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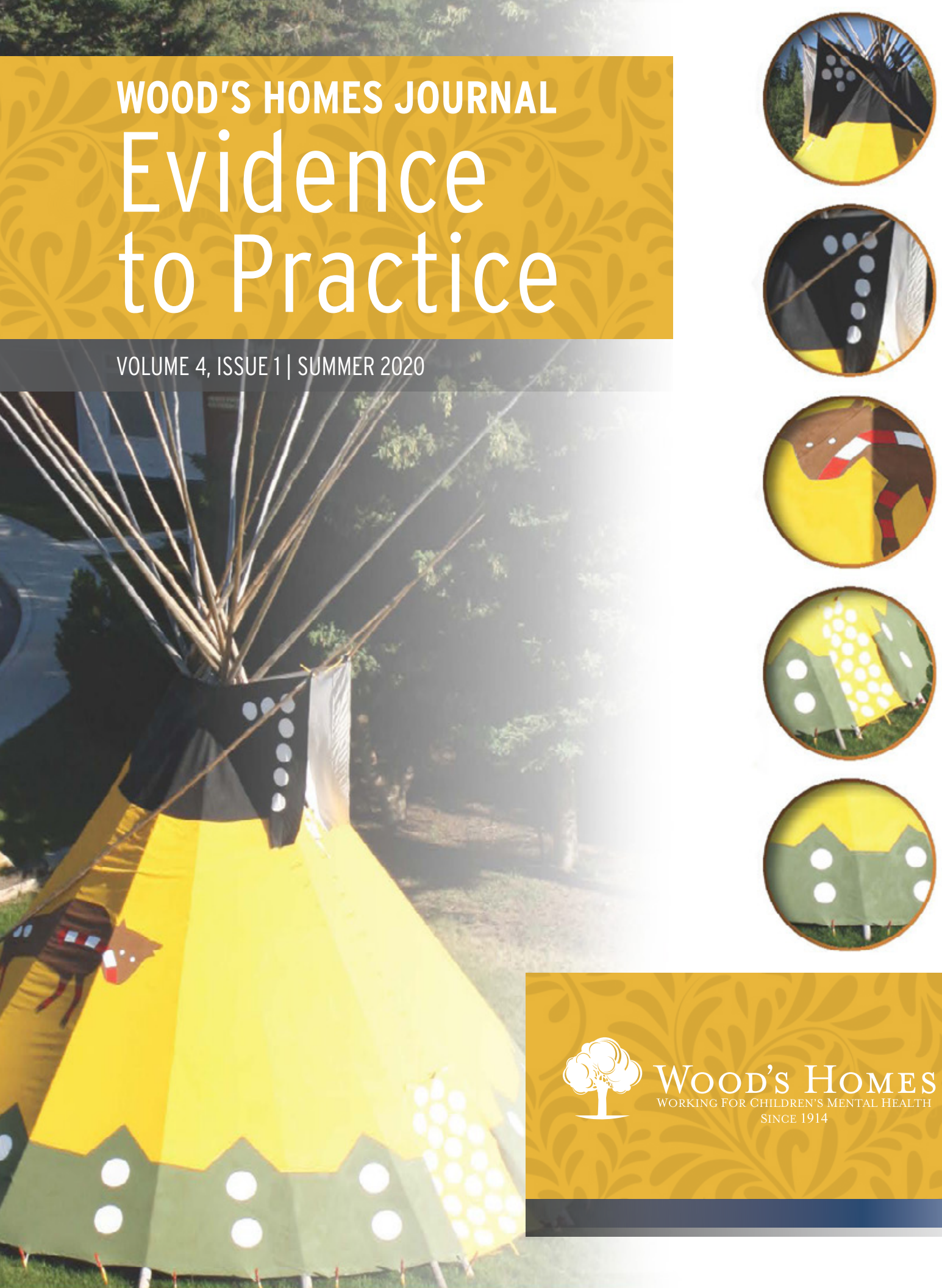

Wood's Homes
Working For Children's Mental Health
Since 1914

Contents

Wood's Homes Journal – Evidence to Practice Wood's Homes Journal – Evidence to Practice is published by Wood's Homes and is designed to showcase leading applied research and practice knowledge on mental health services for children, youth and families in Canada. Articles are the responsibility of the authors.

The photograph on the front cover is the Learning Lodge located on the Bowness Campus of Wood's Homes. Please refer to the article by Tye Rhyno, the Indigenous Liaison of Wood's Homes, for detail on the meaning and purpose of this honour, and the transfer ceremony that occurred on July 17, 2020.

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Introduction to Wood's Homes Journal – Evidence to Practice, Vol. 4 Issue 1

BRUCE MACLAURIN

This issue of the Wood's Homes Journal – Evidence to Practice is being published in the midst of the COVID-19 pandemic. During the past six months, Wood's Homes staff has risen to meet the demands and challenges of these turbulent times. They continue to find ways to adapt and enhance traditional approaches within the context of a best practices approach in order to best serve children and families in a safe and healthy manner.

Volume 4, Issue 1 begins with an overview of the Learning Lodge showcased on the front cover. Tye Rhyno, the Indigenous Liaison for Wood's Homes sets the context and meaning behind this lodge and highlights the purpose and story of this teepee that will certainly move towards better serving Indigenous youth and families coming to Wood's Homes for healing. Subsequent issues of the journal will present articles that continue this narrative.

Dr. Jane Matheson and Bruce MacLaurin prepared the next article - an interview with Dr. Jane Matheson as she completed her tenure as CEO of Wood's Homes on May 1, 2020. Jane worked at Wood's Homes for more than 35 years and she has played a pivotal role in establishing Wood's Homes at the forefront of children's mental health services in Canada. This interview explores her journey at Wood's Homes from her first impressions of the organization in 1984 to her parting hopes for the future in 2020. We look forward to future contributions by Dr. Matheson in subsequent issues of the journal.

As part of an initiative to increase data literacy within Wood's Homes program staff and management, Jenna Passi and Anita Blackstaffe of the Wood's Homes Research Department designed and facilitated two foundational trainings about the Wood's Homes Outcomes Measurement annual reporting. These boot camp style trainings focused on creating a foundation for data collection and annual reporting. The presentations were infused with hands-on actions and practical tips, and strategy development. All of this had an end goal of being able to reduce feelings of stress and/or disconnection from the purpose of annual reporting. This article provides an an overview of the process and outcome of this innovative training approach

Family involvement in campus-based services is an essential element for children and their parents. The Exceptional Needs Program is one example of how family-centred care is utilized in a short-term campus-based treatment program. Alex MacDonald led a writing team that highlights select findings informing successful outcomes of this program and how family-centred care is operationalized in treatment planning, goal development and in the milieu culture.

Another article examines the increased risk for street-involved youth who have a history of child welfare and foster care involvement. Bruce MacLaurin reports on secondary analysis conducted with a large street youth dataset (Calgary Youth, Health and the Street Study), and highlights differences between child, family and service involvement factors for street-involved youth with prior child welfare involvement compared to those with no previous child welfare. Data indicates that child welfare history is an indicator of elevated risk for all domains.

The Wood's Homes Research Department attempts to address practitioners' questions about clinical approaches and best practice. Bruce MacLaurin, Janet Stewart and Rupinder Hehar address two questions about the Eastside Family Centre's walk-in counselling model that were identified by practitioners: 1) do outcomes vary depending on the characteristics of the therapist doing the session (student, therapist, volunteer, therapist, consultant, etc.)? and 2) do outcomes vary by the cultural heritage of the client accessing walking therapy? These analyses provide further evidence and validation of single session, walk-in therapy as an essential clinical approach.

The final article continues the tradition of practice lessons learned over time. Story #30, written by Bjorn Johansson is reproduced with the permission of Clem Martini, Editor of "One Hundred Stories for One Hun-

dred Years" published in 2013. The article describes a compelling story about a youth in care and how his learning was actualized years following treatment.

This issue of the Wood's Home Journal – Evidence to Practice is an opportunity to share our knowledge with others who are committed to improving mental health services for children and youth. We invite suggestions and and discussions on the material in this issue. Feel free to contact Bruce MacLaurin at (403) 774-1662.

The Learning Lodge

TYE RHYNO

Spring 2020 - It began with a prayer, a ceremony, a hope to have the things we need to better serve the Indigenous children and families who come to Wood's Homes for healing. Many times we have offered tobacco and asked for guidance for connection to Creator. This year one of those prayers was answered and we offered protocol to our dear friend Elder Treffery Deerfoot. This blessing and gift we received came alive on July 17, 2020 when we completed a transfer ceremony. Our teepee is now alive with meaning, purpose, song and story. Our new home is more than canvas and is alive. It lives through the oral tradition as it was passed down. This is a Learning Lodge, a place to welcome community members, a place to receive, a place to connect. We do this by connecting to the rolling hills of the foothills, the falling meteors that have landed on earth, the day that Creator has given us, the night sky, the milky way, the big dipper, the sacred Buffalo Calf, the life line of the Blackfoot people, the balance between man and woman, our wings that keep us connected to Creator. The land and all the gifts that keep us all together, we are truly blessed and filled with gratitude. This is part of our journey as we continue to learn from the First Peoples of this country.

An Interview with Dr. Jane Matheson

JANE MATHESON & BRUCE MACLAURIN

What follows is an interview with Dr. Jane Matheson as she completed her tenure as CEO of Wood's Homes on May 1, 2020. Her involvement with Wood's Homes extended for more than 35 years. One could say she played a major role in establishing Wood's Homes at the forefront of children's mental health services in Canada. This interview explores her journey at Wood's Homes from her first impressions of the organization in 1984 to her parting hopes for the future.

Q. I'd like to ask you to begin with your story of how you first became involved with Wood's Homes and your first impressions of the organization at that time?

Prior to me working at Wood's Homes, I worked for Alberta Mental Health which happened to be the funder of Wood's Homes. I heard through the grapevine about some problems that were happening there. The psychiatrist who was in charge of Wood's Homes at the time, Dr. Brian Plowman, actually worked at Alberta Mental Health and did consultations there. In my role as a family therapist there who mostly saw adolescents, I would consult with him. So I knew him as a clinician, not as an administrator. Naturally, I was concerned when I heard about all the challenges that were happening. I had been on a short maternity leave – at the time maternity leaves were 6 months - and I had a lot of holidays so I went to my sister's wedding in Toronto. I wound up getting very sick and could not get onto the plane. I had been thinking about leaving Alberta Mental Health and going back to Ontario but this changed due to my illness.

During this time the people I had worked with - six years before at Youthdale Treatment Centres - told me I should talk to Philip Perry[1]. He had just taken over Wood's Homes, and they said he should hire me as we would work well together. So I wrote him a letter while I was still in Toronto and said that perhaps he would like to meet me. When I finally got back to Alberta, he called me up and asked me to come in for an interview. During this time I was still recovering from this unusual illness that I had that nobody could diagnose.

I went to this interview and I remember thinking that I hoped that nobody that I knew would be there because of course Alberta Mental Health people went to Wood's Homes and they could wonder what I was doing there. I also remember sitting in that lobby and when Philip came out to get me for the interview and distinctly thinking "... all right, I'm going to work there, I'm going to work for this man." I told Philip this story about two weeks ago on the phone that I had no idea why I felt that way but I did. I went into his office and for about an hour he talked about himself and his ideas about Wood's Homes. At the end, I asked "aren't you going to ask anything about me?", and he said that he already knew all about me. I asked how he knew all about me and he said that he had asked around all the people who knew me in this community. He had been in Calgary since July and it was now September.

Eventually I ended up going to my doctor as I was still ill. She said that I might have a brain tumor and so I ended up going back to Philip to tell him that I may not be able to show up for my first day of work because I had to go and get a CAT Scan. I still remember the look on his face. He was thinking, or probably thinking, "Who the hell did I hire, who is this person?" But it turned out that I did not have a brain tumor and I started to work there on October 15th, 1984.

At this time in my life, my youngest daughter at that time was nine months old, my second daughter was three and Chloe[2] was eight. So we had a very busy household, we were in a very small house and I had a new job. It was a very hectic time and I was working for a guy who was very creative and very demanding and so I was basically working 24 hours a day, seven days a week for quite a long time. It was extremely entertaining and interesting and I would say for the first 11 years that I was the Residential Director for Bowness Campus, every day was a learning experience. But there were times that I asked "what have I done and why have I come to work here?"

1 Dr. Philip Perry was hired in 1984 as the Executive Director and later CEO of Wood's Homes.
2 Chloe Westelmajer is now an Associate Director at Wood's Homes

A lot of very crazy things happened and I must admit, I wondered at times about Philip and his management style. But as time went on I suppose the two of us learned how to work together. He was the ideas guy and I was the one who had to put it into practice – as long as I understood what the idea was. And then he hired other folks like Shari Shaw[3] and Dr. Arnie Slive[4] and they had to figure out the same thing. All the people who went to work there had to figure out how to capture what Philip had in his mind by listening to him talk about his ideas, and then try to put it into practice. You then had to talk to all the people that you were supervising, the people who you had to get to do the work with clients in the particular way that he and hopefully, you wanted. Once you figured that out and you realized that all of his ideas, though they might have seemed a lot of the time to be over the top, were actually innovative and ahead of their time. Ideas like the creation of Exit, Discovering Choices, the Eastside Family Centre and the Stabilization Program.

Philip worked there for 11 years and I would say that our relationship over time just got better and better, even though we had more and more "spirited debate" over time. I would say that was a sign of a good relationship given that at the end of each conflict we still liked each other and thought the person had great value. And to this day, I talk to him at least once a month.

Q: So this may have been healthy conflict, not necessarily a bad thing?

A: Yes. Sometimes it didn't feel all that healthy at the time that it was happening. But I learned how to make a very good argument from him. In working with Philip, you had to have a better idea than his if you were going to change his mind. You couldn't just say you didn't want to do it or that it sounded crazy. And so I learned how to make a better idea from Philip actually, and to convince him that my idea was better than his or we were making it together. I relied on a lot of other people to help me with getting these good ideas too – I owe all of them a great debt of gratitude. Over time, Philip actually expected you to have an idea and sometimes he would even give a little test to see if your idea would have longevity and would be able to stand the test of time. It became more of a meeting of the minds and at the end of the conversation, sometimes you would think that your idea was the worst idea and wonder why you had not thought of all the things that could go wrong. But other times, he could show you he could change his mind on a dime! I don't like to use the term mentor here for this situation because it's not really true. He was my boss and he could fire me in a minute if need be, so he was singularly focused on what it was that he wanted to do. Mentoring a person was not his first priority, however he did it anyway. He provided me with a way of thinking that I had never had before and I would say that I use most of those ideas, those things that I learned, in various ways to this very day. So even though I knew some things about Wood's Homes before I came there, I was mostly just excited to have a job where I felt like I could actually do what I wanted to do.

So even though I knew some things about Wood's Homes before I came there, I was mostly just excited to have a job where I felt like I could actually do what I wanted to do.

When I was with Alberta Mental Health, I had this dream in my mind, for quite a long time that I was going to be a famous family therapist like Jay Haley. However in the middle of some training with Karl Tomm's group, I realized that that was never going to happen. I'm a good therapist but I'm a much better supervisor than a therapist. I decided to leave Alberta Mental Health, not because I wasn't happy there as I loved my team and had such interesting work to do with clients and my colleagues, but because I just was not using my core talents. Many of the people I worked with at Alberta Mental Health thought I had lost my mind, and that I was going to a sinking ship to work for a guy that had come from Toronto and nobody knew. You know during those days Ralph Klein was saying that anyone coming from Toronto was a creep and a bum.

Q: Jane, I know from reading your work that you possess core values and beliefs about what is need-

3 Shari Shaw was the Residential Director for the Parkdale Campus at Wood's Homes
4 Arnie Slive was the Clinical Director of Wood's Homes during this period

ed when working with children and youth in care. Some of it may have come from your experiences at Youthdale, or other places that you worked, but much of it is also about who you are as a person. Can you talk a little bit about how you used those beliefs as a principle for working with youth?

A: In a way that is a difficult question…

Q: I'll tell you where this comes from – it comes from reading that caring story where you told that young person to put on his mitts and scarf[5]. I think it is a truly beautiful story as it talks about doing the most important things first.

A: Let just start with values first of all. You know Philip had 13 values, they had been put on a brass plaque. These had to be changed when we did a strategic plan and I remember involving about 25 people, people reviewing the old values and keeping the things they liked and taking out the things that they didn't. Truly, I worried that we might end up with values that didn't match what I thought the agency should be doing. I'd been there as the person in charge for about three years at that time. The values that we have now are actually a compilation of what we collectively created back then and they have stood the test of time. The values, with the addition of trustworthiness about 10 years ago, are exactly the same as when we did our first strategic plan post Philip. And I'm pretty happy about that because those values stood the test of time.

