FRN Standards of Practice

Jurisdictional Review

PolicyWise for Children & Families

Acknowledgments

PRIMARY CONTRIBUTORS

Janine Elenko, Laurie Vermeylen, Naomi Parker

PROJECT SPONSORS

Alberta Children's Services

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Executive Summary

Overview

Alberta's Family Resource Networks (FRNs) were recently established by Children's Services to provide prevention and early intervention supports and services for children and youth (aged 0 to 18 years) and their families, through a hub-and-spoke model. FRNs aim to provide equitable access to a range of universal, targeted, and intensive services that contribute to three outcome domains: child development, caregiver capacity building, and social connections and supports.

PolicyWise for Children & Families has been contracted by Alberta Children's Services to co-develop FRN Standards of Practice. **The goal of the Standards of Practice is to help support high quality service delivery by promoting provincial consistency while also allowing agencies the flexibility to respond to their unique community context and the specific needs of the children, youth, and families who access their services.**

The purpose of this document is to share the findings from a jurisdictional review of Standards of Practice for similar supports and services in Canada and the United States. A total of eight documents were determined to have relevant content for the FRN Standards of Practice, from British Columbia (1), Ontario (4), New Brunswick (1), and the United States (2). These findings will be used to propose content areas for the FRN Standards of Practice. In combination with feedback from the Program and Policy Standards Task Team (Task Team), findings from this review will be discussed with the FRNs in upcoming online engagement sessions.

Findings

Findings have been organized into four main content areas: foundations, programs and services, administration, and accountability (Figure 1).

Figure 1: Content areas from jurisdictional review

The following sections provide an overview of content within each of the four areas, concluding with next steps for developing the FRN Standards of Practice and key questions for the Task Team and FRN engagement. References are cited numerically throughout the sections according to the following legend:

Reference Legend

1. New Brunswick Early Childhood Development Division (2019)
2. Little Drum Consulting (2016)
3. California Network of Family Strengthening Networks (2014)
4. New York State Department of Health, Bureau of Early Intervention (2013)
5. Infant Mental Health Promotion (2011)
6. Ontario Ministry of Children and Youth Services (2015)
7. Ontario Ministry of Children Community and Social Services (2018)
8. Region of Peel Human Services (2019)

Foundations

Several foundational principles emerged from the jurisdictional review to guide both operations and the delivery of supports and services. These were well aligned with the six principles and emphasis on inclusive practices outlined in Children's Services' Well-Being and Resiliency Framework (Alberta Children's Services, 2019a). Jurisdictional documents included content that aligned with the Well-Being and Resiliency Framework, occasionally framing them in a slightly different way.

Foundations

- Support Diverse Populations (including Indigenous Experience)[2,3,6,7,8]
- Preserve Family[2,7]
- Strengths-based[1,2,3,7]
- Connection[2,3,7]
- Collaboration[1,2,6,7,8]
- Continuous Improvement[3,6,8]

Programs & Services

Standards regarding program and service delivery were often the focus of the content in the jurisdictional documents reviewed. This section provides broad standards that are applicable across numerous types of services, although not all of the content will be applicable to all FRN programs and services. The two main categories of information present were eligibility and program and service activities.

Eligibility

Eligibility Criteria

- Age range for services offered[1,2]
- Physical, psychological, emotional, and/or social criteria for programs and services[1,2,8]
- Geographical boundaires[1,2]

Referrals

- Accepted referral sources[1]
- Accompanying information needed with referrals (e.g., assessments, reason for referral)[1,6]
- Readiness of family[1,2,7]

Screening

- Screening approach (purpose, timeline, and process)[1,2]
- Screening components and tools[1,2,6]

Program and Service Activities

Assessment

- Assessment approach (timeline and frequency, process, and family involvement)[1,2,6,7]
- Assessment components[1,2,6,7]
- Assessment tools[1,4,6,7]

Service Delivery Planning

- Develop an individualized plan (purpose, timeline, process, and components)[1,4,5,6,7]
- Timeline and process for reviewing individualized plans[1,6,7,8]

Programs and Services

- Services are available and accessible[2,3,4,5,6,8]
- Frequency, intensity, and duration of services[1,2,4,5,6]
- Service delivery approach (with families, community partners, and service providers, as well as specific models, practices, or programs that guide service delivery)[1,2,4,5,6,7,8]
- Group supports and services (criteria, participant numbers, ratio of participants to staff)[1,4,6]
- Assisting families through crisis[2]

Referrals

- Make referrals to other programs (internal or external to organization)[2,6,7,8]

Developing Connections

- Connections with potential clients (outreach plan and approach, timeline of outreach efforts)[1,3]
- Connections with other organizations and service providers (collaborative relationships, coordinated pathway to supports and services)[2,3,6]

Administration

Content addressing administrative standards was included in most of the documents reviewed. These standards covered three main categories which complement the standards in the Programs and Services section: staffing, communication, and caseload and waitlist management.

Staffing

Staffing Requirements

- Staff qualifications (for all staff and for specific positions)[1,4,5,7]
- Staff ratios (ratio staff: clients, supervisors: staff)[1,4,5,8]

Staff Support and Development

- Staff are provided opportunities for reflection[1,5]
- Staff are aware of and provided opportunities for professional development to strengthen knowledge and skills[2,3,5]
- Staff wellness is supported through workplace practices and environment[2,5]

Communication

Information Sharing

- Information sharing processes (communication with families, confidentiality safeguards, release of information)[1,2,6]
- Care coordination (communication between service providers, family access to information, shared commitment to confidentiality)[2,4,5,7]

Documentation

- Documentation included in client record (forms, reports, notes, correspondence)[1,2,6,7]
- Timeline for retaining documents[1,2]

Caseload and Waitlist Management

Caseload Volume

- Determination of appropriate caseload volume (minimum caseloads, division of time, breakdown of caseloads by client status)[1,2,5]

Case Closure

- Case transition or closure (reasons and processes)[1,2,5,6,7]
- Referral pathway for clients exiting supports (transition planning, smooth transitions)[1,6,7]

Waitlist Process

- Consistent process for waitlist management (tracking when referrals are received, communication and support for families while on a waitlist)[1,2,6,7]

Factors to Determine Priority for Service Delivery

- Develop factors to determine priority for services (physical, psychosocial, environmental, family situation, availability of other supports, age of child)[2,6,7]

Accountability

Accountability standards outlined governance, financial accountability, evaluation and monitoring, and compliance with legislation.

