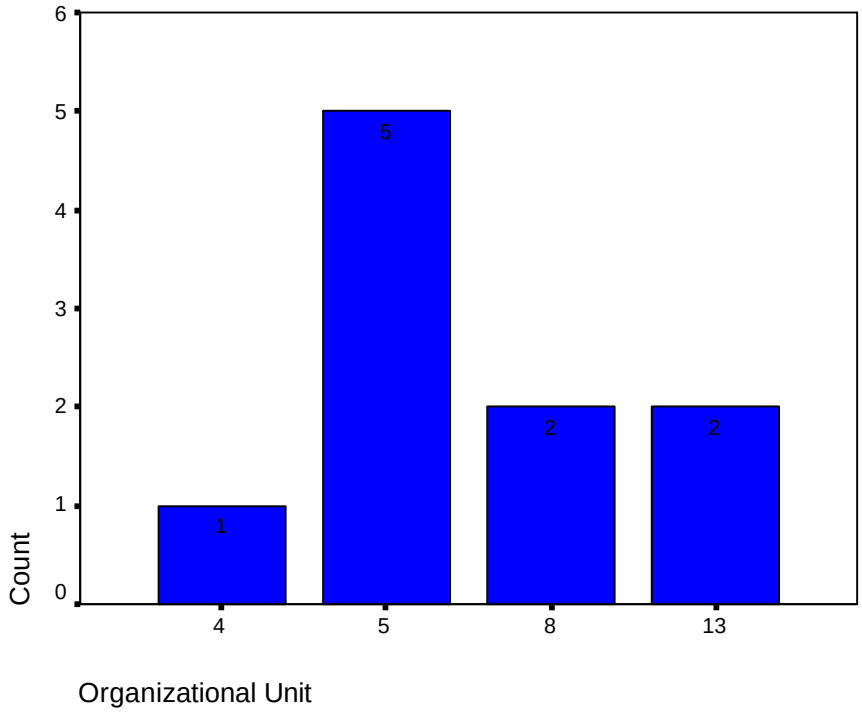
	Expenditures ($)		Days	
	Urban[a]	Rural[b]	Urban[c]	Rural[d]
Mean	2000	2415	128	167
Median	655	962	60	75
Minimum	40	251	1	7
Maximum	21,865	25,549	640	667
SD	3,669	4,606	160	195

[a]n = 69, [b]n = 32, [c]n = 64, [d]n=29

2. Self Managed Care - Interview Participants

This section presents data on the 10 SMC interview participants. As is evident in figure 2, there are a limited number of SMC families from the pilot project units who participated in the interviews. For example, of the SMC interview participants, five were identified as residing in the unit 5 area and only two were from one of the identified pilot project's site (unit 8). There was an even split between rural and urban SMC cases.

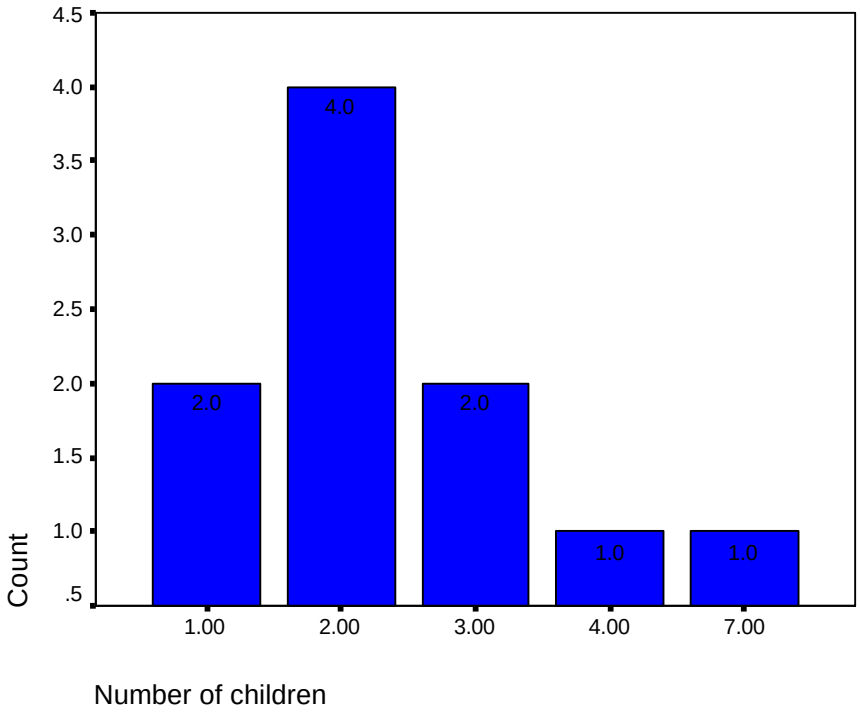
Figure 2. Self managed care interview participants by unit location.



Family Characteristics of SMC Interview Participants

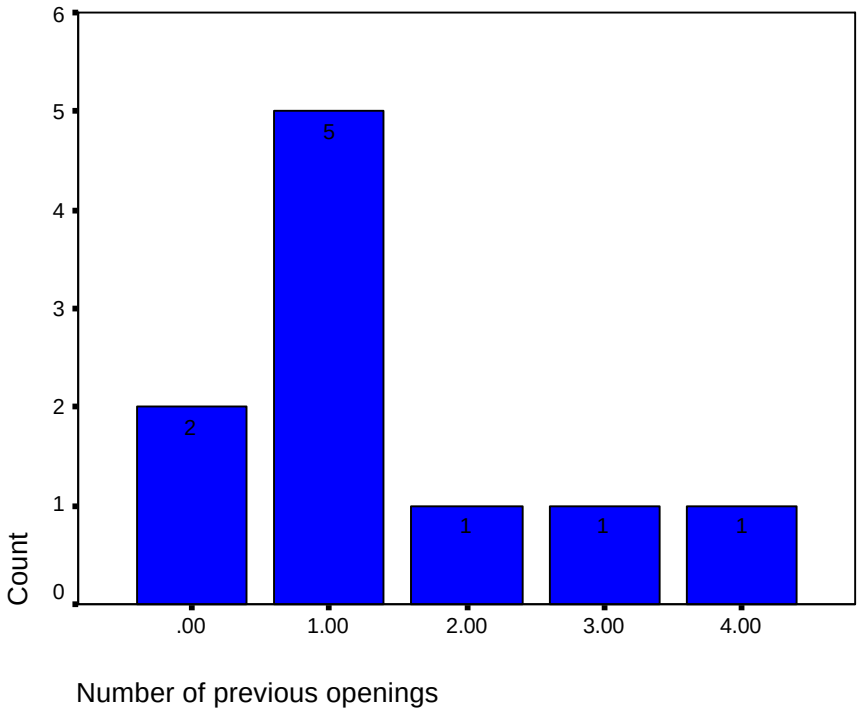
Six of the SMC families were identified as two-parent and four were recorded as one-parent families. Three of the families were reported as having one full-time employed parent, four part-time paid employment and five families' source of income was social assistance. Nine of the participating parents self-identified as non-Aboriginal and one parent identified herself as Aboriginal. Parents receiving SMC ranged from ages 28 to 44 years, with a mean age of 37 years. These families varied in size and reported having one and seven children with a mean of 2.7 children.

Figure 3. Self managed care interview participants' number of children.



Eight of the SMC families had never had a child placed in the care of the organization. However most of the families receiving SMC had previous involvement with the organization. Only two of the families reported no previous involvement.

Figure 4. Self managed care interview participants and previous openings with organization



Regarding the eight families who had previous involvement, the mean length of time in years between the initial case opening and the receipt of SMC was 5.8 years. There was a range in this length of time from a very short period, .1 year, to a much longer period of over 10 years.

Table 6

Self Managed Care Interview Participants Length of Time between Initial Opening and Receipt of SMC Services

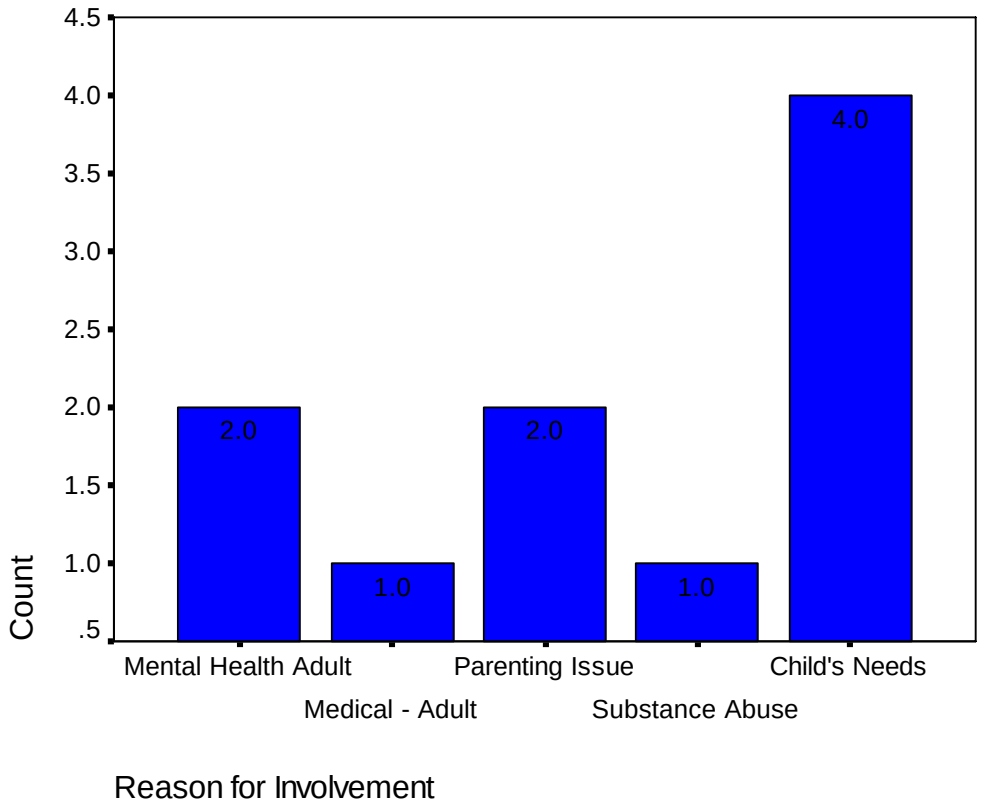
	Time Expended (years)[a]
Mean	5.8
Median	5.9
SD	3.8
Minimum	.1
Maximum	10.7

[a]n = 8

Reason for Involvement with Organization

Based on the file reviews, the reason identified for family involvement with the organization included parental issues such as mental health, addiction, medical needs, parenting, and 'child needs'. The latter category included issues related to a child experiencing emotional or behavioural problems or medical needs. Six of the families were identified as having parenting issues as the reason for involvement with the organization and four identified the needs of the child as the reason for receiving SMC.

Figure5. Self managed care interview participants: primary reason for involvement.



Total Days and Expenditures

The number of days recorded for SMC interview participants ranged from a minimum of 52 days to a maxim of 667 days. The mean number was recorded as 402 days and the median was 611 days. When examining the total amount of dollars spent per family receiving SMC, the range varied from a low of $650.00 to a high of over $25,000.00 with a mean of $8,265.60. Of note, the number of days does not correspond to expenditures per case. The SMC participants that were involved with the study were on average, higher users of the service. As noted in Table 3, the mean expenditure for SMC overall was $2,131 compared with the mean for research participants which was $8,265.

Table 7 provides summary information regarding SMC interview participants based on accounting and file review data.

