Symposium 5: The AIDES initiative: description and assessment of the Quebec adaptation of the Common Assessment Framework

Convenor: Claire Chamberland

BAPSCAN 2012

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1. The AIDES initiative: a social innovation focusing on the needs of children

presented

by

Claire Chamberland and research team

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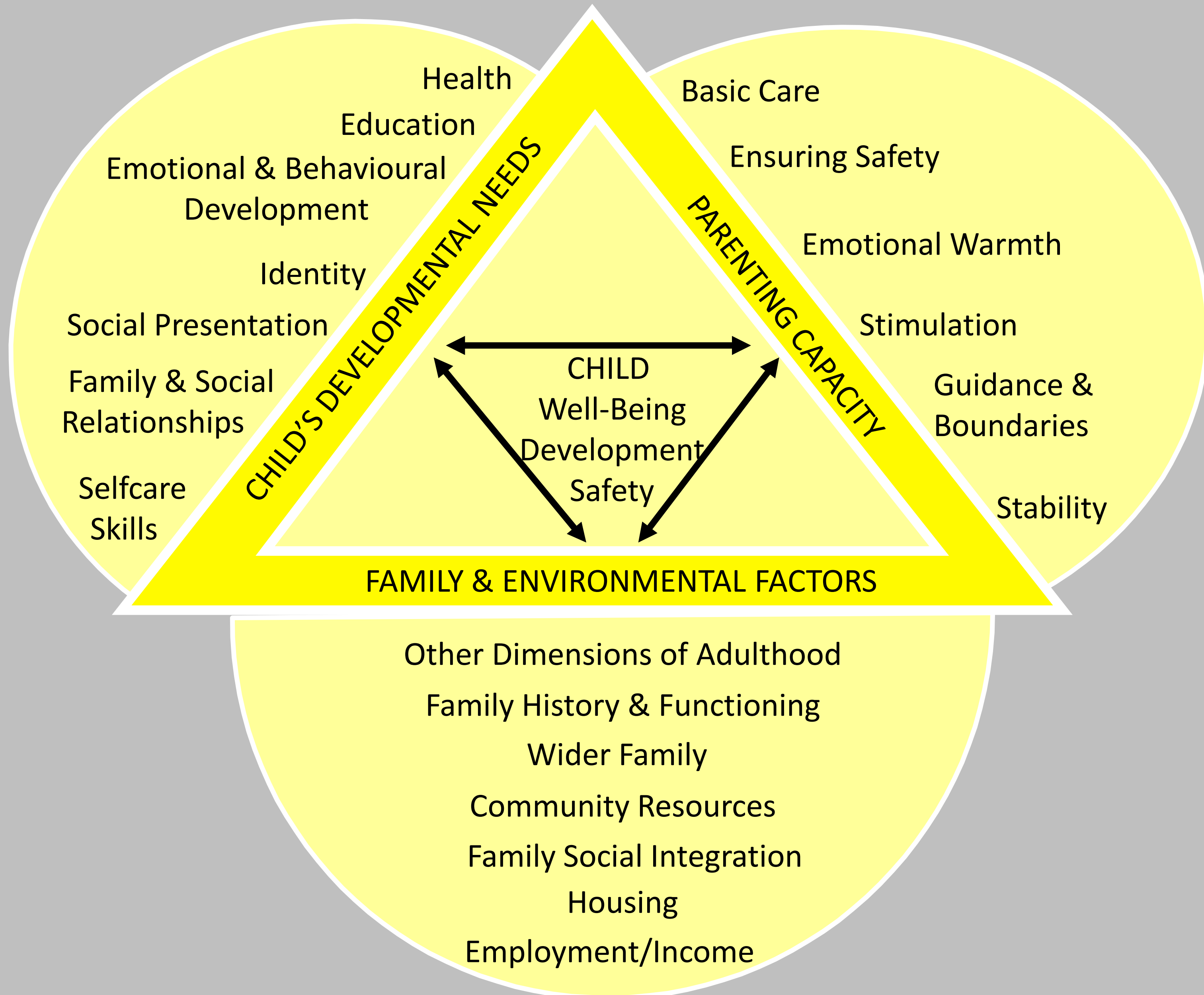
Since 2008, in the province of Québec, Canada, the Inter-Agency Partnership for Child Development and Safety (AIDES) intiative has provided support to practitioners in two youth centres (protective services) and four health and social services centres (preventive services) in the implementation of an innovative intervention approach for improving collaboration between parents, practitioners, and various partners concerned in the well-being and safety of children with complex needs.

The intervention approach consists of:

- a complete analysis of the child's developmental needs using an ecosystemic analytical framework for the developmental needs of children.
- the collection and analysis of information pertaining to elements of the reference framework using a practical analytical tool (Child's Needs Analysis Workbook)
- the participation of the parents and the partners in the needs analysis
- the creation of an action plan

Ecosystemic analytical framework for the developmental needs of children

Department of Health et al. (2000). Framework for the Assessment of Children in Need and their Families. London: the Stationery Office.



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Construction of the sample

Two regions of Québec: urban and semi-urbain/rural

Recruitment setting:
Health and Social Services Centres (preventive services); Youth Centres (protective services)

Criteria for recruitment of the children:

- Aged 0 to 9 years;
- Troublesome family situation;
- Receive or will receive (they or their parents) the services of *at least two institutions;*
- Preferred orientation: maintenance with family.

Experimental group 99 children	Control group 85 children

Recruitment took place from July 1, 2008 to March 31, 2010
80 % (184/230) of the proposed sample was constructed

Implementation assessment

- Inductive approach
- Qualitative design

Telephone interviews

Dimensions	Collection method	n per group	
		AIDES (15)	Control (15)
Participation and collaboration: Positive and negative Experiences	Semi-structured interview guide	14 parents	15 parents
		15 practitioners	15 practitioners
Practice conditions Facilitators and barriers	Semi-structured interview guide	19 practitioners 17 other actors	N/A

