

Sunflower

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**Sent:** September 17, 2008 4:28 PM  
**To:** Ross Wiseman; Doyle, Patricia M; Joyce Penney; jddawe@nf.sympatico.ca  
**Subject:** Report - Residential Treatment and Beyond  
**Attachments:** Residential Treatment and Beyond (Part 3) ; Residential Treatment and Beyond (Part 2); Residential Treatment and Beyond - (Part 1 - pages 1 - 48)

**Forwarded on behalf of Joan Dawe, Board Chair, Eastern Health**

Good Afternoon Minister:

Further to our discussion of earlier this week, as promised I am forwarding to you a copy of the Residential Treatment and Beyond: Towards a New Model of Service Delivery of Children, Youth and Families with Complex Needs document dated December 2003.

Please feel free to call me if you have any questions.

Thanks Joan



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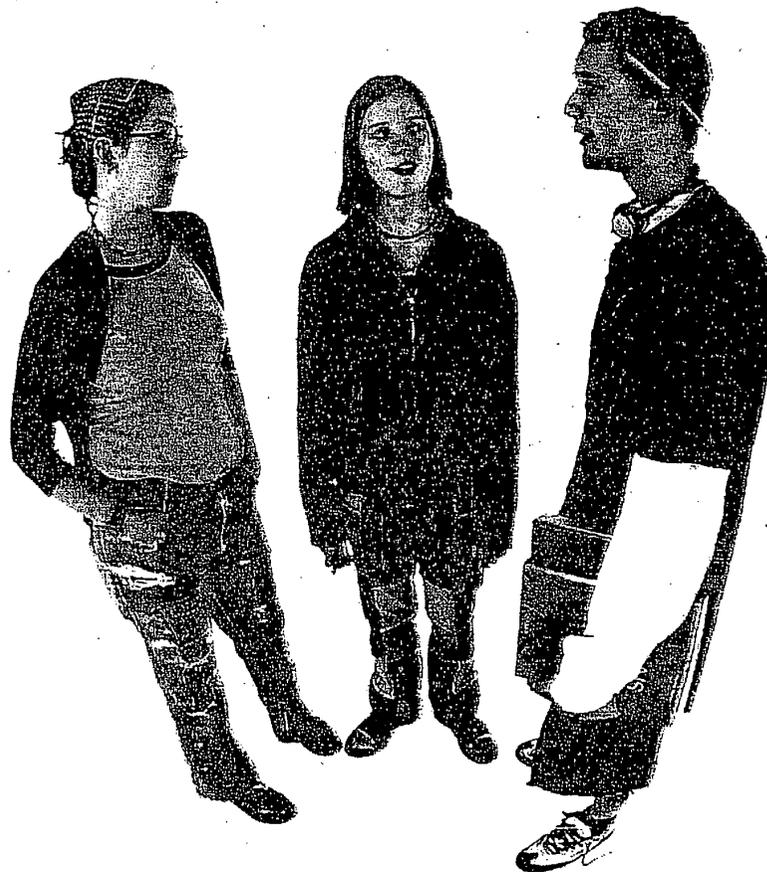
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REGISTRY



M. Ryan

**RESIDENTIAL TREATMENT AND BEYOND:  
TOWARDS A NEW MODEL OF SERVICE  
DELIVERY FOR CHILDREN, YOUTH AND  
FAMILIES WITH COMPLEX NEEDS**



**REPORT OF THE PROVINCIAL COMMITTEE ON THE RESIDENTIAL  
AND TREATMENT NEEDS OF CHILDREN AND YOUTH**

*Michelle Ryan*   

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# **Residential Treatment and Beyond: Towards a New Model of Service Delivery for Children, Youth and Families with Complex Needs**

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Report of the Provincial Committee on the Residential and Treatment Needs of  
Children and Youth

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## Acknowledgements

The Provincial Committee on the Residential and Treatment Needs of Children and Youth was comprised of the following individuals:

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Ken Barter, School of Social Work, M.U.N.

Anne Marie Ottenheimer, Shalom Inc.

Joan Whelan, Health and Educational Services

Heather Modlin, St. Francis Foundation

The Committee would like to thank the following individuals, organizations, and government departments for their contribution to and participation in the work of the Committee:

- Department of Health and Community Services for providing financial and staff support
- Health and Community Services – St. John's Region for spearheading this project and providing staff support
- All Directors and staff in each region who participated in the completion of Child Data Information Surveys and Director in Region Surveys
- Mike Balla of the Child Welfare League of Canada for providing information on literature pertaining to best practices in residential care
- Dr. Grant Charles of the University of British Columbia for providing consultation on the literature review and survey development and analysis

- Dr. Thom Garfat of TransformAction, Rosemere, Quebec for providing ongoing consultation throughout the project
- All individuals who attended and participated in the two day planning session in May, 2002
- All individuals who participated in the roundtable discussion in October 2002
- All individuals who participated in the focus groups and consultation sessions

## Executive Summary

This report was prepared under the direction of the Provincial Committee on the Residential and Treatment Needs of Children & Youth. This committee was established in response to the growing recognition that there is a group of highly vulnerable children and youth with complex and challenging needs that are not being met through existing systems of service delivery.

The committee was formed in December, 2002. It consists of representatives from the Department of Education; the Department of Health and Community Services, including the Division of Mental Health; St. John's, Eastern, Western, and Labrador Regional Boards; the School of Social Work, M.U.N.; and community-based and private organizations involved in the provision of residential care. The mandate of the committee was:

1. To develop a plan of action to broaden and improve the residential and treatment options available to children and youth with complex needs and behaviors, and their families
2. To identify policy and program improvements that would lead to earlier identification of and other interventions with children and youth with complex and challenging behaviors, and their families

The Department of Health and Community Services financially supported the work of the committee.

Research involved a literature review on best practices in residential care; key informant consultation; surveys completed by all Directors in Region; and Child Data Information Surveys completed by social workers in each region on all children between the ages of 0 - 5 in the care of the Director of Child, Youth and Family Services, and youth ages 16 -18 with Youth Services Agreements.

The objective was to prepare a report, with specific recommendations on how to improve services for children, youth, and families in Newfoundland and Labrador, for submission to the Department of Health and Community Services for review and implementation.

## Summary of Findings and Recommendations

The findings revealed that children and youth in the care of the province have family histories with high incidences of neglect, abuse, violence and substance abuse. They are also dealing with significant personal issues and exhibiting a multitude of disturbed and disturbing behaviors. Currently, the system is unable to respond adequately to the needs of all young people in the care of Child, Youth and Family Services, particularly those with complex and challenging behaviors. Significant gaps in the continuum of care have been identified.

This report contains many recommendations, all of which revolve around three main themes:

- Conceptual framework for service delivery
- Planning and coordination
- Development and re-allocation of resources

Specific recommendations for improvements focus on training; assessment; standards; family support; foster care; education; residential treatment; and outreach.

The most comprehensive recommendation is for the development of a residential treatment and outreach program that would provide the following:

- A residential treatment center for young people ages 10–16, with a protective treatment component, that will provide specialized services for young people with a dual diagnosis and specialized services for young people with complex and challenging behaviors
- A community outreach program that will include a treatment foster care program; alternate education program; and family support and aftercare program; all of which will be connected to and resourced through the residential treatment program.

This proposed program would have the capacity to provide treatment and outreach services to more than twenty children and families at any one time for less than the amount that is currently being spent to support seventeen young people in ILAs and out of province placements. This innovative model would provide appropriate and effective services to young people with complex and challenging needs, while also strengthening other essential components of the continuum.

The paper outlines a critical path that can be followed by government to implement the recommendations pertaining to the development of a Residential Treatment and Outreach Program for the province of Newfoundland and Labrador.

## Chapter 1: Introduction

### 1.1 Background

In the past decade, child welfare, youth corrections, institutional health care, and child and youth care services have witnessed an increase in the complexity of the needs and challenges facing the young people they serve. Significant progress has been made with respect to improving services to young people through legislation, policy development and program development. However, there is still a group of highly vulnerable children and youth with needs that are not adequately met through existing organizations or systems of care. This includes young people in the care of the Regional Directors of Child, Youth and Family Services who have either been sent out of the province to receive treatment or placed in Individual Living Arrangements (ILAs).

While Individual Living Arrangements have been utilized consistently since the late 1980's, concern has been raised that they:

- Do not represent a "best practices" approach to meeting the complex needs presented by the children and youth,
- Do not adequately draw upon the expertise available through other organizations with a mandate to serve children and youth,
- Are extremely expensive relative to congregate living arrangements utilized by other provinces.

ILA's have evolved to fill a legitimate gap in the services to young people in the province who have serious emotional and behavioral challenges. In light of the significant resources that are utilized to support young people in out of province treatment and ILA's, there is great potential for service providers to work together to build a new, evidence-based approach to service delivery for these children and youth.

The need for effective services for this population of children and youth is not a problem that is unique to Newfoundland and Labrador. The province of Nova Scotia conducted a review of their residential child-caring system in 2000, and one of the recommendations arising from this supported the development of a secure treatment program. This program has been developed, and is scheduled to open in December 2003 (J. Connolly, personal correspondence, October 28, 2003). The other Atlantic provinces, PEI and New Brunswick, are conducting similar reviews, with a focus on developing more appropriate resources for hard-to-serve young people (M. Balla, personal correspondence, February 28, 2003). Even in provinces where there is a full continuum of services available, caregivers and professionals are struggling to meet the needs of children and youth who appear to be demonstrating more violent and disturbing behaviors than in the past (G. Goodwin, personal correspondence, March 21, 2003).

The growing awareness of the seriousness of this issue in Newfoundland and Labrador prompted Health and Community Services - St. John's Region to plan a two-day, provincial workshop to look at developing a new model of service delivery for youth with complex

needs. This workshop was held in March, 2002. Representatives from every region in the province, including decision-makers and front-line staff from residential treatment backgrounds, child, youth, and family services, youth corrections, institutional health care, education, and the private practice community, were brought together to participate in the solution building process. The primary action plan emerging from this day was to develop a provincial working group that would continue to address the issues identified during the workshop. This recommendation was endorsed by the Department of Health and Community Services in the Fall of 2002 and the Provincial Committee on the Residential and Treatment Needs of Children and Youth was established.

Following the two-day forum, a round-table discussion was held in October, 2002, to further explore some of the issues that were raised at the provincial workshop. Twenty-four people attended, with representation from government, H&CS regional boards, community agencies, and an invited group of experts, from around the world, on the care of troubled children and youth. The invited guests were in St. John's to attend the 12<sup>th</sup> National Child and Youth Care Conference. This roundtable validated our belief that the continuum of care for children and youth in Newfoundland and Labrador needs to be improved. It also helped us to understand that many other jurisdictions in North America, and beyond, are struggling with similar issues. Minutes of the roundtable discussion and a list of all participants are in Appendix 1.

The first meeting of the Provincial Committee was held in December, 2002. The committee is comprised of representatives from the Department of Education; the Department of Health and Community Services, including the Division of Mental Health; St. John's, Eastern, Western, and Labrador Regional Boards; Memorial University School of Social Work and community-based and private agencies involved in the provision of residential care. In order to facilitate the work of the committee, the Department of Health and Community Services provided funding for a support person. The committee contracted with the St. Francis Foundation to provide this support through their Executive Director, Heather Modlin. The mandate of the committee was:

1. To develop a plan of action to broaden and improve the residential and treatment options available to children and youth with complex needs and behaviors, and their families.
2. To identify policy and program improvements that would lead to earlier identification of and other interventions with children and youth with complex and challenging behaviors and their families.

The Terms of Reference for the committee are included in Appendix 2.

## 1.2 Research Process

### 1.2.1 Introduction to Research Process

The Provincial Committee on the Residential and Treatment Needs of Children and Youth was originally set up to look at residential treatment options for the most challenging young people. It became clear very early in the process, however, that this mandate was too narrow. Since residential treatment is part of a system of care and services, it must be viewed within the context of that system. To do otherwise

would result in a fragmented, disjointed approach to identifying and solving problems that exist within the current system of care. Further, there are other ongoing provincial initiatives designed to improve the existing systems of long-term care and supportive services, and mental health and addictions. The work of this committee is nested within the broader context of the Long-Term Care and Supportive Services Strategy that acknowledges the need for the development of a plan to respond to the residential and treatment needs of children and youth.

The Committee, therefore, broadened its' focus to look at the full continuum of care, and to make recommendations based on resources and activities required to improve the range and quality of services available to children and youth in Newfoundland and Labrador. The committee did not examine options that were designed to meet the unique needs for substance abuse treatment for aboriginal youth in Labrador.

What follows in this paper is a synthesis of the research that was conducted by the committee, and the related findings and recommendations.

This paper outlines a plan for improving the continuum of services to children and youth who are at risk of, or in need of, residential treatment services. The plan was developed with consideration of the principles of the Child, Youth and Family Services Act, the Strategic Social Plan, the Strategic Health Plan, and the Model of Co-ordination of Services. The work of the committee was:

- Focused on promotion, prevention and early intervention
- Child, youth and family centered
- Focused on the enhancement of meaningful partnerships
- Built on evidence and best practices research
- Committed to fiscal responsibility and sustainability

The questions the committee was established to answer were:

- What are the gaps in the current continuum of residential care for children and youth?
- What is considered best practice in the area of residential treatment for children and youth?
- What models of care can be delivered at less cost than current models, that would also be more appropriate and sustainable?
- What is a recommended model for a secure treatment approach, including policy and legislation implications, best practices, and location and continuum of services issues?
- How can partnerships between the relevant stakeholders, particularly institutional and community health boards and education be improved?

- What other activities and initiatives could be undertaken by respective Health and Community Services Regional and Integrated Boards in the interest of improving earlier identification and intervention with challenging children and youth?

In order to ensure that the committee was able to meet the mandate and develop a plan of action that was sound and sustainable, a number of activities were conducted:

#### 1.2.2. Literature Review

To ensure that any recommendations made by the committee were evidence based, a literature review was conducted of best practices in residential care. This started with a look at the continuum of care - what it should include, how it should be utilized - and continued on to review specific elements of the continuum, including residential treatment. It was critical that the literature review include all components of the continuum, as it would be impossible to conduct a best practice review of residential care in isolation from the other resources with which it is inherently intertwined. The complete literature review is presented in Appendix 3.

Questions the committee wanted answered through this review included: What are the essential components of the continuum of care? How should services within the continuum be accessed and utilized? What is considered best practice in residential treatment? What is best practice with children and youth who have complex and challenging behaviors? When is secure treatment necessary? How does residential and secure treatment fit with other services on the continuum?

#### 1.2.3. Key Informant Consultation

The key informant consultation process consisted of the provincial workshop, roundtable discussion, ongoing contact with Dr. Thom Garfat and Dr. Grant Charles, who were hired as consultants for the project, and a report validation process which included focus groups and individual interviews with relevant stakeholders from all regions of the province, including all Health and Community Services Regional and Integrated Boards. Financial information gathered through the Director in Region Surveys was validated by financial officers associated with the Department of Health and Community Services and Health and Community Services Boards.

#### 1.2.4. Regional Surveys

To conduct an adequate review of the Residential and Treatment Needs of Children and Youth in Newfoundland and Labrador, it was essential to know, first of all, just who these young people are. To obtain this information, surveys were designed that asked specific questions about these children and youth. Targeted areas included child history; presenting problems/diagnosis at the time of initial placement and in present placement; length of time in current placement and in the care of the province overall; placement history; treatment planning and use of the ISSP model; and other services provided to the child and family. These surveys were then forwarded to the Directors in all Regions, who distributed them to the appropriate social workers to complete on all children between the ages of 0-15 years in the care of the Director of Child, Youth and Family Services, and youth ages 16-18 with Youth

Services Agreements. All surveys were completed between April 10 and May 26, 2003. Complete survey results are presented in Appendix 4.