Accountability

Governance, Roles, and Responsibilities

- Establish organizational structure including roles and responsibilities[7,8]

Financial Accountability/Funding Requirements

- Reporting requirements and auditing[1,8]
- Budget and eligible expenses[2,8]

Evaluation and Monitoring

- Monitor and evaluate outcomes at an individual and program level[1,2,3,6,7,8]
- Monitor compliance with the standards[1]
- Develop an evaluation framework and determine/create data collection and reporting tools[1,2,8]

Compliance with Legislation

- Ethical conduct, including traditional Indigenous code of ethics[2]
- Duty to report[2]
- Safety (home visits, working with families with heightened emotions, conflict resolution, trauma and loss)[2,5]
- Specific legislation for program compliance[1]

Next Steps

This document summarizes the consistent elements included in other jurisdiction's standards for comparable programs to the FRNs. Feedback from the Task Team will be used to revise and reorganize the content areas to share with the FRNs. The FRNs will have opportunities to provide their perspectives through multiple surveys and online engagement sessions. These consultations and the corresponding revisions will lead to a "working draft" of the FRN Standards of Practice, which will continue to be refined in response to what is learned through their initial implementation.

Table of Contents

Introduction and Background

Alberta's Family Resource Networks (FRNs) were recently established by Children's Services to provide prevention and early intervention supports and services for children and youth (aged 0 to 18 years) and their families, through a hub-and-spoke model. FRNs aim to provide equitable access to a range of universal, targeted, and intensive services that contribute to three outcome domains: child development, caregiver capacity building, and social connections and supports.

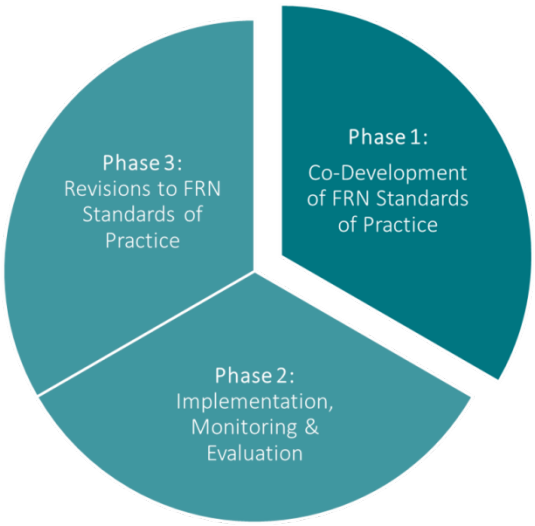

Figure 1: FRN Standards of Practice Project Phases

PolicyWise for Children & Families has been contracted by Alberta Children's Services to co-develop FRN Standards of Practice. **The goal of the Standards of Practice is to help support high quality service delivery by promoting provincial consistency while also allowing agencies the flexibility to respond to their unique community context and the specific needs of the children, youth, and families who access their services.**

The project of developing the FRN Standards of Practice, along with corresponding implementation and evaluation plans, will span three years (2020-2023) and is divided into three phases (Figure 1). This paper serves as the foundation for Phase 1. Figure 2 shows a high-level summary of activities in the first phase of the project. At the end of the first phase, a working draft of the FRN Standards of Practice will be developed, informed by the jurisdictional review, ongoing feedback from the Program and Policy Standards Task Team (Task Team), as well as consultation and engagement with the FRNs.

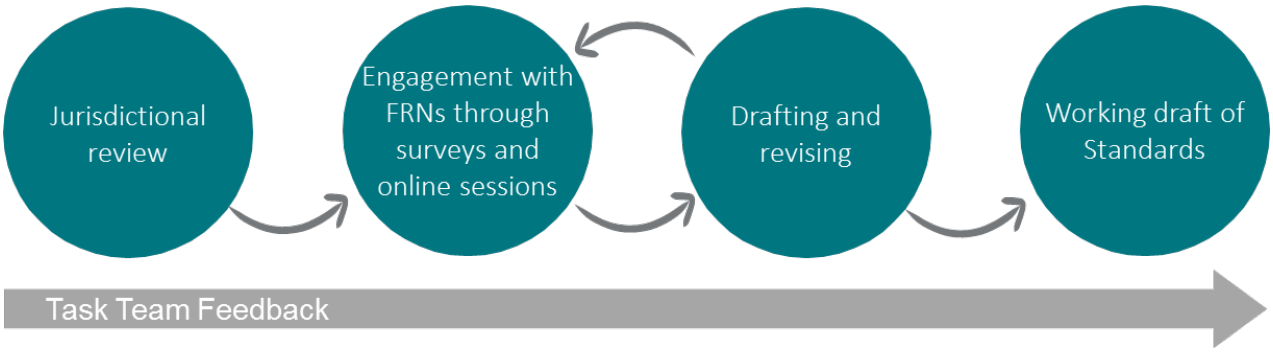

Figure 2: Activities for Phase 1 of FRN Standards of Practice co-development

The purpose of this document is to share the findings from the jurisdictional review which will be used to propose content areas for the FRN Standards of Practice. In combination with feedback from the Task Team, findings from this review will be discussed with the FRNs in upcoming online engagement sessions.

Methods

A jurisdictional review was conducted in order to learn what comparable programs use for standards of practice. The search strategy included publicly available standards for prevention and early intervention supports and services for children, youth, and families from Canada, the United States, the United Kingdom, and Australia (refer to Appendix A for the search strategy). A total of 15 documents were retrieved based on document title and review of the executive summary or introduction section. This was narrowed to eight documents that were determined to have relevant content for the FRN Standards of Practice (e.g., were not focused on child intervention services or standards that were specific to a professional body). Included documents are from British Columbia (1), Ontario (4), New Brunswick (1), and the United States (2).

Documents were analyzed using a combination of deductive and inductive coding in NVivo 12 Software. The Well-Being and Resiliency Framework (Alberta Children's Services, 2019a), the miyo resource (Alberta Children's Services, 2019b), and the FRN Expression of Interest (Alberta Children's Services, 2019c) were used to inform the coding framework. As themes emerged from the jurisdictional documents, inductive codes were developed and integrated into the framework. Themes from the analysis were synthesized and discussed among the research team.