Assessment of results

- Hypothetical-deductive approach

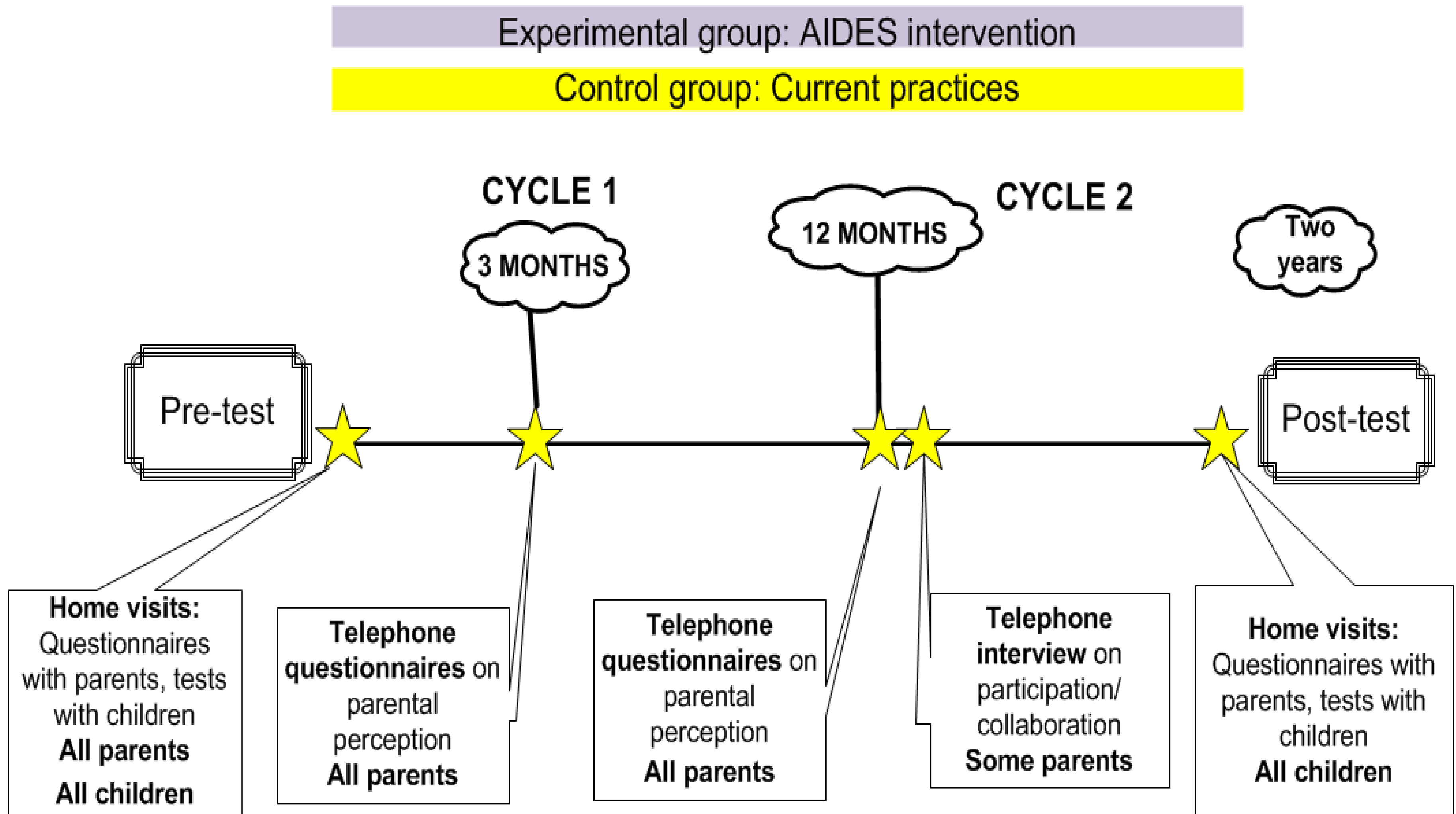
- Comparative change design

- Children and parents

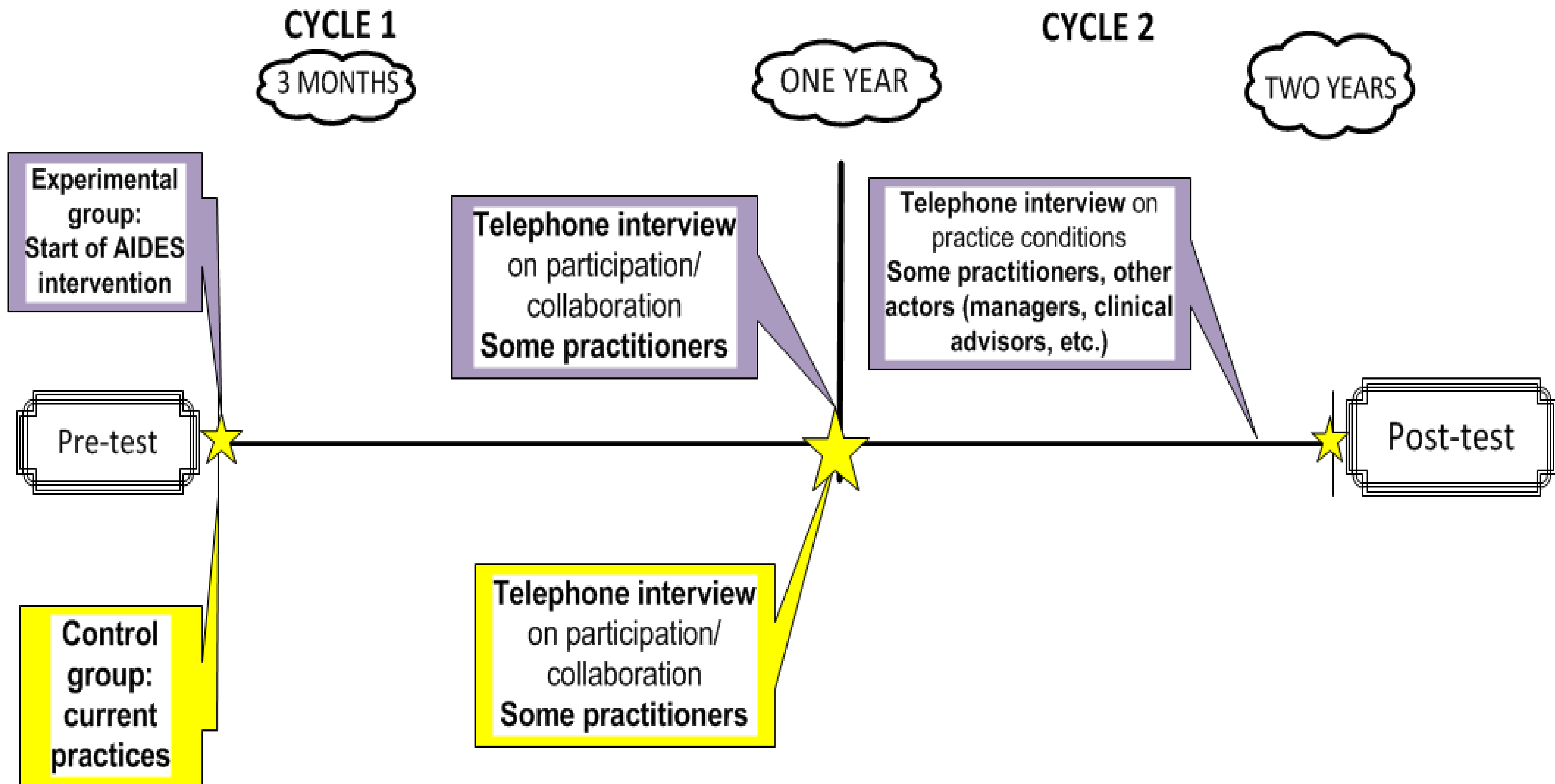
Questionnaires and standardized tests

Dimensions	Collection methods
Proximal effects (QPPSR) – perception of parents regarding services received: ▪ Quality of helping practices of the assigned practitioner ▪ Extent of control over decisions concerning services provided ▪ Quality of collaboration with assigned practitioner	Helping Practices Scale (HPS) Personal Control Appraisal Scale (PCAS) Questionnaire on parental figure-practitioner collaboration (QPPC)
Intermediate effects: ▪ Adaptation of parental figures to their role, and exercise of their responsibilities toward the child ▪ Victimisation of the child ▪ Quality of family environment to which the child is exposed	Parental Stress Index (PSI) Family Support Scale (FSS) Child Abuse Potential Inventory (CAPI) Home Observation for Measurement of the Environment (HOME)
Final effects – development of the child ▪ Cognitive ▪ Language ▪ Motor ▪ Behavioural and emotional	Development Assessment Tool (DAT) (≤ 5 ans) Peabody Picture Vocabulary Test (PPVT) (≥ 5 ans) Child Behaviour CheckList (CBCL) (≥ 1,5 ans)

Sequence and measurement periods – children and parents



Sequence and measurement periods – practitioner and other actors



2. Practitioner-parent collaboration: under what conditions?

The view of parents who participated in the AIDES social innovation

presented

by

Louise Lemay, Ph. D., Stéphanie Plourde, Véronique Bouchard and Sarah Dufour, Ph. D.

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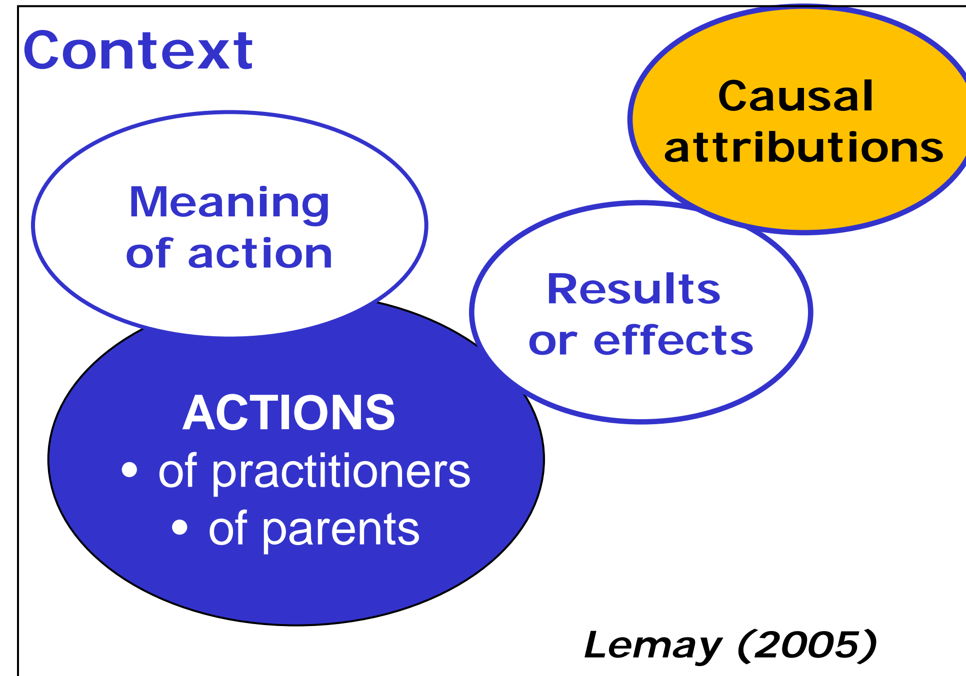
Method and conceptual framework

- **14 parents from the AIDES group** (+ and - satisfied)
- **Telephone interviews** (± 30 minutes)
- **Critical incident method**