Table 7

SMC Interview Participants: Summary of Family Information

Family	Urban/ Rural	Reason[a]	Age[b]	No. Children	CIC Y/N	Total $[c]	Aborig./ Non-Aborig.	No. Days
1	Urban	M.H.	29.5	7	N	7,217	A.	640
2	Rural	P.I.	43.9	2	N	25,549	N.A.	667
3	Rural	M.H.	39.5	1	N	8,630	N.A.	612
4	Urban	C.N.	37.3	1	N	8,081	N.A.	611
5	Urban	C.N.	38.2	2	Y	16,239	N.A.	67
6	Urban	S.A.	44	4	N	10,836	N.A.	60
7	Urban	P.I.	52	3	Y	2,016	N.A.	637
8	Rural	C.N.	42	2	N	749	N.A.	n/a
9	Rural	C.N.	30.8	3	N	650	N.A.	273
10	Rural	M.A.	28.6	2	N	2,688	N.A.	52

[a]Reason for Involvement: M.H. = Mental health, adult; P.I. = Parenting issue; C.N. = Child's needs; S.A. = Substance abuse, adult; M.A. = Medical adult. [b]Age of parent. [c]Figures have been rounded off to the nearest decimal.

3. SMC and Traditional Respite Services

This section presents findings highlighting similarities and differences between SMC and TR users. Due to the small sample size, all of these findings should be interpreted with caution, as they reflect a minority of SMC and TR users. Additionally, because of some of the differences noted, comparisons between the two groups may be of limited relevance in terms of interpreting service users' experiences with, and perceptions of the two programs as the participants in the sub-groups appeared to be qualitatively different.

Of the interviewed families, including both SMC (10) and Traditional Respite (TR) users (6), all of the parent participants were female. All of the TR participants were lone parent whereas there were six 2-parent and four single parent families in the SMC sample. All of the TR families resided in an urban setting whereas the SMC families were divided between urban and rural locations. All of the participating TR families received income from social assistance whereas half of the SMC families received social assistance and half reported paid employment.

Table 8

SMC and Traditional Respite Services: Income Source

	SMC or Traditional	
Income source	SMC	Traditional
Employed F.T.	1	
Employed P.T.	4	
Social Assistance	5	6
Total	10	6

The number of previous openings ranged from zero to ten. All of the SMC participants had four or fewer previous openings. Two TR participants had five previous openings and one TR user had 10 previous openings.

Table 9

SMC and Traditional Respite Services: Number of Previous Openings

	Service Users	
No. of previous openings	SMC	TR
0	2	1
1	5	1
2	1	0
3	1	1
4	1	0
5	0	2
10	0	1
Total	10	6

Thirty-eight percent of the interview participants were Aboriginal and 62% were non-Aboriginal. However there was only one non-Aboriginal participant in the TR participants, and only one Aboriginal participant in the SMC sample.

Table 10

Aboriginal Status of Participants

	Service Users	
Aboriginal Status	SMC	TR
Non-Aboriginal	9	1
Aboriginal	1	5
Total	10	6

Compared with SMC mothers (mean age = 37 years), the mean age of the TR participants was 32 years. TR families had a minimum of one child and a maximum of seven. The age of the participant's children ranged from under one year to over 16 years. The mean number of children was 2.7 for SMC participants

and 3.3 for TR participants. The number of children ranged between 1-7 for SMC participants and 1-6 for TR participants.

Table 11

Participants Number of Children

	Service Users	
No. of Children	SMC	TR
1	2	2
2	4	
3	2	1
4	1	1
5		1
6		1
7	1	
Total	10	6

Many of the TR participants had a child in alternate care at some time in the past. Differences between the two groups are evident in Table 12.

Table 12

SMC and TR Participants' Children in Alternate Care

No. of children in care	Service Users	
(at any time)	SMC	TR
Yes	2	5
No	8	1
Total	10	6

The participants' reason for involvement with the organization was similar for the two groups.

Table 13

SMC and TR Participants' Primary Reason for Involvement

	Service Users	
Reason for Involvement	SMC	TR
Mental Health - Adult	2	1
Medical - Adult	1	
Parenting Issue	2	2
Substance Abuse	1	
Child's Needs	4	3
Total	10	6

The data obtained through in-depth interviews provided a richer understanding of the service user's perspective on the reason for receiving respite services. Compared with the TR users, the SMC sample tended to be more forth-coming about their personal circumstances, elaborating in detail in response to this question. It should be noted that for both groups, that the reason for respite is defined by the participant, and may not be the same as what the social worker would define as the reason for respite or what was noted in the file as depicted in Figure 5.

Participants discussed whether the need for respite was related to themselves, their children, or a combination of both. Two participants identified the reason they were receiving respite was due to their own personal circumstances that prevented them from meeting the needs of their children without assistance. One woman suffered from a chronic degenerative disease, and another reported recovering from major surgery. Both of these women were married and lived in the rural area.

Five women indicated that their children's needs were the primary reason that they were receiving respite. The identified needs of the children included

severe autism, Fetal Alcohol Syndrome, physical disability, obsessive compulsive disorder, attention deficit disorder, and high emotional or behavioural needs. Three of these participants were also single parents. Four lived in the city and one in the rural area.

Three participants identified circumstances in themselves (or their spouse) and their children that in combination created the need for respite. For example one participant stated 'My son was premature and had a lot of health complications and delays in his physical and mental needs. I needed it for myself, I have health issues as well.' Some of the issues that they identified for themselves included mental health issues, recovery from drug and alcohol addiction, and physical health conditions. Children's circumstances included physical disability, complex medical needs, emotional problems, and an exceptionally large number of children in the family. One of these participants was a single parent, the other two were married. One lived in the city, the other two lived in the rural area.

Most participants receiving TR stated that the reason for the respite service was 'to have a break' or 'have time to myself'. Two women mentioned more specific issues that they were dealing with including past history of drinking, and current issues of anxiety and depression. One woman indicated that the respite service was part of an overall plan to reunify her daughter. Another woman stated that respite helped to look after her children while she visited her son who lived outside the home.

A strong theme that emerged from the SMC participants was that many were receiving respite from an additional source. Five out of the ten participants indicated that part of the reason they were receiving respite was because of the limitations in the respite already in place from another organization (4 Children's Special Services, 1 Homecare). For example, Children's Special Services (CSS), a provincial government division of the Department of Family Services and Housing, provides respite to families with a child with a disability. Participants most often indicated that CSS only provides respite for the child with a disability and this was not sufficient to meet their overall needs for respite. One woman

who is the guardian of her three grandchildren, one of whom has Fetal Alcohol Syndrome stated, 'I get respite from CSS, but it's not enough and it doesn't include…the other two kids. We just felt like we needed something that was going to help the whole family…'. One participant indicated that she received home health care services to assist with her daily care (bathing, etc.) but that these services do not include providing care/respite for the children.

These responses do not address the reason SMC is used instead of TR, but they do highlight the issue of other respite providers as a potential factor. Typically, the respite provider that is used by another organization becomes the SMC respite provider. These cases are considered 'logical' candidates for a SMC approach to respite.

SECTION II. FINDINGS: ELIGIBILITY REQUIREMENTS AND RELATIONSHIP BETWEEN FAMILY, CARE PROVIDER AND SOCIAL WORKER

This section begins the presentation of findings based solely on qualitative data and is divided into two sub-sections. The first sub-section presents findings related to staff's understanding of service users' eligibility criteria to access SMC and the second sub-section highlights the perceptions of the relationship between the respite care provider, the social worker and the social worker.

1. Eligibility Criteria

In terms of SMC eligibility criteria, staff responded with clear expectations. Most of the staff stated that parents who receive SMC should 'want' the service and maintain an honest relationship with the organization. One staff person also clearly clarified that the expectation was that the family had someone available to them as a resource for respite. If they were unable to locate a person within their network then they would not be considered.

Staff expected families who received SMC to be cooperative with the organization and able to articulate their needs as well as be 'motivated':

> Families that should be considered eligible for SMC are those that are somewhat articulate, families who can have some insight that they recognize for themselves that just with a little bit of help that their children can be served. I guess from my experience people who are kind of up front and honest.

Trust and confidence that the money would be appropriately spent on respite services were additional criteria identified by staff. There had to be an assessed

level of responsibility. High needs, often medical problems with either the parent or child, were also identified as typical characteristics of families receiving SMC.

The majority of the interviewed staff stated that parents with acute addictions were not appropriate for SMC due to their difficulty in planning and honest insight into their needs.

> I don't know how appropriate it is for addictions at all. I think it's appropriate for anyone that can plan ahead and return reasonably close to that time…even mental health you can have people that are able to do that. So it's probably less so the type of problem that the individual is facing, and more about their ability to regulate that piece of their life.

One supervisor disagreed that families had to be 'up front and honest' and could not identify any characteristics of families that would be inappropriate for SMC, other than families with no resources to identify a care provider.

These findings are generally consistent with the written SMC program description which outlines four eligibility criteria (Appendix A):

1. The family is known to the organization and is currently using respite or requiring respite services;
2. The family is relatively stable and has a working relationship with the organization;
3. The family is able to articulate a need for respite and has a resource identified;
4. Needs for respite include facilitation of the organization plan (e.g. Childcare for parents to attend therapy, parenting groups, AA, etc.), planned parental absence, and time for self care.

While parents with current addiction problems were not excluded from SMC based on the stated criteria, staff identified service users with addictions as generally ineligible. Staff also identified families with high needs, often due to medical issues, as typically eligible for SMC.

2. Family, Care Provider and Social Worker Relationship

In most situations, the SMC care providers were not related to the parent. For many of the SMC participants the care provider was previously employed in the capacity of providing respite to their family, prior to entering into the SMC arrangement. Types of respite provision previously provided included Children's Special Services, Home Care and Complete Care. Five participants found their own care provider through family members, friends or through the community. Some examples included a teaching assistant at child's school, a landlord's daughter, an aunt on father's side of the family, a friend, a volunteer in the community.

SMC participants were asked if, to their knowledge, their social worker and respite provider had contact with one another. Half of the respondents indicated that they thought there was contact, however most often the reason was related to payment issues as opposed to service issues.

Most of the interviewed staff stated that the organization should not attempt to locate a care provider for the family. As well, most stakeholders agreed that the social worker did not need to have direct contact with the care provider. This was based on the concept that the organization was at an 'arm's length' distance from the parent when using SMC. This argument was founded on the belief that as the organization did not hire the care provider and there was no expectation of a contract between the organization and the care provider, then the relationship was considered to be solely between the family and the care provider. Two stakeholders argued that if contact was required then the family was likely not appropriate for SMC:

> We're either in or we're out. If we have other concerns, if we want them to do specific things, if we want them to do anything beyond baby-sit, if then obviously they need information and perhaps they need some

> supervision and guidance then we should not be using self-managed care...That should come from our Family Support Program.

All of the stakeholders believed that the organization should not pay the care provider directly and that the parent had that responsibility, in effect this was a core piece of SMC. There was a very real concern that if a relationship developed between the organization and the care provider then that resulted in an employee-employer contract and the organization then becomes liable for potential damages that might result:

> …I would be very hesitant because then we haven't done the police checks, we haven't the Registry checks and we are sanctioning that person as a care provider, then I am concerned about liability.

One stakeholder identified a case example in which a meeting between the parent, care provider and social worker would be appropriate, but stressed that it was based on the principles of partnership:

> For example, medical situations or mental health situations regarding children, we have kids with very difficult behavioural problems. I could see that the parent could find and arrange and hire respite workers for that purpose. I think it would be appropriate and important for there to be occasional meetings with the three of them: With the client, the worker and the social worker in that case. Because that's really a partnership. You're all working together and that worker's not in there for any other agenda.

Supervisors however varied on the issue of social worker–care provider contact. Some identified that contact with the care provider as a regular part of the

intervention was appropriate and that the care provider could help in monitoring a situation (for example sexual activity between children) or identifying specific concerns about a family (for example substance abuse). Others identified the social worker–care provider contact as dependent on the intervention goals.