Findings

Findings have been organized into four main content areas: foundations, programs and services, administration, and accountability (Figure 3). The areas of programs and services and administration were present in all documents reviewed, and content on accountability was included in all but one document. Foundations content was the least represented in the literature, however, was still present in five of the eight documents. These four content areas provide a base to develop the FRN Standards of Practice through contextualizing the content to reflect the various settings and services of the FRNs.

The jurisdictional documents reviewed covered a range of supports and services that address the following areas: parenting skills, capacity building, and connections; child mental, social, emotional, physical, and spiritual well-being; responding to family crisis; and coordination and connection with other supports and services. These supports and services are delivered in a variety of formats such as group programs, educational supports, home-based supports, and community-based supports.

Figure 3: Content areas from jurisdictional review

An area of significant variance in the literature was the extent of detail included in the different content areas (see Appendix B for more information). Detail ranged from broad statements that were applicable to a range of activities and programs, to highly detailed standards incorporating specific tools, approaches, and implementation supports (e.g., examples, worksheets, appendices, and links to resources). The level of detail in each category of the FRN Standards of Practice will be determined through Task Team feedback and FRN engagement.

The following sections provide an overview of content within each of the four areas, concluding with next steps for developing the FRN Standards of Practice and key questions for the Task Team and FRN engagement. References are cited numerically throughout the sections according to the following legend:

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1. New Brunswick Early Childhood Development Division (2019)
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8. Region of Peel Human Services (2019)

Foundations

Foundational components of the Well-being and Resilience Framework are aligned with findings from the jurisdictional review. Principles were identified in distinct sections of the standards as well as woven throughout the standards to provide guidance on operationalization.

Several principles emerged from the jurisdictional review to guide both operations and the delivery of supports and services. These were well aligned with the six principles and emphasis on inclusive practices outlined in the Well-Being and Resiliency Framework. This provides a foundation for the FRN Standards of Practice that will be woven throughout the other content areas of program and service delivery, administration, and accountability.

The aligned content from the jurisdictional documents was occasionally framed in a slightly different way than in the Well-Being and Resiliency Framework. For example, in the jurisdictional documents, the principle of *preserve family* often had a focus of providing family-centred supports and services to increase the capacity of the caregiver rather than on explicitly keeping the family unit together.[7] Another example is that the jurisdictional documents often included the *Indigenous experience* under the principle of *inclusive practice*, whereas in the Well-Being and Resiliency Framework, *inclusive practice* and *Indigenous experience* are outlined each as a distinct pieces.

Multiple principles in the Well-being and Resiliency Framework include engagement with children, youth, and families in the decision-making process (i.e., *Indigenous experience*, *strengths-based, connection, and collaboration*). A nuance on engagement that is present in the Well-Being and Resiliency Framework and emphasized in the jurisdictional literature was that children, youth, families, and the community are to be involved in overall program planning and evaluation, beyond decisions related to individualized supports and services.[2,3,6]

Table 1 outlines examples of how the foundational principles were operationalized through the standards reviewed.

Table 1. Foundations

	Content from Jurisdictional Documents
Support Diverse Populations (including Indigenous Experience)	*Policies and programs are inclusive and respect, affirm, respond to, and strengthen cultural, racial, and linguistic identities*[2,3] · Service providers have a comprehensive understanding of the population they serve and aware of appropriate approaches for service delivery[6,7,8] · Perspective of diverse populations are incorporated in long-term planning[6] · Incorporate discussion with clients about cultural supports and services[6]

	Embed cultural safety in policies and practices · Understand the principles and intended purpose of cultural safety and reflect these in policies and practices[2] · Three key principles for cultural safety: 1) "Understanding the ways in which Aboriginal peoples' health and wellbeing are influenced by historical, political, and socio-economic factors that are often beyond their immediate control"[2(p.26)] 2) "Understanding how power imbalances play out in routine practices and policies, often in ways that have become so ingrained that we don't question them"[2] 3) "Think about and question the cultural nature of our knowledge and taken-for-granted practices, and to view Aboriginal knowledge and healing practices as equally valid and important"[2] · Strategies for cultural safety include: ongoing self-reflection; learning from communities and families; investing in relationships; creating safe environments; shifting power from staff to communities and caregivers; and communities and caregivers being partners in program development and monitoring[2] *Support and services are sensitive to poverty, discrimination, imbalances of power, and other factors and challenges that their population faces*[6,7] · Staff, volunteers, and interpreters come from the community of the population served[7]
Preserve Family	*Policies and programs define family and family-centered in a way that is respectful and responsive to the population being served, and service providers understand how to use these definitions in practice* · Who is included as part of the family circle (e.g., parents, children, siblings, grandparents, uncles, aunts, cousins, members of clan or houses)[2] · Understand who is involved in decision making[2,7] · The strengths of the family are recognized and used as resources in supports and services[2]
Strengths-based	*Recognize and build on community and individual strengths* · A strengths-based, relational approach to supports and services to foster interpersonal reconciliation[2] · Recognize that families and Elders and/or Knowledge Keepers are resources and involve them in respectful ways[2,3,8] · Supports and services identify and build on the strengths of an individual/family[7] *Relationships between staff and families/clients are equitable and respectful*[2,3] · Service delivery is planned in partnership between service providers and the family[7]
Connection	*Children, youth, and families are engaged in the decision making process in a meaningful way* · Engaged in the development, implementation, and monitoring of their plan for supports and services[7] · Engaged in the planning, development, and evaluation of programs, supports, and services[7]

	Family is engaged in supports and services · Multiple family members are engaged in the supports and services provided[3] *The community is included in program development and delivery* · Community members can be involved in ways such as: sharing wisdom, experience, expertise, and traditions; volunteer their time to support programs; donate items needed for programs and services[2] · The community is involved in program planning, and supports and services provided address needs identified by community stakeholders[3] *Supports and services foster connections between children, youth, and families and their community* · Children, youth, and families are linked to events, opportunities, and other supports in their community[3]
Collaboration	*Collaboration with the family for the planning and delivery of supports and services* · Setting goals for supports and services[1] · Involving family in the delivery of supports and services[7] *Collaborate with other service providers and programs for delivery of supports and services* · Communication with other service providers and programs[2,7] · Developing partnerships and pathways for service delivery to support coordination and integration of supports and services, including across sectors[6,7,8]
Continuous Improvement	*Programs respond to emerging concerns at the family and community level in an evidence-informed manner that supports positive outcomes[3,6]*

Programs and Services

The focus of the jurisdictional documents ranged from providing guidance for a specific program to guidance for a broad group of programs and services. Recognizing that FRNs incorporate a wide range of programs, the content outlined below will be primarily for targeted and intensive programs, to be used as applicable.