Overall, surveys were completed on 589 children and youth across the province. This represents 70% of all children and youth in the care of the Director of Child, Youth and Family Services or with a Youth Services Agreement in the province at that time. There were regional differences in interpretation on who the surveys should be completed on, and data submitted for some regions was incomplete. However, the core group that the committee was interested in, which was children in care and youth with Youth Services Agreements, had an excellent return rate. Because of this high response rate, the committee is confident in the validity of the findings. It must be further noted that conducting a survey of this magnitude and scope is unprecedented in this province. The information gathered has provided a great deal of data that can be used for further research and as a baseline for future planning.

#### 1.2.5. Director in Region Surveys

In addition to the information gathered above, surveys were distributed to the Directors in Region for all Health and Community Services Boards across the province. The Directors were asked what they believed to be the biggest gap in the continuum of care in their region, and in the province, and to comment on any trends they had observed in child welfare over the past five years. The survey also sought to capture a financial picture of what is currently being spent on children and youth in ILAs and out-of-province treatment, and other hard-to-serve young people in the province. This information is provided in a separate section.

#### 1.2.6. Financial Analysis

The Committee was intent on developing a plan that was financially sound, sustainable and one that represented a more effective and appropriate use of the resources currently supporting young people in ILAs and out of province treatment (OPT). In order to meet this goal our methodology included the following features:

- Trend analysis using financial data for ILAs and OPT for the four years (2000-2004) since Regional and Integrated Boards became responsible for these expenditures.
- The development of a comprehensive financial plan for projected start-up and operating costs for the proposed residential treatment and outreach program.
- Validation of the financial plan and assumptions through a review by national experts in residential treatment programs, chief financial officers, and the Finance Division of the Provincial Department of Health and Community Services.

Further, while projecting *some* of the savings that will likely accrue due to a reduction of the indirect costs of serving the identified population (e.g. FTE staffing, support and preservation of tenuous foster care placements), this was not comprehensive or critical to the success of the proposed solutions.

## Chapter 2: Findings and Recommendations

This chapter presents excerpts from, and summaries of, each phase of the research process as they relate to the original questions posed by the committee and numerous recommendations based upon an analysis of the findings. The many recommendations presented in this part of the paper revolve around two basic ideas:

- there are *gaps* in the continuum of care that we can fill by better utilizing resources currently directed towards crisis intervention responses (this is the subject of chapter three),
- there are *quality issues* with some of the existing elements of the continuum that need to be addressed as part of a systemic approach to finding solutions to the complex needs of children and youth.

The committee's work emphasized planning the action needed to fill the gaps.

### 2.1 Profile of children and youth in care.

Information on the status and characteristics of children in care and youth with Youth Services Agreements was gathered from the Child Data Information Surveys. As mentioned previously, data was collected on 589 children and youth across Newfoundland and Labrador. The data from these surveys yielded some concerning results.

The children and youth in the care of the province are coming from a range of unhealthy backgrounds with high incidences of neglect, abuse, violence, and substance abuse in the family. Other typical family characteristics include poverty, isolation, discrimination, unemployment, and deprivation (Barter, 2003; Schorr, 1997). This information is understood anecdotally and through the literature, but was not gathered from the surveys. Furthermore, children coming into care are dealing with significant issues, both prior to initial placement and while in care, and are exhibiting a multitude of disturbed and disturbing behaviors. Of particular note are the high percentages and numbers of children entering care with special education needs (30% or 175 children) and developmental delays (27% or 149 children). For the 12-18 age group, the prevalence of negative peer involvement (30% or 112), violence towards others (25% or 96), irregular school attendance (36% or 135), and severe parent-child conflict (37% or 142) is noteworthy. In most cases, these presenting issues overlap. The majority of young people have a minimum of three presenting issues, with some young people having ten or more in each category.

With regard to placement experience, half of all young people have been in their current placement for more than one year. While this would, ideally, indicate some level of stability for these young people, almost half of all respondents indicated that the anticipated length of stay in the current placement is unknown; and more than half indicated that the planned future placement is unknown. This runs contrary to the concept of permanency planning.

Given the early traumatic experiences of many children who end up in care, it is imperative that all young people have treatment or intervention plans that focus not only on their current presenting issues, but their presenting problems at intake and issues related to the early experiences in their family of origin. There must also be a coordinated effort on behalf

of all professionals and agencies involved with each young person to work together in the best interests of the child. To that end, the survey looked at the number of young people with treatment plans and ISSPs in place. While the majority of young people do have treatment plans (67%), one third do not. The stats for ISSPs are more concerning - more than half of all young people do not have an ISSP in place. Furthermore, although the ISSP model was rated as working at least fairly well for the majority of young people, there are some for whom this process was rated as not working at all.

In addition to the placement itself, children and youth in care are often provided with a variety of additional services. The most commonly provided services are counselling, recreation, and respite. Many young people, and their families, are receiving multiple services.

When asked about the impact of the current placement, the majority of social workers rated the placement as having a positive impact on the young person, particularly in the younger age group. The most prevalent placement is foster care, with 98% of children under the age of 12 having experienced at least one foster home placement. The average number of placements experienced by children in care was between 2 and 5.

The involvement of family and the presence of community support have been found to be critical to post-discharge success. More than 90% of children and youth were reported to have a support system in the community, while only two thirds of young people experienced optimal family involvement. This is related to the fact that the majority (52% under the age of 12) of children are in permanent care.

### **2.1.1 Children and Youth With Complex and Challenging Needs**

Since the focus of the Committee was to look, specifically, at those young people whose needs are not being served adequately by the current system, data for young people who have required residential care (which includes group homes, open custody, and closed custody), and those who have been in ILA placements or out-of-province treatment, was analyzed separately. Although this is a small segment of young people in care, they are the most costly. Placement in a group home, which includes open custody, costs approximately \$100,000 – 125,000 per child, per year; placement in the Newfoundland and Labrador Youth Center costs more than \$100,000 per child; out-of-province treatment can range from \$130,000 to \$500,000 (this does not include the cost of transportation, telephone long distance, and other “hidden” expenses associated with sending a child to another province); and the cost of an Individual Living Arrangement (ILA) for one young person ranges up to \$450,000 per year. This is an enormous amount of money to spend on a small group of children, particularly given that the most expensive of these living arrangements – out-of-province treatment and ILAs – are utilized only in response to crisis situations and are not necessarily reflective of best practice. A review of the characteristics of this group, however, reveals significant differences between them and the larger group. These young people present with numerous issues, indicating that there is a definite need for specialized services and more intensive intervention than that required by other children in care. The most relevant information gathered from the surveys on this group is provided below:

- There were 64 young people who had been in residential placements and, of these, 16 had been in ILAs or sent out of province for treatment. Young people in ILAs and out-of-province treatment scored higher than all other young people in many areas of child history, most notably neglect (81%), family substance abuse (63%), violence (56%), family violence (56%), family psychiatric disturbance (44%), and sexual abuse (25%).
- This group also scored higher in the categories of presenting issues at intake and current presenting issues. The most noteworthy differences, at intake, occurred in the areas of special education needs (81%), negative peer involvement (75%), violence towards others (69%), irregular school attendance (63%), developmental delay (44%), depression-anxiety (38%), and attachment disorder (19%).
- Young people in ILAs and out-of-province treatment are much more transient than other young people. One quarter had been in their current placement for less than a month, and only a third had been in their current placement for more than a year. How long they will remain in the current placement, and where they will go after the placement, is unknown for a vast majority (up to 80%).
- These young people have experienced a much higher percentage of multiple moves while in care. **Sixty three percent have had 2 - 5 placements; 19% have had 6 - 11 placements; and 15% have had more than 12 placements.** These numbers do not include admissions to the Janeway psychiatric unit, although there is evidence to suggest that many of these children have had periods of acute hospitalization. Clearly, the lack of appropriate placement options for these children is resulting in "foster care drift." This is compounding the problems of these children, and, with every move, making them potentially more resistant to effective intervention.
- All young people in this group have a treatment plan in place, while only half have an ISSP. The ISSP process was rated as not working for 56% of young people with ISSPs. It appears the ISSP process was perceived as less effective by those surveyed as the needs of children and youth become more complex and challenging. This does not necessarily correlate with the presence or absence of effective collaboration, as is the intent of the ISSP model, but rather may be interpreted to reflect the lack of appropriate resources available for these young people.
- A larger percentage of young people in ILAs and out-of-province treatment are in permanent care, and the majority of these have been in care for more than two years. An examination of in-depth case histories of these young people would reveal that the majority of children and youth who end up in ILAs or out-of-province treatment were initially placed in care as small children.

To provide the reader with a more detailed description of the children and youth with "complex and challenging needs," who are the primary focus of this report, composites of young people who have required ILAs or out-of-province treatment are presented below:

### Profile 1: Johnny...a young man with dual diagnosis.

Johnny has been in care since he was three years old. He lived in one foster home from the ages of three to twelve, at which point this placement broke down due to Johnny's increasing aggressive behaviors. Johnny was then placed in another foster home, which broke down six months later for the same reasons. Johnny's behavior included verbal abuse, threatening, hitting, kicking, spitting, damage to property, and sexual intrusiveness.

Johnny has been diagnosed as mildly to moderately developmentally delayed. Cognitively, he functions at an eight year old level. Emotionally, he operates at a two to three year old level. Johnny has also been diagnosed with conduct disorder, antisocial personality disorder, and ADHD. Johnny's family history includes violence, physical abuse, sexual abuse, emotional abuse, neglect, and mental illness.

At the age of thirteen, after two more foster homes, Johnny was placed in an ILA with two on one staff. While at the ILA, Johnny assaulted staff on several occasions, was charged with three of these offences, and served four months at the Newfoundland and Labrador Youth Center. Johnny did not understand why he was in custody. After serving his time, Johnny returned to the ILA and the behaviors continued. These included causing extensive damage to staff's vehicles, ripping doors off hinges, throwing furniture through walls and windows, tearing shingles off the roof (staff had to go up on the roof and talk him down), and exposing his genitals to staff and neighbors. The ILA has had to move twice in one year due to concerns from neighbors and other community members about Johnny's behavior and their safety.

### Profile 2: Mark... "Out-of-Control"

Mark's family has been extensively involved with child welfare since Mark was an infant. He was placed in a foster home at the age of six months, and returned home at the age of one year. Issues in the home include violence, substance abuse, prostitution, drug trafficking, and other illegal activities. Mark's mom was arrested on several occasions for assaulting her spouse, and other acquaintances, and has served three short sentences in jail for these offences. Mark was placed in care for the duration of each sentence, in a different foster home each time.

By the age of 11, Mark was described as being completely "out of control." He rarely attended school and, when he did go, he was disruptive in class and violent towards other students. His behavior also included the use of foul language, threatening the teacher, breaking the classroom windows, chasing the student assistant down the hallway while threatening to kill her, and cutting the phone lines in the office. At home, Mark's behavior was just as aggressive. He bullied his younger siblings and physically damaged the house.

He often wandered the streets with a group of older adolescents, and was suspected to be involved in drinking and drug abuse. There were nights that he did not go home.

Mark was diagnosed with oppositional-defiant disorder, ADHD, and reactive attachment disorder. He was assessed as having above average intelligence.

Due to the extreme nature of Mark's behaviors, he was placed in an ILA with one on one staff. As soon as staff tried to impose any limits on his behavior, the behaviors escalated. They included threatening, spitting at staff and in food, hitting, punching, kicking, urinating and defecating in public spaces, self-mutilation, suicide ideation, extensive property damage (including the destruction of entire walls), and false allegations of abuse. Within a month, the staffing ratio went from one to two to three and then, finally, to four staff on at a time. Mark was physically restrained daily. Still, his behavior could not be contained. He constantly tried to run, and when he did get out into the community he wreaked havoc. The unit had to move after three weeks because of the severity of Mark's behavior and the impact this had on the neighborhood.

After three months at the ILA, Mark was placed out of province in a residential treatment center.

### 2.1.2 Linkages Between Child, Youth, and Family Services and Youth Corrections

The information gathered through the Child Data Information Surveys is validated by other work that has been done in the province. A recent study conducted by the Youth Services Division of Health and Community Services – St. John's Region on **Court-Involved Youth in the St. John's Region: A Client and Community Profile** indicates that there is a strong correlation between the characteristics of young people involved with youth corrections and the characteristics of young people in the child welfare system who are considered to be the most challenging. Many of these youth float back and forth between systems. In fact, over 60% of families of the court-involved males and over 70% of females were identified in the court-involved youth study as having used child welfare services.

The comparison is valuable on a couple of levels. First, it illustrates that the challenges facing children and families in Newfoundland and Labrador are pervasive, and ongoing. They cross all government departments, institutional and community health boards, and education boards. This provides further evidence that the need exists for a collaborative approach between service providers.

Child, Youth, and Family Services has historically relied on youth corrections to contain young people in need of a protective setting – this is evident from the survey information provided. A comparison of the number of residential placements available in the province for child, youth and family services (less than thirty) with youth corrections (more than forty closed custody and more than fifty open custody) reveals that there are at least 60% more youth corrections placements than child, youth and family services placements. It appears that the safety and treatment needs of young people in child, youth and family services have, in many cases, been redirected to the youth corrections system. While services within this system, such as open and closed custody, play a valuable role in the re-education of troubled youth, it

is detrimental to the quality of the care provided, in both youth corrections and child, youth and family services settings, when young people are inappropriately placed.

Implementation of the new Youth Criminal Justice Act on April 1, 2003, has caused a considerable decrease in the number of young people sentenced to serve time in either open or closed custody. Furthermore, youth court judges, under Section 35 of the Act, have begun to order young people to reside in child welfare placements. It is believed that these trends will continue, as the principles upon which the Act are based emphasize community-based interventions over custodial dispositions, except for the most serious offenses. It is therefore imperative that Child, Youth and Family Services become better equipped to deal with these young people within the child, youth and family services system. A broader range of effective services within the Child, Youth and Family Services system must be developed.

### 2.1.3 Recommendations Regarding Best Practice in Service Delivery

#### A. Reallocation of Resources

- Any savings incurred as a result of closures to open custody facilities, or staff reductions at the Newfoundland and Labrador Youth Center as a result of decreased sentencing patterns related to the Youth Criminal Justice Act, should be redirected to Child, Youth and Family Services to invest in the provision of community-based and residential services to children and youth. This should occur in addition to the development of alternate programs for Youth Corrections.

#### B. Training

- Considering that the majority of children in care come from unstable family backgrounds and have an average of two or more placements while in care, all caregivers should be trained in attachment theory, and all children entering care should be assessed for attachment impairment.
- All caregivers should be trained in the use of strength-based interventions with children and families
- There must be increased training and education provided to social workers in Child Protection. The complexities of their work require on-going education and professional development that must be accompanied by consistent consultation, supervision, and training
- Increased training on the needs and treatment issues of children and youth with complex needs and challenging behaviors must be provided to all professionals who work with this group. This includes teachers, social workers, caregivers, nurses, doctors, and youth care workers

### C. Assessment

- All young people in care must have a plan of care supported by the ISSP model, with clearly identified short-term and long-term goals, objectives, and action plans in place. Case plans should be recorded and reviewed according to Child, Youth, and Family Services guidelines
- Comprehensive, interdisciplinary, and high quality (best practice) approaches to assessment must be developed. This can be achieved by building upon the collective expertise of the various partners involved
- A provincial crisis response team should be developed to assist with the assessment of children and youth with complex and challenging behaviors. This team should include professionals from the Health Care Corporation, Health and Community Services, and other applicable community-based organizations
- Child, Youth, and Family Services must adopt a long-term view of service provision and case planning and move away from ongoing crisis response.
- The concept of permanency planning must be reviewed, particularly as it relates to multiple placements of children in care
- In relation to permanency planning, support services, particularly in an aftercare capacity, should be provided to families who adopt children from continuous care.
- It must be recognized that there are regional differences across the province with regard to the needs of children, youth, and families. All services provided must be sensitive to these regional differences. Services must be culturally relevant, and able to meet the needs of the child, family, and community.