> We use both approaches to SMC: where the parent will find their own person to help them for a short period of time or even one night a week and we will also do the police checks to make sure they are safe. But we've also sat down with that care provider in other situations and asked them to provide specific help. For example, we would ask the care provider to please be there at 8 o'clock every morning to help the child get to school because this is what she says she would like help with and we will do that for 3 weeks or a month and this is what, in return, you can expect…tailor made and not as loose ended sometimes.

One staff person noted that in rare situations if there was a prior existing relationship with the care provider, then contact with the social worker would occur:

> If there was an established relationship there already, then the worker would initiate contact. But if we didn't have that relationship we didn't try to make the contact. So it was just in a few situations where the worker might initiate.

None of the supervisors in the focus group argued that there should never be contact between the worker and the care provider. This appeared to be premised on service provision flexibility in meeting unique family needs, and not having service delivery limited by proscribed program guidelines.

SECTION III. FINDINGS: BENEFITS OF SMC

This section continues with a presentation of both staff and service users' perceived benefits of the SMC program. Through the data analysis, six primary benefits of SMC were identified, four of which are particularly relevant to direct service issues: empowerment of service user, flexibility of SMC respite provision, familiarity and consistency of care provider, and a positive tool that has the potential to reduce the number of children in care. As well, the development of social networks and cost-benefits of SMC were perceived as program benefits. The following discussion presents respondents' views within these categories.

Table 14

Self Managed Care Benefits

1. Direct Service:
   - Empowerment of Service User
   - Familiarity & Consistency with Care Provider
   - Flexibility
   - Positive Staff Tool
2. Social Network Development
3. Cost Benefits

1. Direct Service: Empowerment for Parents

The empowerment of parents was identified as the primary benefit of the SMC program. Staff identified that the provision of SMC gave families the message of support for self-determination in their lives. This belief is reflected in the following comments:

> I think you are giving them a message that you are truly wanting to support them and encouraging them to have some self determination. I think that helps with empowerment – validates and confirms the positives that they are doing.

One supervisor connected the organization's mission statement to the SMC empowerment of parents in making decisions and taking control of their lives and their children's lives.

2. Direct Service: Familiarity and Consistency with Care Provider

Familiarity was identified as a benefit of the SMC program by both staff and service users. Staff referred to familiarity in two contexts, the first relating to the care provider's connection to the family, and the second referring to the care providers' comfort with the family's culture. One staff person commented on the benefits of SMC and believed that families were satisfied with it because of the familiarity of the care provider with the family:

> I think the people tend to be known to the children so it's familiar for the kids. It's not a stranger that's working with them it's someone that they

know and hopefully already have a relationship. The quality of care is probably higher due to that reason, the familiarity. The commitment to the family is probably higher. The comfort level for the family is higher.

In a similar vein, one staff person gave an example of a case in which SMC was provided:

> There was a case where the issue was really a mental health issue. Mom was a really good mom when she was ok, but then she'd kind of crash and burn sort of thing. She had a neighbour or friend who she really trusted and who took care of the kids a lot. Anyway, we implemented it there.

Three stakeholders identified that due to the high turnover of traditional respite staff, families were uncomfortable with the unfamiliar respite workers providing services. As a result, SMC was considered a means of responding to that limitation:

> (Family Support is made up primarily of) a casual workforce, they come and they go, they come and they go. Clients really were very uncomfortable sometimes with having strangers in their homes…so we thought it was an opportunity to basically empower the client, to use people that were already family, friends or relatives to provide care for their children. And we thought it would be, maybe more successful in keeping the supports in the home.

One stakeholder explained that some staff from TR can perceive certain neighborhoods as threatening to work in. It can be difficult to find and keep in staff in these situations. SMC can be an alternative. For example, one supervisor identified that the SMC program allowed for a match between the care provider

and the family's culture, which resulted in a comfort level for both the care provider and the family:

> I think some of the best examples where communities and family members help each other is in the First Nations community where they are dependent and they have the support systems and they can relate better to community members and extended family members and being able to do this, than somebody who may be able to come in who is somewhat removed from their understanding and knowledge where it's intimidating for them.

Another supervisor explained that the value of SMC due to the inability of the TR program to provide families with one care provider, and the use of multiple care providers can negatively affect the quality of service provision.

> These are people are familiar with the family already, they know what the family is about – the family is comfortable with them. The service they get is more personalized, in many cases, better than the service they are going to get from a rotating staff of other people coming through their door.

An additional benefit of familiarity with the care provider was considered to be a means to maintain a family positively in meeting their needs, for example attending treatment:

> We thought that if we were able to use people who were known to the family and children, there was a greater likelihood that the client would continue with their program as opposed to a stranger coming in.

One staff person gave a case example where children were maintained in the home because the care provider was familiar with the family and was able to be

involved in the family's life when traditional respite providers would not have managed due to the parent's mental health issues.

When talking about the benefits of SMC and the sense of empowerment it gives to service users, supervisors and stakeholders identified consistency in the service provision as a benefit. For example this stakeholder discussed the difficulties of consistency of care providers with respite and the positive effects of being able to have one care provider with one family as opposed to a variety of people going into the family setting.

> To be able to have more consistency because it's very difficult to provide that consistency particularly around respite…So it can be empowering, less frustrating, more successful for them (families) that way, but it has to be, it has to be the right person and the right type of case.

Another supervisor identified that SMC was 'tailor made' to the specific family and as a result care providers are 'more committed to the situation'.

SMC service users identified having the same care provider for an extended period of time was a positive aspect of the SMC program. This perspective stemmed partly from prior experience. For example some participants indicated having several TR providers before settling on a SMC arrangement. In fact six participants indicated that they had tried the TR program but there were problems with the care. Four indicated that one of the problems was respite workers not showing up for designated appointment times. Another concern was the quality of care in terms of workers not having the skills that the participants felt were important for the job. For example one participant stated 'I've had other people come as respite workers, and I had to fire a couple because they wouldn't listen to my instructions with (my son's) medical needs. There were some, I'm glad they left because they were scared. I want someone reliable.'

Some SMC participants also felt that their children weren't comfortable with the TR providers. 'When I started with (traditional) respite and the first lady came in, she took the older ones out, but (my youngest son) was scared of her, I

still had to stay home and be with him.' Another participant explained 'we tried a support worker from CFS but it just wasn't working…I'm not sure that CFS has the proper people, my granddaughter needs someone very special.' The consequence of this dissatisfaction was that a turnover of workers and an inconsistent pattern of care. This is a contrast to the SMC arrangements that participants described.

SMC appears to enable a consistent care provider over time and fewer care providers at one time, which results in both consistency of care providing and familiarity between the care provider and the family members. Participants indicated they preferred fewer respite providers in the home. This consistency and familiarity of care provider resulted in multiple benefits such as a close relationship between care provider and children, genuine caring and commitment on the part of the care provider, and a sense of 'friendship' between the parent and the care provider. For example, one parent commented: 'The workers are really keen to work whenever I ask them to come, they come. My son likes them and they're interested in what they do.' Another parent noted that 'My care provider has kids of her own and she knows what it entails to take care of kids.' An example of the relationships that develop because of SMC is evident in the following comment: 'This (care provider) has been with me for two years now. Her whole family is quite involved with the children. They come for Christmas, we go there for Thanksgiving, so it's become a family unit, I have no family of my own, so therefore it's been turned into an extended family.'

Many of the interviewed SMC participants were able to extend the time of another organization's respite provider who was already providing respite through SMC. This resulted in fewer respite providers in the home.

Participants from the TR sample described many positive aspects of receiving service such as special relationships between the care provider and children, and in some cases between the parent and the care provider. Some of the positive comments include 'she's good with my kids, she's honest, and if she sees a problem, she will say it. She gives my son the structure he needs.' 'She's been great, she's a respectful person.' Reasons for dissatisfaction clustered around

communication between the care provider and the social worker and parents being upset or put off by this. Some identified their care providers as too 'nosey' or 'bossy'. Given that the hours are fewer, and the length of contracts are typically of a shorter duration, this group may not see the secondary benefits that are experienced by the SMC group.

Neither group of participants identified the issue of the culture of the care provider, whether it was the same or different than their own and what impact that had on their relationship.

3. Direct Service: Flexibility

Flexibility was highlighted by supervisors as a key benefit of SMC. One supervisor gave an example of parents being able to change the schedule of when the care provider goes to the home:

> The parent gets a lot of flexibility….she needs to use it maybe on a weekend and not on a Monday or Tuesday she doesn't have to start making all of these phone calls to everybody to change the contract.

Flexibility was also identified as an advantage to the administrative process for putting SMC in place. For example SMC was identified as being flexible in responding to families changing needs. The following supervisor explained that SMC allowed for flexibility:

> You fill out a form one day but tomorrow your need may be a little different and it allows that kind of freedom. I think that adds to the whole feeling in control of your life and in charge of and contributing. It is a little less formal and I think that is good for families.

As well, flexibility was highlighted as a benefit of the SMC program by service users. SMC interview participants indicated that one aspect they liked

most about self-managed respite was having the flexibility to schedule the number of respite hours depending on their need. One woman explained 'I don't have to use all the hours, I can use the hours as long as it's within the budget in a six month period.' For some women this flexibility was very important in terms of coordinating respite around other activities such as hours of employment outside of the home, or at times when the children are not in school and their need for respite was high.

SMC participants also liked the flexibility in being able to hire their own care provider. For some participants, being able to hire their own care provider had a lot to do with their satisfaction with the service. One woman discussed how this was important to her because her son is unable to verbalize his needs, so she relied on a relationship with the care provider based on trust. This was very important for the parent. Many participants had described negative experiences they had with the TR program where they did not have the flexibility to hire their own care provider. Participants most often did not feel they had flexibility in how much the care provider was paid. Most indicated that this was predetermined by the social worker.

4. Direct Service: Positive Staff Tool

There was a perception that the program was a positive intervention method which provided tangible support to families. The SMC service was considered to be a 'tool in the toolbox' along a continuum of service interventions which had positive effects on both staff and service users. One organizational benefit identified was the staff excitement during the initial implementation of SMC. A stakeholder described her perception of a supervisor shortly after the pilot project was implemented:

> I remember shortly after the pilot got going…there was a steering committee and the supervisor was talking about how her staff were so excited and regenerated. If I hear that staff feel better about the work that

they do and the way in which they can work it, that's great because the work will be better at the end of the day.

Another stakeholder believed that SMC provided concrete, positive support to a family. This intervention was considered useful for the family, but also resulted in a positive perception of the organization:

> It's one tangible way that we could show that a child welfare organization and a child protection service and a child protection worker can truly be helpful. It's a real positive service that we can provide...

Similarly, one supervisor noted that the improvement between the organization and the parent due to the provision of SMC.

> The parent was somewhat intimidated and hostile with the organization. They consented to participate in a study which is really so different than it would have been a year ago. The father actually dropped off a computer printed Christmas card for us at the office. We couldn't believe it. This is the man …this man actually kicked out one of the agency's support workers prior to us moving to self managed because the values were so different. I think it's just been so much progress in the family and I really attribute this to giving them some control.

A further noted benefit of SMC as a positive intervention method was the perception that it resulted in the reduction of children coming into care or facilitated returning children from care more quickly:

> I'm hoping if parents are more in charge of what they need, when they need it, we may never be able to quantify it, but I have to believe at some level it's contributing to the safety and well-being of children in their care,

or facilitating a quicker return of children, and not only the return of children, but that once children are returned maybe they'll get to stay.