Standards regarding program and service delivery were often the focus of the content in the jurisdictional documents reviewed. This section provides broad standards that can apply across numerous types of services, but with the recognition that not all of the content will be applicable to all FRN programs and services. The two main categories were eligibility and program and service activities.

Eligibility

Eligibility was a consistent topic in the standards, present in seven of the eight documents reviewed. Content on eligibility for entry into programs and services is summarized in Table 2 in three topic areas: eligibility criteria, referrals into the program, and screening.

Table 2. Programs and Services – Eligibility Standards

	Content from Jurisdictional Documents
Eligibility Criteria	*Standard: Age range for services offered* · Infant-parent attachment program: infant under 12 months to start program[1] · Group-based parent support: parents with children birth – eight years old[1] · Early intervention services: children eight years or younger[1] · Infant birth to five years old, six if no other services available[2] · In-home visitation services: age range varies from birth – eight years, often with a caveat on age range for priority of service delivery such as zero – four years[1,2] *Standard: Physical, psychological, emotional, or social criteria for program* · Child or youth have, or are at risk of having, a developmental delay[1,2] · Functional challenges[1] · Mothers with postpartum depression or caregiver mental health concerns[1,2] · For creative outreach: Family is undecided whether to commit to services[1] or would benefit from services but are not accessing them due to variety of reasons (e.g., adolescent parents, transportation)[8] or extenuating circumstances[1] *Standard: Geographical boundary or catchment area*[1,2]
Referrals In	*Standard: Accepted referral sources* · Health care providers: family physician, pediatrician, allied health, public health nurse[1] · Child support workers: social work, child protection services[1] · Community organizations or programs[1] · Parent/caregiver, self-referral[1] *Standard: Accompanying referral information* · Assessments or information to accompany referrals (e.g., Ages and Stages Questionnaire[1], Public Health Priority Assessment[6], other recent history and assessment information[6]) · Reason for concerns[6] *Standard: Readiness of family* · Family/client aware of and agree to the referral prior to initial contact[1,2] · Consent from parent/legal guardian[1,7]
Screening	*Standard: Screening approach* · Purpose: part of intake process is to collect eligibility information, family concerns, and introduce program[1,2]

	· Timeline for completion: Within the first 60 working days of receiving the referral[1] · Process: how to complete screening (e.g., phone, in person) and any considerations related to different approaches (e.g., how to document consent over the phone)[1] *Standard: Screening components* · Intake form (example may be provided as an appendix)[1] · Developmental screens: Ages and Stages Questionnaire[1], Ages and Stages Questionnaire – Social Emotional[1,2], Nipissing District Developmental Screen[1] · Reviewing caregiver concerns, awareness and expectations about services, and receptivity to participating[6]

Program and Service Activities

The standards reviewed were heavily focused on program and service activities, typically for defined programs (e.g., the Aboriginal Infant Development Program in British Columbia) or one area of service delivery (e.g., Infant and Child Development Program Guidelines by the Ontario Ministry of Children, Community and Social Services). Of the standards reviewed, two were developed for models that covered a range of core services and locally-determined programing.[3,8]

Table 3 provides a synthesis of program and service activities standards under five themes: assessment, service delivery planning, programs and services, referrals to other programs and services, and developing connections.

Table 3. Programs and Services – Program and Service Activity Standards

	Content from Jurisdictional Documents
Assessment	*Standard: Assessment approach* · Timeline/frequency: at intake and every six months[1]; within first 90 days of intake and at discharge[6], follow-up and repeat assessments after three months[2] · Process: Use of interviews and observations along with standardized assessment tools[2,6,7]; home visit component as part of assessment to understand family routines, transitions, environment, and typical day[6]; use of assessments from other providers (e.g., pediatrician, speech language pathologist, occupational therapist) to identify any functional challenges[1] · Family involvement: Include family in the assessment process[3], including discussing assessment results[1,6], including their views[7], and providing family copy of assessment reports to build trust[2]

	Standard: Assessment components · Areas identified as needs (e.g., physical growth and development[1,2], cognitive development[1,2], emotional development[2], spiritual and cultural development[2]), mental health[7], strengths and protective factors[1,2,6,7] · Parent-child interactions (e.g., caregiver responsiveness to child; type and nature of physical contact; visual contact; expression of positive affect)[6] · Availability of social supports[1] · Family factors and environment (e.g., parents' knowledge, attitudes, ability to interact, and confidence)[1,6] · Additional resources required or immediate needs (e.g., housing, financial)[1,6] *Standard: Assessment tools* · Select assessment tools that: reflect individual assessment needs[2]; serve purpose of assessment[2]; are within professional scope[2]; are appropriate for age[2]; support re-assessment and monitoring[6], align with accepted standards[6], and are evidence-informed[7] · Assessment tools are appropriate for: language, culture, socio-economic, and religious contexts (e.g., tools that include spiritual and cultural development when working with Indigenous children, youth, and families)[2] · Specific prompting questions to use in interviews/observations, such as: "what would you like your child to participate in during daily routines?" and "are there specific routines you would like to improve?"[6] · Example tools: Developmental Assessment of Young Children[6]; Total Environmental Assessment Model for Early Child Development[6]
Service Delivery Planning	*Standard: Develop an individualized plan* · Purpose: develop family-centered plan that is outcomes oriented and supports professionals to focus on specific child/caregiver goals and strategies[1,5,6,7] · Timeline: How soon after intake, screening, or assessment a plan should be developed (e.g., 60 working days)[1] · Process: Informed by results from screening and assessment[1]; involvement of caregivers[1,4,5,6,7] and other partners in child development or service delivery[1,7] (e.g., through case conferencing to develop integrated care plan between service providers[6,7]). State who should have a copy of the service plan (e.g., in the child's file, copy to the family, all agencies involved in service delivery)[6] · Components that need to be included in the plan: strengths and challenges[1], goals and actions[1,7], information from assessments[1], and responsibilities of service providers[7] *Standard: Develop a timeline and process for reviewing individualized plans* · Timeline: every three months[1], every six months[1,7], on an as needed basis[7] · Process: Completing a progress report (e.g., every six months) outlining history and baseline[6], involvement with programs[6], assessments[6], and understandings and observations including strengths and challenges using information from caregiver and partners in service delivery[1,6,8]