### D. Planning and Coordination

- All children in care must have an ISSP in place. The focus of the ISSP must be on the process of interagency and interdepartmental collaboration, in the best interests of the child, and not on the "tool" itself.
- All professionals involved in the ISSP process must be trained in the appropriate use of this model.
- All children and youth in Newfoundland and Labrador should have access to services they need, e.g. psychiatry, psychology, speech language pathology. Waiting lists for these critical services must be reduced and, ideally, eliminated.
- Currently, families often receive multiple services from several different sources. There is potential for duplication and redundancy, resulting in higher costs and lower efficiency. A more coordinated, co-operative, interdisciplinary approach to the provision of wraparound and other services to families must occur

### E. Community Capacity Building

- There must be an increased focus on prevention and early intervention, with an emphasis on the Determinants of Health as outlined in the 1996 Health Canada Discussion Paper.
- Community capacity building must be recognized as a viable framework for services to children and youth. This includes a commitment to the principles of innovation; collaboration; horizontal vs. hierarchal thinking; relationship based practice; reflective practice; empowerment; sustainability; diversity; equilibrium; needs, rights, and participation; family-centered practice; and community based (Barter, 2003)
- Connections and collaboration between community based organizations, such as the Foster Families Association of Newfoundland and Labrador and the Child and Youth Care Association of Newfoundland and Labrador, should be encouraged and supported

## 2.2 Elements of the continuum of care.

### 2.2.1 What are the essential elements of the continuum of care?

Services to children, youth, and families who become involved with the child welfare system are generally conceptualized as being provided within a continuum of care. This continuum ranges from services that are preventive, or least restrictive, in nature to services that are considered to be reactive, or most restrictive. The continuum usually consists of the following range of services: prevention/diversion; early intervention; family support; family preservation; respite care; foster care; specialized or treatment foster care; day treatment; group homes; hospital based psychiatric treatment; and residential treatment (Stuck, Small and Ainsworth, 1997; Pecora, Whittaker and Maluccio, 1992).

Ideally, the continuum should provide a diversified set of services that can meet the needs of children and families at varying levels of intensity. Use of services in the continuum is governed by the current predominant beliefs in child welfare, which include an emphasis on permanency planning, the provision of family-centered services, a focus on utilizing the least restrictive intervention, and the belief that children are best cared for in families, preferably their own (Steinhauer, 1993; Pecora et al., 1992; Government of Newfoundland and Labrador, 2002).

According to Whittaker (1997), the goal of service providers should be to develop an integrated continuum of care that provides a full range of home-based and residential options and contains an easily activated set of linkages between the various service programs and other major systems in which the child participates: family, peer group, school, church, and community (p.4). Services should be offered seamlessly, as part of an **integrated service net** (Whittaker, 1997, p.6), and families should be able to access the services that they need at the time they need them.

Stuck et al. (2000) suggest that the manner in which the continuum of services is utilized is often detrimental to the clients being served. Although the continuum is

based on the principle that the least intrusive, *appropriate* intervention should be utilized first, this has been widely interpreted to mean that the least intrusive intervention, appropriate or not, becomes the starting point for services.

...the continuum has become a one-way street children and families must travel until they reach the point where the system can meet their needs at that time or until diversion of the child client into mental health or youth corrections takes the pressure off the system all together (Stuck et al., 2000, p.83)

They have put forth the idea that there are flaws in the concept of a continuum of care. The first such flaw is that there are logical inconsistencies in the least restrictive standard, which can result in services being provided based on a systemic bias towards a particular type of service rather than what is actually needed. Second, "an approach that requires that the least intensive interventions should always be used first results in a system with case management decisions driven by failure" (p.85). Often, a child or family is only able to receive a more intensive intervention if it has been demonstrated, often repeatedly, that less intensive interventions do not work. This occurrence, particularly with regard to foster care placements versus placement in residential treatment, has been well documented (Raychaba, 1992; Landsman et al., 2001; Whittaker, 2001). "Experience has given us many examples of highly motivated, caring foster parents who eventually burned out because they were unable to cope with very troubled children, well after it should have been evident that more intensive interventions were warranted" (Stuck et al., 2000, p.85).

A system that sees clients moving from one service to the next along a continuum, racking up failures along the way, is characterized by negativity. Identifying problems becomes much more prevalent than identifying strengths, and the system becomes crisis driven. The concept of family reunification, the ideal upon which the continuum actually rests, becomes compromised. Furthermore, there are often overly rigid boundaries between services, which limits the possibility of offering simultaneous, versus sequential, interventions.

While the concept of a continuum of care has contributed to humanizing child welfare services over the past two decades, and there have been numerous positive outcomes as a result, it is now time to reconceptualize. The idea of a care management service system has been proposed by Stuck et al. (2000), which would transform the continuum of care into a more integrated set of services for children and families. Taking a care management approach to the longest term, highest risk clients in the system allows an approach to service implementation that would:

- acknowledge that some children and families will require services at various levels of intensity over time, and that this may be a decidedly nonlinear process;
- retain the emphasis on family empowerment and family connections at all levels of service, but recognize that optimum connections may not mean that every parent and child lives together full-time;
- put a premium on continual, coordinated assessment where the operative question is not where does the child and family fit into the service system, but

rather how do services in the system best fit the child and family needs at the time;

- put an equal premium on care and support to families *after* the course of intensive services;
- blend services so there are step-up and step-down options at all levels of intervention, and in particular so that the rigid boundaries between home-based and out-of-home services are eliminated;
- develop outcomes, including cost-benefit measures, not limited solely to discrete services but to long-range family stabilization and the real cost of services across time (p.89).

Regardless of how one chooses to view the continuum, it is widely understood that to provide effective intervention, the full range of services must be available and accessible. Otherwise, any discussion of how to utilize the services becomes an exercise in futility, with service providers attempting to fit clients into available services, rather than utilizing services that best match their needs.

### 2.3 Gaps in the continuum of care for children and youth.

At the provincial workshop held in March, 2002, the following gaps were identified:

#### Resources

- need for more caregiver homes, and development of therapeutic or treatment foster homes
- inability of the current education system to adequately meet the needs and demands of young people with emotional and behavioral problems
- lack of sufficient educational alternatives or day treatment
- lack of effective prevention/family preservation services
- lack of residential options, including residential treatment, and the need for safety and security for young people who are out-of-control

#### Process

- as a result of the gaps in resources, there is a lack of assessment and matching of clients to services
- need for more collaborative approaches
- need for long term planning instead of crisis response

### Quality

- lack of appropriate staff training for those who work with troubled children and youth (this includes social workers, youth care workers, and teachers)
- lack of ongoing monitoring or evaluation of services provided

The above was reiterated by the Directors in Region through their survey responses. The majority identified a lack of residential care for adolescents and lack of therapeutic foster care as the biggest gaps in their region. These were also identified as the biggest gaps for the province, along with the need for a residential treatment facility/center of excellence that would provide support to the entire province and coordinate placements for children who are hard to place. At the roundtable discussion in October, 2002 the perceived gaps in the continuum were discussed. Specifically, the focus was to get input and suggestions from the experts on what could be done to provide more effective services to the children and youth in ILA placements or out-of-province treatment. The recommendations from this group were in line with information gathered in the literature review, and included the following:

- It is necessary to invest in training qualified staff to work with our most challenging youth, and to ensure that staff have adequate supervision, support, and resources to meet the challenges they face
- It is necessary to adopt a long-term view and move away from crisis response. The province needs to invest in dedicating resources to this challenging population of young people.
- Resources must be developed based on the needs of children, not driven by the deficiencies of the system or an ideological view of how things should be
- There is a need for the province to develop a secure treatment model and treatment options for children, including those *under* 12 years old. When these services aren't available, the entire system is impacted - young people don't feel safe, they are bounced around, foster care collapses.
- There is a need to minimize multiple placements
- There must be a focus on attachment and relationships as the core of all interventions.

Table 1 outlines the services and resources that are part of a comprehensive continuum of care. The table is intended to illustrate, using "no", the clear gaps that exist in the province. The use of "yes" in the table is intended to describe which of the identified elements are currently available to children and youth in Newfoundland and Labrador. It is understood that there are improvements that can be made in the elements of the continuum that *do* exist in the province therefore "yes" should not be interpreted as a judgment of quality, quantity or accessibility.

**Table 1:**  
The Continuum of Care for Children and Youth in Newfoundland and Labrador.

Primary Prevention		Secondary Prevention		Tertiary Prevention	
Program Type	Status in NL	Program Type	Status in NL	Program Type	Status in NL
Family resource Centers	Yes	CYFS involvement	Yes	Residential diagnostic assessment	No
Parent education and support groups	Yes	Home based family support services	Yes	Emergency group care	Yes
Out-patient ind. & fam. Counseling	Yes	Intensive family preservation services	No	Long term foster care	Yes
School based inclusion support	Yes	Planned respite	Yes	Long term residential care	Yes
Alternate education programs	Yes	Whole family residential treatment	No	Treatment foster care	No
Day treatment	No			Residential treatment	No
				Acute hospitalization	Yes
				Part-time residential care	No
				Secure residential treatment	No
				Staffed apartments for independent living	No
				Residential support for high risk foster family care	No

**2.3.1 Recommendations Regarding the Continuum of Care**

In order to effectively meet the needs of children, youth, and families in the province of Newfoundland and Labrador, the range of services available and the manner in which those services are utilized must be improved upon. The Provincial Committee on the Residential and Treatment Needs of Children and Youth is therefore proposing the following:

**A. Conceptual Framework**

- The province has adopted a conceptual framework for service delivery that recognizes the need to offer a full range of services to children, youth and families. This is clearly identified in the principles and services sections of the *Child, Youth and Family Services Act*, and supported by the Strategic Health Plan, the Model for Coordination of Services, and the Strategic Social Plan. In order to support the legislative and conceptual framework that currently exists, however, the appropriate resources must be provided.
- Services must be offered seamlessly, as part of an integrated service delivery system, and families should be able to access the service they need at the time they need it, in a non-linear fashion. The concept of "least intrusiveness" must be accurately interpreted to mean that the least intrusive, *appropriate* intervention should be the starting point for service delivery, and that this will vary depending on the needs of individual children and families.
- Policy makers and service providers must recognize the importance of identifying and resourcing all parts of the continuum equitably.

- Government must have the ability to transfer funds between departments and divisions. Services to children and youth cross all government departments, and funding should not be strictly tied to the specific mandates of any one department or division. In order for true inter-disciplinary collaboration to occur, these artificial boundaries must be removed.

#### B. Family Support

- A wider array of family-based services, ranging from family support to family preservation, must be developed and provided across the province. This will further enhance the work already being done by Health and Community Services Boards in this area, and improve earlier identification and intervention with challenging children and youth

#### C. Foster Care/Caregivers

While there have been significant improvements to the foster care system over the years, particularly with the introduction of PRIDE training, recruitment of caregiver homes continues to be an ongoing challenge across the province. In order to adequately address this problem, the perception of foster care must change.

- Compensation rates for caregivers must be reviewed to ensure they are in line with the changing role of foster care and the increased expectations of caregiver
- Extended support networks and opportunities for ongoing training and consultation must be provided to caregivers, and there must be continued support for ongoing efforts in this area
- Caregivers must have the knowledge and skills to work with the families of children in their care, and to comply with the program objectives, outlined in the *Child, Youth and Family Services Act*, of family preservation and reunification
- Treatment foster care programs must be developed for high-risk children and youth. Efforts to provide more intensive treatment services to this group will fail in the absence of specialized caregiver homes that are able to effectively meet their needs on a long-term basis. This issue is addressed further in Chapter 3.

#### D. Education

- Effective alternate education programs and/or day treatment programs must be developed for children and youth whose needs are not being met in the mainstream education system
- More effective collaboration and child/youth centered programming is required in the mainstream schools

### E. Residential Care

- A broader range of community-based residential care options must be provided across the province, and residential treatment options must be developed. Recommendations pertaining to residential care and treatment are provided in more detail in the next section.

## 2.4 Best practice in residential treatment for children and youth

A review of the literature on residential care reveals a wide variety of programs and philosophies governing the provision of services. Residential settings range from small, community based group home programs to facilities that provide a total treatment environment with all services, including school and leisure activities, provided within the facility or campus. Much of the literature focuses on residential care in the context of child welfare, but it is important to note that this service also has its roots in the juvenile justice and mental health systems. There may be some differences between the programs provided by each jurisdiction, usually as a result of systemic and philosophical factors, but the types of children, youth and families served across systems are generally the same (Durrant, 1993).

Within child welfare, there are two distinct categories of residential group care placements - those that provide treatment and those that exist within the framework of permanency planning (Aldgate, 1987). The latter type have become much more scarce over the years, as the use of foster homes as the preferred placement option for children has significantly reduced the number of children being served in group care programs (Anglin, 2003). There is evidence to suggest, however, that residential settings should be viewed within the context of permanency planning and, in some cases, may be a preferred placement option (Anglin, 2003; Aldgate, 1987).

Residential care has been subject to much scrutiny over the years, and residential programs have faced considerable pressures, including deinstitutionalization, economic constraint, an increased demand for accountability and quality assurance (Anglin, 2003) and frequent reports of institutional abuse (Charles and Gabor, 2003). "To many, it is the most intrusive and, consequently, most unwanted form of state-sponsored intervention. To others, it is the most effective form of intensive treatment for troubled and troubling young people" (Charles and Gabor, 2003, p.1). One of the contributing factors to this polarization of opinion has been the lack of evaluative data or outcome research in residential services (Curry, 1991; Frensch et al., 2003; Anglin, 2003; Pecora et al., 1992). As stated by Whittaker (2000):

A full and rigorous examination of the theoretical and empirical underpinnings of residential group care with respect to their implications for current service policy, practice and future research is long overdue and ought to receive the highest priority on the new century's emergent agenda (p.60).

There is currently no unified theory for residential treatment (Whittaker, 1997). As a result, there are still many models of residential programs operating from different theoretical bases. These include behavioral; psychoeducational; positive peer culture; and Circle of

Courage approaches. Since outcome data is not yet available on all of these models, it is difficult to ascertain which program represents best practice. Based on the information that is currently available, it appears that the psychoeducational approach may be more effective at producing change that can endure in the post-placement environment.

Regardless of the specific program model, the following elements have been found to be critical to successful treatment:

- A focus on the development of trusting relationships and attachment formation (see, for example, Falberg, 1990; Krueger, 1986; Gaffley, 2001; James, 1994).
- A focus on promoting competence and enhancing the child's development (see, for example, Ainsworth and Fulcher, 1981; Maier, 1990; Durrant, 1993; Whittaker and Pfeiffer, 2001).
- Intervention that is needs based, and tailored to the specific needs of children and families served (see, for example, Whittaker, 1997; Garfat, 2003; Maier, 2001)
- The provision of emotional, psychological, and physical safety provided through the design of the physical setting and the presence of structure, routine, and clear limits and expectations (see, for example, Whittaker, 2001; Agee, 1979; Anglin, 2003; Small et al., 1991).
- The development and implementation of individual treatment plans (see, for example, Whittaker, 1997; Pope, 1997).
- The use of activity programming and a focus on skill building (see, for example, VanderVen, 1985 & 1999; Barnes, 1991).
- The involvement of families in the residential program (see, for example, Landsman et al., 2001; Frensch et al., 2003; Garfat and McElwee, 2001; Tam and Ho, 1996; Noble and Gibson, 1994; Ainsworth and Small, 1995).
- The provision of aftercare and support services upon discharge (see, for example, Pecora et al., 1992; Guterman et al., 1989; Frensch et al., 2003).