That being said, I am a pretty privileged white woman from middle-class Toronto. My parents were not wealthy but they were traditional I suppose. My mother worked which was not all that traditional in the 1950s. My father was a strict guy with pretty clear ideas about how his three girls should behave. At the same time my father did unusual things. He was very strict about certain things such as politeness and manners, but he would let me go out with a boy who was older than me when I was 14. He would give me money saying to me that boys didn't really have enough money, and they didn't like to show that they didn't and that I should always pay my own way, or that I should always be able to offer to pay. If I wasn't able to pay because he was being so polite, then I should let him know that I wanted to. If that was not necessary, and if I got into some trouble, then I could just take the money and come home in a taxi. I would tell my friends that, and they just thought he was nuts. I tell that story because, on the one hand he was so strict, but on the other hand by the time I was 12, my mother would say I was doing exactly as I wanted. I would be obedient up to a point but then I would just get an idea and just do it without asking permission and then suffer the consequences later whatever they may be – they were never too terribly bad. So that is important to know. I feel like I received a large measure of freedom on the one hand and high expectations on the other from my parents with an equal dose of kindness and concern about others. This was part of my upbringing.

How I started in this business was really just serendipitous. I needed a job and I applied and got an interview. The person who interviewed me asked me why I wanted to be a child care worker – that's what they were called in those days. I said I had no idea what a child care worker did and still she hired me. I worked for $100 a week, on a grant that Prime Minister Trudeau put out for people who didn't have work. I worked in a residential program with adolescents that were probably five or six years younger than me, that's it. I would say that I was mostly terrified every day. But I am not a quitter so I just showed up every day. I was lucky – so lucky – to receive supervision from this fantastic guy named Wally. He was politically savvy and a very smart academic guy. I would tell him stories about what was happening to me and how I was feeling and he would make sense of them for me and give me suggestions about things that I could do. He was also very positively focused and affirmative, and yet at the same time he was a person who could tell you that you did a bad job - never making you feel like you were a bad person. I think you learn these things when they happen to you and I wanted to emulate that too.

Over time, I got more confident and became a supervisor and learned a great deal about basically human behaviour from my new supervisor. All those adolescents, and their difficult behaviours, were entertaining once I figured out that they were not there to harm me at all. If I put myself in harm's way by saying the wrong thing to them, or being nasty, or critical or not listening, then OK I probably would put myself in harm's way. But all

5 For those interested i n hearing the full story, please refer to the Practice Lessons: Story #39 written by Jane in the Wood's Home Journal: Evidence to Practice, Vol. 3, Issue 1, p. 44

their anger and all the things that they would say, they were just telling me how bad they felt. Somebody taught me that and I just incorporated it and I believed it and I stayed out of harm's way. I have rarely ever restrained a child, and I've never been assaulted by a kid and I don't think the kids that I dealt with back then were any less difficult than the kids that we deal with now. My skill was talking – I ask questions, I am interested in answers, I tell stories and reframe all kinds of things and I just like the way kids think. That is what both saved me and made the job fascinating.

When I went to work at Wood's with Philip, he helped put theory into practice for me. He would tell me to do things that I thought were crazy; things that were quite the opposite of what I thought one should do. I was resistant at first, and then I saw that it worked. For example, I would be in those meetings with kids, watching Arnie or Philip and I would start to do the same things in my own way which is where that story that you asked about occurred. I really cared about that kid, let's call him Carl. I really enjoy all kids with difficulties as they have so much strength; but some kids are special for whatever reason. The more difficult they were, the more I seemed to like them. Carl was a very savvy kid with a real determination to live even with some major emotional challenges of the past. He just captured my heart in a way. Perhaps as a result of the combination of those things that I told you as well as being a mother myself, I realized when I was talking with him that what he actually needed was to experience exactly what Wood's Homes had been saying theoretically. Plus, he was being obstreperous in that meeting and I also knew that changing the subject might get him off that track. And that is why I said to him "Do you have a cold?", and he said "Yes", and I said "Are you wearing your hat, and your scarf and your mitts?" And I still remember the look on his face. So I just repeated it and he just looked at me and then I said "If you aren't, it is just going to get worse." And then we went on to something else.

When he graduated from the Hillhurst program, his supervisor, Barry Mickelson[6], asked him about one thing he would remember about Wood's Homes. What he remembered was the meeting that we had, and what I said about his cold. Don't you think it's fascinating? Of all the things we know - theoretical knowledge and the techniques we use when doing "treatment" and that is what a person remembers.

It was not planned to be a beautiful story; rather it was simply trying, at that particular moment in time, to get a kid who was being highly resistant and a bit of a brat to actually stop. That is why I think you have to have the awareness that all those things that kids are saying and doing have nothing to do with you, nothing to do with the things that you are trying to get them to do, like grow up, to be a better person or calm down or whatever. It only has to do with what it is that they are trying to tell you. It's like they are talking Greek, and you are trying desperately to figure out what they are saying. Unfortunately, we have a tendency to focus on ourselves - on "I think what I'm telling you to do is more important" than "what is it that you are trying to tell me."

Q: When you took on the position of CEO, there began a period of rapid growth and innovation where Wood's changed quite a bit and new programs were being developed. Can you talk about some of the new programs and initiatives that were critical to that growth and the work that you did in moving in that direction.

A: That is a pretty interesting question. I was on educational leave when the Board of Directors at Wood's Homes began the process of hiring a new CEO. There were no successful candidates on the first round, so they had to change what they were looking for. They decided on two Managing Directors – Bill Roberts to look after the money and myself to look after the programs. And you know I was looking back over my evaluations and I saw that I was made the Executive Director year or so after that, and then two years after that I was the CEO. I guess they had a bigger plan in place that I was not aware of except in retrospect. I wouldn't say that I came in with any priorities to be honest, rather I was just trying to do the job. I didn't think I knew anything and it might surprise you to know that what I was most worried about was that I might have no ideas. I actually thought Philip was the ideas king and I was just the operational person and that I would have no more ideas. For the first year, I suppose I felt like I was 12

6 Barry Mickelson was the Supervisor of the Hillhurst Program at that time

years old and dressed up in my mother's clothes and nobody noticed.

I would just say that at that time we had a challenging relationship with Child Welfare; we were arguing with the Calgary Board of Education; we had completely lost our credibility with Justice, no psychiatrists wanted to work with us and we were in some major debt. In November, which was about 2 months after I took over, there were some changes that needed to happen. I was overwhelmed about where to begin. Understandably, there were changes at the director level unfolding also during this time as Sue, Arnie and Grant had all been my colleagues. But in the end, these problems needed to be tackled. And so that's basically what I did.

There are countless stories about years of repairing relationships, and making new ones; changing

It only has to do with what it is that they are trying to tell you. It's like they are talking Greek, and you are trying desperately to figure out what they are saying.

what we were doing, winning people over, people giving us a chance. At the same time, we were offering programs for kids who were using solvents. We were still growing the Exceptional Needs Program into the Catalyst Program, and adapting the new Temple Program. And I realized that I had to get the managers in line and interested in research because I had completed the Ph.D. program and was totally fascinated by what I knew was the power of data to make those good arguments for change. There were all those things happening but I don't remember ever having an innovative idea.

During that period of time I felt like I was fixing things, and thinking about new ideas was probably stimulated by the question you were going to ask about research. At that point, I began having people count things that were important to them, just by hand. That was the way the Research Department started – marvelous things can happen in the simplest of ways. With all the managers and supervisors, we developed grids on sheets of paper about the things they determined were important to track. This included the number of incidents of violence, the number of times that kids ran away, the number of times kids threatened suicide or the number of relief staff utilized, for example. People were quite resistant in the beginning. Every Tuesday, when we had the manager's meeting every week, I'd tell them to bring those grids and have them filled in. I'm sure some people didn't fill them in until the day of the meeting and just put numbers in them because they knew they were going to be asked to report on them. Gradually over time, people started to get the message. One time, I asked them if they knew that last year we spent $400,000 on relief staff - people were surprised. For an $11,000,000 budget that is a lot of money. Don't you think we should do something about that? Do you think we should find out who these people are, who are we paying, do they even like working for Wood's Homes? That resulted in a whole review of the relief staff and who was on it, how they got on it, and who was supervising them. People started to see that when they found out about a problem – the facts of the matter, so to speak, then they could do something about it.

These initial counts then morphed into more specific events (such as different kinds of running away or violent actions) and then later into systems like the WHOMs (Wood's Homes Outcomes Measurement) reporting. That is how it all started – just trying to get people to be interested in what it was that was happening in their programs and feel some power over what they were doing and if it was having any effect.

It also came about because of our good friend Doug Rogan[7]. Doug came to me one day and said that he kept getting asked by donors about how he knew that Wood's Homes was successful... what should he say about that? I started telling stories about how people were so pleased with a service and he interrupted me – saying, no, that was not what he needed. He said he needed facts and he wanted me to be able to prove success. Oh dear, I thought – that is a much bigger demand and I did not know

7 Doug Rogan is a long-time Board Member with Wood's Homes. For those interested in learning more about Doug, please read the article in Vol. 1, Issue 1 of the Wood's Homes Journal

the answer. So we have to do something about that! I asked managers for a statement about what was success in each program. Ideally, I thought, two different programs (Eastside or New Horizon, for example) should be able to identify different measures of success. Then the question is how you are going to measure that success. This sounded simple but it involved dragging people to first actually identify something successful – a statement of success that actually could be measured and then getting them fascinated enough to want to measure it and find out if they were successful. What people feared was that they might not be successful and thus, a manager might be putting their job in jeopardy. We had to reinforce the importance of knowing when things are not working and not being afraid to call the question so that improvements could be made. Living in a bubble does not help.

Once the idea about data collection took hold, it was clear we needed more time devoted to making use of it. I remember saying to the Finance Director that I needed about $80,000 to hire my first researcher to start my Research Department. So then I hired our first researcher. Shortly afterwards, we then hired Ann Lawson who is a psychologist and had worked at Wood's Homes as a clinician. She knew a lot more about research than most people do but it was still a steep learning curve for her. It was critical that Ann had enthusiasm and a curious mind and the rest is history.

Q: Jane, you describe this as being a step-by-step journey, but in the beginning did you have a sense of where you wanted to get to on that journey?

A: Oh yes, I was determined to have a research department and even in the early days. Perhaps not in 1995 but definitely by the time I graduated in 2000. All I kept thinking of was whether I had to quit my job to become a Research Chair. But then I realized that I'm not that good a researcher. I'm interested in research and pretty good at it, but I'd have to become a whole lot better at it – similar to my desire to be a family therapist. So then I thought, how does one get to develop a Research Chair? I got those magazines at the University when they used to be in newspaper form and they'd advertise Canada Research Chairs and I'd go online and look it all up. I asked Gayla Rogers[8] about the process to develop a Research Chair – how does one get on the list for the University?

Then I asked her "how about it, do you think it would be a good idea?" She thought it would be a great idea but then this got put on a back burner when the Faculty of Social Work received funds for a Chair in Domestic Violence. Long story short, it took us 12 years to get the financing together for the Wood's Homes Chair in Children's Mental Health. Between 1996 and 2000, Gayla and I were working and reworking our case for support. There were some easy converts in that group – people who think research is important and thought it was fantastic. There were other people however who wondered why we were doing that and thought it was a waste of time or more paper work. I learned from this 12 year process that critics are important and not to be feared, and getting something to happen takes way longer than you think – patience and tenacity are virtues when one is involved in such projects. One cannot lose hope. If you try to make something happen before its time, things just fall apart.

Ideally, two different programs should identify two different measures of success. And then the question is how you are going to measure that success.

Q: So as you look back on it from this point in time, you can just see incredible change in the uptake and the interest within Wood's Homes.

A: Yes, every year when the financial statements get presented to the Boards, I look at the graphs on the whiteboard, and it goes from $2.6 million up to $9 million, up to $40 million and I say how did that happen? It almost feels like it happened without me, I felt like we were just having fun, that's it. At the same time, bad things did happen. You know the young person who was admitted after

8 Dr. Gayla Rogers was the Dean of the Faculty of Social Work, University of Calgary at this time

being involved in a murder and we all had to get our heads around that. Another young person who left us in spite of Philip trying so desperately to keep him, and then being involved in a tragedy and walking all the way back to Wood's Homes to look for his staff.

And the tragic death of the young person we call Miss Adventure[9]. Losing funding for important programs and wondering how we were going to survive; people coming to work for us but then leaving unhappily – always a worry. They all become stories of both success and sadness. These events have woven themselves through the story of Wood's Homes. And helped us to improve, change and grow.

For example, the Whole Family Treatment Centre and how that got started. It is usually one singular little thing that happens, that's what I remember and then some really smart people take it and run with it and then it becomes something. I can always see the original intention there but it has morphed into often bigger things, or better things or more diverse things. It's so interesting.

At the same time, I feel that I'm protecting programs that Philip started. I get very upset with what is not happening at Eastside Family Centre for example. I lament the shortsighted views on the need for the Stabilization Program. There are certain programs that need to be protected because of their remarkable innovation in the past. This does not mean they get to stay the same, they should be changing and adapting to needs of clients and funders. At the same time, if change does not happen, one must be ready to end something or put it on pause for some time until it gets a new outlook. I think like it is "snap my fingers, how did that happen - 35 years?" I really do feel like we were just having full-on fun.

Q: Well thank you. We've moved into the question about research but were there other things you wanted to share about the Research Department or the Research Chair.

A: The Research Chair is a big deal and raising money is incredibly hard work. It is a partnership with the University where we share the good times and the bad times with them. And the support towards the end from Dr. Jackie Sieppert[10], Gayla, the Provost and Heather Heasman[11] was one thing that clinched it. I feel really, really blessed to have had that relationship with the University. I think it was solidified with that and I think it will remain solidified well into the future. I do want us, not just with the Research Chair, but I would really like us to put ourselves on the map. We should publish more and write about what we are doing. You've been encouraging us but I'm sure you don't always see the progress – even simply getting people to talk about what it is that we do and talk about how we do this. I do take responsibility for that because I'm not one for blowing our horn so to speak. And I take for granted that what we do is just nothing special. I've come to realize that that is probably misguided. If I'd been more of an out-there person, less behind the scenes, perhaps we'd be further along with that.

At the same time I do think that there is a lot to be done finding out what it is that we do that works and finding out what doesn't work, and helping the world understand vulnerable children and families. And that is both a research issue and a marketing issue also. I'd like to see that happen over time as that work also requires people who are champions of research, to find out what does happen. I'm pretty happy with the way that things are going overall. With the Research Chair, I think there are all sorts of things that need to continue to happen. More quantitative research than just qualitative research. More results will be happening over the next two years of this first five-year term. There are challenges these days with ethics, which would not have been a problem 20 years ago. For me this raises the question of who we are protecting.

I worry that we are going to end up with less innovation because we are trying to protect ourselves from everything that might go wrong. I mean, life is a risk. If you just take laws and rules at face value and march your way through them, nothing will ever change. It's just a moment in time and you have to choose when you are going to push back. There has to be some pushing back. Sometimes you have to be ask why are we doing this and is it actually working for people? You cannot just say it has always worked, or that's the way it is now, and agree.

9 Those interested in learning about the story of Miss Adventure, please refer to the Practice Lessons: Story #56A written by Susan McIntyre in the Wood's Home Journal: Evidence to Practice, Vol. 2, Issue 1, p. 28

10 Dr. Jackie Sieppert was the Dean of the Faculty of Social Work, University of Calgary at the time that Research Chair was established

11 Heather Heasman was the Chair of the Board of Directors at that time.

There are times when I've wondered why something is happening as it makes no logical sense... it makes absolutely no logical sense. And then people try to talk me into it and I still ask where the logic is; you still haven't told me the logic? A plus B plus C equals... and they can't do it. The importance of data, knowledge about what is actually happening can help a lot here – and that is where the Research Department and the Research Chair can play a big part - especially during these times of many opinions and people wondering who to trust.

Remember those days when we would go to the Outcomes Based Service Delivery (OBSD) meetings after getting that contract? I remember going there and saying to our funders that I really didn't want to change anything right away. Why don't we do what we've been doing and if it does not show promise, then we could do something different then. Some of our funders have become really interested in data and they are pleased to know that you are not going to just make a decision based upon somebody's idea or feeling about something. If you gather information that shows an argument for something you are more likely to get change happening than simply pleading for more dollars or crying foul if a tender does not go your way.

Q: The last thing was about looking forward and your forecast about where you might see Wood's Homes in 20 years?

A: We are in the middle of a very difficult time, not just COVID-19 but with the murder of a staff, the myriad investigations with OH&S, and the reporting that needs to be accounted for. We're in a bit of a hiatus with COVID, but it's not like it has gone away. And so Bjorn Johansson[12] and the agency have big challenges to face ahead with COVID and the financial situation that has resulted. With the price of oil and all the other things that are happening in Alberta economically, I think this will be a major challenge.

I think it is important to think ahead about the kinds of things that need to happen now, so Wood's Homes does not find itself behind the eight ball later on. This challenging and turbulent time will eventually end and life will be different. It won't be the same as before. People will have more fears about all sorts of things. Nevertheless, there will always be a need to take care of very difficult kids - how is that going to happen?