Programs and Services	*Standard: Services are available and accessible* · Programs offered at a time that is convenient for families to increase accessibility.[3,5] May include weekends and evenings[8] · Choose settings that are convenient and respect the privacy and comfort of families/clients[2,3] (e.g., offer both center-based and mobile services[8], services in natural setting in the community or home[4,6]) · Provide transportation or transportation reimbursement[2,3,4] *Standard: Frequency, intensity, and duration of services* · Timing of initial visit (e.g., two weeks within initial contact)[2] · Determining re-occurring service frequency and intensity o Team considerations (include caregivers): developmental, medical and behavioural needs; age; ability to engage in programs; specific goals; optimal time of day for child and family; child and family daily routines and schedules; and availability of programs[4] o Child and family characteristics; child's developmental progress, achievement of established goals and developmental milestones; access to other supports; family strengths, needs, and available support[6]; and overall complexity[5] o Determination and discussion of frequency with caregivers and how/when re-assessment will occur[6] · Determining when service delivery stops o Child has reached developmental goals[1] o Creative outreach – after 90 days if family does not want to participate in services or unable to resume services[1] *Standard: Service delivery approach* · Families: Services are individualized to families, and families are partners in design, planning, delivery, and feedback.[4,6,7] Materials provided to families are culturally and linguistically appropriate[2] · Community partners: Collaboration with other community partners to deliver different programming, especially in group sessions[1] · Service providers: Consider developmental needs and skills; family's resources, priorities and concerns; theoretical basis/methods that are a good fit; and evidence-informed practices.[4] Outline discipline/professional-specific standards as appropriate (e.g., occupational therapy)[4] · Service providers are supported in taking time to build a therapeutic relationship with families[5] · Specific intervention approaches o Practices: Direct instruction, naturalistic intervention, consultation, coaching modelling [4] o Models: Pyramid Model for Supporting Social Emotional Competence in Infants and Young Children (child development and well-being)[4], Developmentally Appropriate Practice[4], Modified Interaction Guidance Program[1], the Circle of Security Program[1], Family-Centered Routines-Based Intervention Approach[6], Play-Based Inquiry Learning[8]

	Standard: Group supports and services · Criteria on determining group intervention or individual intervention[4], including outcomes that cannot be achieved in home or community-based settings (e.g., socialization, communication, peer interaction, functional skills)[6] · Ratio of service provider to participants: 1:4 ration for basic early childhood development, 1:3 for enhanced developmental intervention[4] · Minimum participant numbers for group to run (e.g., for parent capacity building: minimum of three families)[1] *Standard: Assisting families through crisis* · Make referrals, assist in access to services, and advocate[2] · Include Elders and/or Cultural Knowledge Holders in list of community supports[2] · Assist family in maintaining as normal of routine as possible[2] · Encourage communication; ask for permission to call to check in[2] · Provide age-appropriate information about trauma, that is aligned with local teachings and protocols[2] · Know when it is appropriate to provide support and how based on honouring and respecting local traditions[2]
Referrals Out	*Standard: Make referrals to other programs (within or external to the organization as appropriate)* · Recognize the scope of practice and make referrals to other services to meet identified needs of the family (e.g., community supports and organizations including Elders and/or Cultural Knowledge Holders)[2,6,7] · Support families in accessing other supports and services through providing information (for universal supports) or making referrals[6,8]
Developing Connections	*Standard: Connections with potential clients* · Develop outreach plan[3] · Focus on developing and maintaining constructive relationships and provide outreach and information to potential participants[3] · Use of positive outreach methods to build trust and be non-intrusive[1] · Define the length of time the agency will attempt to contact family after initial screen or extenuating circumstances (e.g., 90 days)[1] *Standard: Connections with other organizations and service providers* · Build collaborative relationships with other organizations and provincial programs[6] to provide stronger service delivery to the comunity[3]. Range of relationships includes being aware of and working with other providers[3], sharing resources/information[2,3], and having a formal partnership for continuum of care and to respond to emerging community concerns[3] · Develop coordinated pathway of supports to promote system-level plan and integrated delivery, including understanding how clients (children/youth) receive services across multiple sectors[3,6]

Administration

Standards related to program and service management were a significant component in many of the jurisdictional documents. These ranged from standards regarding staffing to the management of documentation, caseloads, and waitlists.

Content surrounding administrative standards was included in most of the documents reviewed. Complementing the standards in the Programs and Services section above, these standards are organized into three main categories: staffing, communication, and caseload and waitlist management.

Staffing

Standards focused on staffing considerations included content to support sufficient staffing ratios, a qualified and competent workforce, and opportunities for growth and development. The level of detail included in staffing standards greatly varied. The California Network of Family Strengthening Networks and the Ontario Ministry of Children and Youth Services used broad statements, such as service delivery being provided by appropriate and skilled staff. The other documents that included staffing standards provided detailed standards around specific areas including provider qualifications, the staffing structure, ratios for group program delivery, reflective supervision, and supportive work environments.[1,2,4,8]

Table 4 provides a synthesis of standards related to staffing requirements and staff support and development.