Self managed care was identified as supporting the parent in developing a regular respite provider to allow the parent a break, for whatever reason determined between the worker and the parent. As a result the tasks of the care provider under SMC were negotiated between the parent and the care provider, not with the social worker. When asked how care provider duties were determined, this stakeholder responded:

> I think that discussion happened between the worker and the families. It came up just as part of the discussion in terms of what they were needing and the role of the care provider was discussed in terms of how does it fit the need - not necessarily all the different things that they're going to do. Can they do the dishes? Can they do these things? It was more how do they provide you with a break? Or how do they take care of the kids so you can go to group?

4. Social Network Development

The development of social networks was identified a significant program goal and staff believed that SMC was as means to develop networks in a family's community. This was linked to the concept of empowering families to make positive choices regarding their children's care providers.

> What we thought would be some of the benefits is to empower families to build on their community and their networks in the community so hopefully by identifying people that over time would become familiar with the family and would hopefully find another means of supporting it.

One supervisor commented that SMC was particularly useful in the rural area for two reasons: first, SMC involved the community in the family's life, and second, SMC involved the family in the community:

> In the rural area particularly, there is that community sort of getting behind a family in need. It does get the community involved with the family, but the family involved with the community as well.

The development of social connections in the community was considered to be an important benefit of SMC.

> I think that's a huge piece of what social work is all about. Particularly what child welfare work is all about. I think we need to do much more of it. Many of the families, whether they live rural, urban or core that social relationships and connections are non-existent. That's why they're at our doorstep. I think that child welfare work, needs to focus more on helping to establish those kinds of support networks and connections in the community for all the families that we work with and to the extent that we do that, we'll be able to get out…I don't think we were ever intended to be that long term support.

Several supervisors considered SMC as a means to provide the opportunity to identify resource people: 'strong community leaders or helpers'. These people were also identified as potential respite resources for other families in the community who may require respite.

One supervisor in an urban unit believed that SMC provided a connection between the parent and her community. She explained that because the parent received SMC she became more involved in the community and was active in organizing a fundraising activity:

> It has given the parent enough strength to say 'I think I can go out there and do this in the community'. And she's solid. She's lived in the community for a long time…so I think that's quite an endeavour.

Supervisors identified that another benefit of the SMC program was its role in giving parents a means to develop reciprocal relationships in the community. Through the provision of funds to hire a care provider, a reciprocal relationship is encouraged when a parent locates a care provider. One supervisor provided an example of a case in which SMC transformed the family's relationship with its community:

> As an example of a family who didn't feel that they belonged in the community, (believed) that they were a bit different and everybody looked at them differently. Being able to assist them in order to get respite, suddenly they were hiring somebody to help them, from that community. I think that was extremely empowering. That elevated their status level, if I may use that word, in that community.

This perception that SMC developed community relationships based on reciprocity was raised by anther staff person. The supervisor explained that giving parents the opportunity to participate in SMC allows the parent to ask for help (respite) and bring a greater equality to the relationship with their ability to pay:

> I think most people develop a sense of reciprocity as they develop from a young age onwards. When a person is in a situation where they know they need some help, but they know they can't reciprocate it's a terrible position to be in. But when you offer them this extra tool – money – in order to reciprocate, that is wonderful. And from there it just builds their ability…

It is worth noting that when SMC participants were asked directly if they felt more a part of or less a part of their community since becoming involved in the program, most did not consider community networks particularly relevant for SMC. For the most part SMC participants did not articulate that by forming a relationship with their care provider did they feel a sense of enhanced relationship with their community. Nonetheless many described activities that would be consistent with enhanced community relationship or expanded social network. 'Community' was not defined for participants leaving them to interpret the word as they determined.

Four participants felt that although they had a child with a disability, or were ill themselves, the respite allowed them to be involved in the community. Some examples of community involvement were maintaining employment outside of the home as a result of respite, attending AA meetings, engaging in recreational activities, attending meetings with social workers, attending medical appointments, and helping others.

Some participants felt that their child's disability, or their own illness or physical condition was preventing them from being involved in the community in a way that they would like. For example one participant stated 'I'm not involved with my community because of my illness…I don't feel the community 'comes to me'. The feeling of being isolated as a result of their illness or disability was paramount, and that any impact that respite might have in increasing their sense of community would be negligible.

Three participants indicated that there was no change in their relationship with the community since becoming involved in the program. For some that meant they were involved before and they were involved after the program, for others that meant that they were not involved prior to receiving SMC and they were not involved after SMC became available.

Some participants had a negative perception of their community and that being 'involved' with the community could pose certain risks for them. One women stated 'I don't bother other people…because the people that live right next door to me they are drinking all night long and the people on the other side of me

are selling drugs…so it's like I'm right in the middle trying to raise my family.' Some of the participants who had negative perceptions about their community nevertheless talked about some of the positive activities that they engaged in because of SMC such as attending a children's concert, or going for walks in the neighborhood.

Only one participant from the TR sample indicated that she was more involved in the community since receiving respite. She talked about attending her children's activities and participating in a parent support group, neither of which she felt she was able to do when she was not receiving respite. Four TR participants indicated that there hadn't been a change in their level of involvement in the community. Three had negative perceptions of the community and did not see being involved with community as a positive thing for them. One woman stated 'where I'm living, is not always the nicest place and sometimes it's better to keep more to yourself.' One participant stated she was involved in the community through volunteering at the community center, but this had not changed as a result of respite. One participant felt that she was less involved with the community since becoming involved with respite because of 'all the meetings' she had to attend with workers.

6. Cost Benefits

The cost benefit analysis was a very difficult component of the evaluation to complete for several reasons. First, due to administrative requirements, SMC and TR are budgeted differently. This impacts the amount of time a family is eligible to receive for the two types of respite, and the total amount of money budgeted for each program. Additionally, some cost-benefits are difficult to measure with concrete outcomes.

However, some staff presented perceptions related to cost benefits that include issues such as a decrease in paper work requirements for SMC when compared with TR. For example, when discussing perceived benefits of the SMC program, one stakeholder identified greater options in service provision, the

development of creative collaborative relationships with parents, and less paper work.

> I think for workers it feels like they have other tools to use to build relationships, to address service gaps. I think it fosters creativity. It just really allows them to get to know the family in a different kind of way. We're working collaboratively when we're using self-managed care. It really feels like people are sharing in the solution. And that's not always the case with our traditional services. The other positive things for social workers, is there's less forms to fill out. You don't have a service request. You don't have to answer all these questions. You don't have to sit down and fill out all these contracts. What you do have is a verbal discussion with your supervisor, which your supervisor documents. And the worker has a verbal conversation with the family and clearly specifies it. So it's a more natural feeling process without all the paperwork. I think workers like that.

Two other stakeholders stated that SMC was less expensive compared with traditional respite: 'It's cost efficient. I think you can certainly provide service to a lot more families that way.' However this perception was not shared between all interviewed staff. For example, one stakeholder identified that a supervisor believed that the SMC care providers should be paid the same rates as the TR providers under the Family Support program.

> One of the problems that I did notice was I know one of the supervisors kept arguing that we should be providing the same amount of money, for people as our Support Workers get. And they felt that somehow that was a class issue that we were discriminating against these people cause we weren't paying them as much. The problem is that's exactly what that would prevent it's being informal, because if you pay babysitter rates for someone to baby sit your kids while you're getting SMC respite, there's at

least the possibility that you could continue to do that in the future without Organization support.

One additional positive cost benefit outcome noted by a staff person was the ability of the SMC program to provide more respite hours to families. While the long-term cost would not necessarily be lower, the family was able to have more respite hours. She explained the reasoning based on lower hourly costs and qualified her statement by clarifying it was not with families with high needs children, but more regular respite:

> So not so much with the high needs kids, but with the standard respite. If you hire somebody for $7, 6 or $7 an hour you can get more hours than if you hired someone for $10, $12 an hour. So if you have a Complete Care (purchased respite service) worker who's getting $12 an hour they may not be as skilled as what a family's neighbour is. And you're getting them for half the cost. So there were some that we could put in more hours of service for less cost.

Staff varied on the amount of time spent on SMC cases compared with TR services. Some supervisors believed that social workers required less time with cases that used SMC respite while others believed that more time was required on the part of the social worker. For example the following quote reflects the perspective that SMC required a greater time commitment on the part of the social worker:

> They might even be putting in more time…if there's a self-managed provider as opposed to there just being somebody from the organization providing the services. Yeah they're putting in more time because if it's an organization support worker, you know, a telephone call or something like that, then the social worker feels updated on what's going on. This way

they feel they need a little more information so it is more investment of time.

In contrast, another supervisor argued that it was far timelier to have TR as the time required in both administrative and clinical processes to replace support workers was much greater:

> And you know, the referral form…or then you're back re-introducing cause that support worker couldn't do it at those hours…..sometimes you're back 3 or 4 times in 3 or 4 months cause they quit or they move on or they get fired or whatever. Whereas when our families have the people they are usually pretty solid and in there for the long term.

IV. FINDINGS: SMC CHALLENGES

The following section presents findings related to challenges to the SMC program as identified by staff and/or service users. This discussion surrounds two principal categories: liability issues and SMC program administrative issues. Administrative issues include variation in SMC definition, a lack of administrative responsibility, a lack of organization-wide access and support of the program and larger service delivery system gaps.

Table 15

Self Managed Care Challenges

1. Liability Issues	2. Program Issues:
▪ Abuse Registry/Criminal Records Checks	▪ Variation in SMC Definition
▪ Parent Use of SMC Funds	▪ Lack of Administrative Responsibility
	▪ Limited Organization-wide Access & Lack of Organizational Support
	▪ Service Delivery System Gap

1. Liability Issues: Abuse Registry and Criminal Records Checks

Issues related to liability were openly discussed by staff. Staff explained that questions concerning liability were raised with the organization's legal counsel prior to the implementation of the SMC program. Two key issues were identified: 1) the child's safety; and 2) the parent's use of the organization money. For example, the following staff person identified what she considered to be liability issues:

> You are giving people money and you have no accountability for that money. I don't know what they're spending it on. So that was one of the concerns. Would they spend it on what they were supposed to? Since we weren't technically hiring these people, it was felt that we could limit our liability by saying you're hiring them, the client is hiring them, not us. And so we wouldn't do any background checks. And that way we wouldn't take any responsibility. It was solely the family's responsibility to find good people.

All of the key stakeholders stated that the organization was not required to complete abuse checks and criminal record checks prior to the disbursement of funds to the parents. Three stakeholders identified that prior to the implementation of the pilot project a discussion occurred with the organization's legal counsel and steering committee members and the organization was advised that they would not be legally liable because they were at arm's length from the care provider. A comparison was made between SMC and organization foster parents who receive respite money monthly and who select respite providers without organization approval. The perception held by all the stakeholders was the importance to keep the organization 'at arm's length' from the families' decisions. There also appeared to be a connection made between disempowering parents (through the requirement of abuse checks) and empowering parents (via arm's length relationship).

> I believe that if we start doing the Criminal Records checks…or those kinds of things, then we are taking on far more responsibility than the Self Managed Care initiative was intending to do. And if we take on that kind of responsibility, then I think at the end of the day, there's a much greater accountability.

A related argument was that a family would normally not be required to complete checks when hiring a babysitter and there was therefore no reason that the organization be required to perform checks

One stakeholder explained that the very nature of the SMC program was to allow the family to select the care provider and that the organization's role was simply to provide funds. She believed that this unique aspect of the service differentiated it from the traditional respite. This staff person also noted that the administrative process can be lengthy and result in long delays for care providers waiting to be paid and the process was shortened when the parent paid them directly. This also demarcated to the care provider that the organization was not her employer and that she needed to negotiate changes to their agreement

Another stakeholder compared the organization's provision of money to that of another social service organization and argued that it is not held liable for illegal service user behaviour:

> If we hire that person, there certainly is. The more that we get involved, the more corporate risk there is. And I've always maintained, either we hire these people outright or we put as much distance that as we can. All we're doing is providing money. It's like social assistance provides money, the fact that you go out drinking with it and run someone over is not their responsibility.