I think it is important to keep the bigger systems at play (Children's Services, PDD, Health) aware of data being created inside each of the programs and the ongoing pressures that the organization is facing – not lamenting, but trying to find common ground about these very challenging young people who need a safe place to be. That same place needs to be safe for staff too. There is a balance that is needed. Innovation is needed here – can Wood's play a part? How and how much money will it take to do it properly?

This challenging and turbulent time will eventually end and life will be different. It won't be the same as before. People will have more fears about all sorts of things. Nevertheless, there will always be a need to take care of very difficult kids

Wood's Homes has the expertise and a strong commitment to quality and innovation that needs to be preserved. It has not been afraid to make change, stop doing things that are not needed or we were not very good at. This ability to address this needs to be continued as well.

The bigger systems might need some help to communicate with each other and Wood's Homes could help with that too. Places like Wood's Homes are going to be needed even more. We also need to remember that many, many kids are back home with their parents, they are not dead and even more are living on their own independently. There is a major amount of success. These good results can get lost if one is mired in fear.

12 Bjorn Johansson was a Director of Wood's Homes for many years and is now the CEO of Wood's Homes as of May 1, 2020

The great thing is that the Senior Directors all feel very committed to the agency. The intellectual capital available to the agency is huge. Bjorn has the challenge of supervising people with whom he used to work collegially. All of those people are incredibly strong, very committed to their work, love the kids and have good relationships with the funders.

Definitely interesting times right now for sure. We must remember that Wood's Homes has had other trying and turbulent times before and all those things that happened then are now great stories, fascinating stories that can keep you on the edge of your seat. In some we rejoice, in others we learned big lessons. I have no doubt that what is happening now will also turn out to be the similar stories and Wood's Homes will continue to thrive. You don't get to be 106 years old by absolutely having an easy ride. I mean you must have built up some major resilience during that period of time and this is when you call upon it.

Q: Well this has been a brilliant conversation and I've enjoyed learning from this talk - thank you. Jane, is there anything else I should have asked you but did not?

A: I've no idea, you've got me to talk about and think about things that I've not thought about for a very long time and I enjoyed it too. Thank you, Bruce.

'Data Boot Camp' at a Children's Mental Health Centre: How Data Literacy Training Can Help Practitioners with Day-to-Day Reporting

JENNA PASSI & ANITA BLACKSTAFFE

For many practitioners, spreadsheets and databases can often feel detached from the work done day-to-day. However, in a world that is increasingly quantified, efficiency with administrative and outcome tracking is crucial when trying to meet evolving reporting requirements. As part of an initiative to increase data literacy within Wood's Homes program staff and management, the Wood's Homes Research Department designed and facilitated two foundational trainings about the Wood's Homes Outcome Measurement annual reporting. These boot camp style trainings focused on creating a basic foundation around data collection and its connection to the annual reporting structure, and to inform attendees that they could connect with the Research Department for assistance year round. In designing these trainings it was essential to infuse the presentation with a lot of hands on actions and practical tips and tricks to help the initiatives provided translate into useable strategies that staff and managers could implement. During the trainings examples of how the Research Department can support programs to ensure that annual reporting is used to its full potential were provided. However, this was always underscored with the sense that interpretations of data and outcomes rely on blending the knowledge and expertise from a partnership between practice and research. All of this had an end goal of being able to reduce feelings of stress and/or disconnection from the purpose of annual reporting.

LITERATURE REVIEW

As 'big data' continues to garner interest so too does the focus on how to use this data in assessing programs and services as well as produce research to increase knowledge within respective fields (Yampolskaya, 2017). One study reviewed use of quantitative research within social work and found that its use was significantly limited in academic journal publications with slightly more research appearing in mental health based work (Sheppard, 2016). It has also been noted that more research is required around working with individuals who have complex issues such as drug use, homelessness, or mental health concerns and are areas of interest for growing the knowledge base on best practices (Goel et al., 2018; Moriarty, Manthorpe, Stevens & Hussein, 2015). One possibility regarding quantitative methods is that its limited use stems from a lack of quantitative training or teaching within the field, whereas its focus may be more towards qualitative methodologies (Moriarty et al., 2015; Sheppard, 2016).

Being able to fully realize the possibilities of administrative data by pairing practitioners with research staff is important. This type of data is comprehensive in a manner that is unlikely to be reached through other data collection methods, and so can lead to important increases and additions to knowledge (Yampolskaya, 2017). Additionally, since administrative data is already likely collected as part of creating client files, it is information that should typically fit with day-to-day tasks. Specifically within the field of Children's Mental Health, some of the administrative data collected covers information on child maltreatment, risk, resiliency, and health and social factors. This is relevant because the Canadian government has noted the importance of data collection around child maltreatment, child health, and well-being and has launched several initiatives designed to collect such data (Tonmyr, Hovdestad & Draca, 2014). Since Wood's Homes is an agency that provides services within Children's Mental Health, this means that our programs can build a unique research capacity for the betterment of services when working with clients who have experienced an array of adversities.

However, despite any potential lull in capability is likely to become more problematic as there is increasing interest in the world of social work to be able to provide research

and keep up with best evidence-based practices (Moriarty et al., 2015). While administrative data might be collected for each client, it is important that the demands of data collection and reporting processes are met by the capacity of the staff involved to accurately record, and at times respond, to the data collected. Despite research being important within the field of social work, one study found that only about one third of frontline staff had been exposed to any formal research training methods which was often compounded with viewing research as not important or related to their job role (Goel, Hudson & Cowie, 2018). This same study also found that assigned importance to research was more common among management along with a desire and willingness to learn (Goel et al., 2018). This lack of knowledge and/or interest creates further challenges in trying to add additional quantitative research to the field of social work, as there may be concerns about accessibility to those in the field due to a lack of data literacy to be able to interpret and respond to quantitative information (Sheppard, 2016). Therefore beginning to bridge the gaps between research and practice are necessary to continue driving forward the momentum of best practices (Orme & Powell, 2007). Initiatives such as pairing research and practice together and getting practitioners interested are important steps in working towards building stronger research cultures within the social work field (Moriarty et al., 2015).

ANNUAL REPORTING IN A CHILDREN'S MENTAL HEALTH CENTRE (WOOD'S HOMES)

Wood's Homes is a children's mental health centre that provides treatment and support for children and families with mental health needs. It is a non-profit agency based in Calgary, Alberta. Wood's Homes has more than 40 programs that deliver a variety of services that includes live in and community-based programs, street services, community and crisis counselling ser- vices, family support services, and specialized learning centres. Wood's Homes also has a Research Department, one of several support services, and one goal of the Research Department is to assist with annual reporting. In 2011, Wood's Homes began using the Wood's Homes Outcomes Measurement (WHOM) framework to generate annual reports for programs that aligned with the National Outcomes Matrix (MacLaurin, Navia, Matheson, & Johansson, 2018). Programs can report on indicators and outcomes related to their specific interventions and clientele in domains of child safety, child well-being, permanence, and family and community supports (MacLaurin et al., 2018). Specific to annual reporting, the Research Department works with programs to generate a report related to indicators and outcomes of interest to the program, the agency, and to funders. The boot camp trainings detailed below were initiatives by the Research Department developed to (1) increase knowledge around the history of the WHOM annual reporting in the agency, (2) empower and excite practitioners about how their day-to-day work impacts these reports and (3) to inform them how to be involved year-round in data collection and using results from measurement in practice.

THE FIRST DATA LITERACY BOOT CAMP: PREPPING FOR WHOM ANNUAL REPORTING

In 2019, the Wood's Homes Research Department designed and presented two trainings across the agency to increase ease in the reporting process around WHOM annual reporting. The first boot camp focused on the basics of data collection, with real-life tips for everything from client demographics to outcome measures. Much of this data collection would be referred to as administrative data, meaning data collected mainly for administrative purposes. However, administrative data is more commonly being proven as useful for research purposes for agencies, programs and service sectors (Yampolskaya, 2017). Some of the key aims for this training included providing the history and broader context to the reporting structure at Wood's Homes along with explaining the terminology used by the Research Department. The first boot camp also went into details about the purpose and types of indicators contained within each section of the WHOM annual report. Additionally, for many indicators the basics around where that information needs to be stored as well as known issues and helpful tips were discussed. The first set of boot camp trainings were provided in March 2019 near the end of the fiscal year, as the fiscal year is when the majority of WHOM annual reports are completed within Wood's Homes. This created an opportunity to have a built-in component to the training for attendees to prepare a 'to do' list throughout the presentation of what they would need to be able to send to the Research Department in order to have their WHOM annual report generated. This was meant to provide a very hands on and practical skill that could be implemented right away.

The first training had 55 attendees, each attending one of three trainings. Attendees in management

roles (i.e., team leads, supervisors, managers and directors) made up just over half of the training attendees (n=29, 52.7%), followed by frontline staff (i.e., Youth and Family Counsellors and Family Support Counsellors) (n=24, 43.6%), and then other positions (e.g., research assistants, clinicians, foundation staff etc.). Seven program areas within Wood's Homes were represented between the three trainings and a total of 29 different programs had some staff attend, which is represents just under 70% of the programs within Wood's Homes.

Table 1: Agency Representation at the Prepping for WHOM Annual Reporting Boot Camp (N=55)

POSITION TYPE	# of Attendees	% of Attendees
Management	29	52.7
Frontline Staff	24	43.6
Support Staff	2	3.6
PROGRAM AREA		
Therapeutic Campus-Based Services	23	41.8
Community Mental Health Programs	17	30.9
Street Services	6	10.9
Learning Centres	5	9.1
Crisis and Community Counselling	2	3.6
Family Support Services	1	1.8
Support Services	1	1.8

PREPPING FOR WHOM ANNUAL REPORTING: BOOT CAMP PRE- AND POST-TEST RESULTS

Since the first training was grounded in the foundations of the reporting done at Wood's Homes and what the Research Department needed from programs to generate their WHOM annual report, the pre- and post-tests targeted the following areas for increases in ability: understanding the purpose of a WHOM annual report, ability to read and understand a WHOM annual report, comfort in reading a WHOM annual report, and comfort in being able to create a WHOM annual report, and level of knowledge for creating a WHOM report for their program. Pre- and post-tests were completed by 87.2% of attendees and each targeted area asked the attendee to rate their ability using a likert scale from 'strongly disagree' to 'strongly agree'. On average, attendees reported an increase in all targeted areas, with the change between pre and post scores being statistically significant ($p<0.001$) (see Figure 1). Some of the largest gains were seen specifically around the comfort and knowledge around creating a WHOM for their program (increases in average score of both areas of 1.1 points).

*Table 2: Pre and Post Results from Attendees of the 'Prepping for WHOM Annual Reporting' Training **

TARGETED AREAS FOR IMPROVEMENT	Avg. Pre Score	Avg. Post Score	Avg. Change
Understanding the purpose of a WHOM annual report (n=48)	4.2	4.7	0.5
Ability to read/ understand a WHOM annual report (n=48)	3.9	4.7	0.8
Comfort in reading a WHOM annual report (n=48)	3.9	4.6	0.7
Comfort in creating a WHOM annual report (n=48)	2.9	4.0	1.1
Knowledge in being able to create a WHOM annual report for my program (n=47)	2.9	4.0	1.1

** Differences are statistically significant at p<0.001, Wicoxon Signed Rank tests*

In comments from this first training, attendees indicated that they learned new things from the trainings, that they valued the engaging presenters, and how the information was simplified and presented in a way that was easily digestible. Attendees also indicated that they would have appreciated more program-specific elements during the training.

THE SECOND DATA LITERACY BOOT CAMP: A WHOM ANNUAL REPORTING JOURNEY

The second boot camp was about teaching practitioners to read, contextualize, and interpret results. A crucial aspect woven in throughout the second training was to encourage attendees that their knowledge is key in interpreting the values contained in a WHOM annual report. With this in mind, the training elaborated on how their program knowledge can be paired with information from a WHOM annual report to reflect on their program in a variety of ways and can be translated into various research opportunities as well.

The focus of this presentation was to help attendees effectively use the WHOM annual reports generated for

programs in three distinct ways. First, that an accurate interpretation of information contained within a report can help program staff and management take a look retroactively at what has been going on within a program and to see what trends are emerging – both expected and unexpected. Second, the training emphasized that a reporting process does not need to feel like a stressful or overwhelming once-a-year task, but that program staff and management can take an active role in this process year-round. Third, the WHOM annual report can help program staff and managers think about where they want their path forward to lead while also helping to assess potential gaps and areas for further development. Each of these sections was paired with information on how the Research Department can help with various tasks and goals related to these program-related reflections.

The second training had a total of 66 attendees, a majority of whom were frontline staff (n=35, 53.0%), followed by management (n=23, 34.8%) and support staff (n=8, 12.1%). Again, all seven program areas were represented at these trainings with a total of 28 different programs attending. Between both sets of trainings, there was representation between 35 (~80%) different programs throughout Wood's Homes and a majority of programs (n=22, ~50%) had staff attend both boot camps (Refer to Table 3).

Table 3: Agency Representation at the 'A WHOM Annual Reporting Journey' Boot Camp (N=55)

POSITION TYPE	# of Attendees	% of Attendees
Management	23	34.8
Frontline Staff	35	53.0
Support Staff	8	12.1
PROGRAM AREA		
Therapeutic Campus-Based Services	25	37.9
Community Mental Health Programs	17	25.8
Street Services	4	6.1
Learning Centres	1	1.5
Crisis and Community Counselling	2	3.0
Family Support Services	12	18.2
Support Services	5	7.6

PRE- AND POST-TESTS

With the second training having a focus on being able to use and reflect on the WHOM report in various capacities the pre and post test results focused on the following target areas:

1) ability to read, understand a WHOM annual report,
2) perception of the WHOM annual report as a useful tool
3) a negatively worded question regarding indicators reported in a WHOM annual report being selected only by the Research Department
4) confidence in making WHOM annual reporting season easier within their program
5) confidence in how to make the most of a WHOM annual report, and
6) comfort in reaching out to the Research Department.

The pre and post tests were completed by 98.5% of attendees and each question focused on a targeted area asking the attendee to rate their ability using a likert scale from 'strongly disagree' to 'strongly agree'. On average attendees reported a statistically significant change in all desired areas that the training had targeted as goals (refer to Table 4). Knowing how to make WHOM annual reporting easier for their program teams and how to make the most of a WHOM report saw some of the largest increases on average (changes of 1.1 and 1.0 respectively). It was also positive to see that on average attendees felt fairly comfortable reaching out to Research in both the pre-test and post-test scoring (scores of 4.2 and 4.6 respectively).

*Table 4: Pre and Post Tests from Attendees of the 'A WHOM Annual Reporting Journey' Training **

TARGETED AREAS FOR IMPROVEMENT	Avg. Pre Score	Avg. Post Score	Avg. Change
Ability to read/ understand a WHOM annual report (n=65)	3.6	4.4	0.8
Perception of WHOM annual report as a useful tool (n=65)	4.2	4.6	0.4
Perception that indicators included in a WHOM annual report are determined by the Research Department (n=64)	2.4	1.9	-0.5
Ability to make WHOM annual reporting season easier for their program team (n=64)	3.0	4.1	1.1
Ability to make the most of a WHOM annual report (n=64)	3.1	4.1	1.0
Comfort level in reaching out to the Research Department for WHOM annual reporting related needs (n=65)	4.2	4.6	0.4

** Differences are statistically significant at p<0.001, Wicoxon Signed Rank tests*

Attendees commented that despite the topic being inherently dry, the presenters were entertaining and the theme (i.e., a road-trip style journey) of the presentation made the information fun and accessible. Attendees also commented that they appreciated learning about the larger context of their day-to-day reporting or administrative-type tasks. Similar to the first training, attendees noted that it would have been beneficial to have material more specific to their individual programs and to have more interactive components or opportunities for group discussion. Additionally, some attendees felt that the information contained in the two trainings was too similar.

LESSONS LEARNED

After the boot camps there were several main themes that stood out as important for future trainings..

Programs and the Research Department as a Team

With the realization that sometimes a report can feel like a stressful task with little practical value, it was important for the boot camps to contextualize the origin and core purpose of a WHOM annual report, i.e. the ability to reflect client outcomes and assess the effectiveness of interventions on clients within a program (MacLaurin et al., 2018). After contextualizing the WHOM annual report, it was important to highlight that program staff and management should have an understanding of all outcome measures and indicators used to ensure appropriate integration into case management planning. Not wanting the boot camps to leave attendees feeling overwhelmed with all the things they had to do, it was important to connect back to the services provided by the Research Department that would help program staff and management use their WHOM annual report to its full potential.

Linking the practical day-to-day efforts with the more research-based ideas of data collection has been noted as an effective strategy to build a culture of learning around data and research capacity (Orme & Powell, 2007). In trying to further connect practice to research at Wood's Homes, the boot camps were designed to encourage attendees to have an active role in data collection and outcome measurement processes related to their program's WHOM annual report. Being active could include things such as noticing an important aspect of work not being reflected in the WHOM annual report, indicators or outcome measurements that do not reflect core treatment goals of the program, or identifying and addressing areas where discrepancies or confusion within the team are apparent. In each of this instances, attendees were informed that the Research Department could provide support and services to bridge any gaps, or to help with future planning based on their reflections.