All of the above occur within the therapeutic milieu through daily interaction between caregivers and youth and the utilization of daily life events, which must be planned and purposeful (Krueger, 1986; Maier, 1979; Garfat, 1998; Gaffley, 2001; Frensch et al., 2003). According to Krueger (2001), postmodern youth work is "a process of interaction in which workers and youth create moments that change their stories" (p.224). This theme of meaning making, or experiential practice, is prevalent in the literature (see, for example, Garfat, 2003; Phalen, 2001; Maier, 2001). Current writing focuses on the evolving idea of relationship-based programming (Garfat, personal correspondence, March 27, 2003).

Of the essential elements of residential treatment identified above, two of these - the involvement of families and the provision of aftercare and support services - have been repeatedly demonstrated to be the most significant factors in determining post-discharge success (Whittaker, 2001; Frensch et al, 2003; Guterman et al., 1989; Lewis, 1987). What happens to a child upon his or her return to the community appears to be more important, in determining success, than anything that happened while the child was in treatment or the

child's status at discharge. Another factor that appears to be related to positive outcomes is the appropriate matching of child characteristics to treatment type (Frensch et al., 2003). According to Falberg (1990): "it is imperative that any residential center have clear guidelines in place for selecting children for admission - children who are in need of out-of-home care and who, at the same time, are amenable to the treatment approaches and philosophy utilized" (p.95).

Programs that are clear about who they can and can not serve, and utilize admission criteria to ensure that young people are appropriate for the program, based not only on their individual needs but on the composition of the group as a whole, are the most successful (J. Anglin, personal correspondence, October 22, 2003).

The number of placements a child experiences is also a factor in determining positive outcomes in residential treatment (Steinhauer, 1991). According to Falberg (1990):

It is important to be sensitive to the need for ensuring a treatment environment that truly meets the child's needs in a timely a manner as possible. If a child moves from institution to institution, always a step behind the level of intervention that he needs, he eventually becomes unresponsive to virtually all treatment approaches. (p.95).

The more placements a child must endure, the greater the negative impact on the child's development. This can heavily influence the child's condition at the point of exit from care (Stuck et al., 2000, p.85). As stated by Agee (1979):

Unfortunately, with each new placement several things occur. For one thing, the child becomes more resistive to establishing new relationships. Secondly, it is harder to find placement for children who have failed in previous settings. Finally, the child has learned practically foolproof methods of getting out of settings that they do not want to be in (p.12).

Although there is no clear-cut way to determine exactly which young people would benefit from a residential placement, some common characteristics of young people requiring residential treatment have been identified. These include:

- severe behavioral and emotional problems requiring the expertise of highly trained professionals;
- clear and imminent danger to the child, others, or to society;
- an inadequate fit between the needs of the child and the resources available in the environment;
- self-perpetuating cycles of dysfunctional behaviors resistant to less intensive treatment (Whitaker and Pfeiffer, 2001, p.591).

Additional characteristics may include chaotic behavior; poor impulse control, which includes a tendency to harm others, destroy property, and make physical threats; persistent school problems; poor self-concept (Frensch et al., 2003); heightened emotional reactivity;

and extreme difficulty making and maintaining human connections (Small et al., 1991). It is quite aptly pointed out by Small et al. (1991) that:

the expectation of a cure in residential treatment implies lack of continuity between pre-residential and post-residential environments. It must be understood that most youngsters in residential treatment require ongoing supports. Most of them will need continuing affiliations with mental health and social services long after their discharge from out-of-home care. A realistic appraisal of the long-term needs of these children and their families will serve them better than wishful expectations of dramatic transformation... Progress is a reasonable goal; cure, however, is not (p. 337).

As noted earlier, residential care takes place, itself, along a continuum, from "a traditional house with minor modifications, as in the case of smaller group homes, or larger structures built specifically for housing residents and equipped with child proof windows and secure time out rooms" (Frensch et al., 2003, p.9). The latter represents the most extreme end of the continuum: secure treatment.

According to Brian Raychaba (1992), a former youth in care who has written extensively about his experiences, and the experiences of other young people in care, there are times when secure treatment can be positive and necessary. He cautions, however, that "secure treatment and restraining is justifiable only in cases where young people are clearly in immediate danger of harming either themselves or others" (p.4). This opinion is shared by others in the field.

On the web site for Children's Services in the province of Alberta, secure treatment is defined as the following:

Secure treatment is a group of services provided to a child who needs to be confined in a restricted and highly supervised place. It is the most restricting protective service provided for by the Child Welfare Act.

In Nova Scotia, a model for secure treatment services has just been developed. This province has chosen to view secure treatment as a construct which involves much more, and sometimes much less, than a securable facility (Province of Nova Scotia, 1998, p.8). They have developed a Secure Treatment Services Program that consists of a range of services for young people and families. "On one end of this spectrum of services is the situation where the youth might spend the majority of his or her time within a secure or securable facility. On the other end of this spectrum of services is the situation where the youth, while benefiting from secure treatment services, resides within another program with the security being provided by the legal status of the youth, the availability of the Secure Treatment bed as an option should it be temporarily necessary, the structure and clear expectations of the youth's individual treatment plan, the support, involvement, and availability of the Secure Treatment Services staff in the youth's daily life, and the consistency of approach among all the professionals involved" (p.9 -10).

While secure treatment is, perhaps, considered the least desirable of all treatment options because of its severely restrictive nature, it is a necessary resource for children and youth requiring such an intense level of intervention. As Falberg (1990) has stated, "if a youth's

behavior can not be contained within safe limits by the most potent tools an organization has at its disposal, then the child does not belong in that program (p.150).” Appropriate services must be available to children and youth who cannot be safely maintained in less restrictive programs.

#### **2.4.1 Recommendations Regarding Best Practices in Residential Treatment.**

Although the following recommendations pertain to the provision of residential services, it must be noted that residential treatment does not occur in isolation from other services in the community. Therefore, in order for residential treatment to be effective, other resources identified as critical components of the continuum of care, such as family support, alternate education, treatment foster care, and aftercare, must be available and accessible.

- A residential treatment and outreach program, with a protective treatment component, must be developed in the St. John's area as a provincial resource for children and youth with complex needs (this recommendation is described in further detail in Chapter 3).
- Community-based residential programs for young people in the care of Child, Youth, and Family Services must be developed in all regions of the province where there has been an identified need
- Adequate training, support, and supervision must be provided to staff in residential programs to ensure they are qualified and equipped to do the job
- Government must encourage and support the development of diploma/degree programs in Child and Youth Care and recognize that this should be the required, minimal standard of education for all individuals employed as child and youth care workers in the province
- The Child and Youth Care Association of Newfoundland and Labrador should be supported in the work it is doing towards the development of provincial standards and certification for child and youth care workers
- Provincial standards for residential care for children and youth must be developed
- All programs providing residential care to children and youth in the province should be subject to an external program evaluation a minimum of every five years in order to continue being funded. Funding should be contingent on evaluation outcomes.
- Residential care must be recognized as a valuable service that is an essential element of the continuum of care, not as a “last resort.” The continuum of care must be utilized from a best practice perspective, with appropriate services provided at the appropriate time
- The provision of aftercare services must be an integral component of all residential programs

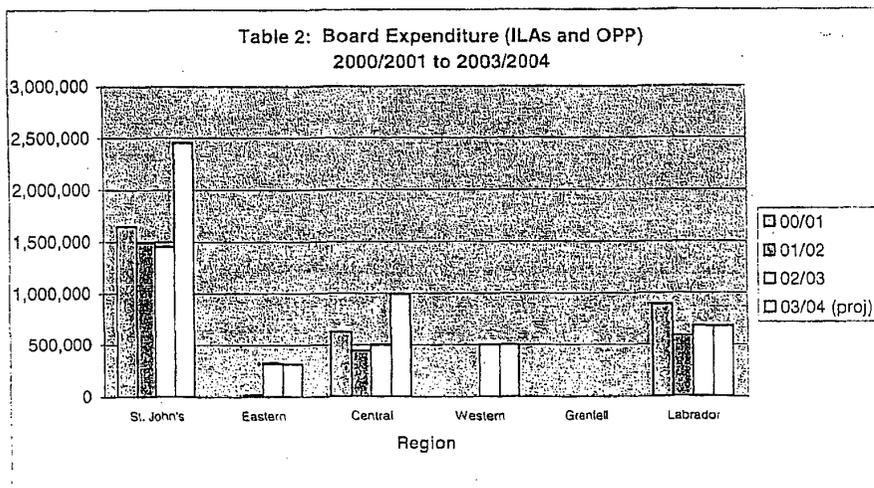
- Family support, involvement, and engagement must be integral components of all residential programs

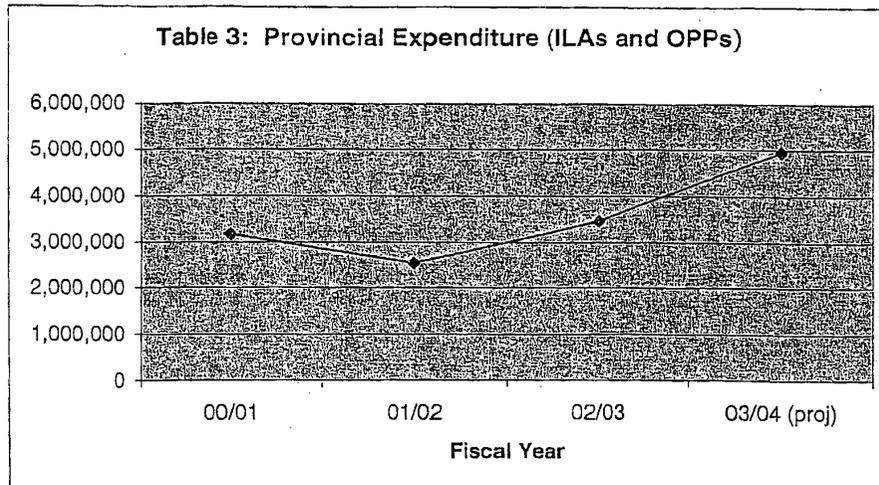
## 2.5 Financial Analysis

Financial data was gathered from HCS and Integrated Boards and from the Department of Health and Community Services to establish the total expenditures in relation to children and youth in ILAs and out of province treatment. Financial and client information was sought from Directors in Region in April 2003, at which point there were 9 young people in ILAs and 8 young people in out of province treatment. At this point the total YTD actual expenditures was \$3,359,096 with a projected cost for ILA and OPP of \$4,238,555. This meant the average combined cost of ILA and OPP per young person in April 2003 was \$249,326.

The financial data was sampled again in November 2003 to ensure the validity of the earlier projections. The data clearly illustrates expenditures related to ILA and OPP are continuing to rise. Indeed, as of November 2003, expenditures for the upcoming year were projected at almost \$5,000,000. This approximately \$700,000 increase in projected expenditures over 6 months demonstrates the challenge of planning costs related to the crisis response approach represented by ILA and OPP. In this regard, it is important to note that the lack of secure funding for meeting the residential and treatment needs of challenging children and youth means some of the HCS and Integrated Boards are funding these arrangements in deficit.

Tables 2 and 3 display the results of the trend analysis conducted for the four fiscal years starting 2000/01 and ending with projections for 2003/04. These tables present the data from both the perspective of the regions and the larger provincial picture. This analysis demonstrates that since the 2000/01 fiscal year that, with the exception of the 2001/02, there has been an upward trend in expenditure for young people with complex and challenging needs. As previously mentioned, these costs continue to escalate. This upward trend in expenditure is validated by the anecdotal evidence suggesting that the needs and challenges of children and youth in the care of Child, Youth and Family Services are becoming more complex and requiring more intensive intervention.





While the committee was intent on building a sustainable financial plan for a new model based solely upon reallocation of resources currently used in ILA and OPP, there were a variety of other costs related to preventing ILA's and OPP that it attempted to capture.

To this end the Directors' in Region were asked in the April 2003 survey to review the files of children or youth in care whose placement was tenuous and at risk of breakdown. The costs of supporting these high need young people was estimated at \$562,000. It is the committee's view that this is a very conservative estimate as it does not include the cost of any additional services provided to these young people, or their families, nor does it take into account the cost of any prior services that were attempted (and most likely failed). It also fails to take into account the cost of youth corrections placements, or the cost of acute care hospitalization, which is often inappropriately utilized for these young people at a cost of approximately \$1100 to \$1800 per day.

### 2.5.1 Recommendations Regarding Funding.

It is the committee's view that a more pro-active, planned approach to service provision would improve the quality of care provided to this group of young people and would result in increased cost effectiveness and decreased spending over time. To this end we recommend:

- The money currently being spent to support children and youth in ILAs and out-of-province treatment should be redirected towards the development of a residential treatment center. This money needs to be converted from case and crisis specific spending to long-term funding and reflected in the budget of the Department of Health and Community Services.
- Bridge funding is required to facilitate the transition from the use of ILAs and out-of-province treatment to the development of a provincial treatment center.

The committee recognizes that there will be a period of funding overlap between ILAs/out-of-province treatment and the residential treatment center. Further, it is possible that a small number of young people currently in these placements may not

be appropriate for placement in the provincial treatment center when it opens. The committee also recognizes that when a provincial treatment center is fully operational there may continue to be cases that will require the use of ILA or OPP. These will be exceptional and rare circumstances, but based upon experiences of other provinces with residential treatment facilities, this does occur.

Finding innovative and creative ways to move and share financial resources is key to the successful strengthening of the continuum of care. The committee is encouraged by the Interdepartmental endorsement of the Model for Coordination of Services. In the spirit intended under this model:

- The committee recommends that the Department of HCS should engage in discussions with other government departments to seek innovative and creative ways of moving resources to meet the needs of the population outlined in this report. For example, the committee believes that any savings incurred in youth corrections or justice as a result of reduced sentencing through the Youth Criminal Justice Act should be redirected towards the development of the residential treatment program and other community based resources for children, youth, and families.

## Chapter 3: Filling the Gap... Establishing a Residential Treatment and Outreach Program

The research and analysis conducted by the Provincial Committee on the Residential and Treatment Needs of Children and Youth reveals that there is a significant gap in services for two distinct groups of children and youth: those who are dually diagnosed, with a developmental delay and concurrent psychiatric and/or behavioral disorder; and those who exhibit emotional and behavioral problems too extreme for existing services to effectively handle. The committee has concluded that there is a clear need for a **residential treatment program** to meet the needs of these children and youth. In order to realize the benefits of economies of scale this program must operate within one facility/location.

The Committee's research also established the importance of supporting and developing other elements of the continuum of care beyond residential treatment. The most pressing needs identified by the committee in this regard are the need for **family support/aftercare, alternate educational programming, treatment foster care and a crisis prevention/response team.**

This chapter presents a detailed proposal for establishing an innovative and sustainable Residential Treatment and Outreach program that addresses all of these needs through a more effective and efficient use of existing resources.

### 3.1 Program Description

#### 3.1.1 Mandate

The committee's vision for the residential treatment and outreach program is of a provincial service operating from a single location that contains the following elements:

- A residential treatment program that will serve two distinct groups of young people...those with a dual diagnosis and young people whose behaviors are too challenging and complex for existing systems of care.
- A residential treatment program with a protective treatment component.
- A comprehensive approach to aftercare that includes a treatment foster care program.
- An on-site alternate education program that accommodates the education needs of all young people in the residential treatment program.
- A family support program that includes the provision of in-home aftercare supports and preventative services.
- A provincial consultation and crisis response team provided in partnership with the HCCSR and Community and Integrated Boards.