Similarly the following stakeholder reiterated the perception that it was necessary to keep an arms' length to empower families in the SMC process and also to limit the organization's liability regarding the choice of the care provider.

> We're trying to make a difference in the traditional. So if we we're checking out all these people and doing all this legwork, then we felt it was taking away some of the work that we would have families do in

terms of taking appropriate people and identifying who those people are in the community. Then it would feel, or it would seem like it would be paralleling with our traditionalists. Why aren't we just hiring them to provide respite in our program? So it made sense at the time that if we're not going to be picking and choosing them, then how far do we want to take the responsibility?

Additionally some stakeholders believed that parents would be angry with the organization if they required abuse or criminal records' checks.

If we truly are arm's length and we're not second guessing the capabilities of parents to select the appropriate people who are appropriate for the care of their children, I can't see any existing policy that we would have that should hinder that. But I think if we're not true to the original concept and Mrs. Smith says 'I've got Susie Jones she can care for my kids', if we're then saying, 'gee our policy, our Organization requires that she be prior contact checked and police checked', I'd be real angry as Mrs. Smith.

Interestingly, one stakeholder identified that she currently believes it to be appropriate to complete abuse registry checks and criminal record checks. She compared the organization requirement of checks with children in care who spend an overnight at another house with children in families receiving SMC.

We do abuse registry, criminal records checks on places where kids go to spend an overnight. We have a responsibility to our kids in care and I think that if we are sanctioning it…I don't know how people find out from other people - have you ever been on the abuse registry? Are people going to really tell you? So I think in some ways it's unfair to families to say pick safe people, but what if people don't tell you. I think that if it's done in the context of a plan of care, it's a participatory approach with families …it's empowering in that sense that they have some say and they're

choosing the people but they're feeling confident that they're involved. And that they know for sure that these people are safe, I think that it can be done in a way that doesn't take away from it.

All of the supervisors who were interviewed strongly stated that a criminal records check and an Abuse Registry check should occur. They stated that all of the participating families had agreed to the checks readily. As one supervisor stated 'any of the mothers I've spoken with really appreciated that, just a precaution' and identified this issue as a teaching issue between social workers and parents. Supervisors were also clear that a history on criminal records did not necessarily exclude people from being respite providers.

The current policy for the pilot units does not make it a requirement for care providers to have Abuse Registry checks, prior contact checks, or criminal record checks. Assessing the suitability of the care provider is considered the responsibility of the parent. Participants were asked for their thoughts on this policy. Many SMC participants indicated that their care provider had been checked because they were previously employed or currently employed by another organization that provides respite (CSS, Homecare). Many also said that because they knew the person, they felt that was more important in determining whether they were safe to provide care to their children. Several participants also stated that if they didn't know the person, they would want to have a criminal record check. One woman stated that having a criminal record check is no guarantee that the care provider is appropriate. '…well that's why I stick to the thing of knowing who's coming into your home. See, even if you have a criminal record check doesn't make them not criminals. That's just a piece of paper that they've coughed up $10-$25 bucks for that still means jack squat anyways as far as I'm concerned. Especially having a non-verbal child…anything could still happen.' Overall it would seem that for most participants, they felt that record checks were important if you didn't know the care provider, but that for most, it was their prior relationship with the care provider that made them suitable care providers.

2. Liability Issues: Parental Expenditure of SMC Respite Funds

Stakeholders identified that concerns were raised by organization staff that the money provided to parents may not be spent on the agreed upon respite needs and could be squandered and inappropriately used. For example, one supervisor identified a major limitation to SMC as being 'not really being on top of things'. However she argued that it was not unique to SMC and was a problem for TR services as well. She gave the example of having a TR worker contracted for 60 hours a week and only showing up for approximately one. She also explained that the organization was made aware of the situation by the service user who telephoned and asked, 'why isn't she coming?'

Collusion between the parent and the care provider was also identified as a concern and one stakeholder provided an example of the use of a relative as the care provider as problematic. This stakeholder explained that the care provider came to rely on the income and she and the parent colluded to maintain high respite needs.

> Well we had a mom with triplets. Her sister was hired to come in and this went on for a long, long time. What happened was that the sister and the mom really sort of colluded in terms of how much help was needed in the home. If you're dealing with people that don't have a lot of money, then money becomes a big deal. And for some clients, if they hire someone to look after their kids and this is a person who hasn't had work that might be quite important to them. That can really get in the way, I mean, you want someone who is in some way in some measure at least is able to walk away from it. And if they can't, that's going to be problematic. I'm not sure how you develop an informal network from a paid network because once you start with the money, people will be looking for money.

This respondent also raises a key question concerning the long-term potential of the care provider's relationship to be maintained once the financial aspects of the relationship are terminated.

Concern about the lack of direct accountability for the money results in the problem of the social worker not being able to determine whether or not defined goals are being met:

> Not being able to know if you're accomplishing your goals or not. There's a lot of reliance on either the client or the respite provider. Neither of which have any clear obligation to you as a provider of the funds in providing any clear assessment on how things are going or whether they're going at all, or that sort of thing. So that's a problem.

One staff person described a case in which the money had not been spent as required. She commented on the pressure that families likely experience when they are given the money with few associated controls. She remarked that families who receive SMC respite demonstrate strength to be able to limit the spending of the funds to respite needs.

> Well the case where we found out the person wasn't getting paid, that was for quite a number of months. It was a family that was struggling in terms of budgeting and had come to rely on the money as an additional source of income and probably some of the money might have even been spent on various substances, but we're not sure of that. But we also know that they used it as a source of income. The money part of it can be hard when you're working with people who are living in poverty and you're giving them money when they have other needs and it just makes choices hard again.

A supervisor identified a case (of two reported) in which the parents were not spending the money on respite as required. When asked how they discovered the misuse of money the supervisor responded: 'Well when we called the care provider they told us that they weren't getting paid.'

Generally, stakeholders identified meetings between the social worker and service user as the method to determine whether the parent was spending the money appropriately. This was a consistently identified 'check and balance' method. Self-reports by the parent and the expectation of receipts by the care provider were also identified as means to monitor expenditures. Another stakeholder identified that a built in check and balance occurred through the care provider if she was not receiving payment. For example, a staff person stated that one SMC case was terminated due to money not being spent as planned, and it was through the care provider that the organization was made aware of the situation:

> In our situation, if our care providers weren't getting paid, they would tell us because it's part of their income, their livelihood. So we would know really quickly.

Disapproval of the SMC approach was identified by one stakeholder who noted that some staff believed that it was not the organization's role to be providing money to service users.

> I know that there were some supervisors who were just appalled at the whole idea of giving clients money directly. I think they just felt that we had no business doing that. These people have problems and trying to give them money, we should be making sure it's spent as it's supposed to be spent: the organization was giving up too much power.

Some SMC service users indicated feeling uncomfortable with the payment coming to them to pay the care providers. One participant stated 'we

don't do a cash transaction. Nobody sends me a cheque or anything. I told them if they could find a way, I'd prefer to be out of that part, writing cheques and becoming the employer, that's just not me.' One participant stated that she felt good about feeling trusted by the organization with the money to 'do the right thing'.

Many suggestions made by SMC participants pertained to how to improve the payment process. Two participants in particular suggested one improvement would be to pay care providers directly (from the organization) resulting in a speedier process. 'I would suggest that the money be paid directly to the people (care provider) instead of directly to me and then me chasing the cheque and giving it to them. It could have gone directly to her.' Other suggestions related to payment were to have direct deposit, and to not 'have to go through so many channels signing everything.'

Responses from the SMC sample suggested that respite was extremely important to them and that because of their special circumstances (for example a handicapped child, rural area, isolated from family); it was difficult to obtain respite and not pay for it. Many participants felt that although they had flexibility in who they hired, and in the hours that they worked, they did not perceive themselves as having flexibility over the money. In most instances the rate was set. They clearly felt that the money was not to be used for anything other than the respite services. For example as one participant stated 'I do have restrictions, I have to pay my sitters, there's not too many people that would come in and watch 5, 6, 7 kids for nothing.'

Some participants believed that the program should be more formalized. One woman stated 'I think that they should have documented times that the people do work. Even if they sent something to the person that does the sitting, they could fill it out, then mail it back, they always have a copy. Anybody could say they are working but not actually working and getting the money.' Another woman stated 'I guess it feels strange to me, it seems like someone could take them for a ride if they wanted to.'

SMC participants also commented that the system is dependant on the honesty of the individual. One woman stated 'it's a very positive thing, I think that's because it's based on trust, they're hoping that the person that's getting (the money) is going to do the right thing and do what they are supposed to do with it. I think if you've got a good relationship with your worker, anything is possible.'

3. Variation in SMC Definition

There was an unexpected variation in the definition of SMC by staff. This ranged from a narrow viewpoint of the parent arranging for their own respite and disbursing respite funds, to broad inclusion of a variety of respite provision. Some staff considered SMC to solely involve cases where service users locate and arrange their own respite. In these cases, the organization, through the social worker, develops a plan with the service user and provides funding to meet identified respite needs. The parent takes the responsibility to locate and directly compensate the care provider.

> The organization, with the family, determines the need for respite, the overall amount of respite, as part of an overall plan and simply provides the financial resources.

Others however considered SMC from a broader perspective. This could include the organization assisting in locating a care provider, to the completion of a criminal records check, a child abuse registry checks and the direct payment of care providers through disbursements. These divergent perspectives were summarized by a supervisor:

> I think that's the two variations to self-managed care. One is pretty straight forward where the parent is assisted financially to find their own respite providers and the second one is, we pay the respite or support workers on

behalf of the parents. They usually find the person, sometimes the person becomes known to us first and we may recommend that person.

One supervisor perceived the variation in the definition of SMC as beneficial because it allowed for flexibility in meeting unique needs of families.

> Many factors come into play as to which type of method would be best. Because sometimes the need is only something like respite and it just makes sense for the parent to have a chance to hire their neighbour or somebody down the road or something like that. Other times we have specific goals in mind or we feel we want some control over whoever is going into the home to help meet those goals.

4. Lack of Administrative Responsibility

Findings also show variation in the administration of the program. Generally all the staff agreed that there should be a regular three month review of the SMC contract and that it should not be a long term service.

> There was a review, it was always approved for a certain period of time and it was usually three to six months. Self Managed Care was never meant as a long-term process. We didn't want people to get dependent upon this, on a long-term basis. Nor dependent on this extra sort of set of funds.

In response to a question about organizational structures or policies that limit the SMC program, the following staff person identified that the requirement of financial accountability could hinder the seamlessness of the service delivery:

> The need to be transparent and accountable for funds that are being expended: we lose accountability the more arms length that it gets from

> us. So with Self Managed Care in particular we don't have control over those funds. We can't say that they were actually spent on what we said that they were. So in that way the accountability of the organization is threatened so it gets tight as to how we monitor and how much we make available. How we pay things now that we've gone to government in particular it's even more slow. So how we send out cheques and compensate people and reimburse - really doesn't make it timely, and we haven't found a way to make that sort of better.

5. Lack of Organizational-Wide Access and Support

Supervisors identified that one limitation of the SMC program was that it was not offered to all units across the organization, due to budget constraints. One supervisor succinctly stated: 'Everybody wants to use it but there is not enough money'. A related challenge to the SMC program identified by a respondent related to the lack of status and support for the program by the organization. She believed that part of the reason for this perception was due to the fact that non-professional people were providing the service, which was a devaluing of respite provided.

> We have these less qualified people that are providing service with SMC, so therefore, this is a different kind of service that isn't as valued. I think we need to be careful that it doesn't get devalued in the same kind of way that things within the home have devalued.