Importance of Presentation Forum and Style

The second thing that stood out was how important it would be to consider not just the information, but how that information is being provided. When selecting the method of training, it was important to consider the forum, and for a larger agency consideration around in person trainings versus online trainings needed to be addressed. One study found that online trainings were not preferable to face-to-face trainings that had a higher sense of engagement and where real-time interaction could occur (Goel et al., 2018). The boot camps were held in person and were held strategically at different large hubs in order to access the broadest number of programs, with an online option for distance programs. This also signaled the Research Department's commitment to the broader agency to help build data literacy for any staff interested, which has been identified as an important building block in working towards having a larger research presence in the field (Moriarty et al., 2015).

Once the form of the trainings was determined, the next consideration was how to ensure the training was engaging and would allow for knowledge transfer. There is a general sense that data, numbers and reports can be boring, confusing and hard to follow. Each boot camp started by building a solid foundation of information around the WHOM annual reports, from which the rest of the training would build upon. Foundational aspects included an overview of WHOM annual reports, reviewing technical language used by the Research Department, an introductory breakdown of data collection processes, and simple tips and tricks for effectively using spreadsheets and databases. While the trainings were not specific to the individual or programs, the decision to start by ensuring all attendees had a strong basic foundation is in line with research noting that it is imperative to ensure a solid foundation and to meet practitioners at their level to build knowledge and confidence (Goel et al., 2018). To ensure these foundational teachings could directly connect back to the work done in their programs, attendees were given opportunities to build 'to do' lists, provided with explicit tips and tricks they could use each day or for regular auditing of program

data, and were provided specific examples of when to involve the Research Department for additional expertise or assistance. As an anecdote of success, after the trainings many programs connected with the Research Department to discuss how to to further build their staff's capacity to think about their services in terms of important indicators and desired outcomes.

Inspiring Engagement

The most immediate goal of these boot camps was focused on increasing efforts towards gathering complete and accurate data, which has been a noted limitation around administrative data especially when the data fields become less directly connected to day-to-day functioning (Yampolskaya, 2017). By reviewing reporting requirements and data collection practices, not only was basic information shared across the agency, but attendees were also reminded that this data can be powerful in informing potential future practices, goals, or areas of development within their programs. Additionally, by ensuring that data and outcomes are collected regularly throughout the year, attendees were reminded that this means they can review trends throughout the year as well and not just during WHOM annual reporting. This can translate into reducing the delay between identifying a trend within the data and being able to further inform services (Tonmyr et al., 2014).

The training also encouraged the practice of having multiple team members in charge of different aspects of data with a collective sense among the program team about what processes took place with their clientele. In suggesting this, the first goal was to increase capacity and understanding around data and data collection within programs since the information and responsibility would be shared throughout the team. This is in line with the suggested practice of having practitioners first build comfort and confidence in smaller aspects of connecting practice to research in order to eventually build towards larger research projects (Goel et al., 2018; Moriarty et al., 2015). The second goal was to help protect against disruption of knowledge or data loss in cases where team members transition out of their programs. With a collective knowledge among the team, staff could be re-assigned with ease.

CONCLUSION

Through trainings on increasing understanding and capacity around data collection and WHOM annual reporting practices the Research Department hoped to increase engagement, interest, and connection between practice and research. Both trainings were successful in increasing knowledge, comfort and ability in attendees around understanding, creating, and using their program's WHOM annual report. With a focus on connecting daily practices to research tasks, building a solid foundation, and providing the training through an effective and engaging forum, the data literacy boot camps provided to Wood's Homes by the Research Department were a good start towards merging research, knowledge and practice in a creative and empowering way.

REFERENCES

Goel, K., Hudson, C. & Cowie, J. (2018). Building research capacity for social work practitioners: A regional perspective. *Social Work Education*, 37(8), 1028-1043, doi:10.1080/02615479.2018.1481205.

MacLaurin, B., Navia, D., Matheson, J. & Johansson, B. (2018). Wood's Homes Outcomes Measurement (WHOM). *Wood's Homes Journal: Evidence to Practice*, 2(1), 25-28.

Moriarty, J., Manthorpe, J., Stevens M., & Hussein, S. (2015). Educators or researchers? Barriers and facilitators to undertaking research among UK social work academics. *British Journal of Social Work*, 45, 1659-1677, doi:10.1093/bjsw/bcu077.

Orme, J. & Powell, J. (2007). Building research capacity in social work: Process and issues. *British Journal of Social Work*, 38, 988-1008, doi:10.1093/bjsw/bcm122.

Tonmyr, L., Hovdestad, W.E. & Drace, J. (2014). Commentary on Canadian child maltreatment data. *Journal of Interpersonal Violence*, 29(1), 186-197, doi:10.1177/0886260513504643.

Sheppard, M. (2016). The nature and extend of quantitative research in social work: A ten-year study of publications in social work journals. *British Journal of Social Work*, 46, 1520-1536, doi:10.1093/bjsw/bcv084.

Yamplskaya, S. (2017). Research at work: Administrative data and behavioral sciences research. *Families in Society: The Journal of Contemporary Social Services*, 98(2), 121-125, doi:10.1606/1044-3894.2017.98.17.

Family Involvement in Short-Term Campus-Based Treatment: Operationalizing Family-Centred Care

ALEX MACDONALD, JENN HOY & BRUCE MACLAURIN

INTRODUCTION

Families provide the context in which children are born, raised, and launched into adulthood as contributing members of this society. They provide a training ground for communications, relationships, and behavioural skills that continue throughout the child's life. Families provide the security which allows children to go off to explore the world, and return when in need of safety. However, not everything goes as planned. Historically, it has taken a village to raise children and provide support for families, to celebrate family milestones, and provide alternate guidance when things are going off track. In Canada, "village" may have a different meaning and involves not only natural supports to a family, but professional supports as well. Campus-based treatment (or residential care) for children and adolescents with behavioural and emotional challenges has been utilized by child welfare, juvenile justice, and mental health systems as a way to help these children and families (Walter & Petr, 2008). Although there has been a historic debate in the research literature on the effectiveness of campus-based rather than residential treatment in general (Whittaker, 2000), there is also an increased demand for high-quality, specialized high-quality, specialized campus-based treatment (Lieberman, 2004; Whittaker, 2000). Some of this debate is based upon the concern that effectiveness is largely influenced by the fact that previously children were removed from their home, engaged in treatment, and then placed back in their home, with little focus on changing the environment to which they returned. It has been argued that adolescent delinquency is shaped by the protective and risk factors from all major domains of that youth's life, and these problem behaviors tend to reinforce each other (Simons et al., 2017). This research reported that combining family-centred training for corrections staff, with attainable ways for staff to promote parental involvement made family-centred care programming valuable for practice (Simons et al., 2017). This research reinforces the need for treatment which focuses beyond the individual and targets different areas of the adolescent's experience. A growing body of research is demonstrating better short-term outcomes for children and adolescents who are in campus-based treatment when their families are actively involved in the treatment process (Knorth, Harder, Zandberg, & Kendrick, 2008).

FAMILY-CENTRED CARE AND FAMILY INVOLVEMENT IN CAMPUS-BASED TREATMENT

Family and youth perspectives on mental health treatment are essential for evaluating services and guiding the development of policies: they are the direct recipients of these services and the experts of their own lives. Family-centred care has been defined as "a philosophy and method of service delivery for children and parents which emphasizes a partnership between parents and service provides, focuses on the family's role in decision-making about their child and recognizes parents as experts on the child's status and needs" (Law et al., 2003, p. 357). Family involvement has been consistently shown to be important for positive outcomes for children and youth during and after treatment (Hair, 2005; Leichtman, 2006; Stage, 1999; Sunseri, 2001; Walter & Petr, 2008). In a review of current knowledge and best practices of campus-based treatment and family-centred practices, Walter and Petr (2008) described that there is a convergence of evidence that suggests family-centred treatment for youth with behavioural and/or emotional disorders is best practice. They furthered that there are three key factors to address: "(a) maximizing regular contacts between child and family; (b) actively involving and supporting families in the treatment, and (c) providing ongoing support and aftercare once the child returns home (Walter & Petr, 2008, p. 12).

Involvement may occur in a variety of forms, including but not limited to, phone or in-person contact while in the program, developing treatment goals and plans, hiring of staff, being a Board member or sitting on an ad-

visory committee, sharing training and knowledge with parents, not unnecessarily restricting contact, transition planning, and actively seeking to share with caregivers updates of the youth's progress in treatment. The level of involvement of the family is influenced by many factors, including the agency's view of family involvement, staff perspectives of family involvement, and families' desire of involvement. Researchers have argued that families be involved in the governance of campus-based treatment (Brown et al., 2011). Hair (2005) demonstrated that of three key factors related to ongoing success after discharge, family involvement and support showed the most consistent and significant effect.

Family-centred treatment includes the involvement of families at a variety of levels of treatment including planning, implementation, and evaluation of program services in addition to helping to strengthen the family, minimizing family disruption, and working towards reunification (Child Welfare League of America, Inc., 2004). Research by Robst et al. (2013) found that most youth had regular in-person or via phone contact with family members while in campus-based treatment rather than residential care for mental health concerns. Despite this, they also found that 20% of the youth had no contact reported (Robst et al., 2013). This finding was similar to other reported findings by Kruzich, Jivanjee, Robinson, and Friesen (2003) and Lee (2011). Further, Robst et al. (2013) reported that younger youth, boys, Caucasian youth, and youth in treatment near their home community all had more frequent family contacts than their respective counterparts. Additionally, Robst et al. (2013) discovered that there were more maternal contacts than paternal or other family member contacts, and that family involvement was lower when youth were in treatment longer. Interestingly, these researchers reported that family contact was less frequent in the beginning of treatment, suggesting that parents are often at a place of burn out by the time their child requires campus-based treatment, and parents need time to recover before engaging in treatment (Robst et al., 2013). This may pose interesting challenges for short-term programs such as the one described in this article. Researchers have shown that family involvement needs to go beyond contact and also focus on improving family functioning in order to improve child outcomes (Sunseri, 2004). This may include family visits, family therapy, assessments of family strengths and challenges, and in-home intervention visits (Sunseri, 2004).

A 2010 study conducted by Damar Services in Indianapolis, Indiana looked to modernize how residential care was operationalized. Demar specializes in youth who have multiple and severe problems including behavioral/emotional disorders. The research sought to determine if youth who experienced non-traditional community based treatment with an emphasis on parents being treatment leaders and focusing interventions on building resiliency outside of treatment had more positive outcomes compared to youth who received a more traditional campus-based service. The community-based population had an increase in family involvement by 88% and showed significant decreases in aggression, non-compliance and restraints. As well their average length of stay was reduced by an average of 4.6 months. These results were based on incident reports as well as family and staff measures not specified in the study (Holstead, Dalton, Horne, Lamond, 2010).

Despite the support for family governance in campus-based treatment, researchers found that few campus-based treatment programs include families and youth in governance activities and do not wish this to be reflected in licensing or accreditation standards (Brown et al., 2011). However, of the programs that involved families in governance, it seemed that these practices reflected the governance structures of the overall facilities rather than unique to any specific program. (Brown et al., 2011).

POTENTIAL BARRIERS AND SOLUTIONS TO FAMILY INVOLVEMENT

Research suggests there are specific barriers and potential solutions to family involvement in campus-based treatment. Family involvement in their youth's treatment process can be impacted by a variety of factors, either in a facilitative manner or as a barrier. Sharrock, Dollard, Armstrong, and Rohrer (2013) explored factors that facilitate or hinder family involvement in their study. They noted that providers identified transportation assistance, cultural adaptations, clarity around expectations and communication, flexible scheduling, relationship building, and family support and education as overarching categories of factors that facilitate family involvement (Sharrock, Dollard, Armstrong, & Rohrer, 2013). Factors that were barriers to involvement fell within similar categories, such as transportation problems, challenges with parent work schedules and appointment/visit availability at the program, geographic distance, lack of family support and education, and

families feeling overwhelmed (Sharrock et al., 2013). Identified solutions to barriers included, but were not limited to, providing gas cards or bus passes to parents, flexibility in visiting or treatment meetings (times, method, location), not restricting contact based on youth's behaviour, translations services, informing parents of involvement expectations as soon as possible, approaching families in a non-judgemental manner, empowering families through education about their child's challenges and treatment, parent support groups, in-home observation and intervention, and written materials for parents (Sharrock et al., 2013).

A FOCUS ON FAMILY INVOLVEMENT IN SHORT-TERM COMMUNITY-BASED TREATMENT

The bulk of research on campus-based treatment involves children and youth living in the program for at least six months. The review of the literature reveals limitations around current research on the effectiveness of short-term, campus-based, family-centred treatment for youths with complex mental health needs. This article will explore this gap in the research by highlighting how family involvement works in brief services based on emerging practice at Wood's Homes' Exceptional Needs Program (ENP) in Calgary, Alberta, Canada. Based on the evidence that children and youth fare better when whole families experience support in improving functioning, this paper will explore strategies and approaches to make family-centred care more than just involving the family in their youth's treatment but rather helping the family own their role in the solution.

INTRODUCTION TO WOOD'S HOMES AND EXCEPTIONAL NEEDS PROGRAM

Wood's Homes is a nationally recognized and accredited children's mental health organization in Calgary, Alberta. Wood's Homes provides a variety of services for children and youth, and their families, with presenting concerns including school problems, child maltreatment concerns, behavioral issues, mental health concerns, and family disruption.

INTRODUCTION TO THE EXCEPTIONAL NEEDS PROGRAM

The Exceptional Needs Program (ENP) is a short-term, campus-based crisis transitional program for youth with complex mental health needs. ENP is located on the Parkdale campus of Wood's Homes, in Calgary, Alberta. In 1985, ENP began as a longer-term campus-based treatment program serving youth from across Canada. In an effort to meet changing needs, ENP evolved into an eight bed contract program with Alberta Health Services' Child and Adolescent Addictions and Mental Health Programs (CAAMHP). All eight program beds are funded through Alberta Health Services and the length of stay is approximately four weeks. Typically, youth reside in the program during the week and attend weekend visits at home with their families. Family contact gradually increases over the duration of the program. ENP has a diverse staff team that includes Youth and Family Counsellors (YFC), an in-home family support counsellor, a family therapist, as well as a team leader and program manager. ENP serves male and female adolescents ages 12 to 17 who have been formally diagnosed with a minimum of two mental health disorders. Clients are referred through CAAMHP from either out-patient clinics or hospitals. A psychiatrist supervises the youth's medical treatment during the stay at ENP and youth maintain a community school placement. The program serves between 70-80 youth and their families each year.

METHODOLOGY

This article reports on secondary analysis of existing outcome data collected for the Wood's Homes Outcome Measurement system (WHOM) on all programs (MacLaurin, Navia, Matheson & Johansson (2018). The WHOM framework builds on the foundation and model of the National Child Welfare Outcomes Indicator Matrix (NOM), a framework for tracking outcomes on four key outcome domains for children, youth and families involved in child welfare (Trocmé, MacLaurin, & Fallon, 2000; Trocmé, MacLaurin, & Fallon, 2009). Wood's Homes collects a range of outcome data on all campus-based and community-based residential programs, special education and clinical services using the four established outcome domains related to child safety, child well-being, permanence and family and community support. A core group of outcome indicators are identified for each domain that can be tracked by all programs and services. As well, additional outcome measurement tools are used for program areas based on the context of their interventions with families. Of note, two measurements used by the Exceptional Needs Program include the Children's Global Assessment Scale (CGAS) (Shaffer, 1983), and the Brief Family Distress Scale (BFDS) (Weiss & Lunsky, 2011). The Wood's data information system is used as the source of data for the majority of WHOM outcome indicators.

Sample

A total of 74 clients were served by the Exceptional Needs Program during the April, 2017 – March, 2018 reporting period. Demographic information is provided on all these children and youth. Of this group, four clients were admitted but did not attend the full treatment stay and were omitted from the sample, while five clients were not yet discharged at the time of the data analyses, leaving 65 clients with pre and post outcome scores (n=65). Families referred to the ENP sign an informed consent to treatment and data, with the understanding that their data is used for aggregate analysis and reporting that does not report on individuals or low response data that might risk identification.

OPERATIONALIZING FAMILY-CENTRED CARE AT ENP

The following section will focus on emerging applications of family-centred care practices and how they are operationalized during various states of the treatment project. Examples will be used to illustrate how select interventions can be used to help families understand, value, and work within a family-centred framework.

Engaging Families Early

From the inception of the referral process, families' understandings of the problem definition and their unique competencies are prioritized in a deliberate way. An in-home support counsellor begins by meeting the family in their home and defining ENP as a "family treatment program." This language is the first step in attempting to create a systemic change perspective. When family expertise and interactions are framed as crucial aspects to beginning the treatment project, this symbolizes the importance of their involvement towards a successful treatment outcome. Salvador Minuchin sums this logic up nicely, stating, "The individual influences his context and is influenced by it in constantly recurring sequences of interaction" (Minuchin, 1979, p.8). From the perspective of the in-home support counsellor, engaging families in a meaningful way by helping them see themselves as influential is the most challenging aspect of the front-end work. The following are several important focuses which may help families become engaged in the treatment project and resist any inferences of blame.