The Newfoundland and Labrador Residential Treatment and Outreach Program will be mandated to provide a safe, secure, therapeutic environment to children and youth who require a level of intensive intervention that cannot be provided in a community-based setting. It will also provide a variety of consultative and support services to agencies and individuals throughout the province.

Young people will access the treatment program through one of three program streams: dual diagnosis; residential treatment; or protective treatment.

The provision of protective treatment will need to be mandated under the *Child, Youth, and Family Services Act* to provide a safe, protective, crisis stabilization/treatment placement for young people who are in the care of Child, Youth, and Family Services and who have been deemed to have a behavioral or social disorder, to be out of control and a danger to themselves or others, who require treatment to alleviate the disorder, and who are unable or unwilling to consent to treatment.

### 3.1.2. Sample Vision and Mission Statement

**Vision:** To facilitate optimal growth and development of young people and families, and assist them to become healthy, responsible, contributing members of society through successful reintegration into the community.

**Mission:** To provide safe, intensive, highly structured, individualized residential treatment, treatment foster care, education, and support services to children, youth, families, and caregivers in the province of Newfoundland and Labrador.

### 3.1.3. Program Objectives/Elements

- The program will provide treatment services using the least restrictive means of intervention possible
- Protective treatment will be available when warranted. Protective treatment can be utilized by young people in the other two program streams, and by young people in the community, as per the criteria outlined in the *Child, Youth, and Family Services Act*
- The program will increase the efficiency of staffing compared to the current model. Economies of scale will be realized by the sharing of staff and common space within larger congregate living arrangements
- The program will promote consistent and effective use of the model for co-ordination of services. A particular emphasis will be placed on strengthening relationships with mental health and education, and enhancing linkages with the Janeway
- The program will provide a range of services to children and youth, including education; recreation; individual, group, and family therapy; and life space intervention.

- The involvement of families will be an integral component of the program. Families will be involved on-site, in daily life events with their children, to the extent that this is possible. Parent support and education programs will also be provided. In order to facilitate the level of family involvement that will be required, there will be a residence for out-of-town families on the program grounds
- In order to facilitate the smooth transition of young people from residential treatment to the community, a transitional house will be established on-site. Up to three young people will live here for a period of time prior to discharge to assess their readiness and ability to cope in a less structured setting. This transitional house will be the same residence provided to the families. In this way, the parents of young people in the treatment program will be able to practice their new skills with the young people in the transitional house, and vice versa. This house will be staffed by one youth care worker on shift at all times.
- The program will provide support to all regions of the province in the form of case consultation, program development, aftercare, and other supports. This will include direct support to caregivers.
- This program will establish and support treatment foster homes that will be connected to the residential treatment programs. These treatment foster homes will provide long-term placements for young people who are discharged from the treatment program, where appropriate, if a long-term placement was not identified at admission. Dependant upon availability, treatment foster homes will also be accessible to young people in the community. The treatment foster care model will be transportable and able to be replicated throughout the province.
- The program will complement existing resources and assist to strengthen or expand community-based programs already in operation
- The program model, for each of the three streams, will be evidence-based and will contain all of the elements necessary for effective residential treatment, as outlined in the literature review.

The Newfoundland and Labrador Residential Treatment and Outreach Program will be responsive to the needs of the community; will stay current with research and trends in the field; and will be flexible and adaptable to emerging needs

#### 3.1.4. Program Limitations

The program will be designed to meet the needs of children and youth with complex and challenging needs who can not be served in a less structured environment. There will be admissions criteria, and admissions to the program will be based on assessments conducted by an admissions committee. Inevitably, there will be young people and situations that fall outside the mandate and purpose of the program. Although the number should decrease significantly, there will still be crisis situations that require a response outside of the available array of services.

The program will not be effective if there is nowhere for young people to go when they are ready for discharge. Young people must be able to leave the program and move into appropriate long-term placements when it is time for them to do so. This requires a commitment to the development and maintenance of long-term placement options in the community for high needs children and youth.

In most cases, young people are likely to require ongoing support and assistance long after discharge. This could take the form of a community-based residential program (i.e. group home), a treatment foster home, or intensive family support. Residential treatment is not a cure. Regardless of the service required, if the gaps on the continuum are not filled, and the appropriate community resources not available, the provision of treatment will be futile.

### 3.1.5. Where will it be located?

The Newfoundland and Labrador Residential Treatment and Outreach Program will be located in the St. John's Region. This location has been selected for the following reasons:

- It will be in close proximity to other service providers and a significant percentage of provincial health care services.
- There are services and agencies operating in St. John's that must be linked with the Residential Treatment Program in order for it to be effective. These include the Janeway Child Health Center, Memorial University of Newfoundland, community-based residential programs, and the Newfoundland and Labrador Foster Families Association.
- The majority of young people in the care of Child, Youth, and Family Services reside in the St. John's Region, as do the majority of young people who have required out of province treatment and ILAs.
- Locating the program outside of the St. John's Region would result in fragmentation of services and increased travel costs to and from St. John's for appointments, meetings, and family visits. This occurrence has been clearly demonstrated with the Newfoundland and Labrador Youth Center located in Whitbourne.
- The program will employ a significant number of professional staff who must be highly qualified, competent, and experienced. Recruitment and retention of staff will be much easier in a larger center than in a smaller community.

## 3.2. Program Design Considerations

### 3.2.1. Who and how many will it serve? How long will young people stay? Where will they go upon discharge?

- Twelve young people, between the ages of 10 - 16, will be served within three separate living spaces - protective treatment, dual diagnosis program,

and residential treatment program. It is proposed that there will be six beds in the dual diagnosis program; six beds in the residential treatment program; and eight beds in the protective treatment program. Although only twelve beds will be filled at a time, this will allow the flexibility to accommodate young people in the program they require at the time they require it. Young people may be accepted into the dual diagnosis program after the age of sixteen if deemed appropriate by the admissions committee. Young people who are in the residential treatment or protective treatment programs prior to their sixteenth birthday may continue in the program after they turn sixteen if this is considered to be in their best interests.

- The program will accept males and females
- The program will be transitional and needs based. Where possible, young people will remain connected to their long-term placement in the community while in residential treatment. This has implications for caregiver homes, and the manner in which they are funded, in that it will be a requirement for a young person's bed to be held in a caregiver home if the long term plan is for the young person to return to that home.
- The young people, families, and/or caregivers will be involved in the treatment process and discharge planning process to ensure a smooth transition from the treatment program to the community. Discharge planning will begin at intake.
- Length of stay in protective treatment is intended to be short-term, with the average length of stay estimated to be between three and thirty days.
- Length of stay in the other two programs will vary, depending on the needs of the young people. Some young people could stay for more than a year.
- A minimum of six treatment foster care homes will be established within the first year of operation, and these will fall under the umbrella of the residential treatment program. These homes will, therefore, be able to accommodate at least six young people in long-term placements.

### 3.2.2 Who will run the program?

The provincial committee on the Residential and Treatment Needs of Children and Youth recommends that the program be operated by an organization or group that has a proven track record of working effectively in residential and group care. The operator of the program should be selected through a competitive bid process that is open to community-based agencies, non-profit boards and private business operators. While not being an exhaustive list, the characteristics of the successful proponent should include the following:

Experience and leadership in providing residential group care and/or related services.

- Demonstrated track record in providing high quality service.
- Clear evidence of the utilization of best practices in their area of service.

Commitment to accountability, risk management and evaluation

- Statements of mission, values, objectives, policy and procedures that are clear and consistent with program vision in this document.
- Demonstrated ability to ensure children, youth and staff have access to a safe, secure, and therapeutic environment.
- Demonstrated ability to manage and sustain a complex service within budgeted financial resources.
- Compliance with past service contracts.
- Ability to comply with provincial standards.
- Research and evaluation plan.

Commitment to collaboration, outreach and community development.

- Demonstrated ability to lead the creation of high quality interdisciplinary teams within their agency.
- Willingness to work with a provincial advisory committee
- Ability to provide child, youth and family centered practice.

Clear and concise human resources plan.

- Highly qualified and experienced staff.
- Child and youth care workers who meet recognized standards for competency
- All professionals registered with their regulatory body.
- Recruitment, retention and training plan.

### 3.2.3 Standards of Care: Provincial Monitoring Committee

A provincial monitoring committee will be established to oversee the operation of the Residential Treatment and Outreach Program. This committee will be comprised of individuals with interest and expertise in the provision of services to children and youth. They will be appointed by the Provincial Director of Child, Youth and Family Services. Representatives will be drawn from integrated and community health boards, the general public, and related agencies. This committee will monitor adherence to the service agreement between the Residential Treatment and

Outreach Program and government, and will provide a mechanism for quality assurance.

### 3.3 Human Resources Plan

The Newfoundland and Labrador Residential Treatment and Outreach Program will operate within an interdisciplinary teamwork model. All professionals working within the program will be employed by the organization that is responsible for running the program. This is critical to the success of the program, in that it ensures all employees will operate within the same mandate and philosophy.

It is anticipated that the following will be required as core program staff:

- **Program Director:** Responsible for overseeing the entire Residential Treatment and Outreach Program, including all residential programs; family support; aftercare; school; and transitional living unit. All employees of the residential treatment program will report to the Program Director.
- **Program Managers (2 positions):** Responsible for the day-to-day supervision and management of the three residential programs. One Program Manager will be responsible for the secure treatment program, the other will be responsible for the dual diagnosis program and the residential treatment program.
- **Psychologist :** Responsible for psychological assessment and individual and group counseling. Will work as part of a team in the development and implementation of treatment plans. Will be available for outreach and crisis response in the community, and will provide consultation to treatment foster homes.
- **Clinical Social Worker – Outreach:** Responsible for outreach services; part of the in-home family support team and crisis response team; monitors and provides support to treatment foster homes; assists with aftercare support.
- **Clinical Social Worker – Residential:** Responsible for intake and **assessment**; case planning; individual, group, and family counseling; participation in the development and implementation of treatment plans.
- **Teachers (2):** Responsible for providing academic instruction to all young people in the Residential Treatment and Outreach Program; liaising with community schools to prepare for intake and discharge; working as part of a team in the development and implementation of treatment plans.
- **Youth Care Workers – Residential (29.4):** Primary treatment agents, will engage in milieu therapy, utilizing the life space of young people to facilitate growth and change. Will work as part of a team in the development and implementation of treatment plans. Will facilitate family involvement in the program, and be involved with the provision of aftercare.
- **Youth Care Workers – Outreach (2):** Part of the family support team and crisis response team; will provide in-home support to treatment foster homes.

- **Financial Officer:** Responsible for all accounting and bookkeeping duties, as required.
- **Administrative Assistant** – All secretarial, filing, and other duties as required.

### 3.3.1 Interagency Partnership Plan

In addition to the above, consultative relationships will need to be established with various medical and rehab professionals from the Health Care Corporation. The model of interagency collaboration between the Health Care Corporation of St. John's and Health and Community Services – St. John's Region is a good example of a successful partnership and one which both groups have committed to continue in relation to this project.

There will need to be a psychiatrist affiliated with the Residential Treatment and Outreach Program who can provide psychiatric services on an immediate consultation basis to all young people involved with the program. The psychiatrist will also provide input on clinical challenges and help facilitate admissions to the Janeway psychiatric unit when necessary.

Other professionals who will need to be linked with the Residential Treatment and Outreach Program include general practitioners, advanced nurse practitioners, speech language pathologists, physiotherapists, and occupational therapists. These professionals will need to be available for consultative purposes on an ongoing basis. There will also need to be a process established, through a Memorandum of Understanding, in which young people in the Residential Treatment Program will be given some priority on wait lists and be able to access services on a timely basis, corresponding with their stay in the program.

### 3.3.2 Staff Training and Development

It is critical that a considerable, up-front investment be made into staff training for all staff of the Residential Treatment and Outreach Program. Staff in this program will be working with the most troubled and troubling young people in Newfoundland and Labrador. In order for the program to be successful, it is critical that all staff be highly trained and educated in best practice and current approaches in their respective disciplines. Ongoing staff training and development must be mandatory. The quality of the Residential Treatment and Outreach Program will be determined purely by the quality of its staff.

## 3.4 Financial Plan

The key questions that underpinned the committee's financial planning process were: "Can a comprehensive residential and outreach program become sustainable through the reallocation of resources currently used to support ILA and OPP?" and "What are the likely one-time costs associated with the establishment of this program?" The committee is encouraged by the projected operating costs given that it is less than that currently being spent in the province on ILAs and out-of-province treatment and that the province will be able to offer a more comprehensive, coordinated and effective service.

Table Four presents the start up budget for the Residential Treatment and Outreach program that is estimated at approximately \$3 million. Some of the key elements contained in this budget include: the hiring of a Program Director and staff prior to the opening of the program, up-front staff training and development, land and facility construction, and vehicle and other equipment purchase. It is understood that the start-up costs will decrease if the facility is constructed using a mortgage buy-back model.

<b>Table 4: Residential Treatment and Outreach Program - Start-Up Budget</b>	
Land/facility construction	\$2,000,000
Human Resources	
• Staff training and development (all professional staff @ 3 months)	\$550,000
• Program Director (salary for one year)	\$80,000
• Recruitment/hiring costs	\$10,000
Miscellaneous program development (travel, consultation, telephone, etc.)	\$20,000
Furniture/Equipment:	
• Facility vans (2)	\$40,000
• Living rooms/rec rooms	\$80,000
• Kitchen/dining rooms	\$40,000
• Bedrooms	\$45,000
• Curtains, linens, etc	\$5,000
• Computers	\$14,000
• Resource materials	\$5,000
• Craft/art/workshop/sport supplies	\$25,000
• Desks/school furniture	\$20,000
• School supplies/classroom materials	\$5,000
Miscellaneous	\$5,000
• Cable, phone, internet installation	\$800
<b>Total Start-Up Budget</b>	<b>\$2,959,800</b>

Table 5 presents the annual operating budget for the program which is estimated at approximately \$3.2 million. Some of the key features of this budget include:

- a comprehensive staffing budget including allocations for teachers, a variety of allied health professionals, a consulting psychiatrist fee, and administrative services,
- detailed provision for standard operating costs,
- resources to support 6 treatment foster care homes, program evaluation, and family support and outreach.

If the mortgage buy-back option is selected as the preferred method for building the facility, the operating budget would increase to reflect this.