Table 4. Administration – Staffing Standards

	Content from Jurisdictional Documents
Staffing Requirements	*Standard: Staff qualifications* · General staff requirements o Criminal record check and vulnerable sector check[1] o Training on how to report abuse[1] o Training on relevant policies[1] o Maintaining knowledge in best practices[1] · Front line service providers o Minimum number of staff who need certain certifications[1,7] o List of specific staff/professional qualifications for programs (e.g., special education teachers, physical therapists, occupational therapists, psychologists, social workers, and speech language pathologists)[4] o For non-specialized staff or assistants, the minimum experience and education needed[4]

	○ Staff have knowledge of, and are responsive to, the community they are working in (social, linguistic, cultural, racial, and other services available)[5,7] · Supervisor ○ Certification[1] or licensure/registration[4] required by supervisors (e.g., university degree in related field, minimum five years of experience, minimum eight years of work with families and children with developmental delays, and demonstrated supervisory skills)[1] · Director ○ University degree in related field and a minimum of six years' experience including three years in management and three years working with children, parents, or individuals with developmental delays[1] *Standard: Staff ratios* · Staff models may be based on minimum number of staff required[1], on ratios based on site capacity[8], or flexibility for sites to determine staff model based on services provided and organizational context.[8] · Staff may have more than one title/function[4] · Front line service providers: Ratio of staff to participants in group settings (e.g., 2:30)[4] · Supervisor: Ratio of supervisor to service providers (e.g., 1:12)[1,4]
Staff Support and Development	*Standard: Staff are provided opportunities for reflection* · Amount of scheduled supervision for each employee (e.g., minimum one hour per week[1], bi-weekly meetings[5]) · Ratio of supervisor to staff allows time for support and reflective supervision, especially with complex caseloads[5] · Reflective supervision style including: regular coaching and feedback using strengths-based approach, assisting in problem solving and choosing appropriate interventions, assisting with crisis intervention, identifying areas of growth, and reviewing individual family service plans[1] · In addition to reflective supervision, reflection can be supported through reflective peer support (e.g., mentoring) and clinical consultation from experts as needed[5] *Standard: Staff are aware of and provided opportunities for professional development to strengthen knowledge and skills* · Potential topics: diversity and how to navigate dynamics of difference[3]; different ways of learning and knowing including traditional Indigenous education and knowledge from Elders and Cultural Knowledge Holders[2]; how to partner with other organizations (e.g., Partnership Project Training Modules from British Columbia[2]); and vicarious trauma[5] · Appropriate learning opportunities posted on agency website[2] *Standard: Staff wellness is supported through workplace practices and environment* · Adopt a holistic approach of staff wellness[2] ○ Using cultural practices, religious experiences, and spirituality

	○ Care for body ○ Boundaries between work from home ○ Avoid isolation · Flexible work schedules to account for travel, scheduling of home visits, and ability to take breaks when travelling between sites. Flexible work schedules can promote self-care and positive working relationships[2,5] · Build a strong team environment: staff development, team-building activities, regular staff meetings, and management style of supervisors[2]; staff input into the organization (e.g., policies and procedures, day-to-day work)[5]; and workplace health promotion (e.g., wellness workshops, Employee Family Assistance Programs)[5] · Supports available to address compassion fatigue, burnout, and triggers through work experiences (e.g., de-brief of service providers, connecting them with other supports as needed)[2,5] · Adequate recognition and remuneration to recognize the contribution of service providers and support staff retention[5]

Communication

Communication standards outlined the processes of how to develop, maintain, share, and retain information related to program and service delivery. The main focus of communication-related standards was to support confidentiality through document management and communication with both families and other service providers. Table 5 outlines standards under the themes of information sharing and documentation.

Table 5. Administration – Communication Standards

	Content from Jurisdictional Documents
Information Sharing	*Standard: Information sharing processes* · Communicate with families about confidentiality, including receiving clear consent for the interdisciplinary team to access their information[6], asking for client consent prior to discussing them with other professionals or in case conferences[2], and receiving written consent for disclosing information from the client's record to other service providers/agencies[1] · Confidentiality safeguards: not discussing personal information with non-case staff or others outside of service providers, proper security for sending electronic communication, vigilance in small communities, locked cabinets, and identifying documents kept out of sight when meeting with others [2] · Release of information without consent: Outline when information is released without consent (breach of consent) such as children in need of protection, disclosure of harm to self or others, court orders to release documents[2], professionals providing urgent medical treatment, and child protection workers or social workers in the program[1]

	· Provide broad statement that information is collected and shared to inform services based on "applicable legislation, regulation, and policy directives"[6(p.17)] *Standard: Care coordination* · Staff receive training to support effective care coordination[5] · Communication between the service provides and family about child's experience/progress and recommendations for continuing work/learning at home[4,7] · Ensure family has reasonable access to information related to them[2] · Shared commitment among all service providers on team to confidentiality[2]
Documentation	*Standard: Documentation included in client record* · Forms and reports: referral and intake forms[1,2], consent forms[1,2], screenings and assessments[1,2,7], outgoing referral forms and letters[2], incoming/outgoing reports[1,2]; progress reports[1,2], service plans[1,2,7], case closure/discharge reports[1,2] · Notes: Case conference notes[1], program notes[1,2], supervisor consultation notes[1] · Any videotapes taken[1] · Documentation of correspondence: all contact and discussions with family[2,6] (including discussion on how traditional languages, cultural activities, values, and beliefs are encouraged[2]) and correspondence with other service providers[1] · Statement to mitigate harm: Do not write or say hurtful, disrespectful, or judgmental content that could harm the relationship[2] *Standard: Timeline for retaining documentation* · Clear timeline and procedures for retaining and destroying information[1] (e.g., for time needed to fill purpose[2], five years[1])

Caseload and Waitlist Management

Caseload and waitlist management standards were focused on articulating criteria for case volume, the process for case closure, and managing clients who are on a waitlist for supports and services when demand exceeds caseload capacity. These types of standards were present in half of the jurisdictional documents reviewed. Table 6 provides a synthesis of standards for caseload and waitlist management.