Empowerment

Parents may present as feeling defeated and impotent in their ability to remedy the troublesome behaviours of their child. When these feelings emerge they can be expressed in some variety of "my child has the problems and needs to be fixed," or "nothing I do matters." Creating a clear, transparent conversation at the beginning of treatment can help parents see their involvement and willingness to adapt to a changing young person as their goal, rather than them having the responsibility to do something that will fix the problem. In this way, it seeks to remove the pressure that the solution resides within the parents and rather provides them with many opportunities to invite their young person into a new way of problem solving and organizing together.

Examining Systemic Impact

When parents are first contacted to speak about treatment, it is common that they frame goals around their child's behaviour (e.g., learning how to cope with difficult emotions, making friends, attending school, or completing chores). When this occurs, an emphasis is placed upon exploring the impact of the problems on the family system, rather than challenging the family directly and requesting family-centred goals, which can lead to undesirable inferences of blame. As Tomm, St. George, Wulff, and Strong wrote, "the specific patterns of human interaction in which we are embedded in our daily living have major influence on our experiences and on our mental well being" (Tomm, St. George, Wulff, & Strong, 2014, p. 15). Once the family begins speaking about the practical and emotional impacts of the problem, they can be helped to crystallize the idea that they all have a relationship with the problem which can be the site for new interactions and potential new organizations of family functioning. A child experiencing a mental health crisis implies that the family is also in crisis, thus making family functioning central to the treatment of a child dealing with mental health concerns (Landino, Mabe, & Josephson, 2013). This conversation can lead to the family focusing on how they can mitigate the impact of the problem on the family, which in turn can create new interactions in the family as they reorganize how they interact with the problem behaviour.

Reframing Individual Goals as Family Goals

It is not uncommon for parents to lead the way around goal formation as they typically are the main point of contact with intake professionals. The youth themselves may present as having limited interest around the goals their parents suggested. Often, youth and their family can then come to the understanding that the work is between the youth and the program. It has been found that improving family connection as well as overall so-

cial connectedness is identified as an important protective factor for youth leaving the hospital setting (Czyz, Lui, & King, 2012). Herein lies the rationale for reframing goals in a systemic way. When a youth enters a campus-based treatment program, it is often inferred that some interaction between the youth and the professionals in that setting will help create change. However, when the program is finished that interaction no longer exists. Helping families to see that their involvement in treatment interventions can not only be supportive to their youth but can be an essential factor in creating sustainable change as they will need to be the ones supporting progress after the program ends.

An example of this reframing is as follows. The original goal may be: "The youth will learn three new coping skills and implement them when triggered." The family-centred goal: "The family will practise attuning to emotion cues in themselves and others, and prompt affective regulation skills in a preferred way as decided upon by the family." From this starting point, a more collaborative meeting can be facilitated about what everyone's particular role is in family emotional management and what they need from each other to hear feedback, all with a common goal of lessening tension at home. This can also have benefits around youth engagement as they see themselves as part of a team and the solution residing within the whole family.

TREATMENT IMPLEMENTATION: SEEING THE FAMILY AS THE CLIENT

While in the program, there are several key points of family interventions. As illustrated in the above example, effort is made to frame goals around family organization and functioning rather than individual behavioural change. This is not to say that parenting skills or emotional/cognitive/behavioural skills are not attended to with individuals or sub-systems. However, effort is made to discuss these issues from a framework of family interaction (how interactions contribute to difficulties in these areas or how improvement in these skills may impact the larger system). Also, effort is made to keep the families' voices present when they are not physically in the program and their leadership around decisions making an integral aspect of the program culture.

Weekly family meetings focus on different pillars of family functioning. Typically these address: 1) family emotional management and safety, 2) problem solving and family expectations, and 3) communication and preferred family culture. These focused family meetings provide opportunities to build interventions directed towards the families rather than individuals. Prior to each particular meeting, a YFC contacts the family and discusses the general focus for the upcoming meeting. Emphasis is put on understanding how each of these meetings is relevant to the particular situation the family is dealing with at home. Starting with listening to the family and understanding how this meeting does or does not fit for them creates the opportunity to tailor the facilitation in a more personalized way, or amend the meeting structure to focus on a more pressing concern to the family. Once the family is contacted, the YFC takes time to discuss the meeting with the youth to incorporate his/her voice into the fabric of the meeting. Once these preliminary conversations take place, the YFC consults with the program Clinician to create some psycho-educational components around the issues, tie together themes of concern around what parents and their youth want to discuss, and create questions that help inspire interactive family discussions. Once the meeting takes place, it serves not only as a stand-alone intervention for family problem solving, but also as a jumping off point for experiential practice on visits. A deliberate focus is put on flexibility and personalization of the meetings. An example of this adaptivity is a safety planning meeting, which is typically designed to focus on psycho-education, as well as family discussion and planning around high risk behaviours. However, the meeting can be tailored to focus on conflict around school refusal and how anger and pressure from the parents invites contempt and further non-compliance from their youth, which in return invites more anger and pressure. The same format would ensue: psycho-education around barriers to school participation (anxiety, social challenges, academic struggles, etc.), interactive discussion of people concerns, and planning about what people are prepared to do to remedy the situation. Despite similar formats, the content and focus of the meeting was designed by the family.

Family therapy is designed to be a complementary intervention to the treatment as a whole: it is meant to add depth to and address any interpersonal barriers to family progress. At times, families may be stuck around a particular issue that has occurred at home or they may revert back to their ideology of "fixing their kid." Family therapy can serve as the context to help re-orient the family to their team mentality or process situations that need attention before moving forward with other treatment interventions (e.g., attending to

past episodes of physical aggression, feelings of being unwanted or unloved, power struggles around expectations, etc.). YFCs may identify an unhelpful pattern of interaction in family meetings, which breaks down family collaboration and needs deeper exploration (e.g., parents' role modeling of inappropriate behaviour, blaming and attacking, boundaries between family members, not allowing for equitable communication, etc.). Daily consultations between the Clinician and YFCs are prioritized in order to use family therapy as a way to address and attempt to reorganize family interactional patterns which create barriers to progress both at home and in other areas of treatment.

Treatment milieu. Youth typically reside in the Exceptional Needs Program during the week while the rest of their family is at home. Although the consistency of families' direct involvement illustrates the importance of family change, at times youth feel they are the problem as they are the ones physically living in a treatment program. One way this is explicitly challenged is by deliberately focusing treatment on the importance of relationships. Youth engage weekly in multiple peer groups, which focus on interpersonal concepts (choices/social dilemmas, identity/role models, communication/emotional expression). Peer interaction is deliberately prioritized to maintain the focus on boundaries and relationships, while YFCs are able to observe behaviours and challenges during interpersonal interactions that can then be discussed in family contexts. The relationship the youth develop with the YFC's is also an important focus at ENP. Each youth is appointed a key worker who prioritizes periodic one-on-one conversations. These one-on-one conversations are designed to help the youth practise speaking about difficult issues and feelings, as well as to identify barriers to or celebrate successes of using their family for support around these types of conversations. Lastly, the role of YFC's is focused on empowering families to solve problems together rather than doing it for them. If youth have a request from their parents or an issue with a decision their parent has made, YFC's will suggest they support the youth in setting up a phone conversation and planning with the youth what they would like to say to their parents, rather than staff calling the parents directly to seek clarity. During the treatment process, parents may ask YFC's to take a lead role in communicating with other parties: for example, schools, divorced spouses, or their own child about some poor decision they have made. Although staff maintain consistent collaboration with school programs and work with parents about how they can use their one-on-one meetings with the youths, they are oriented to involve the parents in these situations as primary points of intervention rather than peripheral participants. YFC's do this by first listening to the parents' and/or youth's concerns, then helping them to see the opportunity this situation provides with relation to their established family goals. The YFCs offers suggestions around how he/she can be of support to the parents and/or youth by planning the conversations with them, prepping the other party for what the parent/youth wants to talk to them about, or participating in the conversation directly to help punctuate healthy and unhealthy interactions identified in earlier meetings. By organizing the milieu culture in these ways, relationships, social skills, and family interactions are practised even while the family is not physically present in the program. The intention of this approach is to help families experience their own success and push parents to intervene as competent, capable leaders rather than depending on third parties to solve family problems. When these interactions are difficult, it provides information about and serves as practice for challenges during organic family interactions. When these interventions go well, families have an opportunity to to own the change and their successes.

In-home family-centred aftercare. Research indicates that clients continue to make changes and progress after 30 days of campus-based treatment (Noftle et. al, 2010). Because of this, treatment is extended via structured, in-home support which helps the families stay focused on treatment goals within their own homes. In-home services extend treatment in to the family's home in the form of monitoring, support for families and youth, as well as access to community resources that can serve to prevent future crises (Bettmann & Jasperson, 2009). ENP in-home support provides care prior to intake through telephone contact and a pre-intake meeting. At pre-intake the aim is to gather important information about presenting problems and family demographics. Another primary aim of this contact is to engage the families early in the treatment process by discussing the value of their role in treatment and examining the systemic impacts of the identified problems on the family system. Once a mutual understanding of family-centred treatment model is established, the Family Support Counsellor begins reframing treatment goals as family-centred goals and schedules the admission meeting. During the program discharge meeting, the Family Support Counsellor offers each family in home support for up to six sessions in the family home in order to extend program work and maintain the changes/progress. Finally, the Family Support Counsellor provides referrals for additional supports or

other ongoing resources which the family might require.

DEMOGRAPHICS OF SAMPLE

Children and youth who were involved with the ENP ranged in age from 11 to 17, and included 11-12 (11%), 13-14 (51%), 15-16 (27%) and 17 (11%) (Refer to Table 1). Seventy three percent of all youth lived in the city of Calgary, while another 27% lived in other Alberta locations. The majority of youth remained under their parents' care. Children and youth referred to ENP identify a range of presenting concerns including: Parent/Child Relationship Issues (55%), Suicide (44%), School Problems (38%), Self-harming Behaviours (34%), Behavioural Issues (26%), Family Relationship Issues (26%), and Identified Mental Health Concerns (20%). Youth entering the ENP have a range of DSM diagnoses.

Table 1: Demographic Characteristics of Children & Youth Served by the Exceptional Needs Program 2017-2018

Age at Intake (mean 15.0 years)		#	%
	11-12 years	8	10.8%
	13-14 years	38	51.4%
	15-16 years	20	27.0%
	17 years	8	10.8%
Place of Residence			
	Calgary North East	8	10.8%
	Calgary North West	20	27.0%
	Calgary South East	18	24.3%
	Calgary South West	8	10.8%
	Other Alberta Location	20	27.0%
Guardianship of the Child			
	Child remains in custody of family	70	94.6%
Top Seven Presenting Concerns			
	Parent/child relationship issues	41	55.4%
	Suicide	33	44.6%
	School problems	28	37.8%
	Self harm	25	33.8%
	Behavioral issues	19	25.7%
	Family relationship issues	19	25.7%
	Identified mental health voncern	15	20.3%
Total		**74**	**100%**

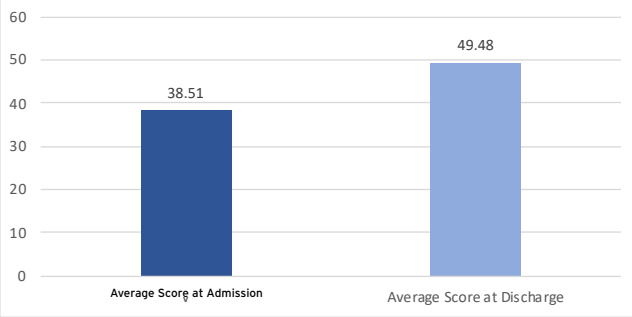
Wood's Homes Exceptional Needs Program 2017-2018

FINDINGS

Campus-based outcomes - Currently, ENP utilizes two pre/post outcome measures in order to capture the effectiveness of the family-centred approach: family distress and youth overall functioning. The tools used to capture these outcomes are the Brief Family Distress Scale (BFDS) and the Children's Global Assessment Scale (CGAS). This article discusses the outcome data for the 2017-2018 year.

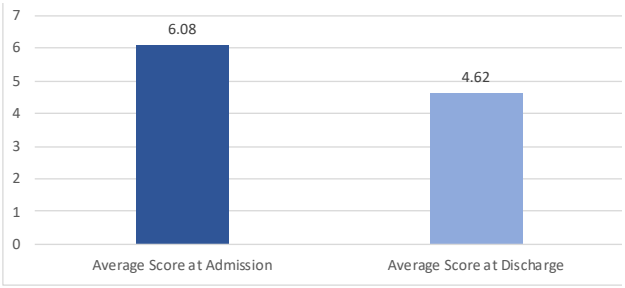
CGAS (Shaffer et al., 1983) is a tool that provides a global measure of functioning in children and adolescents. The measure provides a single global rating on a scale of 0-100. Ratings are done based on client functioning in four main areas: at home with family, at school, with peers, and during leisure activities.. CGAS ratings are completed at intake and discharge to monitor change over time. An increase of 10 points in CGAS scores from intake to discharge is considered to be clinically significant. Appendix A is a description of the CGAS levels of functioning from 0-100. Figure 1 demonstrates the mean score at intake compared with the mean score at discharge for the 2017-2018 year (April 1, 2017 - March 31, 2018). Of the 65 clients who completed pre and post measures the average intake score was 38.51 and the average discharge score was 49.48. The mean average decrease was for all 65 clients was 10.82, indicating a clinically significant change. Of the 65 clients under consideration, 41 clients had clinically significant improvements, 18 clients showed an increase that was not clinically significant (average increase – 7.67), 6 clients showed no change, 0 clients decreased in their level of functioning. A paired-samples t-test was conducted to compare the CGAS score for pre-test measures to post-test measures. There was a significant difference in the scores for Pre-test CGAS scores (M=38.51, SD = 5.292) and Post-test CGAS scores (M=49.48, SD = 7.038) conditions; t(64) = -16.845, p ✣ .0001. These findings suggest that Post-test CGAS scores increase following treatment compared to the initial Pre-test CGAS scores, representing a statistically significant change.

Figure 1: Change in CGAS Scores from Admission to Discharge for ENP Program (2017-2018)



The Brief Family Distress Scale (BFDS) (Weiss & Lunsky, 2011) is used in crisis settings to determine the level of risk indicated by the presenting family and the urgency of response required. The BFDS examines the experience of crisis from the perspective of the caregiver by placing the family's current experiences on a continuum of distress ranging from low levels of distress to crisis. Parents and/or caregivers rate themselves and their families on a 10-point scale based on what level of crisis they perceive they are currently experiencing. Each point along the continuum is grounded in a statement describing no stress to complete crisis. Responses on the single item scale are positively correlated with caregiver worry, distress, child problem behaviours, negative life events, and negatively correlated with quality of life, family hardiness and empowerment. A reduction of one point on the 10-point scale is considered significant and indicates that the family is experiencing lower levels of distress at discharge. Appendix B provides the description of the BFDS levels of distress from 1-10. Figure 2 is a graph which demonstrates the average score at admission compared with the average score at discharge for the 2017-2018 year (April 1, 2017 - March 31, 2018). During that time, 132 family members completed the pre/post measurement of distress (n=132). The average level of distress at intake for the 132 family members score for distress was 6.08 and the average discharge score was 4.62. Out of the 132 family members that completed the pre and post distress measure, the average change was a reduction of 2.05; a clinically significant difference. This number also takes into account those clients who rated that their distress increased or stayed the same during treatment. A paired-samples t-test was conducted to compare the BFDS score for pre-test measures to post-test measures. There was a significant difference in the scores for Pre-test BFDS scores (M=6.08, SD = 2.225) and Post-test BFDS scores (M=4.62, SD = 1.919) conditions; t(131) = 9.264, p ✣ .0001. These findings suggest that Post-test BFDS scores decrease following treatment compared to the initial Pre-test BFDS scores, representing a statistically significant change.

Figure 2: Change in Brief Family Distress Scores from Admission to Discharge for ENP Program (2017-2018)



Aftercare outcomes - Outcomes for the aftercare portion of the program are captured through brief family distress scales (BFDS) and client satisfaction surveys. Of the 65 clients under consideration for this article, 39 participated in after care services (60%). Of the 26 families that did not participate in after care 7 were already connected to community based in home supports, and 19 declined services. In total, 149 in-home visits took place, as well as 53 meetings over the phone in 2017-2018. Using the BFDS, this reporting period finds 61% of clients and their families experiencing a clinically significant improvement in family distress levels between the first and last aftercare session. Using the client satisfaction survey, on a ten point scale, 94.9% of clients and their families reported that their goal for the in home visit was met during this reporting period.