- **Content analysis** (causal attributions)

Critical incident



Practitioner-mother interaction (+)

1. MOTHER: doesn't tell PRAC she's pregnant (afraid), but tells own mother, who reacts well.

2. MOTHER (finally deciding to talk about it): "*What are the consequences?* "

3. PRAC: "None, congratulations!"

4. MOTHER: (surprised) "Really?"; (confidingly) "I was a little scared, I didn't want to talk about it."

5. PRACT: (calmly) "I don't see why I would interfere in your pregnancy; I'm here to follow your child's case."

6. MOTHER (EFFECTS): felt "truly relieved!"; "I expected to get (…) lectured"; "what a relief"; "it took a weight off my shoulders."

Attributions

- **PRAC actions (+):** facilitates access to services and provides material support; communicates with "calm" and "says what she has to say"; respects choices ("doesn't force anything"); negotiates ("let's come to an agreement"); **PRAC characteristics (+):** "always smiles, puts me at ease." **Parent actions (+):** returns calls, communicates with PRAC (+ reaction from mother).

Practitioner-father interaction (-)

1. FATHER: informs practitioner about an oversight (medication-child); “I didn’t hide it!”

2. **PRAC** (in a meeting): reminds him of his oversight; says he is “afraid” to entrust him with the child, “isn’t responsible,” “unable to look after his child.”

3. FATHER: answers that the oversight isn’t that serious, and that the FF has also forgotten.

4. PRAC: tells him the FF parents are “specialists.”

5. FATHER: becomes “aggressive.” Repeats that the FF has also forgotten three times, that he finds it “unfair” (experience: incompetence and unfairness).

6. PRAC: “doesn’t react,” “changes subject.”

7. FATHER: In a meeting, tells PRAC “what’s on his mind” and says that “it was better” afterwards.

Attributions

PRAC Actions (-)

- “always seeing the negative”; blaming; ignoring the parent’s criticism.