6. Service Delivery System Gaps

Service users, and staff participants all conveyed issues and concerns that suggested that there were gaps in the broader service delivery system. In some instances SMC was in place to fill those gaps.

> We don't have the option to say 'well we're out of funding you have to wait till April'. It seems to becoming more prevalent that by January of every year other funding sources dry up and they've reached their maxes. And so then we are asked to pick up a lot and so a big part of our family support and days in care increase due to the limitations of other organizations to have sufficient funding.

This stakeholder believed that by meeting the gaps in services, the SMC program actually prevented children from being placed in organization care. In speaking of another organization and their budget running out she stated:

> Come December, January, they just don't have any budget left and so for anyone that's got any kind of respite needs where the stress is increasing in the home, the only way we can alleviate the stress and to the kids is to put them in respite. We either put in respite or else we're bringing kids into care.

SUMMARY: SMC BENEFITS AND CHALLENGES

Based on the analysis of the data both benefits and challenges to the SMC program are evident. Perceived benefits include direct service elements such as flexibility in respite the process of respite provision, consistency and familiarity of care providers, empowerment of the service user, a positive staff tool for intervention and lower costs. Benefits also include community benefits such as the development of social networks. Identified challenges include issues related to the program's administration such as a variation in the definition of SMC, a lack of administrative responsibility, limited access across organizational units and poor organizational support and larger service delivery system gaps. Challenges are also evident in issues related to liability: parental use of the designated SMC monies and abuse/criminal registry checks.

DISCUSSION AND IMPLICATIONS

The analysis of the data demonstrates that the SMC program provides a unique service to families through an innovative method of service delivery. The following discussion synthesizes the data analysis within the seven research questions that guided the program evaluation.

1. Are the program goals achieved?

The SMC program lacks a clearly identified program goal in any written policy document. As a result, key stakeholders were asked to identify the program's goals. Staff listed the following as SMC goals:

- The provision of respite
- Empowerment of service users
- Working in partnership with service users
- The development of social networks
- Keeping children out of alternate care
- Opportunity for staff to different approaches to working with service users

The program's written values and principles provide additional criteria on which to evaluate the attainment of program goals. Values and principles relevant to program goals include:

- Children belong with their family
- Relationships between families and the organization should be empowering
- In its practices, the organization promotes opportunities to recognize and develop skills for families in self management
- The organization promotes opportunities to develop the community
- A self managed care system allows the organization to redirect scarce human resources to families that require alternative care givers

There is an apparent consistency in the program goals identified by staff and the values and principles espoused in the SMC policy document. Based on the analysis of the data and the SMC Criteria document, it is clear that the program achieves stated goals. Respite services are provided to families under this program which gives parents the opportunity to complete an organization plan (such as attending a program), to be absent from the family (planned absence) and to have time for self care. Service users reported feeling trusted by the social worker and the organization and staff reported a sincere belief in working in partnership with the parents. Many of the case scenarios also suggest that without SMC, alternate care arrangements for children could result.

While service users did not connect their use of the program with an increase in their social network, many identified examples of social network development associated with the receipt of SMC. Staff could identify examples of service user empowerment due to SMC as well as social network development. Of note, most of the SMC care providers were not related to the family and this can be considered positive for several reasons. First, some of the service users stated that family influences were negative and using a non-relative care provider enabled the parent to use positive social networks. Second, the use of a non-relative care provider can enlarge the social network of an individual through hiring community people in differentiated networks.

2. Are services adequate in meeting the needs of the participating families?

Many of the participating families were experiencing multiple, complex issues and the provision of SMC was an important part of their overall case management plan. Most indicated that the amount of SMC respite they were receiving was adequate and were very grateful and appreciative of the option to use SMC. The care providers provided a range of activities in respite providers including child care, light housekeeping, and transportation. These are consistent with activities that would be provided by a respite worker from the TR program. The exception in terms of activities provided with SMC, is that several care

providers took the child to their home for an overnight visit. This was an option that many SMC service recipients felt positively about.

On a broader level, SMC appears to be responding to larger gaps within the service delivery system. For example, staff believed that SMC respite responded to needs created by capped respite budgets in other voluntary service agencies. Because the Winnipeg Child and Family Services organization provides mandated services, SMC was viewed as a means to continue to provide families with respite services when they were no longer available through other voluntary agencies and prevent children from being placed in alternate care. This issue requires further examination as it was not the focus of the program evaluation. However data suggests that on occasion, the organization responded to larger service system problems through the provision of SMC.

3. Are the service users satisfied with the program?

All of the SMC service users reported being satisfied with the SMC program. The key reasons include the familiarity with the care provider, the flexibility in scheduling respite and working in partnership with the organization (for example, being trusted with the SMC money). Many participants had also received respite from the TR program and had negative experiences which included a high turnover of workers, workers not showing up, or poor quality of service by the respite worker. These negative experiences were a contrast to participants' positive experiences with SMC.

4. Are staff satisfied with the program?

The stakeholders and supervisors that participated in the study reported satisfaction with the program. Most felt that the program had merit and they would like it to be more widely accessible across the organization. Staff participants acknowledged the risks associated with SMC and felt there was a need to ensure appropriate safeguards were in place to minimize risk. Only two

examples were sited of funds being mismanaged by parents who were recipients of SMC. In one case the parents were required to pay the funds back to the organization and in both cases none of the children were considered to be at increased risk as a result of the misuse of funds.

5. What are the cost benefits of the program?

This research question proved to be difficult to evaluate. Due to limitations in accounting data, and different administrative requirements, eligibility requirements, budget specifications and service access availability across the organizational units, a cost benefits analysis of the SMC program, particularly in comparison to the TR program, was difficult to complete. Some staff perceived the program to require less paperwork and less contact with the family which resulted in fewer hours per case. However other staff believed that more time was required to monitor case issues through telephone contact or face to face meetings. Additionally, some staff believed that while the total dollars spent per SMC case was similar to TR, there was a greater cost-effectiveness with SMC as a greater number of hours of respite were provided. The quantitative data does not provide an answer to this issue as data is not recorded in a measurement of hours of respite per family and the researchers could only crudely estimate the number of days of SMC received. As a result it is impossible to know how many hours per day a family received respite services.

Superficially the SMC recorded a greater number of expenditures and days per case, however this may be a misrepresentation of the reality of SMC respite, as it likely provides a greater number of hours each day. This issue requires further consideration and a systematic evaluation based on the accurate and consistent measurement and recording of respite hours, expenditures per hour and social worker involvement with the case (telephone contacts, face to face contacts, and other involvement). Finally, as noted, many of the SMC families are experiencing complex, multiple needs. SMC may in effect be preventing higher organizational expenditures by supporting children in their family home.

6. How is identified risk contained or managed within the program?

Risk is managed by the worker and supervisor by carefully selecting families who are not likely to mismanage the funds and if they were to do so, there would be no negative consequences for the children. Typically the following criteria are applied; the family is cooperative with the organization, the family is relatively stable, the parents are not abusing substances, and there is a clear need for respite. As described, abuse and criminal record checks were left to the discretion of the worker and supervisor. By relying on the worker and supervisor's judgement of the family and applying the above criteria, the organization has had very few situations where funds were mismanaged.

Feedback from the SMC participants would suggest that there is an inherent check and balance in place with this arrangement. The parent is motivated to use the funds appropriately because they have a real need for respite. Very few respite workers would work for free and therefore expects to be paid for their work by the parent. For many care providers, providing respite is an important part of their livelihood. Also, if payment doesn't occur as expected, the social worker will be contacted by the care provider or the parent on behalf of the care provider.

There may be greater potential for there to be collusion between the parent and care provider if they are related. The two examples provided of fund mismanagement occurred when the respite provider was a family member. It is possible that in these situations, family are assisting the parent with providing a source of respite as part of their regular routine, so the parent is not jeopardizing this source of help if they were to keep the money and not pay the respite provider.

In terms of corporate risk, many stakeholders interviewed were of the opinion that a "hands off" approach to SMC would reduce corporate liability. Presumably if the parent is in the position of "employer" then they assume responsibility for the care that is provided by the respite provider. In addition to

reducing corporate liability this approach was also thought to allow for greater empowerment and self-determination on the part of the client.

During the course of the study no incidents of corporate liability were raised with respect to SMC cases. However a provincial inter-departmental committee has been formed and includes representatives from across government departments that engage in "self-managed/self-directed respite provision, to examine the issue of corporate liability and risk management.

7. How does the SMC program compare with TR?

Families with respite needs present extremely diverse issues and needs with a great variation in maltreatment risk. Sometimes respite is the only service a family will accept from the organization, and may be used in situations where families are hostile or resistant to the organization. While SMC cases can be complex and challenging, situations they are typically considered to be of lower risk given that eligibility requires families to be stable and motivated in their work with the organization. For that reason there can be substantial qualitative differences between families who receive respite from the traditional program, and those who were receiving respite from SMC.

It is important to note that both SMC and TR participants reported being satisfied with the respite that they were receiving and many TR participants were able to articulate positive outcomes in their lives that they attributed to receiving respite. Many spoke positively about their respite provider and the special relationship this individual had with their children and the things that they had learned from them that assisted them in their own parenting.

Direct, specific comparisons were very difficult to make between the two programs because of differences between programs. However it was helpful to hear from TR recipients, to enhance our understanding of SMC recipients and the extremely varied needs and issues that families present with that require respite from the organization.

CONCLUSION AND RECOMMENDATIONS

CONCLUSION

The research goal was to evaluate the Self Managed Care (SMC) program. This was an exploratory study, relying predominantly on service user and staff perceptions of the program. The SMC program evaluation concludes that the program goals are achieved and that the services are meeting the needs of families, many of whom face complex issues. Both staff and service users responded positively about the program and would like it to continue. Direct service benefits identified include flexibility in the respite provision process, consistency and familiarity of care providers, service user empowerment and a positive intervention method for staff. With some families, the development of social networks was also apparent. Identified challenges include program administration issues such as contested definitions of SMC, unclear administrative responsibility, limited organization-wide access and larger service system gaps. The corporate risk associated with the potential harm to a child as a result of the parent's selection and screening of the respite care provider and the risk of fund mismanagement were identified as ongoing challenges facing the organization. It is important to note however, that there were no identified cases of SMC care providers harming children in their care, and in two identified cases of fund mismanagement the money was recovered. There appears to be a functioning 'check and balance' process related to fund management due to the program's eligibility criteria and the social worker's assessment, the very real need for respite and the care provider's ability to contact the social worker. These elements are integrated into the concluding recommendations for change.

RECOMMENDATIONS

Recommendations based on findings include continued use of the program with a greater emphasis on systematic, consistent and equitable administration and eligibility criteria. Service user and corporate liability emerged as a contested area and strategies to respond to these issues were identified.

There is a lack of clarity and consistency around program management

Although this is a small program, the expenditures are significant and warrant the attention and review at the management level on a regular basis. The approval process for SMC is consistent across the organization and is dependent on whether the case originates from a "pilot" unit where the supervisor can authorize it, or a non-pilot unit in which case the assistant program manager is required to authorize it. The funding for SMC comes from the Family Support budget yet the Family Support program and its management do not have any input or involvement in its administration. Each case is managed separately and there are no mechanisms for sharing knowledge and information about SMC cases amongst managers or line workers. Information gathered during the study would suggest that the decisions made on a case by cases basis are appropriate, but that attention needs to focus on the program level, particularly around expenditures per unit and per family. The organization may want to consider one manager as being designated responsibility for overseeing the program. This manager, in conjunction with government respite committee, could also oversee the development of a written policy document defining program goals, eligibility criteria, the service provision process and administrative requirements. This person could also help to monitor program expenditures.

Additionally, a consistent approval process would be beneficial, whether it be at the supervisory level or the assistant program management level. This

should apply to all units as there is no longer a need for designated "pilot" units with a different approval process.