AREAS FOR FUTURE RESEARCH

Many areas for future research continue to exist at ENP. Research into how ENP manoeuvres families' roles in program governance and future program development could further enrich literature on family-centred care. Another area of focus may be around after-care services and ongoing supports once treatment is completed. ENP has an in-home support counsellor who serves dual roles of intake worker and after-care worker. Their after-care role is intensive, often spanning multiple months and involves in-home interventions. An important area to consider may be how to gauge the amount of involvement that would be ideal for a specific family. Typically, ENP operates under the impression that more is better. There are virtually no restrictions to family contact and input is encouraged in as many areas of treatment initiatives

as possible. Yet it remains unclear if the attempt to involve family and to build resiliency can at times be counterproductive or overwhelming for families.

CONCLUSION

The purpose of this article was to highlight how the Exceptional Needs Program at Wood's Homes operationalizes a family-centred approach to short-term campus-based mental health treatment and report on select outcome measures of success. Significant energy is invested to involve families as early as possible in the treatment planning and goal development. Empowering families to see that they may not have the power to control their youth's choices but they do and will continue to have opportunities for influence and teach them, is a fundamental philosophy in the ENP approach to family-centred treatment. The goal is to help families view the larger implications and interactions with their youth's problematic behaviour and invite families to become drivers of creative ways to invite preferred change into their family organizational structure. It is important to always remember that each family is unique, and that this uniqueness provides opportunities for creative interventions if programs are willing to engage, listen, adapt, and provide flexibility to families in a way that demonstrates their importance as key players in their children's lives while also respecting that every family has capacity and competency if programs create the atmosphere to reveal it.

ENP interventions were designed with a focus on relational practice based on the research gathered around the importance of families being the focal point change in campus-based treatment. This is done through modeling, open communication, and working hard to create both emotional and physical closeness between people. ENP has suggestive evidence to support their effectiveness in reducing crisis and enriching overall youth functioning. On average, youth who completed treatment at ENP increased significantly in their daily functioning across the areas of home, school, social, and leisure. Also, on average, overall family distress decreased significantly as well.

REFERENCES

Bettmann, J. E., Jasperson, R. A. (2009). Adolescents in residential and inpatient treatment: A review of the outcome literature. *Child Youth Care Forum*, 38 (1), 161-183.

Brown, J. D., Ireys, H. T., Allen, K., Krissik, T., Barrett, K., Pires, S. A., & Blau, G. (2011). Youth and family participation in the governance of residential treatment facilities. *Residential Treatment for Children & Youth*, 28(4), 311-326. doi: 10.1080/0886571X.2011.615238

Child Welfare League of America, Inc. (2004). CWLA *Standards of Excellence for Residential Services*. Washington, DC: Author.

Czyz, E. K., Lui, Z., & King, C. A. (2012). Social connectedness and one-year trajectories among suicidal adolescents following psychiatric hospitalization. *Journal of Clinical Child & Adolescent Psychology*, 41 (2), 214-226.

Hair, H. J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993 to 2003. *Journal of Child and Family Studies*, 14(4), 551-575.

Holstead, J., Dalton, J., Anita H., Lamond, D. (2010). Modernizing residential treatment centre for children and youth – An informed approach to improve long term outcomes: the demar pilot. *Child Welfare*, 89(2), 115-116.

Knorth, E. J., Harder, A. T., Zandberg, T., & Kendrick, A. J. (2008). Under one roof: A review and selective meta-analysis on the outcomes of residential child and youth care. *Children and Youth Services Review*, 30(2), 123-140.

Kruzich, J. M., Jivanjee, P., Robinson, A., & Friesen, B. J. (2003). Family caregivers' perceptions of barriers to and support of participation in their children's out-of-home treatment. *Psychiatric Services*, 54, 1513-1518.

Landino, D. L., Mabe, P. A., & Josephson, A. M. (2003). Child and adolescent psychiatric emergencies: Family psychodynamic issues. *Child and Adolescent Psychiatric Clinics*, 12, 629-647.

Law, M., Hanna, S., King, G., Hurley, P., King, S., Kertoy, M., & Rosenbaum, P. (2003). Factors affecting family-centred service delivery for children with disabilities. *Child: Care, Health and Development*, 29, 357-366.

Lee, L. J. (2011). Adult visitation and permanency for children following residential treatment. *Child and Youth Services Review*, 33, 1288-1297.

Leichtman, M. (2006). Residential treatment of children and adolescents: Past, present, and future. *American Journal of Orthopsychiatry*, 76(3), 285-294.

Lieberman, R. E. (2004). Future directions in residential treatment. *Child and Adolescent Psychiatric Clinics of North America*, 13(2), 279-294.

MacLaurin, B., Navia, D., Matheson, J. & Johansson, B. (2018). Wood's Homes outcomes measurement (WHOM). *Wood's Homes Journal – Evidence to Practice*, 2(1), 25-28.

Minuchin, S. (1979). *Families and family therapy*. Cambridge, MA: Harvard University Press.

Robst, J., Armstrong, M., Dollard, N., Rohrer, L., Sharrock, P., Batsche, C., & Reader, S. (2013). Characteristics related to family involvement in youth residential mental health treatment. *Children and Youth Services Review*, 35, 40-46.

Noftle, J. W., Cook, S., Leschied, A., St. Pierre, J., Stewart, S. L. and Johnson, A. M. (2010). The trajectory of change for children and youth in residential treatment. *Child Psychiatry and Human Development*, 42, 65-77.

Shaffer, D., Gould, M. S., Brasic, J., Ambrosini, P., Fisher, P., Bird, H., & Aluwahlia, S. (1983). A children's global assessment scale (CGAS). *Archives of General Psychiatry,* 40, 1228–31. doi:10.1001/archpsyc.1983.01790100074010

Sharrock, P. J., Dollard, N., Armstrong, M. I., & Rohrer, L. (2013). Provider perspectives on involving families in children's residential psychiatric care. *Residential Treatment for Children & Youth*, 30(1), 40-54. doi: 10.1080/0886571X.2013.751807

Simons, I., Mulder, E., Breuk, R., Mos, K., Rigter, H., Van Domburgh, L. (2017). A program of family centred care for adolescent in short term stay groups of juvenile justice institutions. *Child and Adolescent Psychiatry and Mental Health*, 11(1), 61-69.

Stage, S. A. (1999). Predicting adolescents' discharge status following residential treatment. *Residential Treatment for Children and Youth*, 16(3), 37-56.

Solbaken, O., Abbass, A. (2015). Intensive short-term dynamic residential treatment program for patients with treatment resistance disorders. *Journal of Affective Disorders*, 181, 67-77.

Sunseri, P. A. (2001). Family functioning and residential treatment outcomes. R*esidential Treatment for Children & Youth*, 22(1), 33-53.

Sweeny, M. T. (2010) "Outdoor behavioral healthcare treatment outcomes: Wediko children's services short-term residential treatment program" (Doctoral dissertation). Available from ProQuest Dissertations & Theses Global database. (Accession Order No. ATT 3397310)

Tomm, K., St. George, S., Wulff, D., & Strong, T. (2014). Patterns in interpersonal interactions. I*nviting relational understanding for therapeutic change*. New York, NY: Routledge.

Trocmé, N., MacLaurin, B., & Fallon, B. (2000). Canadian child welfare outcomes indicator matrix: An ecological approach to tracking service outcomes. J*ournal of Aggression, Maltreatment, and Trauma*, 4, 165-190.

Trocmé, N., MacLaurin, B., Fallon, B., Shlonsky, A., Mulcahy, M., & Esposito, T. (2009). *National child welfare outcomes indicator matrix* (NOM). Montreal, QC: McGill University: Centre for Research on Children and Families.

Walter, U. M., & Petr, C. G. (2008) Family-centred residential treatment: Knowledge, research, and values converge. *Residential Treatment for Children & Youth*, 25(1), 1-16. doi: 10.1080/08865710802209594

Wiess, J. A., & Lunsky, Y. (2011). The brief family distress scale: A measure of crisis in caregivers of individuals on the autism spectrum disorder. *Journal of Child and Family Studies*, 20, 521 – 528.

Whittaker, J. K. (2000). Reinventing residential childcare: An agenda for research and practice. R*esidential Treatment for Children & Youth*, 17(3), 13-30.

APPENDIX A - CHILDREN'S GLOBAL ASSESSMENT SCALE (CGAS) DESCRIPTORS

CHILDREN'S GLOBAL ASSESSMENT SCALE. David Shaffer, M.D., Madelyn S. Gould, Ph.D., Hector Bird, M.D., Prudence Fisher, B.A. Specified time period: 1 month.

100-91 DOING VERY WELL: Superior functioning in all areas (at home, at school and with peers), involved in a range of activities and his many interests (e.g., has hobbies or participates in extracurricular activities or belongs to an organised group such as Scouts, etc.). Likeable, confident, everyday worries never get out of hand. Doing well in school. No symptoms.

90-81 DOING WELL: Good functioning 'in all areas. Secure in family, school, and with peers. There may be transient difficulties and "everyday" worries that occasionally get out of hand (e.g. mild anxiety associated with an important exam, occasionally "blow-ups" with siblings, parents or peers).

80-71 DOING ALL RIGHT - minor impairment: No more than slight impairment in functioning at home, at school, or with peers. Some disturbance of behaviour or emotional distress may be present in response to life stresses (e.g., parental separations, deaths, birth of a sib) but these are brief and interference with functioning is transient, such children are only minimally disturbing to others and are not considered deviant by those who know them.

70-61 SOME PROBLEMS - in one area only: Some difficulty in a single area, but generally functioning pretty well, (e.g., sporadic or isolated antisocial acts, such as occasionally playing hooky petty theft; consistent minor difficulties with school work, mood changes of brief duration, fears and anxieties winch do not lead to gross avoidance behaviour; self-doubts). Has some meaningful interpersonal relationships. Most people who do not know the child well would not consider him/her deviant but those who do know him/her well might express concern.

60-51 SOME NOTICEABLE PROBLEMS - in more than one area: Variable functioning with sporadic difficulties or symptoms in several but not all social areas. Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in other settings.

50-41 OBVIOUS PROBLEMS - moderate impairment in most areas or severe in one area: Moderate degree of interference in functioning in most social areas or severe impairment functioning in one area, such as might result from for example , suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other antisocial behaviour with some preservation of meaningful social relationships.

40-31 SERIOUS PROBLEMS - major impairment in several areas and unable to function in one area: Major impairment in functioning in several areas and unable to function in one of these areas, i.e., disturbed at home, at school, with peers, or in the society at large, e.g., persistent aggression without clear instigation; markedly withdrawn and isolated behaviour due to either mood or though disturbance, suicidal attempts with clear lethal intent. Such children are likely to require special schooling and/or hospitalisation or withdrawal from school (but this is not a sufficient criterion for inclusion in this category).

30-21 SEVERE PROBLEMS - unable to function in almost all situations: Unable to function in almost all areas, e.g., stays at home, in ward or in bed all day without taking part in social activities OR severe impairment in reality testing OR serious impairment in communication (e.g., sometimes incoherent or inappropriate).

20-11 VERY SEVERELY IMPAIRED - considerable supervision is required for safety:

Needs considerable supervision to prevent hurting others or self, e.g., frequently violent, repeated suicide attempts OR to maintain personal hygiene! OR gross impairment in all forms of communication, e.g., severe abnormalities in verbal and gestural communication, marked social aloofness, stupor, etc.

10-1 EXTREMELY IMPAIRED - constant supervision is required for safety: Needs constant supervision (24-hour care) due to severely aggressive or self-destructive behaviour or gross impairment in reality testing, communication, cognition, affect, or personal hygiene.

APPENDIX B – BRIEF FAMILY DISTRESS SCALE (BFDS)

Brief Family Distress Scale - Jonathan Weiss, Ph. D., & Yona Lunsky, Ph.D.

On a scale of 1 to 10, please circle where you and your family currently are right now in terms of crisis by picking one of the following statements:

Everything is fine, my family and I are not in crisis at all.
Everything is fine but sometimes we have our difficulties.
Things are sometimes stressful, but we can deal with problems if they arise.
Things are often stressful, but we are managing to deal with problems when they arise.
Things are very stressful, but we are getting by with a lot of effort.
We have to work extremely hard every moment of every day to avoid having crisis.
We won't be able to handle things soon. If one more thing goes wrong – we will be in crisis.
We are currently in crisis, but are dealing with it ourselves.
We are currently in crisis, and have asked for help from crisis services (emergency room, hospital, community crisis supports.
We are currently in crisis, and it could not get any worse.

Understanding the Impact of Child Welfare Involvement on Street-Involved Youth

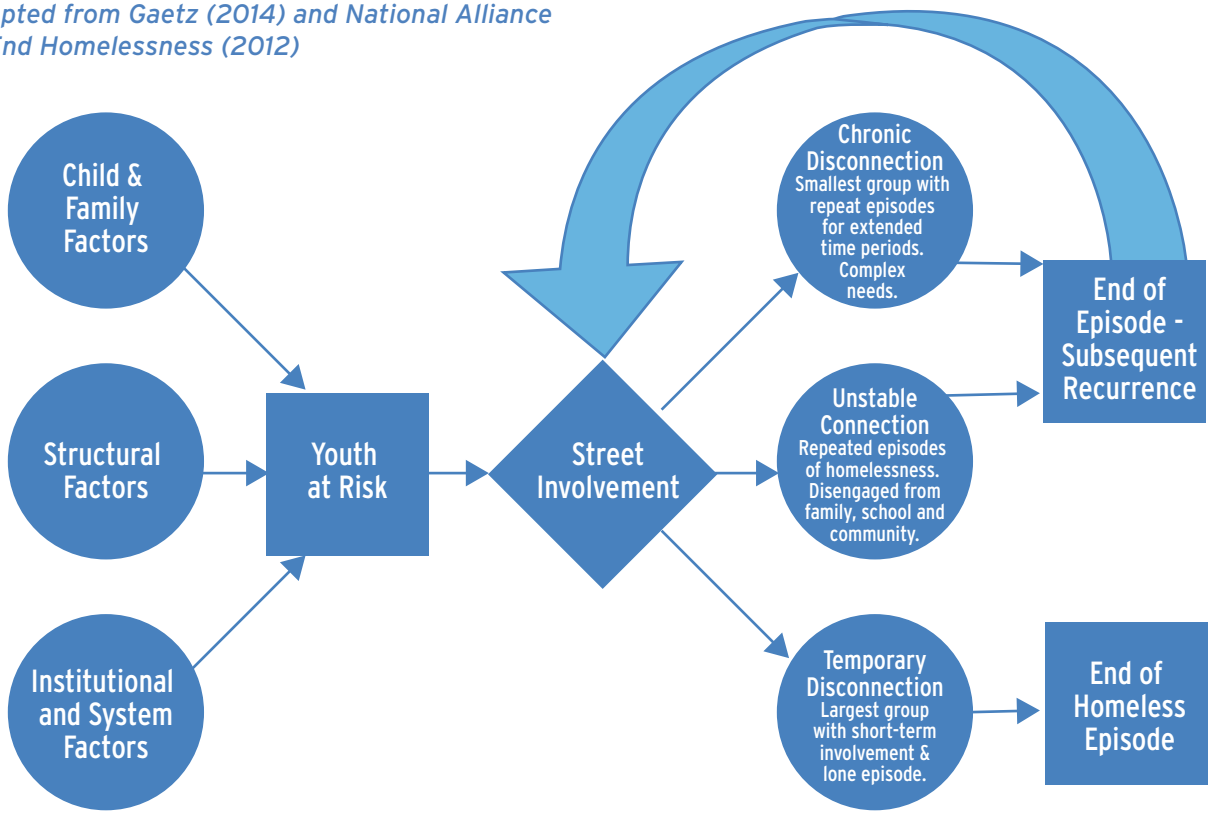
BRUCE MACLAURIN

INTRODUCTION

Street-involved youth in Canada experience decreased rights, opportunities and social supports and this may exacerbate the risks associated with living on the streets (MacLaurin & Worthington, 2020). Street-involved youth are also at higher risk of developing mental health problems, some of which can lead to suicide (Boivin, Roy, Hayel, and Galbaud du Fort 2005); becoming involved in survival or obligatory sex (Haley, Roy, Leclerc, et al. 2004b); developing physical health concerns, including contracting sexually transmitted diseases (Public Health Agency of Canada 2006); getting involved in criminal and delinquent activity (Baron & Hartnagel 2006); using and abusing drugs (Roy, Haley, Leclerc, Cedras & Boivin 2002); and simply not meeting their basic physical needs for food, clothing, and shelter (Dachner and Tarasuk 2002). Canadian street youth are frequently characterized as having unsuccessful experiences with the helping professions including child welfare (Worthington & MacLaurin, 2008; Min Park, Metraux, & Culhane, 2005; Robert, Pauze, & Fournier, 2005); the criminal justice system (Baron & Hartnage, 2006; Gaetz, 2004; Hagan & McCarthy, 1997); children's mental health (Worthington & MacLaurin, 2008); and education (Thompson, O'Brannon III, and Maccio (2004).