**Table 5: Residential Treatment and Outreach Program – Annual Budget**

Human Resources	
• Teachers (2)	\$120,000
• Consulting Psychiatrist	\$20,000
• Psychologist	\$80,000
• Social Workers (2)	\$120,000
• Program Director	\$80,000
• Program Managers (2)	\$120,000
• Financial Officer	\$40,000
• Administrative Assistant	\$35,000
• Janitorial/Maintenance	\$30,000
• Youth Care Workers (31.4 staff x 45,000)	\$1,413,000
Replacement	
• Extra Assistance (20 days annual leave, 7 days sick leave, and 3 days family leave for youth care staff; $1,467,335 \times 1.5 = \$1,687,444$ ; $168,744 \times 11.5 = 1,940,664$ )	\$188,150
• Staff training replacement costs (10 days per year x 31.4 staff x 173.04 per day)	\$54,335
• Stat Holidays (9 stat x 8 hours x 1.5 x 21.63 x 18 staff)	\$42,049
Employee Benefits	
• CPP (4.3%)	\$98,921
• EI (2.85%)	\$65,564
• WCB (3.74%)	\$86,038
• Group Insurance	\$10,000
• Pensions (5%)	\$115,024
Additional Staffing Costs	\$200,000
Payroll Tax	\$50,000
	<b>Total Staffing Costs</b>
	<b>\$2,676,032</b>
Operating Costs	
• Food/Household	\$50,000
• Heat & Light	\$6,000
• Phone/Communications	\$8,000
• Videoconferencing/Telemedicine	\$5,000
• Repair & Maintenance	\$50,000
• Replacement of Minor Equipment	\$5,000
• Administration Fees	\$10,000
• Staff Training	\$20,000
• Transportation	\$60,000
• Resident Funding	\$70,000
• Professional Fees	\$3,500
• Insurance	\$40,000
• Gas/Van Maintenance	\$5,000
• Equipment Rental	\$8,000
• Office Supplies	\$5,000
Treatment Foster Homes (6 homes)	\$150,000
Program Evaluation	\$15,000
Steering Committee (travel and adm.)	\$10,000
Miscellaneous	\$10,000
	<b>Total Operating</b>
	<b>\$530,500</b>
	<b>Total Annual Budget</b>
	<b>\$3,206,532</b>

### 3.5 Implementation Issues

#### 3.5.1 Provincial Implementation Committee

The establishment of a provincial implementation committee is a critical element in the next phase of this project. The committee's mandate should include the responsibility for overseeing the implementation of the essential elements highlighted in this paper.

As previously stated, there is a need for bridge funding to support the movement away from ILAs and OPPs to the implementation of the Residential Treatment and Outreach Program. Given that the amount required for Bridge funding is dependent upon the outcome of discharge and case planning related to the individuals currently in ILAs and OPPs, monitoring case planning will require a high degree of vigilance and consistency. To this end, it is suggested that a sub-committee of the provincial implementation committee is established to oversee the planning process. This subcommittee should include representatives from all regions to ensure that plans of care are reviewed for all children and youth in ILAs and OPPs across the province. The subcommittee will serve as another service quality assurance in that children and youth who are in these placements are assured timely and appropriate planning for their future placements.

#### 3.5.2. Policy and Legislative Implications

There is usually legislation in place to govern the use of protective treatment in order to ensure that it is used appropriately. This is contained within the Child Welfare Act. According to George Savoury, former Director of Child Welfare and Residential Care for the province of Nova Scotia, "secure care means that a child or youth is being placed in a locked facility to receive treatment that cannot be provided in a less restrictive setting, and that is a significant curtailment of a person's rights. Under the Charter of Rights and Freedoms it would be inappropriate to limit a person's rights in this way unless you have clearly defined it in provincial legislation that spells out the due process requirements, etc. and the clear admissions criteria and time lines for its usage" (personal correspondence, September 25, 2003).

These comments are echoed by Bryan Hume, Program Coordinator of the Secure Treatment Program at Hull Child and Family Services in Calgary, Alberta. He adds that there must be a rationale for what constitutes criteria for protective treatment – "you must identify the reason for secure treatment and justify it in the legislation" (personal correspondence, September 30, 2003). For example, the reasons a child may be admitted to secure treatment in Alberta are:

- The child has a severe mental or behavior problem that severely affects the child's ability to deal with life;
- because of this problem, the child has done something that placed herself, himself or others at immediate risk of serious bodily harm;

- this harmful act happened within the past few days or has happened repeatedly over the past few months;
- secure treatment can likely reduce the problem;
- less restrictive services can't meet the child's needs;
- the child won't accept other services or won't stay under adult supervision.

The procedure varies from province to province, and there appears to be some discretion available to the provinces with regard to protective/secure treatment legislation. Manitoba, for example, provides secure treatment services without any specific legislation in place. In Newfoundland and Labrador, children and youth have been sent away to residential treatment programs in other provinces for years, without any specific provision pertaining to this in the Child, Youth and Family Services Act.

To provide a protective treatment program in Newfoundland and Labrador, an amendment to the province's Child, Youth and Family Services Act may be required. This issue is currently under review, and discussions have been initiated with the Department of Justice and other key individuals and government departments across the country. Whatever the outcome of this review, the committee recommends that the resolution of this issue should not become a barrier to the timely development and provision of a protective treatment program in this province.

### 3.6 Critical Path

The critical path is designed to outline, in a general way, the activities, phases, and project timelines that are necessary for implementation of the recommendations in this report. This section is not intended to be a final implementation plan, but a general framework that can support the Implementation Committee as they operationalize the plan.

#### Phase I (6 – 9 months):

- Government receives, reviews and endorses report
- Government approves concept and funding
- Implementation Committee is established
- Call for Proposals is advertised; deadline for submissions is established. Applicants are asked to indicate their level of skill, expertise, and experience in residential care that makes them (the organization) qualified to take on this project.
- Government, through the implementation committee, reviews submissions and the successful applicant is selected

**Phase II (12 – 16 months):**

- Provincial Committee on the Residential and Treatment Needs of Children and Youth is established as the Steering Committee to oversee the development of the program
- The Program Director is hired
- Provincial standards are developed
- The physical facility is designed and construction begins
- Program development begins - this includes liaising with other treatment centers in the country to look at specific program components, including the use of physical restraint and time out rooms
- Hiring of staff begins
- Staff training begins
- Facility opens

**3.7 Conclusion**

This paper represents a culmination of work that began almost two years ago. A great deal of energy, enthusiasm, excitement, and commitment has been generated by and for the work of the Provincial Committee on the Residential and Treatment Needs of Children and Youth. In order to truly improve the range of services provided to children, youth and families in Newfoundland and Labrador, it is essential that this momentum be continued.

The work of the Provincial Committee on the Residential and Treatment Needs of Children and Youth was guided, in large part, by the needs of children and youth with complex and challenging needs. The most extensive recommendation, therefore, focuses on the development of a provincial Residential Treatment and Outreach Program. However, many other important recommendations are also included in the report. It is critical that Government, in a timely manner, develop an action plan for follow-up and implementation of all recommendations contained in the report.



**APPENDIX 1**



**Round Table Discussion  
St. John's, NL  
October 23, 2002**

**Introduction of Attendees:**

Moderator: Lynn Vivian-Brook, ADA Department of Health and Community Services.

Heather Modlin, President, Canadian Council of Child and Youth Care Associations, Executive Director, St. Francis Foundation.

Thom Garafat, TransformAction Consulting and Training, Rosemere, Quebec

Grant Charles, University of British Columbia School of Social Work

Carol Stuart, School Of Child and Youth Care, Ryerson University

Marilyn McCormick, Deputy Child Advocate, Province of Newfoundland and Labrador

Jack Phelan, Grant MacEwan College, Edmonton, Alberta

Ian Shortall, Mental Health Division, Health Care Corp., St. John's, NL

Debby Perry- Manager, Mental Health for Children, Janeway Hospital, St. John's, NL

Betty Day, Director, Child Youth and Family Services, St. John's, NL

Rick Ash- Corrections, Western Newfoundland Region

Sandra Humphries- Department of Education, St. John's, NL

Anne Marie Ottenheimer, Director, Shalom Inc., St. John's, NL

Susan Macleod, Program Supervisor, Youth Services, St. John's, NL

Lorraine Fox, Professional Growth Facilitators, San Clemente, California

Sibylle Artz, School of Child and Youth Care, University of Victoria, Victoria, BC

Joan Whelan, Health and Educational Service, St. John's, NL

Rosalind Pratt, Director, Youth and Family Services, St. John's, NL

Niell McElwee-President, Irish Association of Social Care Educators, Ireland

Kathy Barker-Pinsent, Director, Child Youth and Family Services, Eastern Newfoundland

Debby Smart, Coordinator, ISSP Services, St. John's, NL

Leon Fulcher, Victoria University of Wellington, Wellington, New Zealand

Varda Mann-Fede, Concordia University, Montreal, Quebec

Mark Krueger, University of Wisconsin, Milwaukee, Wisconsin

**Purpose of meeting:**

- To kick-start looking at the continuum of care
- To discuss the idea that more children presenting at a younger age with more "bizarre behaviours."

**Our Impression of Prevalence and Incidence.**

Jack: The only thing every one agrees on is that kids are "crazier." These problems were always there.

Sibylle: We are better trained, we can recognize the problems.

Thom: Are we changing or are the kids getting more difficult?

Sibylle: Are youth really more violent than they were? We have to look at our own experiences as well as theirs.

Grant: We've become less tolerant of violence and have higher expectations as service providers. The kids aren't tucked away, for example Mount Cashel; the wrong kind of resources spent in the wrong way.

Lorraine: There is nobody that doesn't say "the kids are getting more violent."

Susan: We encouraged kids to tell their experiences-we were ill equipped to deal with it.

Thom: Changes in where we place children. We haven't created supports for caregivers. It's the same population shifted one degree.

Rick: Young people are labelled by the system.

Sibylle: Equip workers with skills. It's about transition and engagement rather than control.

Lorraine: In the Maritimes they are shifting from just looking at the kids to looking at the whole family. Morale appears to be better within workers.

Carol: Concept of labelling the child - that's not the only aspect of the child - we need to support young people in working with the issues that they come with; i.e., family, peers etc... are resources.

Lynn: Would international guests concur?

- Niell: In Ireland there are 86 childcare workers servicing a population of 3.6 million. Family support workers are "return to work moms". They make more money than a childcare worker. The experience of being a childcare worker is different.
- Leon: Family voice needs to be heard, the voice of the child, professionals - lots of them, public-politicians, funders, and experts. All six voices have something to say about the young person. We need to have all the voices saying the same thing. We can't see putting kids in care as failure. We need to recognize kids that need to "go to jail." How do we slow down the cycle?
- Varda: We have to recognize that there are kids who do not have viable families. Kids are bounced around by the system we've created.
- Thom: There's a perception that it's wrong to say a child shouldn't get home. Look at what the child needs in the context of the family.
- Varda: There's a line in the sand in regard to family staying together or being separated. It becomes not about the family but the ideal.
- Grant: Response to the crisis in Labrador is a good example of what's wrong with the system. What's needed as opposed to least intrusive. We respond out of necessity.

### Elements of Continuum

Prevention\Early intervention ----- Secure Treatment

Heather:

We are missing both ends. No structured family intervention. Group Homes and residential programs only in St. John's. Seven at St. Francis, three at Shalom. No residential or secure treatment programs. No services for young people under the age of 12. We have the will to develop these but there are serious gaps. When looking at the needs we look at beds. The young people who have serious issues get bounced around and often end up in secure custody due to safety issues for themselves and others. There are problems with assessment and matching placements.

There are typically three or four young people per year - we are not providing appropriate services to them. The more placements a young person has the less likely he/she is to succeed. By the time we are willing to pay it is often too late.

Marilyn:

There are about 14 per year with special living arrangements. There is no treatment, just control and maintenance.

Leon:

The Avalon Peninsula has about one third of the population. The rest are scattered. Realities of a scattered population – lack of professionals.

Rural vs Urban: Island Portion-Minimal cultural issues.

Social Class: Rural has higher unemployment rate.

Out Migration: Older families are staying-troubled youth will often stay with them while the rest of the family leaves.

### Secure Treatment

No one wants to see the child in jail.

It should be secure not punitive.

What's stopping the secure not punitive idea?

Conflicting ideology.

All most traumatic are in Independent Living Arrangements at a cost of a half a million dollars. It's a response to crisis 4:30 on a Friday afternoon.

It may help if you could identify the client. What are the challenges?

- 13 year old medicated due to psychosis. Aggressive to himself and others. Suicidal. If he is around other people he will act out.
- 11-year-old parented by a schizophrenic. Sexually acting out. 13-year-old brother just out of secure custody. Attacked foster family - \$1000.00 worth of damage. Moved to Aunt and Uncle's. Ran out into a blizzard. Two on one staffing couldn't maintain her. Five on one staff at one point. Now out of the province (Ontario), she may not be able to maintain her placement due to her sexually acting out behaviours and aggression toward other young people.

Historically programs work independently of each other, a true continuum supports.

Carol:

The "Famous 15" are surfacing in different communities. What's going on in the community that is causing this kind of pathology? How can we support the community?

Varda

When we don't have the services the young people are bounced around- plug one hole- spring a leak in another. Look at what's going on with pre-adolescents.

Jack:

When you can't make kids safe it gets crazy. Without secure treatment the kids don't feel safe. Don't just build a building; you have to train the staff. We need a place that is secure and safe.

Special Secure treatment in Norway:

Security built around staffing not bars.

4 beds - emergency fifth.

At least three staff on at a time.

20 Kilometres outside the community.

These kids can be successful with relationship building, actually working with the kids.

Build security around people not the building. Locate one Central, Eastern and Western. The staff has to be well trained.

Mark:

Look more at ways that all the people involved with the young person can come together to make the young person feel safe.

Jack:

Legislation - there seems to be enough money for incarceration - not for secure treatment. What if there was legislative security for social services kids?

High-risk behaviours - they run, we bring them back, it becomes a game. We feed into the problem.

Lorraine:

It's amazing what happens when a run-away can't run. They become different people. They spend the energy they would expend on running more productively.

Thom:

Security is more than a secure space. The service is needed but it doesn't have to be a big ugly building.

Niall:

We consistently miss children - the famous 15 provides an opportunity to do interesting research involving them in the project.

Varda :

Concerned about Pre-Ad, history of the famous 15 would reveal opportunities for intervention at Pre-adolescence.

You need to have a good relationship with psychiatry.

We are not doing a good job of early intervention. We have seen enough challenges to show us we need to get our act together.

How do you debrief from these things? Foster Care will collapse without it.

Lynn:

We have to support the people on the ground by better using technology, paying attention.

Mark:

Once a decision is made to remove kids, give the kids time to form relationships. There are no quick fixes in foster care or out of home placements.

## Summary

How can we deal with young people that haven't had the opportunity to avail of these services? There are some young people that will never form an attachment. We still have to provide service to them.

Niall:

Pat yourselves on the back more so than Ireland. The fact we're meeting shows you're willing to do the work.

Lorraine:

Appreciate the openness to self-expression. Don't forget the unlovable kids. We can stop them from hurting themselves.

Thom:

Whatever we do - these are children.

Leon:

Muggles doesn't understand witches. Offers ways to re-frame difficult children. How can we engage these kids?

Mark:

' Having the right people to work with these young people is key.

Sibylle:

Try whatever you can. Very encouraging that you are asking for help and looking at the life space model.

Jack:

Congratulations on the meeting. There is no magic solution. Do the best you can with what you have.

Varda:

One of the mistakes is leadership yo-yos; flavour of the month.

Carol:

Think about staff and how they are being serviced; i.e., training, self-care, etc...

Grant:

Realign services to build up the critical mass. Rural services - how is it that they are making it work.

Ros:

It seems as though we are on the right track in an effort to find a solution to the problem.

The meeting concluded with words of appreciation to all participants and Moderator Lynn Vivian Brook.



**APPENDIX 2**



## TERMS OF REFERENCE

### Provincial Committee On The Residential And Treatment Needs Of Children And Youth

#### A. MANDATE

- To develop a plan of action to broaden and improve the residential and treatment options available to children and youth with complex needs and behaviors and their families.
- To identify policy and program improvements that would lead to earlier identification of and other interventions with children and youth with complex and challenging behaviors and their families.

#### B. GUIDING PRINCIPLES

This committee, in concert with the principles of the Child, Youth and Family Services Act, the Strategic Social Plan and the Model of Coordination of Services to children and youth will be:

- a) Focused on promotion, prevention, and early intervention
- b) Child, youth and family centered
- c) Focused on the "enhancement of meaningful partnerships"
- d) Built on evidence and best practices research,
- e) Focused on fiscal responsibility and sustainability.