PARENT actions (+)

- Communicates (expresses his dissatisfaction)

General observations

The attributions/reasons for describing a relationship as positive (+) or negative (-), relate, in order of importance, to the :

1. Actions/practices of the practitioners (including the practitioners' characteristics): 6 dimensions

2. Actions/reactions of the parents: 3 dimensions

Conditions (+ et -) related to PRACTITIONER's PRACTICES
1) View toward parent, and professional attitude

(+) View toward parent

- Focuses on the person
- Recognises parent's uniqueness
- Sees what's "normal" / puts perceived problems in perspective

(-) View toward parent

- Focuses on the "negative"
- Anticipates parental deficits, failure
- Ignores strengths, progress
- Judges on the past

(+) Attitude of listening and collaboration

- Has a "good ear"
- Does not judge, understands
- Welcomes parent's difference of opinion and criticism
- Puts him/herself "at the same level," does not "put down" parent

(-) Attitude of expert

- Ignores criticism: "Changes the subject."
- Blames, criticises

Conditions (+ and -) related to PRACTITIONER's PRACTICES
2) Communicating, informing, creating awareness

- (+) Saying things "as they are" / (-) Lack of consistency-transparency or doubting the parent's (not believing the parent)
- (+) Exercising "discretion" (confidentiality) / (-) Talking negatively about the parent in front of the children
- (+) Talking "about this and that" (taking focus away from the problem)
- (+) Informing in advance about an action / (-) Not informing (rights, actions, reasons), informing at the last minute, not talking directly.
- (+) Sharing one's experience (normalising effect)
- (+) Providing objective information (creating awareness)
- (+) Helping to see more clearly, putting the parent's responsibility in perspective.

Conditions (+ and -) related to PRACTITIONER's PRACTICES
3) Seeking solutions and access to services

- (+) Focusing more on solutions than on faults
- (+) Seeking the "best solutions"
- (+) Proposing appropriate and effective solutions
- (+) Asking questions, seeking solutions from the parent.

"She throws the answer back to me, and when I look at things, I realise I had the solution all along."

- (+) Facilitating access to services; intervening for expediting

"It's mostly thanks to her that my children have a family doctor today (…) it was a lot faster going through the worker."

Conditions (+ and -) related to PRACTITIONER's PRACTICES
4) Decision making

PRACTICES (+)	PRACTICES (-)
▪Not forcing, not pressuring parents to take a direction:	▪ Not taking a position
▪Respecting their decisions; not judging their choices	**Deciding unilaterally**
▪Sharing one's point of view "without saying what to do."	▪ Excluding the parent from the decision-making process
▪seeking consensus; "coming to an agreement."	▪ Maintaining one's decision despite the parent's requests
▪Warning about the negative consequences of decisions	▪ Changing a decision without warning
	▪ Making decisions between partners without considering the parent's own pace

"(...) they [partners] took their decisions, and (...) we had no say, we couldn't do anything."

Conditions (+ and -) related to PRACTITIONER's PRACTICES
5) Mobilising, accompanying

- (+) Focusing on immediate concerns, responding to all questions
- (+) Mobilising for parents' requests/
  (-) not reacting, ignoring requests
- (+) Respecting parents' own pace
- (+) Accompanying, involving them
- (+) Encouraging, reassuring, giving hope
- (+) Supporting at various levels / (-) Focusing only on helping the child
- (+) Going beyond one's mandate /
  (-) Interfering or intervening without the parent's request.

"(…) everything goes through her **[practitioner].** ***If we call her, she's on it right away."***

Conditions (+ and -) related to PRACTITIONER's PRACTICES
6) Actions related to temporal dimensions of the intervention

RAPIDNESS

- (+) Responding to requests rapidly; being available at the "right time."
- (+) Returning calls quickly / (-) long waits

"I'd call and she'd answer right away (...) It was always quick, always A.S.A.P.."

DEGREE OF INTERVENTION

- (+) Adjusting the support (frequency, length, conditions) according to the situation / (-) too much/not enough support vs. perceived needs

« "Well, it's because we've known each other for a long time. So it's easier for me to talk, and I know she's there to listen to me, to help me."

CONTINUITY OF THE RELATIONSHIP

- (+) Long-term relationship / (-) change of practitioners

THREE conditions (+) related to the parents’ actions

1. Attitude of parents

- Receptiveness, openness to the practitioner
- Sensitivity to the practitioner’s reality

2. Communication

- Transparency (reciprocal); Expressing their experience, their dissatisfaction

3. Mobilisation of parents

- Following practitioner’s advice; making the necessary changes

”[…] she knows I need someone to listen to me, but I also know she’s got her own problems.”

“[...] since I separated, I find they’re more on our side [...] they work more with the parents.”

Lessons learned from the experiences of parents who participated in the AIDES project

1. Promote practitioner <-> parent <-> community relationships and access to resources;

2. Create space for dialogue with parents; include them in decision making

3. Help parents foresee the possibility of actions/decisions being taken to protect the child.

4. Examine professional practices and their effects on parents, collaboration, and ultimately, the well-being of the children (e.g., analytical framework and interaction schemas)

3. Quality of exposure to the AIDES social innovation and developmental outcomes of the children and parents

presented

by

Claire Chamberland, Ph. D., Marie-Ève Clément, Ph.D., Carl Lacharité, Ph. D. and Véronique Bouchard

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Formation of the experimental group+

- Population per protocol → n=44
- Child cases most closely matching the experimental intervention, based on two criteria:

  1) Quality of completion of the Needs Analysis Workbook for the child

  2) Quality of exposure to the intervention (training, support received, number of families referred to the project).

Statistical analyses

- Three hypotheses: differential proximal effects, differential intermediate effects, differential final effects.

- Repeated-measures ANOVA examining the effects Group x Time.

Significant differences between the AIDES+ and control groups at pre-test

	AIDES+	Control
Characteristics of the children	Tend to be younger on average†	
Characteristics of the families	Are more likely to live in cramped housing conditions*	
Cognitive, language, behavioural, and emotional development of the child	Are more likely to experience difficulties in three areas of their development (DAT)*	Are more likely to have high levels of internalising problems (CBCL) **
Victimisation	Are more likely be at high risk for being victim of abusive behaviours of a chronic nature by the responding parent (CAPI)*	
Adaptation of the parental figures to their role, and exercise of their responsibilities toward the child	Are more likely to report high dysfunctional interaction with the child targeted by the study (PSI) **	Are more likely to report normal levels of dysfunctional interaction with the child targeted by the study (PSI) **
Quality of the family environment to which the child is exposed	*No significant difference*	
Perception of the parental figures regarding the quality of collaboration with the assigned practitioner		Are more likely to report high quality collaboration with the assigned practitioner (QPPC)*

($p < 0.1$† $p \leq 0.05$* $p \leq 0.01$ $p \leq 0.001$***)**

Outcomes of differential proximal effects

Mean change over time for measures of proximal effects

Measures of proximal effects (expected direction)	Mean change (T2 - T1)		*p*
	AIDES +	***Control***	
HPS – Helping Practices Scale (↗) (scale of 1-5)	**-0.11** (0.73)	**0.01** (0.74)	*ns*
(PCAS) – Personal Control Appraisal Scale (↗) (scale of 1-10)	**0.14** (1.66)	**0.37** (2.70)	*ns*
QPPC – Perceived quality of parent/practitioner collaboration (↗) (scale of 1-5)	**-0.15** (0.59)	**-0.19** (0.58)	*ns*