A number of typologies have been developed in Canada and the US to help practitioners best understand the characteristics of youth who become involved with street life. MacLaurin (2018), adapted a typology from work by Gaetz et al. (2013) that assists in understanding the range of child and family factors, structural factors and institutional systems factors that impact upon family stability and leads to initial involvement with the street and recurring homelessness (See Figure 1).

Figure 1 – Risk of Street Involvement - MacLaurin (2018) Adapted from Gaetz (2014) and National Alliance to End Homelessness (2012)



Children and youth who have experienced maltreatment and family conflict frequently become involved with child welfare and are referred to child welfare care (MacLaurin and Bala 2004). Children in the care of child welfare (e.g., foster care, group homes, or treatment centres) are overrepresented in most street youth populations (Barker et al. 2014; Biehal and Wade 2000; Duval and Vincent 2009; Fitzgerald 1995; Kulik, Gaetz, Crowe, and Ford-James 2011; Min Park, et al. 2005; Worthington, MacLaurin, et al. 2008). Worthington et al. (2008) reported that 62% of street-involved youth surveyed in Calgary reported that their family had a history of child welfare involvement, and of this number 52% had been placed in either foster or group care as a result of the involvement. As well, children who experience repeated episodes of street-involvement are more likely to have had a significant history of child welfare prior to the street (MacLaurin, Johansson, McDonald & Soenen, 20018). This overrepresentation of child welfare involvement in youth on the street reflects both youth who ran away from current child welfare care or of those youths who became homeless following emancipation from care (Lenz-Rashid 2006).

This paper reports on a secondary analysis of a dataset to examine the differences between street-involved youth with a history of child welfare compared to those street-involved youth who have not had contact with child welfare. Analysis will be done using the Calgary Youth, Health and the Street dataset, a CIHR funded study designed to examine the spectrum of youth on the street in Calgary, Alberta (Worthington & MacLaurin, 2008).

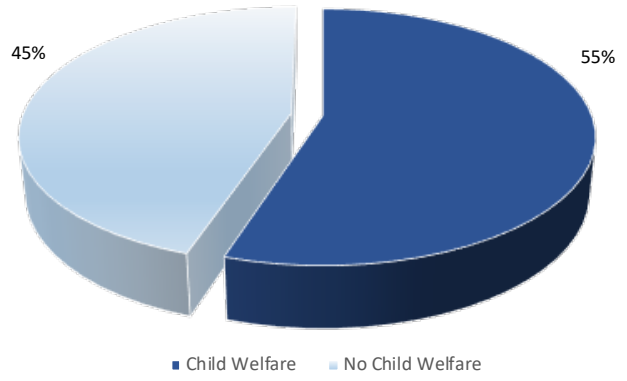
OVERVIEW OF THE CALGARY YOUTH, HEALTH AND THE STREET STUDY

Working in partnership with many youth serving agencies, AIDS Calgary and researchers from the University of Calgary developed The Calgary Youth, Health and the Street Study to examine the health and HIV risks, coping mechanisms, and service needs of the broad spectrum of street-involved youth. Funding was provided by the Canadian Institute of Health Research (CIHR) for a 3-year term. The study has two primary goals: 1a) to describe the spectrum of street involved youth in Calgary and b) to explore variation among these different sub-populations in terms of HIV and health risks, coping mechanisms, and service needs, and 2) to use the process of data collection and the information collected as a basis for a reciprocal planning process among youth and HIV service organizations in order to develop and enhance existing services. The study used a community-based research design where the principles of community involvement and collaboration are applied using scientifically accepted research methods. Partner organizations included fourteen non-profit organizations in Calgary serving children and youth involved with homelessness. The study team conducted 355 surveys of street-involved youth aged 14-24 and an additional 44 in-depth qualitative interviews of youth at all points of the spectrum of street-involvement.

FOCUS OF THE ANALYSIS

This chapter reports on secondary data analyses of the Calgary Youth, Health and the Street dataset to examine the differences between street-involved youth with a history of child welfare compared to those street-involved youth who have not had contact with child welfare. As indicated in Figure 1, this analysis will report on an extensive range of child and family factors, structural factors and institutional and system factors that have an impact upon the initiation of street involvement for youth at risk. For all bivariate analyses, Pearson's chi-square test of independence was calculated to determine significant interactions. The dichotomous child welfare history variable included 1) child welfare involvement, and 2) no previous child welfare involvement.

Figure 2 – Street Youth and Child Welfare Status



FINDINGS

A total of 445 street-involved youth surveyed reported on child welfare involvement. Of this group, 55% (n=190) had a history of child welfare involvement while 45% (n=155) had no child welfare involvement

(See Figure 2). A statistically significant interaction as tested by Chi-square test of independence was found for child welfare status for the age of the youth and the sex of the youth, while there was no significant relationship for ethnic identity of the youth. Street-involved youth with a child welfare history were younger as 64% were less than 19 compared to 36% for those youth with no child welfare history. A higher percentage of street youth with a child welfare history were female (44%) compared to no child welfare history (31%) (See Table 1).

Table 1: Child Factors Associated with Child Welfare History and No Child Welfare History for Street-Involved Youth in Calgary

		CW History	No CW History
Age of Youth*		%	%
	< 19 years	64%	36%
	19-24 years	32%	56%
	>24 years	4%	8%
Sex of Youth *			
	Male	55%	68%
	Female	44%	31%
	Transgendered	1%	1%
Ethnic Identity of Youth ns			
	White	60%	62%
	Indigenous	27%	25%
	Other cultural heritage	13%	13%
Calgary Youth, Health and the Street Study		190	155

**p less than or equal to .05*
ns p is not significant

A statistically significant interaction as tested by Chi-square test of independence was found for child welfare status for all forms of child maltreatment as well as suicidal ideation and suicidal attempts, however there was no significant interaction for level of physical health. Street youth with a child welfare history experienced much higher levels of physical abuse (74%), sexual abuse (32%), neglect (43%) and emotional maltreatment (78%) than did those youth with no history of child welfare involvement. It is remarkable however that these children with no child welfare involvement did reflect relatively high rates of maltreatment that had never been reported or investigated by child welfare while the youth was living at home. This included physical abuse (44%) sexual abuse (23%), neglect (39%) and emotional maltreatment (70%) (See Table 2).

Table 2: Child Risk Factors Associated with Child Welfare History and No Child Welfare History for Street-Involved Youth in Calgary

		CW History	No CW History
History of Maltreatment		%	%
	Physical Abuse *	74%	44%
	Sexual Abuse *	32%	23%
	Neglect *	43%	39%
	Emotional Maltreatment *	78%	70%
Suicide			
	Suicidal Ideation *	66%	47%
	Suicidal Attempts *	48%	26%
Physical Health ns			
	Excellent or Very good	45%	46%
	Good	33%	31%
	Fair or Poor	23%	22%
Calgary Youth, Health and the Street Study		190	155

**p less than or equal to .05*
ns p is not significant

A statistically significant interaction as tested by Chi-square test of independence was found for child welfare status for all forms of handling stress, sexual health risks, and how friends made money. Street involved youth with a child welfare history reported higher rates for drugs and alcohol use (74%), having started drugs and alcohol prior to age 12 (32%), involvement in cutting or burning their bodies (43%), and violence to others (78%). The child welfare group also reflected higher sexual health risks for involvement in survival sex at least once (31%), prostitution at least once (33%), and PCHiP (Protection of Children Involvedin Prostitution) (15%) than those youth with no child welfare involvement. A higher percentage of the child welfare group reported having friends who relied on making money by illegal means including drug sales (65%), prostitution (22%), trading sex (11%), and selling stolen goods (50%) while

a higher percentage of youth with no child welfare involvement reported their friends were employed full-time (55%) (See Table 3).

Table 3: Child Risk Factors Associated with Child Welfare History and No Child Welfare History for Street-Involved Youth in Calgary

		CW History	No CW History
Handling Stress		%	%
	Drugs and Alcohol *	74%	44%
	Drugs/Alcohol Started 12 or Less *	32%	23%
	Cutting or Burning *	43%	39%
	Violence to Others *	78%	70%
Sexual Health Risks			
	Survival Sex At Least Once *	31%	19%
	Prostitution At least Once *	33%	31%
	PCHiP Involvement *	15%	6%
How Friends Making Money			
	Employed Full-time *	43%	55%
	Drug Sales *	65%	43%
	Prostitution *	22%	10%
	Trade Sex *	11%	5%
	Stolen Goods *	50%	30%
Calgary Youth, Health and the Street Study		190	155

**p less than or equal to .05*
ns p is not significant

All street-involved youth reported living in families that were challenged by separation, poor family functioning, and involvement in alcohol and drug abuse, domestic violence and unemployment. A statistically significant interaction as tested by Chi-square test of independence was found for child welfare status for all family risk factors however. The child welfare group was more likely to report living with a lone parent family (34%), or a blended family (31%), to

Table 4: Family Risk Factors Associated with Child Welfare History and No Child Welfare History for Street-Involved Youth in Calgary

		CW History	No CW History
Family Category *		%	%
	2 Parent Biological	21%	29%
	Blended Family	31%	29%
	Lone Parent	34%	25%
	Other	15%	17%
Family Functioning *			
	Very Good	13%	26%
	Fairly Good	22%	34%
	Somewhat Poor	37%	23%
	Very Poor	28%	16%
Family Problems			
	Alcohol Abuse *	62%	45%
	Drug Abuse *	53%	27%
	Domestic Violence *	63%	44%
	Unemployed *	14%	1%
Calgary Youth, Health and the Street Study		190	155

**p less than or equal to .05*
ns p is not significant

have somewhat poor (37%) or very poor (27%) level of family functioning, and to report parental alcohol abuse (62%), drug abuse (53%), domestic violence (63%), and unemployment (14%) that the group with no child welfare involvement (see Table 4).

Again, all street-involved youth reported high levels of involvement with other systems. A statistically significant interaction as tested by Chi-square test of independence was found for child welfare status for reported mental health issues, school issues and involvement in special education, and involvement with juvenile justice charges. Ninety percent of youth with child welfare involvement reported juvenile justice involvement, while 49% reported mental health issues and an additional 48% reported involvement in special education for school issues (See Table 5).

Table 5: Systems Involvement Factors Associated with Child Welfare History and No Child Welfare History for Street-Involved Youth in Calgary

		CW History	No CW History
Systems Involvement		%	%
	Mental Health Issues *	49%	36%
	School Issues - Special Education *	48%	33%
	Juvenile Justice and Charges *	90%	64%
Calgary Youth, Health and the Street Study		190	155

**p less than or equal to .05*
ns p is not significant

CONCLUSIONS

Street-involved youth in Canada are a diverse and marginalized population that face a range of challenges and insufficient and fragmented support from institutions and services prior to and during their street-involvement. The comparison of the youth cohort with a history of child welfare involvement to youth with no child welfare history highlights a concerning level of risk and trauma experienced by these youth related to their own personal risks, family well-being and support, poverty and involvement with helping professions. An increased focus on evidence-based intervention is required to better identify what can work best for what groups of this diverse population.

REFERENCES

Barker, B., Kerr, T., Taiaiake, G., Fortin, M., Nguyen, P., Wood, E. and Debeck, K. (2014). High prevalence of exposure to the child welfare system among street-involved youth in a Canadian setting: Implications for policy and practice. *Public Health*, 14(197): 1-7

Baron, S. W., and Hartnagel, T. F. (2006). Street youth, strain theory, and crime. *Journal of Criminal Justice*, 34(2), 209-223.

Biehal, N., and Wade, J. (2000). Going missing from residential and foster care: Linking biographies and contexts. *British Journal of Social Work*, 30: 211-25.

Boivin, J. F., Roy, E., Haley, N., and Galbaud du Fort, G. (2005). The health of street youth: A Canadian perspective. *Canadian Journal of Public Health*, 96(6), 432-437.

Dachner, N., and Tarasuk, V. (2002). Homeless 'squeegee kids': Food insecurity and daily survival. *Social Science and Medicine*, 54, 1039-1049.

Duval, D.M., and Vincent, N. (2009). Affect regulation of homeless youth once in the child welfare system. *Child and Adolescent Social Work Journal*, 26: 155–73.

Fitzgerald, M.D. (1995). Homeless youths and the child welfare system: Implications for policy and service. *Child Welfare*, 74(3): 717–31.

Gaetz, S. (2004). Safe streets for whom? Homeless youth, social exclusion, and criminal victimization. *Canadian Journal of Criminology and Criminal Justice*, 46(4): 423–55.

Gaetz, S., O'Grady, B., Buccieri, K., Karabanow, J., and Marsolais, A. (2014), Introduction – Chapter 1, In N. S. Gaetz, B., O'Grady, K. Buccieri, J. Karabanow, and A. Marsolais, (Eds), *Youth Homelessness in Canada: Implications for Policy and Practice,* (pp. 1-14). Toronto: Canadian Homelessness Research Network Press.

Haley, N., Roy, E., Leclerc, P., Boudreau, J-F., and Boivin, J-F. (2004b). HIV risk profile of male street youth involved in survival sex. *Sexually Transmitted Infections*, 80(6), 526-530.

Kulik, D., Gaetz, S., Crowe, C., and Ford-James, E. (2011). Homeless youth's overwhelming health burden: A review of the literature. *Paediatrics & Child Health*, 16(6): 43–7.

Lenz-Rashid, S. (2006). Employment experiences of homeless young adults: Are they different for youth with a history of foster care? *Children and Youth Services Review*, 28: 236–59.

MacLaurin, B., and Bala, N. (2004). Children in care. In N. Bala, M.K. Zapf, R.J. Williams, R. Vogl, and J.P. Hornick (Eds), *Canadian Child Welfare Law* (pp. 111–38). Toronto: Thompson Educational Publishing.

MacLaurin, B., Johansson, B., McDonald, M. & Soenen, D. (2018). Recurrence of street-involvement: Exploring the experiences of Calgary youth, *Wood's Home Journal Evidence to Practice*, Vol.2 (1); 13-21.

MacLaurin, B. & Worthington, C. (2020). Street Involved Youth in Canada. In J. Winterdyk, K. Gorkoff, D. Antonowicz & R. Smandych (Eds), *Youth Justice: A Canadian Review* (pp. 349-378). Toronto: Oxford University Press

Min Park, J., Metraux, S., and Culhane, D.P. (2005). Childhood out-of-home placement and dynamics of public shelter utilization among young homeless adults. *Children and Youth Services Review*, 27(5): 533–46.

Public Health Agency of Canada. (2006b). *Street youth in Canada: Findings from enhanced surveillance of Canadian street youth, 1999-2003* (No. HP5-15/2006). Ottawa, ON: Minister of Health.

Robert, M., Pauze, R., and Fournier, L. (2005). Factors associated with homelessness of adolescents under supervision of the youth protection system. *Journal of Adolescence*, 28: 215–30.

Roy, E., Haley, N., Leclerc, P., Cedras, L., and Boivin, J. F. (2002). Drug injection among street youth: The first time. *Addiction*, 97(8), 1003-1010.

Thompson, S.J., Zittel-Palamara, K.M., and Maccio, E.M. (2004). Runaway youth utilizing crisis shelter services: Predictors of presenting problems. *Child and Youth Care Forum*, 33(6): 387–404.

Worthington, C., MacLaurin, B., Huffey, N., Dittmann, D., Kitt, O., Patten, S., et al. (2008). *Calgary, youth, health and the street—Final report*. Calgary: University of Calgary.

Eastside Family Centre: Using Data to Examine Practice

BRUCE MACLAURIN, JANET STEWART & RUPINDER HEHAR

INTRODUCTION TO EASTSIDE FAMILY CENTRE

The Eastside Family Centre (EFC), now called Eastside Community Mental Health Services, was developed in 1990 in response to the need for immediately accessible and affordable mental health services on the east side of Calgary, an ethnically diverse and lower socio-economic quadrant of Calgary (Stewart, McElheran, Park, Oakander, MacLaurin, Jing Fang & Robinson (2018). During this period, social service funding was being cut, while the population of this area was dramatically increasing. Clients from this area, as well as from all quadrants of Calgary, are able to walk in to the centre and request the next available therapy session when they are ready to do so (McElheran, Stewart, Soenen, Newman & MacLaurin et al, 2014). Counselling is delivered by a team of therapists and may include a consulting psychiatrist, and the use of a one-way mirror. The EFC therapists include social workers, psychologists, clinical nurses, consulting psychiatrists, marriage and family therapists, masters level clinical students and family physician.

Walk-in therapy at EFC is designed for individuals, couples and families to experience a sense of emotional relief and positive outcome at the conclusion of the one-hour session (Slive & Bobele, 2012). Walk-in sessions are organized around the Milan 5-part session model (Boscolo, Cecchin, Hoffman, & Penn, 1987). The development of the centre and the clinical approach are well documented in the research and practice literature over the past two decades (Slive, MacLaurin, Oakander & Amundson, 1995; Miller & Slive, 2004; Slive, McElheran & Lawson, 2008; Clements, McElheran, Hackney & Park, 2011; McElheran, et al., 2014).