#### C. RESPONSIBILITIES

1. To identify and describe gaps in the current continuum of residential care for children and youth.
2. To identify the best practices in the area of residential treatment for children and youth.
3. To identify models that can be delivered at least cost and less expensive than current models, balanced with appropriate care and sustainability.
4. To recommend a model for a secure treatment approach. This would include the identification of policy and legislative implications, best practices, recommendation of location and continuum of service issues.
5. To suggest a blueprint for improving the partnerships between relevant stakeholders with a particular emphasis on the interaction of institutional and community health boards.
6. To identify other activities and initiatives that might be undertaken by respective Health and Community Service Boards in the interest of improving earlier identification and intervention with challenging children and youth.

7. To inventory all stakeholders currently providing resources in the service of children and youth with severe behavioral and/or mental health issues and identify potential strategies and other interventions to improve the quality of service coordination and partnership.
8. To build on gaps and best practice research that has been done to date over the nine month period prior to the formation of the provincial committee.
9. Produce a document that will represent the recommendations of the committee with regard to an action plan for the province to address the treatment needs of children and youth with complex needs.

#### **D. DELIVERABLES AND TIMELINES**

The Committee will oversee the completion of a report detailing their deliberations, analysis, proposed strategies and resource issues. A preliminary report will be tabled for discussion and review by the end of April 2003. A recommended model for service delivery and plan of action will be completed by September, 2003.

#### **E. MEETING FORMAT**

Meetings will be at the call of the co-chairs and will be primarily through teleconference, with two face-to-face meetings.

#### **F. COMMITTEE COMPOSITION**

Sectors with representation on the committee will include government, regional health care boards, institutional boards, community, university, private and not for profit service providers.

**APPENDIX 3**



## Provincial Committee on the Residential and Treatment Needs of Children and Youth

### Best Practices in Residential Care Literature Review

#### The Continuum of Care

Services to children, youth, and families who become involved with the child welfare system are generally thought to be provided within a "continuum of care." This continuum ranges from services that are least restrictive in nature to services that are considered to be most restrictive. The continuum usually consists of the following range of services: education, prevention/diversion; family support; family preservation; respite care; foster care; specialized or treatment foster care; day treatment; group homes; and residential treatment (Stuck, Small and Ainsworth, 1997; Pecora, Whittaker and Maluccio, 1992a).

Ideally, the continuum should provide a diversified set of services that can meet the needs of children and families at varying levels of intensity. Use of services in the continuum is governed by the current predominant beliefs in child welfare, which include an emphasis on permanency planning, the provision of family-centered services, a focus on utilizing the least restrictive intervention, and the belief that children are best cared for in families, preferably their own (Steinhauer, 1993; Pecora et al., 1992a).

According to Whittaker (1997),

Our goal should be to develop an integrated continuum of care that provides a full range of home-based and residential options and contains an easily activated set of linkages between the various service programs and other major systems in which the child participates: family, peer group, school, church, and community. (p.4)

Services should be offered seamlessly, as part of an "integrated service net" (Whittaker, 1997, p.6), and families should be able to access the services that they need at the time they need them.

Stuck et al. (2000) suggest that the manner in which the continuum of services is utilized is often detrimental to the clients being served. Although the continuum is based on the principle that the least intrusive, *appropriate* intervention should be utilized first, this has been widely interpreted to mean that the least intrusive intervention, appropriate or not, becomes the starting point for services.

...the continuum has become a one-way street children and families must travel until they reach the point where the system can meet their needs at that time or until diversion of the child client into mental health or youth corrections takes the pressure off the system all together. (Stuck et al., 2000, p.83)

They have put forth the idea that there are flaws in the concept of a continuum of care. The first such flaw is that there are logical inconsistencies in the "least restrictive" standard, which can result in services being provided based on a systemic bias towards a particular type of service

rather than what is actually needed. Second, "an approach that requires that the least intensive interventions should always be used first results in a system with case management decisions driven by failure" (p.85). Often, a child or family is only able to receive a more intensive intervention if it has been demonstrated, often repeatedly, that less intensive interventions do not work. This occurrence, particularly with regard to foster care placements versus placement in residential treatment, has been well documented (Raychaba, 1992; Landsman et al., 2001; Whittaker, 2001).

...experience has given us many examples of highly motivated, caring foster parents who eventually burned out because they were unable to cope with very troubled children; well after it should have been evident that more intensive interventions were warranted (Stuck et al., 2000, p.85).

A system that sees clients moving from one service to the next along a continuum, racking up failures along the way, is characterized by negativity. Identifying problems becomes much more prevalent than identifying strengths, and the system becomes crisis driven. The concept of family reunification, the ideal upon which the continuum actually rests, becomes compromised. Furthermore, there are often overly rigid boundaries between services, which limits the possibility of offering simultaneous, versus sequential, interventions.

While the concept of a continuum of care has contributed to humanizing child welfare services over the past two decades, and there have been numerous positive outcomes as a result, it is now time to reconceptualize. The idea of a "care management service system" has been proposed by Stuck et al. (2000), which would transform the continuum of care into a more integrated set of services for children and families:

Taking a care management approach to the longest term, highest risk clients in the system allows an approach to service implementation which would:

- acknowledge that some children and families will require services at various levels of intensity over time, and that this may be a decidedly nonlinear process...
- retain the emphasis on family empowerment and family connections at all levels of service, but recognize that optimum connections may not mean that every parent and child lives together full-time...
- put a premium on continual, coordinated assessment where the operative question is not where does the child and family fit into the service system, but rather how do services in the system best fit the child and family needs at the time;
- put an equal premium on care and support to families *after* the course of intensive services...
- blend services so there are step-up and step-down options at all levels of intervention, and in particular so that the rigid boundaries between home-based and out-of-home services are eliminated;

- develop outcomes, including cost-benefit measures, not limited solely to discrete services but to long-range family stabilization and the real cost of services across time (p.89).

An illustration of the care management approach is provided in Figure 1. The ideas presented in this model have been voiced by others, including Small, Kennedy, and Bender (1991).

Regardless of how one chooses to view the continuum, it is widely understood that to provide effective intervention, the full range of services must be available and accessible. Otherwise, any discussion of how to utilize the services becomes an exercise in futility, with service providers attempting to fit clients into available services, rather than utilizing services that best match their needs." The absence of an adequate range and variety of residential care facilities and other services translates into young people living in placements which are often inappropriate and unsuited to their unique needs" (Raychaba, 1992, p.6).

### Family Centered Services

Over the past two decades, there has been an increased focus on the provision of family-centered services. These services vary widely in duration of treatment, caseload size, nature and/or number of services provided, type of intervention and clinical methods utilized, and other program characteristics (Pecora, Fraser, and Haapala, 1992b). In an effort to try and organize these services into distinguishable categories, the following typology of family-centered programs was proposed by the Child Welfare League of America in the early 1990's (Pecora et al., 1992a):

1. *Family resource, support, and education services.* Community-based services that assist and support adults in their roles as parents. These services should be equally available to all families with children and should not impose criteria for participation that might separate or stigmatize certain parents.
2. *Family-centered services.* These services encompass a range of activities for families that threaten their stability, such as case management, counseling/therapy, skill building, advocacy, and/or provision of concrete services.
3. *Intensive family-centered crises services.* These services are designed for families in crisis, at a time when removal of a child is imminent, or the return of a child from out-of-home care is being considered. (p.270).

The latter category is usually referred to as "intensive family preservation services." The common characteristics of this model include the provision of clinical and concrete services in the home setting; services tailored to meet the needs of each family; a service delivery that is intensive (a minimum of four hours per week of face-to-face contact) and of short duration (four to six weeks). Therapists in the program have small caseloads (two to five families at a time) and are on call twenty four hours per day (Pecora et al., 1992a; Pecora et al., 1992b; Hess, McGowan, and Botsko, 2000).

One of the oldest and most well known family preservation program is Homebuilders. This model is "based upon Rogerian, cognitive-behavioral, crisis, and ecological theories. The

family and its social support system are viewed as the focus of services, with an emphasis upon promoting client independence and psychosocial skill-building. Therapists use a variety of clinical methods, including parenting training, active listening, contracting, values clarification, and problem management techniques" (Pecora et al., 1992b, p.179).

Research findings for family-based and family-preservation services have been contradictory. Some studies have shown a significant reduction in child placement rates as a result of the intervention (Pecora et al., 1992b) while others have demonstrated no impact at all (Wells and Tracy, 1996). Concerns have been raised that most outcome studies have measured success in terms of placement prevention rather than child well-being (Trocmé, 2003). There are also limitations to traditional family preservation services, in that they are designed to help a specific segment of children and families in need of support, and provide limited types of services. "They cannot address the socioeconomic forces that contribute to tensions and inadequacies in family functioning nor can they provide the long term assistance and/or specialized treatment required by some parents and children. Thus it is essential to maintain realistic expectations of what these programs can and cannot do" (McGowan, 1990 as cited in Hess et al., 2000). Preservation programs have also been criticized on the basis that they may be used to delay the removal of a child from a dangerous home environment that has shown little likelihood of improvement (Trocmé, 2003). Family preservation should not be interpreted to mean that home-based interventions must be used before a child can be removed - for children who end up being permanently removed, especially young children, a more decisive approach may be required (Steinhauer, 1991). According to Wells and Tracy (1996):

The prevailing goal of intensive family preservation programs - prevention of out-of-home placement - should be abandoned. These programs show only limited success in achieving this aim, and the problems of most families in the public child welfare system are not met effectively when such programs are provided as a single service. Because these programs show promise in improving family functioning, however, it is important to retain in child welfare practice critical features of intensive family preservation services as a mode of service delivery: the emphasis on family strengths and family empowerment, the availability of caseworkers to work with families in their own homes and to help families obtain access to a wide range of services, and the reliance on building parents' skills and social support. (p. 683)

It has been suggested that family-based services that combine elements of family preservation with family support may be more successful than traditional intensive preservation services, for a broader range of families. Hess et al. (2000) describe such a program, which operates similarly to family preservation in that it is family focused; based on the development of a client-centered relationship between family and worker; provides day-to-day staff accessibility; and is flexible in the development of individualized service plans. The additional characteristics of this program are that it has broadly inclusive access to noncategorical services; provides comprehensive, integrated services grounded in the community (mostly through the community center in which this program is housed); and is flexible in service duration. Families can access services for as long as they need, sometimes continuing for a year or more. The program has been viewed positively by both clients and program staff. Numerous other examples of family-based programs are available in the literature.

### Specialized/Treatment Foster Care

As trends have changed in child welfare over the past few decades, so, too, has the face of foster care. What was once viewed primarily as substitute care is now perceived as a resource to aid in the growth and development of children, to help facilitate reunification of children with their families, and to promote permanency planning. This expanded role for foster parents has resulted in the development of specialized foster care programs for children and youth with special needs such as emotional and behavioral problems. The professionalization of foster parents has emerged as a recent trend, as has the development of treatment oriented foster homes in which foster parents are the primary change agents (Pecora, et al., 1992).

Steinhauer (1991) describes some innovative models of specialized foster care. The first of these is the Parent-Therapist Program. This program was developed in Ontario by the Chedoke-McMaster Centre as an alternative to residential treatment for children and early adolescents who were emotionally disturbed. Foster parents, who are referred to as parent-therapists, are trained to serve as both foster parents and surrogate therapists. Extensive screening and assessment is conducted to ensure that interested candidates are suitable for this role and, once selected, parent-therapists receive specialized training, starting with a four week orientation.

Parent-therapists are organized into extended family units, each consisting of five couples. All members of the family unit are responsible for all children in the group, with the individual couples having specific responsibility for the children actually living in their homes. In this way, an extended support network is instantly created for each child and for the foster parents. Each group meets weekly for a three hour session, in which couples provide support to each other and work through any difficulties they may be experiencing.

Evaluation of the parent-therapist program demonstrated that most children in the program made substantial gains and, while a small percentage of children were unable to be maintained in the homes and required a residential placement, most children in the parent-therapist homes did about as well as those in residential treatment, at approximately half the cost.

The Parent-Counselor Program, currently operating in Nova Scotia, is very similar to the one outlined above (T. O'Brien, personal correspondence, June 3, 2000).

The Kent Special Family Placement project was developed in Kent, England for 14 to 17 year olds with severe emotional and behavioral problems. Under the premise that it is legitimate to spend as much on specialized foster care as on residential treatment, the program paid a professional fee to one of the parents in each participating family. As in the parent-therapist program, the foster parents were seen as the child's focal therapists. In many cases, foster parents took responsibility for work with the natural families, which was deemed to be a successful component of the program. Foster parents were carefully matched with young people to ensure that the family would be able to meet the needs of each adolescent. Foster families generally reported great satisfaction with the project.

The Lisdeel Family Placement Initiative is an innovative foster care program recently established in Dublin, Ireland. It is a partnership between a small residential unit for children ages 5-12 years, Lisdeel House, and a local fostering service. All children are referred to Lisdeel House with a view to fostering, and the goal is to have them placed with a foster family in less than one year. Very detailed information about the children is sought upon referral, and

children are selected for admission to the program based upon their capacity to benefit from the service.

Staff of the residential program are focused on preparing the children for a foster placement. This includes a focus on assessing the child's needs and developing an individual plan of care. Staff also have ongoing contact with the fostering social worker and the fostering placement committee. Once a child is placed in a foster home, very high levels of post-placement support are available, which include support from the Lisdeel social worker and resource worker, 24 hour support for emergencies from Lisdeel program staff, timely access to therapeutic help when needed, a support system for foster parents and children, and a commitment to teamwork and partnership. This program is currently being evaluated (Payne and Murphy, 2002).

Examples of other creative fostering programs are prevalent in the literature. The characteristics common to them all appear to be the provision of a support network for the foster parents, the view of the foster parent as the primary treatment provider, and engagement with, or at least consideration of, the family of origin.

Arieli and Feuerstein (1987) describe a program in Israel in which residential care and foster care are combined in an attempt to maximize the advantages and minimize the disadvantages of each type of care. Children in the program are placed in foster homes, which are all located in the same small farming village, but spend their days in a group care center which operates all day and into the evening. The center resembles a residential facility, and includes school, informal education, and psychotherapy provided by a multidisciplinary team. This team also provides consultation to the foster parents. The program appears to be successful in reducing "pressures to which children and adults are exposed to in each of the separate programs" (p.182).

While there has been some support for this program, it has also been suggested that there needs to be more focus on ecological change (Lewis, 1987) and family involvement (Maluccio, 1987). Polsky (1987) has criticized the whole concept, on the basis that it is derived from faulty assumptions about both foster care and residential care, and "the structural invention of having the children move from one setting to the other brings in its train complications of co-ordination, with the kids becoming more alienated and/or playing one system against the other through their powerful peer groups" (p.189).

The program described by Arieli and Feuerstein (1987) bears some resemblance to the SOS Children's Villages that operate worldwide to provide foster homes to children in permanent care. SOS Villages are located in more than 130 countries, including two in the United States, and each village consists of about ten families. Foster parents are carefully screened and trained and receive ongoing support. The goal of the program is to provide children with permanent homes where they can remain until they reach young adulthood. Siblings are kept together and all children in the program are provided with an instant supportive community. Some Villages also provide specialized programs for youth (SOS Childrens Villages, 2003).

### Residential Care/ Group Living Programs

Residential care has played a significant role, for centuries, in the provision of services to children. While the service originated with large children's orphanages mainly concerned with the provision of surrogate care, it has evolved over the years to smaller, treatment oriented

programs for severely troubled youth. A comprehensive overview of the history of residential care in Canada is provided by Charles and Gabor (2003).