Outcomes of differential intermediate effects

Mean change over time for measures of intermediate effects

Measures of intermediate effects (expected direction)	Mean change (T2 - T1)		*p*
	AIDES +	*Control*	
PSI – Parental stress (↘) (Additive score: 36-180)	**-1.37** (18.81)	**1.11** (14.89)	*ns*
FSS – Informal family support (↗) (Mean score: 1-5)	**0.30** (0.77)	**0.03** (0.72)	*
FSS – Formal family support (↗) (Mean score: 1-5)	**- 0.04** (0.73)	**0.01** (0.76)	*ns*
FSS – Total family support (↗) (Mean score: 1-5)	**0.15** (0.58)	**0.02** (0.60)	*ns*
CAPI- Abuse potential from parent (↘) (Weighted score: 10-370)	**-24.33** (60.46)	**-14.00** (55.73)	*ns*
HOME – Family environment (↗) (Variable score[a])	**4.14** (4.93)	**2.46** (5.54)	*

*$p \leq 0.10$

[a]Varies by age group of children (0-45 for 0-36 months; 0-55 for 3-6 years; and 0-59 for 6-10 years)

Outcomes of differential final effects

Mean change over time for measures of final effects

Measures of final effects (expected direction)	Mean change (T2 - T1)		*p*
	AIDES +	*Control*	
DAT* - Cognitive development (↗) (Variable score)	**1.97** (5.37)	**1.29** (5.22)	*ns*
DAT* - Motor development (↗) (Variable score)	**1.67** (3.85)	**2.29** (2.73)	*ns*
DAT* - Emotional development (↗) (Variable score)	**0.77** (2.80)	**0.76** (1.87)	*ns*
PPVT- Language development (↗)** (Additive score: 0-170)	**15.78** (10.99)	**17.90** (14.10)	*ns*
CBCL – Internalising problems (↘) (Normalised score: 33-83)	**0.91** (8.75)	**-0.57** (7.24)	*ns*
CBCL – Externalising problems (↘) (Normalised score: 32-83)	**-1.40** (8.48)	**0.78** (7.54)	*ns*
CBCL - Total (↘) (Normalised score: 32-80)	**0.37** (7.14)	**-0.31** (6.36)	*ns*

* Only 68 children of the control group and 53 children of the AIDES group (including 35 from the AIDES+ group) completed the DAT.

** Only 31 children of the control group and 23 children of the AIDES group (including 9 from the AIDES+ group) completed the PPVT.

[a] Variable scale depending on age group of children (14 versions based on age blocks of 3-6 months)

Main effects on the child, the parent, and the family environment (greater for AIDES group than for control group):

- Improvement in quality of formal support for the parent;
- Improvement in quality of family environment

Other changes or effects observed in the AIDES* group (no difference with CONTROL group)

- Decrease in victimisation potential of parent toward child
- Decrease in parental stress
- Improvement in cognitive and social-emotional development of the child (compared to children of same age group)
- Decrease in emotional and behavioural problems.

Children in the AIDES group presented more difficulties compared to children in the control group.

Limitations

- Inability to randomly distribute subjects in the AIDES and control groups → No equivalence of groups at pre-test;
- Issues related to measures (proximal effects);
- Small sample size per protocol;
- Decision to reassess children's and parents' situations after a period varying between 12 and 24 months following pre-test;
- Degree of exposure of children and parents to expected protocol.

4. Illustrations of the unique experiences of children and their families participating in a social innovation

presented

by

Danielle Lessard, Claire Chamberland, Ph. D., Guylaine Fafard and Carl Lacharité, Ph. D.

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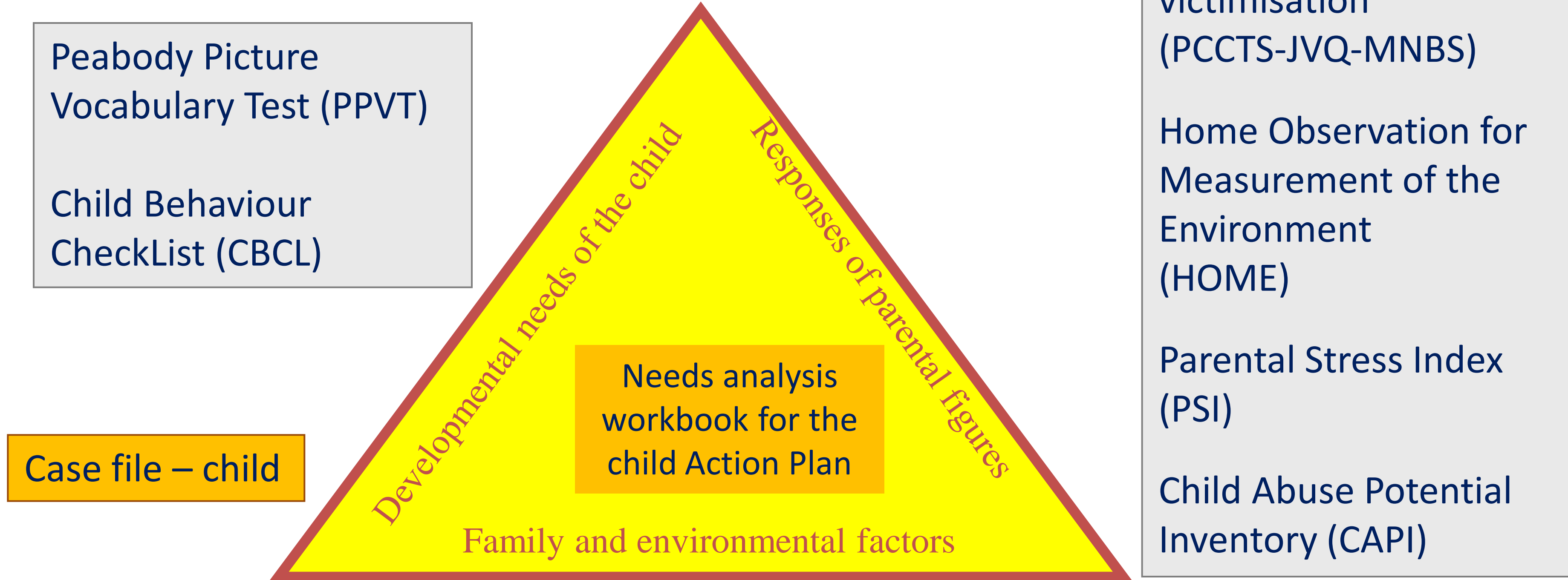
About the selected case histories

- Experimental group (AIDES)
- Selection: one satisfied parent, one dissatisfied parent - Perception of parents regarding services received
- All information sources available
- Children: 9 years old
- Respondents: fathers
- More than one year in project.