The information system used to track information about Self Managed Care cases is limited

A spreadsheet, managed by the accounting department, is the primary means of tracking cases that have received SMC. Information is sometimes entered inconsistently which allows for limited analysis. For example, information about the name of the family is not entered consistently and therefore families are not able to be located on CFSIS. SMC cases are also to be tracked on the Family Support Tracking system however this is also inconsistent and is therefore an unreliable source of data. These are both potentially very good sources of information about SMC usage that could be a valuable tool to management of the program as well as the organization as a whole. Recommendations include the recording of the parents' names (more than one, as appropriate), the care provider's name, the number of hours per week of respite to be provided, the hourly wage, the reason for respite services and the number of children. As well the information system should continue to track the start and end dates of SMC services and the unit location. Essentially, the information systems should be coordinated and complementary.

There is a lack of clarity around the stated criteria for referral

Although many interviewed staff articulated a shared view of appropriate referral criteria, these are not written in the program description. A good example around the lack of clarity is the use of SMC with parents who are abusing substances. Many participants thought families who have addiction issues should

not be considered for SMC and yet the program description indicates that SMC could be used for parents to attend AA meetings.

Specific, clear, documented criteria is important especially if the program is going to be more widely accessible and it will aid in ensure consistent implementation of the program. As with the Family Support referral criteria, it may be helpful to include a list of inappropriate cases/situations, in addition to those that meet eligibility criteria.

There are differences at the case management level between SMC and Family Support respite

During the course of the study, the family support program itself underwent changes that were predicated on a program review. One of the findings from that review was the need for increased attention with respite contracts to ensure that the parent, respite provider and social worker were all in agreement with the goals of the contract, and the activities that would take place to meet those goals. In the past, respite contracts had not required this level of formality. It was hoped that these changes would make best use of the service and would prevent the family from becoming "dependant" on the organization as their only source of respite.

It stands to reason that SMC respite arrangements would benefit from a similar approach. Although initially some felt that a "hands off" approach was considered best for families, the literature and our interviews with service recipients suggest otherwise. Clearly the funds provided to parents are for a specific service that is part of an overall case plan designed to carry out the organization's mandate to support families and protect children. As with any other resource it would be prudent to develop policies and procedures that ensure the resource is being delivered as expected, and is achieving the identified goals of the case plan.

Another recommendation from the review was that Family Support Unit budgets be managed at the unit level, leaving the supervisor to determine what

can be approved and what can't based on the needs of the service users from his/her unit and the hours available in their budget. There is not a clear understanding across the organization whether SMC is to be managed in this way. Further, it became apparent from our evaluation that SMC situations are not always less expensive than traditional and that significant funds have gone to supporting families under this arrangement. Clearly some service users are experiencing chronic or deteriorating health concerns and the need for respite will be ongoing. It is appropriate however that the worker periodically revisit whether other respite services in the service user's network could be utilized. It was noted for example that in some situations, it was not clear what contributions were being made by the spouses of the service recipients. Some worked long hours outside of the home, but it is not clear if under these circumstances whether financial contribution was ever considered.

Risk appears to have been managed adequately to date, however there are opportunities for improvement

Risk has been managed primarily by careful selection of families that receive SMC. Although the view was that a "hands-off" approach would reduce corporate liability, the organization should reconsider this position. Child welfare organizations and their staff must demonstrate that they provide services in ‘good faith’, in order not to be held responsible when children are harmed in a situation in which the organizations were involved. There would have to be a compelling reason why an organization would not do what was in its power to assist a family to make good choices for themselves and their children.

Increased formalization around the service and the administration of funds, and conducting abuse checks, and monitoring of expenditures would be strategies for reducing risk.

There are differences between the Self Managed Care approach at WCFS and other government departments

During the course of this evaluation, the organization was amalgamated into government and became a Branch of the department of Family Services and Housing. The department carries out SMC in other government divisions such as Children's Special Services and Supported Living. The organization's current policies and procedures are not consistent with these other programs. In situations where the same family is receiving respite services from different divisions, shared policies and procedures across programs would create a positive change.

As mentioned previously, a committee has been formed to examine self-managed care/self-directed respite across various programs in the department, including foster care. The focus of this committee has been on the implications of parents who are in receipt of funds to pay care providers, being "employers". This would give parents associated responsibilities of employers, and the Canada Customs and Revenue Organization would hold them liable for Employment Insurance, and C.P.P. contributions. The law is not clear whether families are employers or not, however a recent legal opinion obtained by the province suggested that parents likely could be held liable to the CCRA which has definite implications for this program. Implications for SMC due to employer/employee status and payment/income issues continue to be discussed on a regional level.

This committee could also examine issues related to service equity such as having a maximum amount of respite per family over the course of a year. The committee could develop joint policies and procedures across government divisions and branches to ensure consistent and equitable access to respite and implementation of SMC services. This could result in a seamless, integrated service based on family respite needs and not on program particularities.

REFERENCES

Barter, K. (1999). Building community: A conceptual framework for child welfare. *Journal of Child and Youth Care, 13* (1), 49-72.

Cameron, G., Vanderwoerd, J. (1997). *Protecting children and supporting families: Promising programs and organizational realities.* New York: Aldine de Gruyter.

Chaffin, M., Bonner, B., Hill, R.F. (2001). Family preservation and family support programs: Child maltreatment outcomes across client risk levels and program types. *Child Abuse & Neglect, 25,* 1269-1289.

DePanfilis, D., Zuravin, S.J. (2002). The effect of services on the recurrence of child maltreatment. *Child Abuse & Neglect, 26,* 187-205.

Farrow, F. (1997). *Child protection: Building community partnerships.* Cambridge, MA: The President and Fellows of Harvard University.

Friedman, R. M. (1994). Restructuring of systems to emphasize prevention and family support. *Journal of Clinical Child Psychology, 23* (Suppl.), 40-47.

Froland, C., Pancoast, D.L., Chapman, N.J. and Kimboko, P. (1981*) Helping networks and human services.* Beverly Hills, CA: Sage Publications.

Fuchs, D. (1995). Preserving and strengthening families and protecting children: Social network intervention, A balanced approach to the prevention of child maltreatment. In J. Hudson & B. Gallaway (Eds.), *Child welfare in Canada: Research and policy implications* (pp. 113-122). Toronto: Thompson Educational Publishing.

Sheppard, M. (2001). The design and development of an instrument for assessing the quality of partnership between mother and social worker in child and family care*. Child and Family Social Work, 6*(1), pp. 31-47.

Tracy, E., Whittaker, J. (1990). The social network map: Assessing social support in clinical practice. *Families in Society: The Journal of Contemporary Human Services, 71(8),* 461-470.

Appendix A

SELF MANAGED CARE CRITERIA (March, 2001)

Values/Principles

- Children belong with their families
- When given the opportunity, parents will make good choices for the care of their children
- Relationships between families and the organization should be empowering
- In its practices, the organization promotes opportunities to recognize and develop skills for families in self-management
- The organization promotes opportunities to develop the community
- A Self Managed Care system allows the organization to redirect scarce human resources to families that require alternative care givers

Criteria

- The family is known to the organization (initially, in one of the two test units) and is currently using respite or requiring respite services
- Family is relatively stable and has a working relationship with the organization
- The family is able to articulate a need for respite and has a resource identified
- Needs for respite include facilitation of the organization plan (e.g. childcare for parents to attend therapy, parenting groups, AA, etc.), planned parental absence, and time for self-care
- Initial approval is for a 1 – 3 month period

Rate

- Respite funding will be provided for the assessed number of hours needed for the service plan, as well as up to 5 hours per week for self-care
- Hourly rate will be based on Level 1 Family Support Worker scale ($7 - $8)
- Respite funds will be provided in advance of the service, at either 2 week or 4 week intervals, depending on the family's preference

Evaluation

- Quality Assurance will develop a brief evaluation tool

Pilot Project Timeframe

- Project will be initiated as soon as possible, until December 31, 2001
- Problems with the respite funding and arrangements will be reviewed on a case by case basis by the worker with the family. There will be provisions to try the plan again if it doesn't work the first time

Appendix B

SMC Service User Qualitative Interview Guide

Worker/Agency (We do not need to know your social worker's name)

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1. Can you tell me why you are receiving respite services?
2. Some families have a variety of supports that they can use to "get a break" from caring for their children while others have relatively few. Could you please describe the different sources of respite that you currently receive, if any?
3. How did you come to hear about respite services?
4. What did you want or expect from respite services?
5. Do the respite services meet your expectations? Please explain.
6. How would you describe your experience with respite services?
7. Do you think that you are receiving enough respite hours from this program right now?
8. Would you say that there have been changes in your working relationship with your social worker/agency since you began respite services? Yes, no, or no change - please describe.
9. Do you feel more apart of, or less apart of your community since you became involved in the program? Please explain.
10. What do you like about respite services? What are the good things about respite services?
11. What do you dislike about respite services? Are there any problems with respite services?
12. Do you have any suggestions for how things could improve?

Additional Questions for 'Self-Managed Care' Sample

Just to be clear - we are talking about the person you pay through respite services.

13. Why do you receive SMC versus 'traditional' respite services?

14. How do you decide how much you'll pay the babysitter?

15. How much flexibility do you feel you have in how you use the money you are provided for respite?

16. What has been your experience with budgeting for respite and managing the money given to you?

17. The agency has no control over how the money for respite is spent. What do you think about that?

18. How does it feel for you to have control over the money?

19. Some respite care providers are required to have a criminal records check prior to working as a respite provider. With self-managed care this check is not required. What do you think about that?

This next section will focus on your thoughts/experiences with your care provider. We don't need you to identify her/him, we're interested in the general characteristics of the individuals who are providing care under this program. If you have more than one respite provider through this program we would be interested in hearing the person whose payment comes from WCFS.

Respite Care provider

20. How many care providers do you have at this time?

21. Is the care provider female/male?

22. How old is she/he?

23. Is she/he related to you?

24. How did that person become your child's care provider?

25. Who chose her/him?

26. On what basis? (i.e. neighbor, word of mouth, she/he offered)

27. Does she/he live in your neighborhood?

28. What kinds of things does the care provider do when she/he is providing care?

29. What types of activities do you do when the care provider is looking after your children?

30. How do you feel about the help she/he provides to you?

31. How do you feel about the help she/he provides to your children?

32. Do you know if your worker and the care provider have contact with each other? If yes, please describe.

33. Do you have any contact with the care provider apart from when she/he cares for your children? If yes, can you describe it? If no, why not?

34. Any other comments about respite services?

Appendix C

SMC & TR Service User Social Network Map[3] (Pre and Post Test)

In this section we'll talk a bit about the relationships you have with other people in your life. There is no 'right' or 'wrong' answer to any of these questions, we are trying to get a sense of people's relationships within their community. While answering these questions we are going to complete a 'social network map' that visually describes a person's relationships with other people. To begin with, can you list people in your life – both positive and negative influences (this can include household, family members, clubs, organizations, religious groups, friends, neighbours, community people and professional people)? It is not necessary for you to reveal the identity of these individuals. Can you indicate those individuals:

1. Who do you feel close to? Who makes you feel good?
- Who would be available to you to help out? Can you give an example?
- Who would be available to give you emotional support?
- Whom do you rely on for advice?

2. Who do you feel are critical of you - or who makes you feel bad about yourself?

3. Which of those people live in your neighbourhood?

*Note to interviewer: If the caregiver is identified please highlight.