Table 6. Administration – Caseload and Waitlist Management Standards

	Content from Jurisdictional Documents
Caseload Volume	*Standard: Determination of appropriate caseload volume* · Caseload guidelines, including considerations for complexity of clients (e.g., 15 families per FTE interventionist[1], 25-35 children per FTE[2]; maximum 10 cases when children are complex[5]) · Division of time (e.g., 80% on interventions, 20% administrative duties)[1] · Breakdown of caseload by client status: Active, follow-up (not weekly support), and as needed[2]
Case Closure	*Standard: Case transition or closure* · Reasons for case closure: o Parent/family voluntarily leaves program[1] o Parent/family is not participating and all efforts have been made by agency to engage[1] o No longer need services[2,7] (e.g., Program goals have been attained[1]) o No longer meet eligibility criteria[7] o Existing natural/community supports can meet needs of family[1] o Relocation of family[2] · Process for case closure: o Consult with reflective supervisor[1] o Complete discharge report[1,6] o Final assessment and documentation of accomplished goals/objectives[7] o Provide satisfaction survey[1] o Provide family with parting paraphernalia (e.g., pictures of child from program, card, poem, storybook)[2] and written summary[7] o Follow-up once after discharge (three-six months) to check-in on access to needed services and status.[6] Flexible follow-up for complex or high risk clients[5] *Standard: Referral pathway for clients exiting program/services* · Transition planning to start early in service delivery to track goals of treatment to determine time for transition/discharge[6] · Support transitions to other service providers/settings (can include schools, adult supports, other community agencies, other regions/geographic areas) through providing a transition plan or other referrals [1,6.7], and attending case conferences as appropriate and with consent[1.7] · Goal is for smooth transition from one support to another that reflects needs identified by family and prevents disruption of services[1,6]
Waitlist Process	*Standard: Consistent process for managing waitlist* · When a waitlist is established: caseload exceeding 25 families per full time staff[2] · Maintaining a date of referral (especially when families move between regions)[6] · Keep families informed of where they are on the waitlist at regular intervals[6,7] (e.g., monthly connection[1]) · Provide information, supports, and resources while on waitlist[7], including referrals for helpful alternatives (e.g., other programs by the agency, other

	community base programs, and resource materials)[1,2,6], and interim supports such as drop-in, screening, visits from Elder[2]
Factors to Determine Priority	*Standard: Develop factors to determine priority for services if programs exceed manageable caseloads* · Presence or degree of developmental delay, disability, or medical diagnoses[6], need and urgency[2,7] · Psychosocial or environmental factors[6] · Family situation (e.g., risk for child, if family has high level of concern or need for information and support)[2] · Geographical location[2] · Other agency involvement[2] · Age of child or youth[6]

Accountability

Standards relating to responsible and ethical practices in the areas of legislative compliance, financial requirements, evaluation, and reporting were included in the jurisdictional documents and categorized together under Accountability.

Accountability standards outlined governance, financial accountability, evaluation and monitoring, and compliance with legislation. While half of the reviewed documents included content related to accountability, two stood out in regards to their content on this area due to their direct applicability. The Region of Peel's Human Services' Early ON Child and Family Centres Business Practices and Funding Guidelines were written for a model of service delivery that is similar to the FRNs in that the region receives funding that it distributes among partnered agencies who carry out the service delivery. There was a significant focus in this particular document on governance, roles, responsibilities, and financial accountability.

The second document that included a significant amount of material related to accountability was the Aboriginal Infant Development Program of British Columbia: Practice Guidelines. This program provides supports to Aboriginal families with young children, both in home and office settings. The document provides extensive standards related to legislation, especially around ethics, safety, and duty to report. The standards were developed by an Indigenous consulting firm, and include specific considerations around traditional Aboriginal code of ethics, the history of colonization, and the impact on working with families with heightened emotions, among others.

Table 7 provides a synthesis of standards under governance, financial accountability, evaluation and monitoring, and compliance with legislation.

Table 7. Accountability Standards

	Content from Jurisdictional Documents
Governance, Roles, and Responsibilities	*Standard: Establish organizational structure including roles and responsibilities* · Role of the Ministry: providing funding and oversight[7,8]; leadership[7]; support of policy development[7]; and developing standards[8] · Role of hub-like organizations: manage service agreements; review and approve budgets; monitor service expenditures; respond to family concerns[7]; and report to the Ministry[8] · Role of spoke agencies: deliver programs based on standards; comply with financial, administrative, and program standards; hire and train staff; develop relationships with other services providers and organizations in the community[7]; provide culturally responsive programming[8]; and monitor and evaluate core services[8]
Financial Accountability and Funding Requirements	*Standard: Reporting requirements and auditing* · Financial accountability reports and standards (e.g., standard Canadian accounting practices for not-for-profit organizations)[1] · Reporting schedule[1,8] · Need for financial auditing[8] *Standard: Budgets and expenses* · Budgets that must be developed and descriptions of different types (e.g., start-up budget, operating budget, capital budget, project budget, long-range budget)[2] · Outline of eligible expenses[8]
Monitoring and Evaluation	*Standard: Monitor and evaluate outcomes related to the delivery of supports and services* · At an individual level[1,2,3,6,7] · At a program[2,3,6,8] and population level[8] · Monitoring compliance with the standards[1] *Standard: Develop evaluation framework* · Determine/create data collection and reporting tools[1,2,8] · Data collection tools and outcomes are culturally appropriate[2] · Examples of data collection tools: interviews, observations, standardized and evidence-informed measurements[1,6]
Compliance with Legislation	*Standard: Ethical conduct* · Ethical conduct (e.g., quality, sensitivity, and confidentiality of work[2]; following policies of the agency[2]; relationship boundary setting[2]; and social media guidelines[2]) o Inclusion of traditional Indigenous code of ethics[2] · Confidentiality guidance (if not covered in documentation/communication section) o Guidance on confidentiality of what is said in sharing circles[2]

Standard: Safety

- Conflict resolution guidance[2]
- Personal safety (e.g., during home visits; at the office when working with families who have heightened emotions)[2,5]
- Supporting staff through trauma and loss[2,5]
- Health and safety standards that must be followed when providing programs in community spaces[4]

Standard: Duty to report

- Duty to report – legislation and process[2]

Standard: Specific legislation for compliance

- Pieces of legislation that programs must be in compliance with (e.g., Human Rights Act, Employment Standards Act, Occupational Health and Safety Act, Personal Information Protection and Electronic Documents Act; Right to Information and Protection of Privacy Act; and Workers' Compensation Act)[1]
- Possible use of blanket statement (e.g., "core service providers will be responsible for complying with all relevant legislative, regulatory, and policy directives, including privacy and consent requirements"[6(p.11)])

Next Steps

This document summarizes the consistent elements included in other jurisdictions' standards for comparable programs to the FRNs. Using what has been found in this review, the next steps for this project involve gathering ongoing feedback from the Task Team and FRNs in order to contextualize the content for Alberta FRNs. Key questions for contextualizing the information from the jurisdictional review for the development of the FRN Standards of Practice are in Table 8.