Available information



In-house questionnaire: demographic data / social services received Family Support Scale (FSS)

Perception of parents regarding services received : *Helping Practices Scale* (HPS), *Personal Control Appraisal Scale* (PCAS), *Questionnaire on Parental Figure-Practitioner Collaboration* (QPPC)

Telephone interview: participation-collaboration (parent & practitioner)

Telephone interview: practice conditions (practitioner and other respondents)

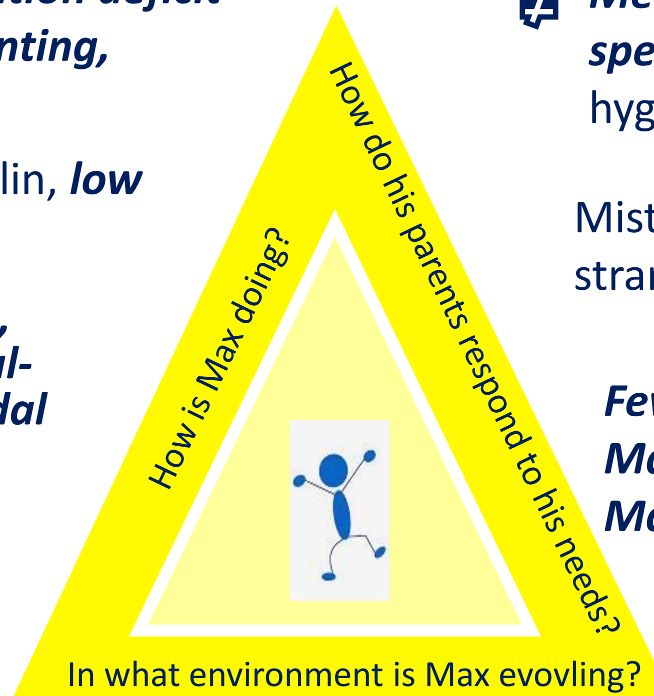
Max in the first 6 months of the project

Hypotonia (difficulty eating), ***Attention deficit hyperactivity disorder (ADHD), stunting, sleeping problems.***

Special education, successful if Ritalin, ***low vocabulary (PPVT)***, likes school.

Distracted, aggressive, introverted, anxious-depressive and withdrawal-depression (CBCL=very high), suicidal thoughts, expresses ideas by shouting/hitting, feels unloved.

Conflicts: siblings, parents, friends at school, gets along better with those older than him.



≠ ***Medical/dental follow-up, special diet?***, proper hygiene.

Mistrust of parents toward strangers and neighbours.

Few compliments because Max regressing; parents love Max.

Parental stress (PSI=very high)

Parents: fear of hospitals and dentists. Seven family members = frail health. DI: spouse, Max's older sister and younger brother

Unemployed. Social assistance. Small dwelling, overcrowded, noisy (HOME);

≠ ***contacts: extended families, neighbours, friends;*** ≠ social activities.

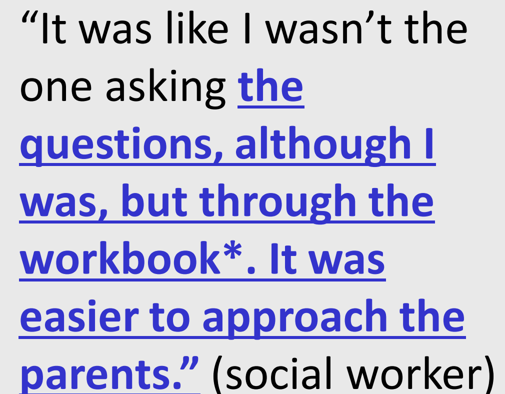
Social worker, special education teacher, and speech-language pathologist = extremely helpful people (FSS).

Familiar with neighbourhood resources, but prefer to cope alone, independent.

Successful appropriation of the methods… *and a parent who feels heard*

1. **Intermediary/vehicle/ occasion** for understanding Max's situation: space for dialogue and awareness;

2. **Provides structure - common thread** in and between meetings – goals better targeted with the parent and more meaningful for the parent;

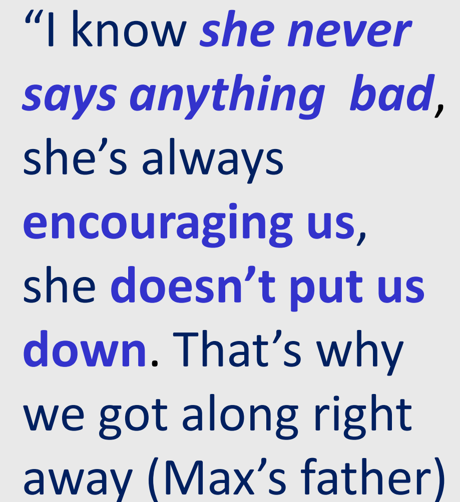


* Tool = Needs analysis workbook for the child

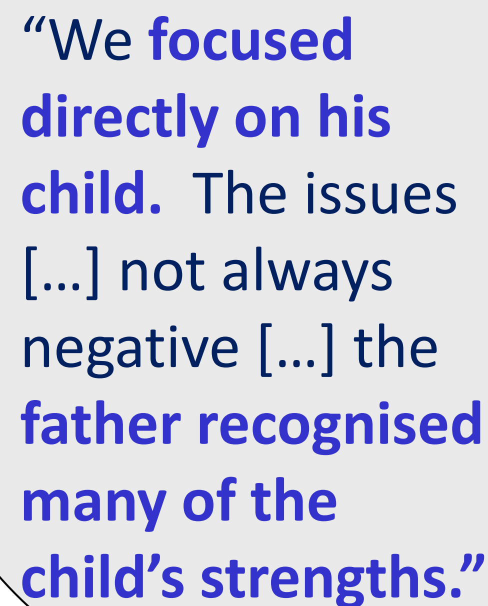
3a. Responds to father's concerns, considers his point of view, supportive and non-blaming;

3b. Focused on the strengths and abilities of the parents – relationship of confidence – confidence and self-reliance as a father;

3c. Centred around effective solutions at an adapted pace;



4. Different picture of Max – strengths and abilities of his son – better quality of father-son relationship;
5. Impact was positive: greater understanding of Max and his family.