1. Tracy & Whittaker (1990).

Appendix D

SMC and TR Service User Survey (Pre and Post Test)

I. Personal Information

1. Are you:

? ? ?
Male Female

2. Date of Birth: _____

3. Martial Status:

? ? ? ? ? ?
Married C.L. Single Divorced
Other: _____

4. Employment Outside of the Home: _____
Please describe

5. Ethnic Background: _____

6. Number of children: _____

II. Additional Information

Please indicate your responses for each child:

1. Would you say your child (or children) has:

Child 1:
Very high needs Medium needs Very low needs

? ? ?
Comment: _____

Child 2:
Very high needs Medium needs Very low needs

? ? ?
Comment: _____
Child 3:
Very high needs Medium needs Very low needs

? ? ?

Comment: _____

*If more than 3 children, please complete on back of this paper.

2. Please indicate to what degree you agree or disagree with the following questions:

- I would describe my relationship with my child(ren) as good.

Strongly Agree Neutral Strongly Disagree

? ? ?

- I would describe my relationship with my social worker as good.

Strongly Agree Neutral Strongly Disagree

? ? ?

- I would describe by relationship with my self-managed care provider/respite worker as good.

Strongly Agree Neutral Strongly Disagree

? ? ?

- My self-managed care provider/support worker meets my child(ren)'s needs well.

Strongly Agree Neutral Strongly Disagree

? ? ?

- I feel that this program has impacted positively on my child(ren).

Strongly Agree Neutral Strongly Disagree

? ? ?

- I feel that the services I receive from the agency are helpful.

Strongly Agree Neutral Strongly Disagree

? ? ?

- I would describe by relationship with my support worker as good.

Strongly Agree Neutral Strongly Disagree

? ? ?

Appendix E

SMC Service User Qualitative Interview Guide Post-Test

1. How would you describe your experience with SMC/respite services?
2. Do the SMC/respite services meet your expectations? Please explain.
3. Would you say that there have been changes in your working relationship with your social worker/agency since you began SMC/respite services? Yes, no, or no change - please expand.
4. Do you feel more apart of, or less apart of, your community since you became involved in the program? Please explain.
5. Do you think that there have been any changes in your life circumstances because of SMC?
6. Since the last time you were interviewed, have there been any changes with your respite/care provider? If yes, please answer questions 7-13. Otherwise please move to question 14.
7. Is the care provider female/male?
8. How old is she/he?
9. Is she/he related to you?
10. How did that person become your child's care provider?
11. Who chose her/him?
12. On what basis? (i.e. neighbor, word of mouth, she/he offered)
13. Does she/he live in your neighborhood?
14. What kinds of things does the care provider do when she/he is providing care?
15. What types of activities do you do when the care provider is looking after your children?
16. How do you feel about the help she/he provides to you?
17. How do you feel about the help she/he provides to your children?
18. Do you know if your worker and the care provider have contact with each other? If yes, please describe.
19. Do you have any contact with the care provider apart from when she/he cares for your children? If yes, can you describe it? If no, why not?
20. Any other comments regarding SMC/respite services?

*Post test also includes The Social Network Map[4] and the SMC Service User Survey

2. Tracy & Whittaker (1990).

Appendix F

Self-Managed Care Focus Group Interview Schedule

1. To what extent have you worked with SMC cases over the years? (Prompt: Number of cases over how many years).

2. In your opinion, what are the characteristics of those families that would be considered appropriate for SMC?

3. Can you identify positive outcomes that you believe to be associated with client participation in the SMC project?

4. From your experience as a family service supervisor, do you feel that the client's relationship with the case manager changes when she/he becomes involved in SMC?
   (Are these changes a result of the Agency's involvement)

5. Similarly, are there changes with the client's relationship with their community when they become involve in the SMC program? Please describe:

6. What kind of case situations/characteristics do you feel are not appropriate for SMC?

7. In you opinion what do you feel are the risks in using the self-managed care approach?

8. What is your opinion regarding whether Abuse Registry and Criminal records checks should be completed on care providers?

9. Do you ever have concerns about the safety/care of the children who are cared through SMC?

10. What strategies do you feel exist to increase the likelihood that the monies provided to parents using SMC will be used appropriately?

11. For some families, they have no one who could be a care provider through a self-managed care arrangement. How can families be assisted to identify a potential care provider?

12. What is your current understanding of the approval guidelines and procedures for SMC cases.

13. How is your work with the SMC program supported/hindered by organizational structures or policies?

14. In your opinion who do you feel should be authorized to approve a self-managed care arrangement?

15. As a supervisor, if you were authorized to approve self-managed care arrangements, what percentage of cases within your unit would you approve?

16. Under the new Family Support Guidelines, respite contracts cannot exceed three months. If there is a need for further services, a new contract is put into place. Should a similar process be in place for SMC?

Additional Questions

17. What do you like about SMC?

18. What do you dislike about SMC?

19. How could things improve?

20. Any other comments about the SMC program?

Appendix G

Self-Managed Care Stakeholder Interview Schedule

1. Can you tell me how the SMC program came to be?

- What were considered the benefits of the service?
- Were there any concerns raised at that time regarding the service?

2. What are the characteristics of those families that would be considered appropriate for SMC?

3. What kind of case situations/characteristics do you feel are not appropriate for SMC?

4. What is your understanding of the approval guidelines and procedures for SMC cases?

- Who should be authorized to approve a self-managed care arrangement?

5. When is it necessary for the social worker to have direct contact with the care provider?

6. Should the agency clarify the role of the care provider in the context of the overall case plan? If yes, under what circumstances?

7. What are the risks involved with the self-managed care approach?

- What is your opinion regarding whether Abuse Registry and Criminal records checks should be completed on care providers?
- Do you ever have concerns about the safety/care of the children who are cared through SMC?

8. What strategies do you feel exist to increase the likelihood that the monies provided to parents using SMC will be used appropriately?

- Are there instances when the agency should pay the care provider directly?

9. For some families, they have no one who could be a care provider through a self-managed care arrangement. How can families be assisted to identify a potential care provider?

10. Under the new Family Support Guidelines, respite contracts cannot exceed three months. If there is a need for further services, a new contract is put into place. Should a similar process be in place for SMC?

11. How is the SMC program supported/hindered by organizational structures or policies?

12. Can you identify positive outcomes that you believe to be associated with SMC?
    - Organizational, service user, social worker…

13. What do you like about SMC? What do you dislike?

14. How could things improve? Any other comments?

Appendix H

Traditional Respite Service User Interview Guide

Respite Services

(We do not need to know your social worker's name)

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1. Can you tell me why you are receiving Agency respite services?
2. Some families have a variety of supports that they can use to "get a break" from caring for their children while others have relatively few. Could you please describe the different sources of respite that you currently receive (in addition to the Agency respite services), if any?
3. How did you come to hear about the Agency respite services?
4. What did you want or expect from Agency respite services?
5. Do the respite services meet your expectations? Please explain.
6. How would you describe your experience with Agency respite services?
7. Do you think that you are receiving enough respite hours from the program right now?
8. Would you say that there have been changes in your working relationship with your social worker/agency since you began receiving respite services? Yes, no, or no change - please expand.
9. Do you feel more apart of, or less apart of your community since you became involved in the program? Please explain.
10. What do you like about Agency respite services? What are the good things about Agency respite services?
11. What do you dislike about Agency respite services? Are there any problems with Agency respite services?

    Do you have any suggestions for how things could improve?

This next section will focus on your thoughts/experiences with your respite provider. We don't need you to identify her/him, we're interested in the general characteristics of the individuals who are providing care under this program. If you have more than one respite provider through this program at this time, we would be interested in hearing your responses to the following questions for each respite provider.

Respite Care Provider

1. How many care providers do you have at this time?
2. Is the care provider female/male?
3. How old is she/he?
4. What kinds of things does the care provider do when she/he is providing care?
5. What types of activities do you do when the care provider is looking after your children?
6. How do you feel about the help she/he provides to you?
7. How do you feel about the help she/he provides to your children?
8. Do you know if your worker and the care provider have contact with each other? If yes, please describe.
9. Any other comments about Agency respite services?

Appendix I

File Review Form

Research #: Interviewed Client_____(indicate with check)

File #: File location:

Case status: Date of most recent opening:

Mother's name: DOB:

Aboriginal status:

Other Care giver's name:

(indicate relationship)

Children

Number in family _____(now)

Have any children been in care? Yes_____ NO_____

D.O.B. of Children :

1 _____ 2____ 3_____ 4_____ 5_____ 6_____

Family service worker: Phone #:

Supervisor/Unit:

Number of previous openings:

Date of initial opening:

Reason for involvement for this current opening or the opening when SMC was received if different:

1. ❑ Severe physical abuse children
2. ❑ Less severe physical abuse
3. ❑ Sexual abuse
4. ❑ Family lacks basic goods or housing
5. ❑ Lack of proper supervision
6. ❑ Domestic violence / parental conflict child
7. ❑ Drug abuse by parents
8. ❑ Alcohol abuse by parents
9. ❑ Neglect of physical, medical, emotional needs of child
10. ❑ Child has emotional / behavioural problems
11. ❑ Parenting problems (not resulting in any other options that are listed)
12. ❑ Parent-teen conflict
13. ❑ Damaging adult-child relationship / emotional abuse
14. ❑ Services to handicapped
15. ❑ Request for information
16. ❑ Transfers from other jurisdictions
17. ❑ Service of court papers
18. ❑ Custody access dispute
19. ❑ Drug / alcohol abuse by
20. ❑ Adult mental health issues
21. ❑ Other _____

Other Agency support provided (during this service spell or the spell when SMC was provided):

1. ❑ Family Support - Respite
2. ❑ Family Support - Teaching / Parent Support
3. ❑ Family Support - One to One
4. ❑ Family Preservation Reunification

Duration and amount of support / service

Other external agency support:

1. ❑ Home care
2. ❑ Ma Mawi
3. ❑ Family Center
4. ❑ Children's Special Services
5. ❑ Other _____

Reason for self-managed care:

Start date of self-managed care:

Number of hours per week:

End date of self-managed care:

Total amount of money:

Hourly rate:

Reason for termination of self-managed care:

1. ❑ Care provider not being paid
2. ❑ Change in level of risk
3. ❑ Change in family circumstance
4. ❑ Child taken into care
5. ❑ Service no longer needed
6. ❑ Misuse of funds
7. ❑ Other

Source of termination:

1. ❑ Client terminated
2. ❑ Worker terminated
3. ❑ Mutual agreement
4. ❑ Other

Relationship of parent to care provider (if more than one please describe each):

Were there positive outcomes noted about the role of self-managed care, if yes, what were they?

Were there negative outcomes noted about the role of self-managed care, if yes, what were they?

How does / did payment take place?

1. ❑ Care provider paid directly by agency
2. ❑ Parent given payment for care provider

Is this family part of a "pilot unit" for self-managed care?: Yes ❑ No ❑
(Jarvis Balan /Redboine Klein)

Socio-economic status / source of income of family:
1. ❑ Social assistance
2. ❑ Employed part time
3. ❑ Employed full time

Family type:
1. ❑ Two parent
   a. ❑ Blended
   b. ❑ Step
2. ❑ Single
3. ❑ Headed by extended family member
4. ❑ Other

Location of residence:
Address:
1. ❑ Core area
2. ❑ Suburb
3. ❑ Rural
4. ❑ Other

Please indicate whether there is evidence of the following checks on the care provider?

1. ❑ Abuse Registry
2. ❑ Agency Prior Contact
3. ❑ Criminal Record
4. ❑ None of the above

Does care provider have contact with the worker?

1. ❑ Yes - frequently
2. ❑ Yes - infrequently
3. ❑ No
4. ❑ Unknown

What activities are the parent(s) expected to engage in while the self-managed care respite was being provided?

1. ❑ Self-care
2. ❑ Programs (please describe)
3. ❑ Errands
4. ❑ Other

Describe contract arrangements made with client and worker regarding self-managed care i.e., were there goals identified, were they reviewed at the end of the contract, etc.

Is there a SMC contract on file?

❑ Yes ❑ No

For further information please contact:

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