DEVELOPING AN OUTCOMES FRAMEWORK AT EASTSIDE FAMILY CENTRE

EFC has been the focus of a number of evaluative and research initiatives over the past 30 years. This work has provided evidence that EFC provides highly accessible and cost effective mental health services, and users consistently report a high level of satisfaction with the walk-in counselling at EFC (Hoffart & Hoffart, 1994; Harper-Jaques, McElheran, Slive, & Leahey, 2008; Miller, 1996, 2008; Miller & Slive, 2004; Whitford, 1994). These independent studies have contributed greatly to the professional and academic body of evidence supporting the use of walk-in, single session therapy as a primary form of intervention.

Over the past 25 years, services designed to serve children and families in Canada have been called upon to initiate an ongoing and systematic approach for outcome measurement. Specifically there is an interest in knowing what interventions are most effective for which type of clients, for what type of presenting concerns, and over what time period (Trocmé, MacLaurin, Fallon, Shlonsky, et al., 2009). This has contributed to the next step of research and evaluation developed at EFC.

During the summer of 2012, the management and staff of the EFC met with Wood's Research Department to examine the changing needs of the clients using single session walk-in counselling. There was speculation that a higher percentage of clients were presenting with acute mental health concerns, specifically depression and anxiety. Early discussions proposed conducting a time-limited research study to examine this practice question, however consensus was reached on developing a comprehensive data collection framework that would support tracking data and outcomes on an ongoing basis. Collecting data each year would generate an ongoing database that could address practice and research questions and monitor changes in client profile and presenting concerns for clinical populations over time. A study team was established during the fall of 2012 with a mandate of developing and pilot-testing an outcomes framework. Data collection primarily used information that was currently collected for all clients, in addition to two new clinical scales measuring acuity of depression and anxiety. Reports on the pilot test data were scheduled throughout 2013 and the outcome frame-

work was modified to incorporate all revisions based upon the pilot test period. The data collection process that was initiated in November 2012 continued for a three-year term.

DESCRIPTION OF DATA COLLECTED FOR MEASURING OUTCOMES

Data Collected Before the Session

The Client Demographic Form gathers information about the client such as how they found out about the service, primary language spoken in their home, and location of residence. The Client Confidential Questionnaire collects information related to what prompted the client to seek counselling on that day. These questions include determining the single most important concern that the client wishes to share; identifying who is most affected emotionally by this concern; and what the client would like from the day's session. Clients also rate their distress level on a scale ranging from no distress to extreme distress (Duncan, Miller, & Sparks, 2004). The forms, questionnaire and distress scales have been used to collect information on all new or repeat clients for the past two decades. Two new scales were added to the data collection process beginning in 2012 and this included the Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder (GAD-7).

Data Collected Following the Session

Following the completion of each session, clients complete a feedback form adapted from the Outcome Rating Scale (Duncan, Miller, & Sparks, 2004). As well, clients provide a measure of their post-session distress, feedback on the goodness-of-fit of the session for them, as well as their therapeutic alliance with the therapist and team for the session (McElheran et al., 2014). The therapist responsible for leading the session provides feedback on additional variables including type of risk and level of risk in the session, client resources, form of intervention, and use of psychiatric consultation.

FOCUS OF CURRENT SECONDARY ANALYSES

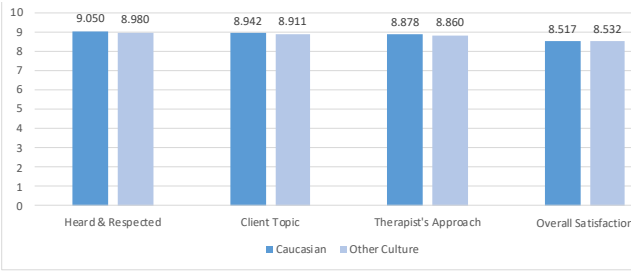
1) Do Short-term Outcomes for Single Session Walk-in Counselling Vary By Cultural Group

Eastside Family Centre was designed to serve the east side of Calgary, a quadrant consisting of diverse cultures. Overall outcomes suggest that clients as a whole are well served with respect to a significant decrease in distress and positive levels of satisfaction following the completion of the session. There is growing consensus that single session, walk-in therapy has achieved positive outcomes for all clients over the past 30 years, however there are some who suggest that clinical outcomes may vary for people from diverse cultural backgrounds. This analysis was conducted to examine if two short-term outcomes measured at EFC (change in distress and session satisfaction) vary by the culture of clients accessing walk-in sessions. T-test is used to assess the statistical significance of the difference between two sample means. Significance indicates that differences did not occur by chance and is determined by: the size of the difference between the group averages; sample size, and standard deviations of the groups.

Walk-in sessions at EFC serve a diverse range of individuals, couples and families who reflect the changing population of Calgary. Approximately 69.4% of clients self-identify as Caucasian, while an additional 6.1% report an Indigenous heritage. The remaining 24.5% of clients reflect other cultural groups which includes African/Caribbean, Arab, Chinese, Filipino, Japanese, Korean, Latin American, South Asian, South East Asian, West Arab, and Other. Numbers for the specific cultural groups are too low to report with confidence. Analysis was conducted on Caucasian (69.4%) compared to all other cultural groups (30.6%).

Level of satisfaction is measured by four questions asked of the participant following the conclusion of the walk-in session. These include: 1) if the client felt heard and respected, 2) if the session focused on what the client wanted to discuss, 3) if the therapist's approach was a good fit for the client, and 4) the client's overall satisfaction with the session. An independent-samples T-test was conducted on the mean satisfaction scores for the two comparison groups (Caucasian and other cultural group) to determine if there is a statistically significant difference in the mean level of satisfaction by cultural group. Chart 1 presents the four satisfaction scores noted for each cultural group. There was no significant difference for the four mean measures of session satisfaction for Caucasians compared to other cultural groups.

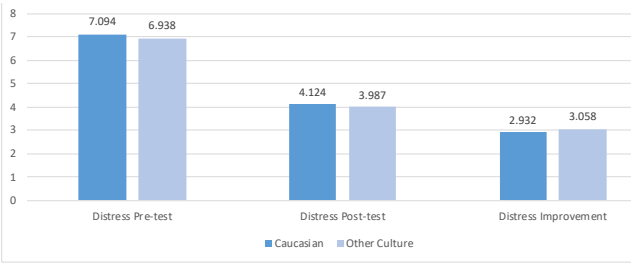
Chart 1 - Mean Satisfaction Score by Cultural Group



(1) Satisfaction (Heard & Respected) did not differ for Caucasians or other cultures: T(2.056) = 1.000, p=.317
(2) Satisfaction (Client Topic) did not differ for Caucasians or other cultures: T(2.053) = .409, p=.683
(3) Satisfaction (Therapist's Approach) did not differ for Caucasians or other cultures: T(2.052) = .224, p=.823
(4) Satisfaction (Overall Satisfaction) did not differ for Caucasians or other cultures: T(2.050) = -.134, p=.893

Change in client distress is measured by a pre- and post-measure of level of distress as rated by the client before and immediately following the end of the session. Chart 2 presents the mean pre-measure, post-measure and distress change noted for each cultural group. There is no significant difference between distress change for the Caucasian group compared to the other cultural group as measured by the independent-samples T-test.

Chart 2 - Mean Distress Improvement by Cultural Group



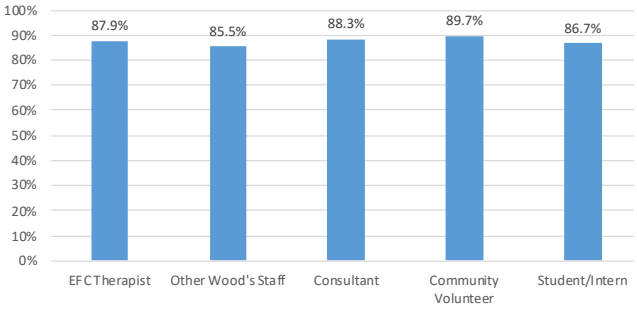
(1) Distress Improvement did not differ for Caucasians or other cultures: T(2.046) = 1.107, p=.269

2) Therapist Characteristics and Session Outcome

Eastside Family Centre has a relatively small core staff group. The work of EFC staff is supplemented by other therapists employed by Wood's Homes, clinical consultants, community volunteer therapists, and student therapists or interns. Some emerging practice evidence would suggest that clinical outcomes may vary by therapist type or orientation. Other evidence suggests this may not be the case. This analysis was conducted to examine short-term outcomes (change in distress and session satisfaction) by role of the therapist conducting the session using Chi-Square. Chi-square is used to examine differences with categorical variables and tests how well an observed breakdown of people over the various categories fit the breakdown that you might expect.

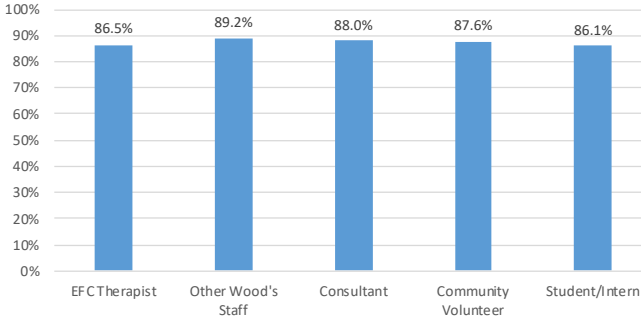
Walk-in sessions are led by a range of therapists including paid EFC therapists (45.6%), students or interns (36.4%), community volunteer therapists (7.9%), other Wood's Homes staff (7.6%), and clinical consultants (2.5%). Level of satisfaction is determined by a series of questions asked of the participant following the conclusion of the walk-in session. Chart 3 presents the overall satisfaction noted for each therapist type. There is no significant difference between overall level of session satisfaction by the type of therapist as measured by Chi-square (p = n.s.).

Chart 3 - Overall Satisfaction by Therapist Type



Change in client distress is measured by a pre and post measure of level of distress as rated by the client before and immediately following the end of the session. Chart 4 presents data on the level of distress improvement by therapist type. There is no significant difference between client distress change by type of therapist as measured by Chi-square (p = n.s.).

Chart 4 - Distress Improvement by Therapist Type



CONCLUSION

The development and implementation of the EFC Outcomes Measurement Framework clearly supports and informs the work that is being done with single session, walk-in counselling at Eastside Family Centre. The depth and breadth of this dataset provides a foundation on which to examine practice questions that come up each reporting period. The first analyses of these data indicate that clients of all cultural backgrounds experience a similar level of satisfaction and distress improvement as there was no statistically significant difference in the mean levels of satisfaction or distress improvement using an independent samples T-test. This is important as Eastside Family Centre provides services in the quadrant of Calgary that is increasingly culturally diverse and it is essential that all clients demonstrate receiving benefit from walk-in counselling. The second analysis indicated that there was no statistically significant difference between overall level of session satisfaction by the type of therapist as measured by Chi-square (p = n.s.), as well as no statistically significant difference between client distress change by type of therapist, also measured by Chi-square (p = n.s.). This analysis was critical given that EFC relies heavily on volunteer therapists, graduate students and paid staff and consultants. All clients demonstrated no differences in their satisfaction and distress reduction based upon what therapist was leading the session.

Documenting positive change over the course of a single session walk-in session is a critical step in intervention research. These findings will further inform best practice and contribute to the development of this model of service.

REFERENCES

Boscolo, L., Cecchin, G., Hoffman, L., & Penn, P. (1987). *Milan systemic family therapy.* New York: Basic Books.

Clements, R., McElheran, N., Hackney, L., & Park, H. (2011). The Eastside Family Centre: 20 years of single-session walk-in therapy. In A. Slive & M. Bobele (Eds.), *When one hour is all you have: Effective therapy for walk-in clients* (pp. 109-127). Phoenix, AZ: Zeig, Tucker & Theisen.

Hoffart, B., & Hoffart, I. (1994). P*rogram evaluation of Eastside Family Centre.* Calgary: Synergy Research Group.

Harper-Jaques, S., McElheran, N., Slive, A., & Leahey, M. (2008). A comparison of two approaches to the delivery of walk-in single session mental health therapy. *Journal of Systemic Therapies,* 27(4), 40-53.

McElheran, N., Stewart, J., Soenen, D., Newman, J., & MacLaurin B. (2014). Walk-in single session therapy at the Eastside Family Centre. In Michael F. Hoyt and Moshe Talman (Ed.), *Capturing the moment: single session therapy and walk-in services.* UK: Crown House Publishing.

Miller, J. K., & Slive, A. (2004). Breaking down the barriers to clinical service delivery: Walk-in family therapy. *Journal of Marital and Family Therapy,* 30(1), 95-105.

Slive, A., & Bobele, M. (2012). Walk-in counselling services: Making the most of one hour. *The Australian and New Zealand Journal of Family Therapy*, 33(1): 27-38.

Slive, A., McElheran, N., & Lawson, A. (2008). How brief does it get? Walk-in single session therapy. *Journal of Systemic Therapies*, 27(4), 5-22.

Slive, A., MacLaurin, B., Oakander, M. & Amundson, J., (1995). Walk-in single sessions: A new paradigm in clinical service delivery. J*ournal of Systemic Therapies,* 14, 3-11.

Stewart, J., McElheran, N., Park, H., Oakander, M., MacLaurin, B., Jing Fang, C. & Robinson, A. (2018). Twenty-five years of walk-in single sessions at Eastside Family Centre: Clinical and research dimensions, in M. Hoyt, M. Bobele, A. Slive, J. Young & M. Talmon (Eds.), in *Single-session therapy by walk-in or appointment*, New York: Routledge, Taylor and Francis Group

Trocmé, N., MacLaurin, B., Fallon, B., Shlonsky, A., Mulcahy, M., & Esposito, T. (2009). N*ational child welfare outcomes indicator matrix* (NOM). Montreal, QC: McGill University, Centre for Research on Children and Families.

Whitford, D. (1994). E*xploration of contributors to volunteer retention at two community based human service programs: Eastside Family Centre and the Community Resource Team*. Calgary: Wood's Homes.

Practice Lessons: Story #30

BJORN JOHANSSON

Wood's Homes celebrated its 100th anniversary in 2014. As part of the celebration, a book was published called One Hundred Stories for One Hundred Years. This is one of these stories.

I've been thinking about things. I mean I've been here twenty years – you're going to think about things. You get a lot of feedback from clients. You get clients, who when I was twenty-four or twenty-five, they were only eight years younger than me. You get a pool of adults who call you or write to you and talk about their experiences.

There's one that is, to me, a lesson about how change happens here. I thought it was interesting. It reinforced how change doesn't always happen when we think it should happen. With a lot of things we do, we wonder, have we changed things or have we helped? Sometimes it is only much later that the things we do, or the advice we give, is lived or listened to – only when the client is ready.

This was a young man who was almost fifteen when he came here, and he lived with us for about a year and a half, at the Habitat Program. Getting there... it takes a lot of things to happen to be referred there. It's an intensive program. Habitat, we ran it for ten years, it was a domestic violence program. It was all these boys who had a number of things in their experience. They'd all experienced violence and had themselves become perpetrators. They were getting pretty old and using violence on family. There's disruptive behavior. It gets to the point where the parents find they are needing a lot of support.

This fellow's father had been a part of his life until he was six or seven. Both the boy and his mother would have described him as very violent. He was charged with domestic violence at the home and that put him in prison. And that meant that by the time this young man was ten, he no longer had any contact with his father.

He saw himself as taking on his father's role, and he was almost proud of that. What got our attention was that he had threatened to hurt his mom's new baby. He had grabbed the child by his head. So that's how he came to us – in the middle of this very big crisis.

I wouldn't have thought I had a lot of hope for him. He fought treatment at every turn. His values on violence were very entrenched. I used him as training with the staff for many years. Anything he thought was unjust or unfair, he saw as an excuse to become violent. In many ways he was a very tough nut to crack.

He was into hierarchy. In some ways he saw me as a leader, but he also challenged me. Daily, I told him that violence is a trick that we get taught. One of my themes with him was how to become a courageous man. People who are courageous, I told him, don't hurt the people they love. They are able to see the impact they have and are able to put themselves in other people's shoes. We had daily groups around beliefs around violence.

Behaviourally, he seemed to improve. But we never felt that he had changed his core attitudes. He graduated and went into a group home – but we were pretty worried about him.

About five years later, we received a note from him, wondering who was still here. I think he was probably, maybe he was about twenty-one or twenty—two, and we received this note and of course he was told that I was still here. I called him and ended up having a couple of phone calls.

He wanted to tell us that everything that we wanted to teach him, he finally understood. When he called, he was very vulnerable. He said, "Every fight we had, every time you challenged me to be a courageous man, I'm finally understanding what it meant." He is now doing very well.

The point of the story is that the way we impact people is not necessarily linear – there isn't this direct line from treatment to healing. But those experiences can result in big changes later on.

Martini, C., (2013) *One hundred stories for one hundred years: A history of Wood's Homes as told by the people who lived and worked there*. Edmonton: Brush Education Ltd.

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