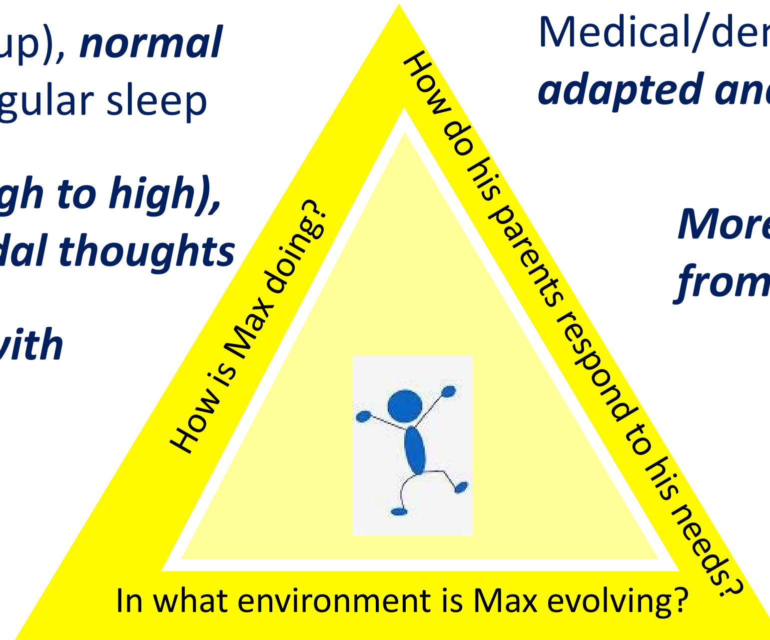
Max at the end of the project

ADHD (Ritalin: regular follow-up), ***normal weight,*** regular/varied diet, regular sleep

Less aggressive (CBCL: very high to high), normal anxiety level, no suicidal thoughts

More "normal" relationships with siblings, closer with father, friends at school/neighbours

Uses microwave oven, responsibilities at home/school



Medical/dental follow-up, ***adapted and varied diet***

More positive attention from parents

Less verbal abuse

Parental stress (PSI: very high to high)

More frequent contact with spouse's mother.

Family still inward-looking, but confides in social worker.

Max allowed to play with two neighbourhood friends.

More services: Educational psychologist , nutritionist, family ***doctor of the pediatric clinic***

Léa in the first 6 months of the project

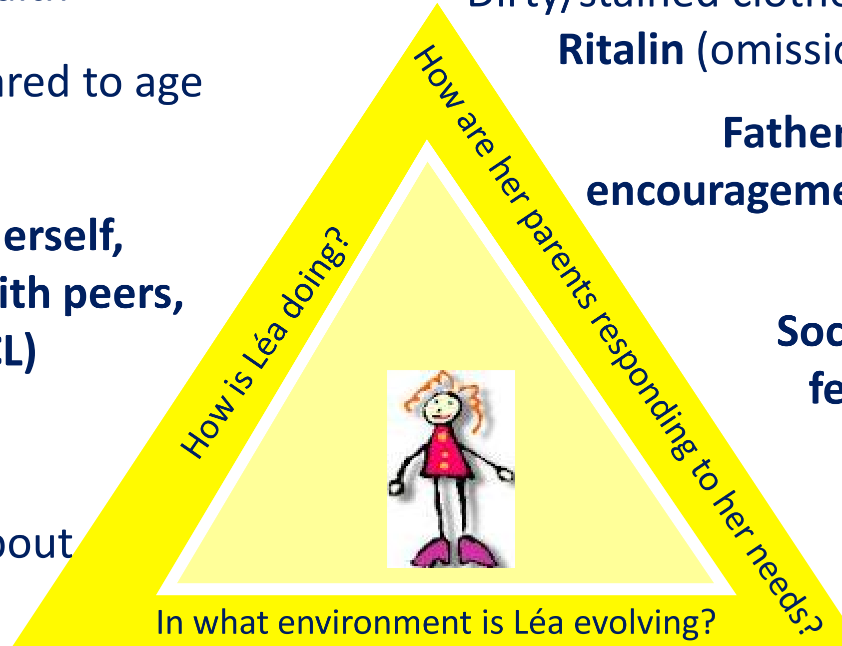
ADHD, overall good health

High vocabulary compared to age group (PPVT)

Introverted, keeps to herself, problems socialising with peers, lies/thwarts rules (CBCL)

Unsure of herself

Does not like to talk about her family



Dirty/stained clothes (HOME), **irregular intake of Ritalin** (omission of father and foster family)

Father unaware of Léa's talents; no encouragement; little parental sensitivity; father unavailable

Social activities not encouraged; few learning materials (HOME)

Verbal abuse; respect and tolerance not taught

Parental stress (PSI:low)

Blended family: 7 children, 4 laced (Léa). Léa's **father alcohol problem**

No extended family

Social assistance; family allowances

Formal and informal support considered weak (FSS)

Owners of 12-room home; **unattractive and unsafe environment (HOME)**

Poor relations with neighbours and authorities

Social worker from protection services, foster family (custody by father from Friday to Sunday)

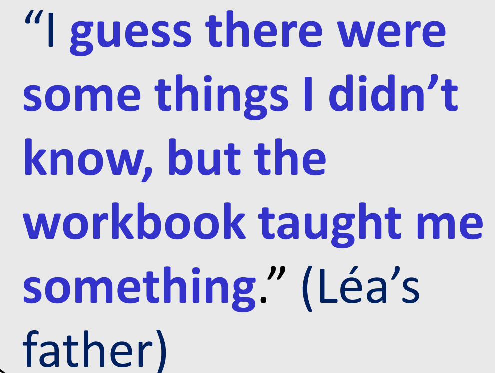
Special educator at school, physician, homework assistance, daycare, clothing bank

A PROMISING BEGINNING… but unsuccessful appropriation in the end ***and a parent whose mistrust deepens***

1a. Knowing Léa's needs (father);

1b. Preparing meetings and stepping back;

1c. Goals: better targeting Léa.



UNSUCCESSFUL APPROPRIATION IN THE END

2a. Lack of understanding of ***framework;***

"Mr. A and I have conflicts, you know. He annoys me (...) Like, **instead of seeing the positive, he's always seeing the negative, and he never shows us the positive**" (Léa's father).

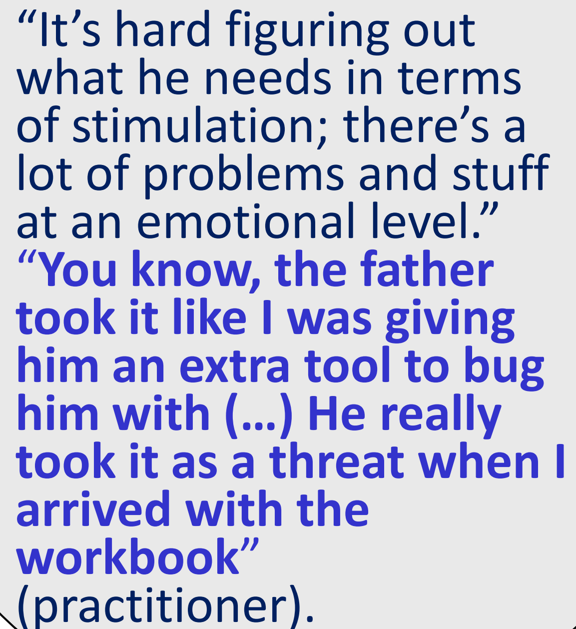
2b. No participatory approach or relationship of confidence;