Table 8. Questions for Developing FRN Standards of Practice

Overarching Questions
• Do these findings, at a high-level, resonate? What might be missing? Are there sections that do not apply within the context of FRNs? • What level of detail is needed in each of these content areas to guide provincial consistency in practice while also supporting flexibility in local service delivery? Are there some sections that might warrant more detail/direction than others? • How can Indigenous worldviews and considerations for diverse populations be acknowledged and incorporated into these content areas?

Content Area	Key Questions
Foundations	· How can these foundation be operationalized in the Standards of Practice to support the FRNs in translating them from statements into action? · How can the engagement of children, youth, family, and community be incorporated into FRN planning, service delivery, and evaluation?
Programs & Services	· Should specific program requirements be included within the overarching FRN Standards of Practice? And if so, what would this involve? · Knowing that not all of the content will apply to all FRN programs and services, should there be guidance included on how to determine applicability?
Administration	· How can existing administrative requirements for FRNs be represented in the standards? · What processes for staffing, communication, and caseload and waitlist management require provincial consistency? What processes can be determined at the agency level?
Accountability	· Understanding the different roles and responsibilities of hubs and spokes within FRNs, what is the most appropriate way to organize accountability standards? · What legislation is important for FRNs to know about and follow for ethical and safe service delivery? · How can the FRN Standards of Practice refer to, or incorporate, other guiding documents related to accountability (e.g., Schedule A's)?

Feedback from the Task Team will be used to revise and reorganize the content areas to share with the FRNs. FRNs will have opportunities to provide their perspectives through multiple surveys and online engagement sessions. These consultations and the corresponding revisions will lead to a "working draft" of the FRN Standards of Practice. Implementation, monitoring, and evaluation of the working draft of FRN Standards of Practice will be the focus of the next project phase, which will inform revisions responsive to what is learned through initial implementation.

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Appendices

Appendix A – Jurisdictional Review Literature Search Strategy

The purpose of this jurisdictional review is to identify the essential components and considerations for practice standards. The following search terms will be run through Google to identify relevant examples from other jurisdictions.

Type of document	Focus area	Services	Population
Practice standards	Prevention	Services	Children
Standards	Early intervention	Education	Youth
Practice guidelines	Resilience	Support	Families
Standards and guidelines	Capacity building	Programs	Parents
Program delivery standards	Child development	Programming	Infants
Program delivery guidelines			Teens
Program delivery requirements			Caregivers
Service standards			Indigenous
Service guidelines			
Quality standards			

Search Combinations

The following search combinations will be used until saturation is reached in search results:

- Type of document + focus area + services + population
- Type of document + focus area + population

Inclusion Criteria

In order to be included in this review, the identified document must:

- Be from 2010 to present
- Focus on standards for program delivery
- Be from a government or organization's website (as opposed to personal blogs, newspapers, etc.)
- Be written in English
- Be from Canada, the United States, New Zealand, Australia, or the United Kingdom

Exclusion Criteria

Documents will be excluded from the review if they:

- Do not focus on standards/guidelines for program delivery
- Are from an unreliable source
- Are opinion pieces
- Require purchase
- Do not fit within the inclusion criteria listed above

Appendix B – Overview of Detail in Content Areas Across Jurisdicitonal Documents

The literature from the jurisdictional review presented four major themes of content areas for standards: foundations, programs and services, administration, and accountability. Within the eight documents reviewed, the level of detail in each content area varied from broad statements to detailed standards accompanied with materials to support implementation. The two content areas of programs and services and administration were present in all documents reviewed. Foundations was the content area least represented in the literature, absent from three of the eight documents. Accountability was only absent from one of the eight documents, which was the most high-level document reviewed (Infant Mental Health Promotion, the Hospital for Sick Children, 2011). The following table provides an overview of the level of detail present in the different content areas across all jurisdictional documents reviewed.

Legend

Detailed (+): Provides extensive detail on standards, such as including specific tools or approaches, and includes materials to support implementation (examples, worksheets, appendices, and links to resources)

Detailed: Provides detailed standards in this content area, but do not include materials to support implementation

Broad: Provides high-level statements in the content area

Absent: Does not include this content area

Source	Level of Detail			
	Foundations	Programs & Services	Administration	Accountability
Infant Mental Health Promotion, The Hospital for Sick Children (2011). *Organizational policies for high quality services*.	Absent	Broad	Broad	Absent
New Brunswick Early Childhood Development Division (2019). *Early intervention service standards: Department of education and early childhood development.*	Absent	Detailed(+)	Detailed(+)	Detailed(+)
Little Drum Consulting (2016). *Aboriginal Infant Development Program of British Columbia: Practice Guidelines.*	Detailed(+)	Detailed(+)	Detailed(+)	Detailed(+)

The California Network of Family Strengthening Networks (2014). *Standards of Quality for Family Strengthening & Support.*	Detailed *Implementation tools available but not included in the document	Broad	Broad	Broad
New York State Department of Health, Bureau of Early Intervention (2013). *Early intervention program: Group developmental intervention services standards.*	Absent	Detailed(+)	Broad	Detailed *Not an extensive area in document, but significant detail in safety policies and practices
Ontario Ministry of Children and Youth Services (2015). *Community-based child and youth mental health. Program guidelines and requirements #01: Core services and key processes.*	Broad	Broad *Focused on minimum expectations of service delivery.	Broad	Broad *Only administrative content was monitoring & evaluation of client outcomes
Ontario Ministry of Children, Community and Social Services (2018). *Infant and child development program guidelines.*	Broad	Broad * Exception is increased detail around service delivery planning.	Broad	Broad
Region of Peel Human Services (2019). *EarlyON Child and Family Centres Business Practices and Funding Guideline: Peel Region EarlyON Service Providers.*	Broad	Broad	Detailed(+)	Detailed(+)