2c. Needs analysis workbook (tool) for the child not completed;

"... **there were areas I really rushed through; like, for example, education, identity, self-presentation** – these are three areas I explored a lot less than the others (practitioner)

3. Negative prognosis by practitioner: parent never took ownership.

4. Needs analysis workbook for the child (tool) perceived as a threat.

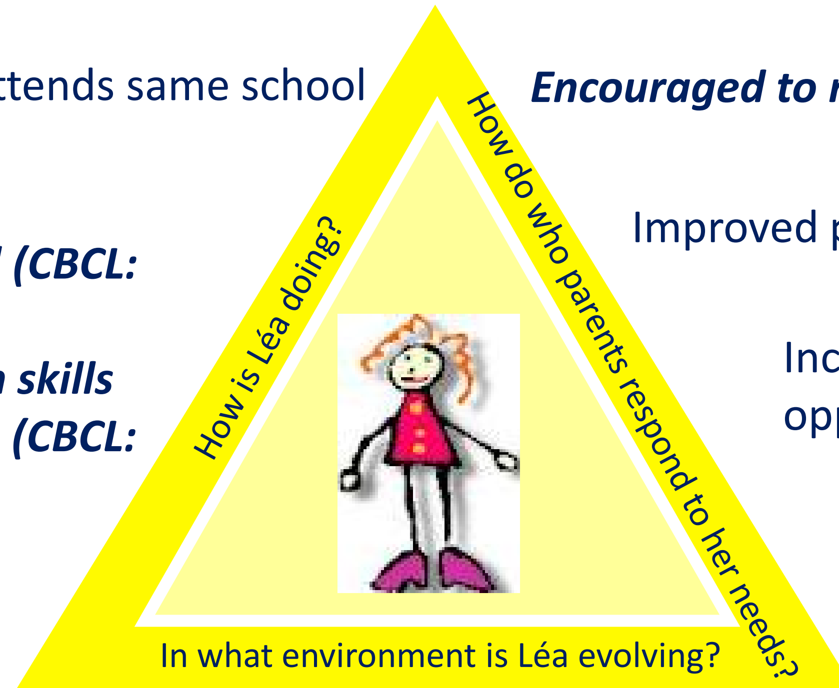


Léa at the end of the project

Difficulties at school, attends same school

Brutish with others, withdrawn, depressed (CBCL: very high), improved socialisation skills (CBCL); internalisation (CBCL: very high)

Placed until majority



Encouraged to maintain daily care routine

Improved parental sensitivity (HOME)

Increased learning opportunities (HOME)

Work and play area kept clean

Foster family: two-parent family

Improved physical environment + clean (HOME)

Special education, speech language therapy, psycho-social follow-up with Léa's protection centre

Supervised visits (3 hours, every other Saturday),

Social worker for father (prevention centre)

Conclusion

- Importance of knowledge, know-how, and human relation skills

- Practice conditions→ factors influencing the acquisition of this knowledge

5. Practice conditions and social innovations: Facilitators and barriers to implementing the AIDES initiative

presented

by

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Method

- Respondents from all participating organizations:
  - 18 practitioners
  - 17 other respondents
- Semi-structured telephone interviews
  (length = +/- 30 minutes)
- Descriptive analysis of content
- Coding by consensus (2 analysts)
- Interview grids and structured analyses according to the literature

Outline of results

1. Quality of implementation

2. Organizational characteristics

    2.1 Organizations themselves

    2.2 Socio-political issues

    2.3 Collaboration between organizations

3. Individual and professional characteristics

1. Quality of implementation

FACILITATORS

Methods:

- Quality of training
- Quality of support
- Formal collaboration agreement

BARRIERS

Methods:

- Absences/dissatisfaction regarding training
- Redundancy of content and heterogeneity of participants

1. Quality of implementation

FACILITATORS

Methods:

- Quality of training
- Quality of support
- Formal collaboration agreement

Process:

- Quality of relationships
- Modeling and mutual aid
- Degree of implementation

BARRIERS

Methods:

- Absences/dissatisfaction regarding training
- Redundancy of content and heterogeneity of participants

Process:

- Relationship difficulties
- Low degree of implementation
- Significant changes w/r to the original initiative

2. Organizational characteristics
2.1 Organizations themselves

FACILITATORS

- Receptiveness to research
- Voluntary participation of practitioners, stability
- Consistency with vision
- Ownership of the AIDES analytical framework
- Quality of support

BARRIERS

- Innovation exhaustion
- Competition with clinical tools in place
- Prior professional skills not acquired
- Staff turnover
- Lack of support
- Involuntary participation of stakeholders
- Difficult to reconcile with mandate

2. Organizational characteristics
2.2 Socio-political issues

FACILITATORS

- Consistency with changes to the Youth Protection Act (2007)
- Consistency with the ministerial mandate of promoting joint programming

BARRIERS

- Creation of a new administrative structure
- Frequent changes in ministerial directions
- Necessary but unavailable services
- Temporary assignments for health emergencies
- Poorly adapted monitoring systems

2. Organizational characteristics
2.3 Collaboration between organizations

FACILITATORS

- Contribution to existing cooperative structures

OBSTACLES

- Lack of availability
- Difficulty reconciling organizational mandates
- Pre-existing conditions not met

- No examples of collaboration regarding childrens' situations

3. Individual and professional characteristics

FACILITATORS

- Interest in AIDES
- Compatibility with intervention philosophy
- Personal qualities
- Snowball effect

BARRIERS

- AIDES seen only as research
- Lack of motivation
- Lack of proficiency in using the proposed methods
- Resistance to change

Recommendations

Deployment of the AIDES initiative must:

1. Strike a balance between

   - a prescriptive approach in terms of compliance with the essential principles and procedures

     and

   - local adaptations (for each setting)

2. Require that certain conditions be met for successful implementation.

Recommendations

Presented by

Claire Chamberland, Ph. D. and research team

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For practitioners and managers

- The AIDES initiative is relevant, meaningful, and structuring;
- Deployment of the AIDES initiative must strike a balance between local adaptations specific to each setting, and a prescriptive approach;
- The next phase of the AIDES initiative will require that certain conditions for success be implemented;
- Practice settings should be the promoters and implementers of the AIDES initiative.

For decision makers

- Adopt broad social objectives across institutional mandates;

- Develop social indicators that will shape policies and programmes for children and their families.

For researchers

- Assessment of the effects of a social innovation such as AIDES should be carried out only when its implementation is well underway, stable, and consistent with what was planned;

- Assessments of social innovations must focus on both their implementation and their effects; they also benefit from mixed evaluative designs that combine qualitative and quantitative approaches.