A review of the literature on residential care reveals a wide variety of programs and philosophies governing the provision of services. Residential settings range from small, community based group home programs to residential facilities which provide a total treatment environment with all services, including school and leisure activities, provided within the facility or campus. Much of the literature focuses on residential care in the context of child welfare, but it is important to note that this service also has its roots in the juvenile justice and mental health systems. There may be some differences between the programs provided by each jurisdiction, usually as a result of systemic and philosophical factors, but the types of children, youth and families served across systems are generally the same (Durrant, 1993).

Within child welfare, there are two distinct categories of residential group care placements - those that provide treatment and those that exist within the framework of permanency planning (Aldgate, 1987). The latter type have become much scarcer over the years, as the use of foster homes as the preferred placement option for children has significantly reduced the number of children being served in group care programs (Anglin, 2003). There is evidence to suggest, however, that residential settings should be viewed within the context of permanency planning and, in some cases, may be a preferred placement option (Anglin, 2003; Aldgate, 1987).

Residential care has been subject to much scrutiny over the years, and residential programs have faced considerable pressures, including deinstitutionalization, economic constraint, an increased demand for accountability and quality assurance (Anglin, 2003) and frequent reports of institutional abuse (Charles and Gabor, 2003). "To many, it is the most intrusive and , consequently, most unwanted form of state-sponsored intervention. To others, it is the most effective form of intensive treatment for troubled and troubling young people" (Charles and Gabor, 2003, p.1). One of the contributing factors to this polarization of opinion has been the lack of evaluative data or outcome research in residential services (Curry, 1991; Frensch et al., 2003; Anglin, 2003; Pecora et al., 1992). As stated by Whittaker (2000):

A full and rigorous examination of the theoretical and empirical underpinnings of residential group care with respect to their implications for current service policy, practice and future research is long overdue and ought to receive the highest priority on the new century's emergent agenda (p.60).

There is currently no unified theory for residential treatment (Whitaker, 1997). As a result, there are still many models of residential programs operating from different theoretical bases.

One such theoretical base is the behavioral perspective. The underlying philosophy with this approach is that the child's behavior is the focus of intervention, and that behavior is controlled by the environment. Treatment, therefore, consists of identifying the problem behavior; determining the controlling conditions, patterns of reinforcement and environmental factors; and applying any of a number of behavioral techniques (Whittaker, 1997). As Falberg (1990) describes, this type of treatment is focused on changing the child from the outside-in, versus the inside-out. Programs that are grounded in behavior modification often incorporate point or level systems, or token economies, to monitor and reward appropriate behaviors (Frensch et al., 2003).

Outcome data on behavioral programs has demonstrated some success in changing in-program behavior in the areas of educational progress and reduction of criminal behavior. Recent studies on the use of behavior modification with conduct disordered youth have also yielded positive results. To date, however, there has been little evidence to suggest that behavioral gains made while in the program are able to be maintained upon discharge (Frensch et al., 2003). The most well known behavioral based program, the teaching family model (with more than 250 group homes across the U.S. and Canada), has been evaluated regularly. While this program has many positive attributes (see Whittaker, 1997), it "appears to fall short in the long-term maintenance of in-program effects and in the post-treatment reduction of delinquent and criminal behavior" (Frensch et al., 2003, p.46).

The use of point and level systems in the treatment of troubled youth has been debated extensively in the literature. While there are many who extol the virtues of this approach, there are others who view it as another way to "fail" children and youth (VanderVen, 1995; Fox, 1994). "This historically common model is currently in decline as the field shifts to more contemporary, individualized family-based approaches" (Garfat, personal correspondence, March 30, 2003).

A very different approach from the one outlined above is the guided group interaction or positive peer culture approach. This is a process of group treatment designed to tap into the power of the peer group and direct the dynamics and strengths of the group into promoting and developing positive change in the group members (Whittaker, 1997; Brendtro and Ness, 1983). Peer group programs first originated in facilities for juvenile delinquents, but have since expanded to other settings including schools and community based programs. "The group itself is seen as the primary vehicle for change, and members are responsible for helping each other resolve problems both in and out of the group meeting" (Whittaker, 1997, p.68). Groups usually meet daily for an hour to an hour and a half, in a highly structured format designed to facilitate problem solving and teach ways of living together.

While there has been some reported success in the use of this model for older adolescents (Agee, 1979; Brendtro and Ness, 1983), there has also been considerable controversy (Whittaker, 1997). The overall effectiveness of positive peer culture is still questionable. It is generally recognized, however, that paying attention to the power of the peer group is critical to the success of any program, whatever the approach.

Perhaps the most widely documented approach to residential treatment is the psychoeducational approach. This is a theoretically eclectic model that focuses on the creation of a total living and learning environment, and "stresses the teaching of competence across the total spectrum of the child's development as the fundamental purpose of the helping environment" (Whittaker, 1997, p.71). According to Brendtro and Ness (1983), the six major tenets of this model are as follows:

1. Relationship is primary
2. Assessment is ecological
3. Behavior is holistic
4. Teaching is humanistic
5. Crisis is opportunity
6. Practice is pragmatic (p.17).

In comparison to the behavior modification model, the psychoeducational approach is based on the belief that behavior is the result of internal and external stimulation, and that learning occurs

through the interaction between maturation and development, the personal meaning and significance an individual attaches to life events, the consequences of behavior, and creative problem solving. The goals of treatment may include changing specific behaviors, but the primary emphasis is on promoting responsible decision-making (Brendtro and Ness, 1983).

Outcome research on this model has largely focused on Project Re-Ed, a short-term residential treatment program designed and implemented by specially trained teachers who work not only with children, but families, schools, and community agencies to help a child's ecology better meet his or her needs (Frensch et al., 2003). Results of one study showed improvement, at discharge, in social behavior, attitudes toward and motivation for learning, and academic skill acquisition. Data also suggested that this form of treatment led to a more positive self-concept, more internal locus of control, decreased motor and cognitive impulsivity, and more constructive family relationships (Weinstein, 1994, as cited in Frensch et al., 2003).

Brendtro, Brokenleg and Van Brockern (1990) have proposed a model of treatment for troubled youth based on traditional Native American child-rearing philosophies. They have introduced the concept of the "Circle of Courage," which includes in it the central values of belonging, mastery, independence, and generosity as the unifying themes of positive cultures for education and youth work programs. This model is used to provide a "reclaiming" environment:

The reclaiming environment is one that creates changes that meet the needs of both the young person and society. To reclaim is to recover and redeem, to restore value to something that has been devalued. Among the features of powerful "reclaiming" environments are these:

1. Experiencing belonging in a supportive community, rather than being lost in a depersonalized bureaucracy
2. Meeting one's needs for mastery, rather than enduring inflexible systems designed for the convenience of adults
3. Involving youth in determining their own future, while recognizing society's need to control harmful behavior
4. Expecting youth to be caregivers, not just helpless recipients overly dependent on the care of adults. (pp.3-4)

This model has received considerable interest, and some residential programs and alternate schools have adopted the "Circle of Courage" as their underlying treatment philosophy. Outcome data is not yet available.

Further to the specific program models already presented, and the limited outcome research that has been conducted on these models, there is information available about residential treatment that is evidence-based, if not empirically validated. Commonly accepted elements that are considered critical to successful treatment are as follows:

1. A focus on the development of trusting relationships and attachment formation (see, for example, Falberg, 1990; Krueger, 1986; Gaffley, 2001; James, 1994).
2. A focus on promoting competence and enhancing the child's development (see, for example, Ainsworth and Fulcher, 1981; Maier, 1990; Durrant, 1993; Whittaker and Pfeiffer, 2001).

3. Intervention that is needs based, and tailored to the specific needs of children and families served (see, for example, Whittaker, 1997; Garfat, 2003; Maier, 2001)
4. The provision of emotional, psychological, and physical safety provided through the design of the physical setting and the presence of structure, routine, and clear limits and expectations (see, for example, Whittaker, 2001; Agee, 1979; Anglin, 2003; Small et al., 1991).
5. The development and implementation of individual treatment plans (see, for example, Whittaker, 1997; Pope, 1997).
6. The use of activity programming and a focus on skill building (see, for example, VanderVen, 1985 & 1999; Bames, 1991).
7. The involvement of families in the residential program (see, for example, Landsman et al., 2001; Frensch et al., 2003; Garfat and McElwee, 2001; Tam and Ho, 1996; Noble and Gibson, 1994; Ainsworth and Small, 1995).
8. The provision of aftercare and support services upon discharge (see, for example, Pecora et al., 1992; Guterman et al., 1989; Frensch et al., 2003).

All of the above occur within the "therapeutic milieu" through daily interaction between caregivers and youth and the utilization of daily life events, which must be planned and purposeful (Krueger, 1986; Maier, 1979; Garfat, 1998; Gaffley, 2001; Frensch et al., 2003). According to Krueger (2001), postmodern youth work is "a process of interaction in which workers and youth create moments that change their stories" (p.224). This theme of meaning making, or experiential practice, is prevalent in the literature (see, for example, Garfat, 2003; Phalen, 2001; Maier, 2001). Current writing focuses on the evolving idea of relationship-based programming (Garfat, personal correspondence, March 27, 2003).

According to Whittaker (1997), residential treatment centers should blend into and be involved with communities that support them, and should have relevance for all of the children in the community, not just those in care. This can be achieved by offering a range of services, such as "milieu therapy, special education, day treatment, community-centered programs, consultation, and parent education" (p.11).

Of the essential elements of residential treatment identified above, two of these - the involvement of families and the provision of aftercare and support services - have been repeatedly demonstrated to be the most significant factors in determining post-discharge success (Whittaker, 2001; Frensch et al., 2003; Guterman et al., 1989; Lewis, 1987). What happens to a child upon his or her return to the community appears to be more important, in determining success, than anything that happened while the child was in treatment or the child's status at discharge.

Another factor that appears to be related to positive outcomes is the appropriate matching of child characteristics to treatment type (Frensch et al., 2003). According to Falberg 1990:

...it is imperative that any residential center have clear guidelines in place for selecting children for admission - children who are in need of out-of-home care and who, at the same time, are amenable to the treatment approaches and philosophy utilized (p.95).

Programs that are clear about who they can and can not serve, and utilize admission criteria to ensure that young people are appropriate for the program, based not only on their individual needs but on the composition of the group as a whole, are the most successful (J. Anglin, personal correspondence, October 22, 2003). A residential treatment program cannot be all things to all people (Agee, 1979). Falberg (1990), for example, stresses the need for different types of treatment for children with attachment issues who experience some anxiety about their situation versus children who need to have their anxiety level increased. As stated by Charles and Gabor (2003):

No longer will broadly defined generic programs be able to claim to provide all required interventions. For example, it is long past the time when sexual abuse victims and adolescent sex offenders should be housed in the same facility. In order to respond effectively to the problems being experienced by some young people, programs will have to develop specific expertise. Coupled with the move to smaller facilities, we are likely to see small, specialized, issue-specific programs developing in community settings (p.6).

The number of placements a child experiences is also a factor in determining positive outcomes in residential treatment (Steinhauer, 1991). According to Falberg (1990):

It is important to be sensitive to the need for ensuring a treatment environment that truly meets the child's needs in a timely a manner as possible. If a child moves from institution to institution, always a step behind the level of intervention that he needs, he eventually becomes unresponsive to virtually all treatment approaches (p.95).

The more placements a child must endure, the greater the negative impact on the child's development. This can heavily influence "the child's condition at the point of exit from care" (Stuck et al., 2000, p.85). As stated by Agee (1979):

Unfortunately, with each new placement several things occur. For one thing, the child becomes more resistive to establishing new relationships. Secondly, it is harder to find placement for children who have failed in previous settings. Finally, the child has learned practically foolproof methods of getting out of settings that they do not want to be in (p.12).

One of the reasons children and youth experience multiple placements is because we do not have clear cut diagnostic indicators for determining, with complete accuracy, where a child should be placed and what the outcomes of this placement will be. The question of whether to place a child in a foster home or a residential setting is a continuous source of debate. While it is generally assumed that the preferred placement option for children in care is a family foster home, very few studies have looked at foster care versus residential care.

Colton (1988) conducted the first in-depth, systematic, comparative study of foster and residential care practices. He compared special foster homes and Children's Homes in Britain on the following four dimensions of care practice: the management of recurrent social events; children's involvement in community activities; the provision of physical amenities; and the techniques used by foster parents and residential staff to maintain control over children.

He found that the foster homes were, overall, significantly more child-oriented than the Children's Homes in the dimensions of care practice explored. Colton cautioned, however, that "the results of this exercise offer grounds for optimism, rather than gloom in the sense that they point to ways by which identified shortcomings might be ameliorated" (1988, p.41).

Aldgate (1987) conducted a study, also in Britain, comparing the experiences of children in foster care versus residential care. She found that there was much more contact between parents and children in residential care than in foster care; that parents felt more threatened in their relations with foster parents than with residential staff; they perceived foster parents as direct rivals, whereas residential staff were viewed as professionals; and they were more willing to admit that their children were in residential care than in foster care. Another perceived advantage of children's homes, according to parents, was that the children could be with others in a similar predicament and siblings could be kept together. Aldgate concluded that residential care was a "major facilitator for enhancing access from natural parents and thereby the reunification process" (1987, p.51).

Anglin (2003) conducted a review, over a fourteen month period, of ten group home programs in British Columbia. His purpose was to discover and articulate the essential elements of residential child and youth care work. He identified three core processes considered instrumental to the group home experience, which were related to: experiencing a sense of normality; creating an artificial living environment; and responding to pain and pain behavior. He also found that, for some young people, group homes were the preferred placement option. Specific benefits of group living were identified, which included: relationships (not having to fit into someone else's family); physical setting (group homes can tolerate a higher degree of damage and acting out behavior and can offer a safer environment); number of people in household (there is a wider variety of possible relationships and role models with staff); time element (group home staff have the opportunity to take time off from the demanding needs and behaviors of the young people); style of care (the more formal and professional attention of staff is preferred by some young people); intensity of care/treatment (consistency of structure and expectations with an intensity that is virtually impossible to maintain in a family or foster family); and supervision of carers (close and direct supervision of youth care staff, by supervisors and by more seasoned staff, that allows for some protection against abusive and inappropriate reactions that can occur in such an intense environment). Anglin concluded that:

The ideological criticisms leveled against group homes tend to relate to their "artificial" (institutional) nature as opposed to the "natural" (family) nature of foster or birth homes. However, the abnormally deep and disturbing pain carried by certain youth, and their resulting challenging "pain behavior" may require a period of transition in a well-functioning artificial living environment where they can experience a "sense of normality" in preparation for living once again in a fully "normal" or "natural" setting.

If a service is to be utilized, then we need to know how, when and for whom it can be best used, and value it as a positive *choice* in those circumstances. A service that is not valued, or that is considered always to be an unsatisfactory or second-rate option will inevitably deteriorate and will ultimately reflect these self-fulfilling expectations (p.10).

Hume, Lowe, and Rose (2000) noted similar findings. They describe a situation that occurred when the county of Lewisham, in South London, closed all of its residential homes and developed a policy that all children in care would live in foster homes. This decision was made

in response to abuse discovered in some of the residential settings, as well as a national trend of moving away from residential care and placing an emphasis on foster care. At the time this policy was implemented, Lewisham had a successful foster care system and was investing in the capacity to recruit, support, and retain foster homes for all young people coming into care. It did not take long before residential placements were being created. As concluded by Hume et al:

It is clear that, despite those who would wish to see all looked after children in substitute families, residential care is still seen by large numbers of looked after children as having advantages over foster care (p.13).

Although there is no clear cut way to determine exactly which young people would benefit from a residential placement, some common characteristics of young people requiring residential treatment have been identified. These include:

- severe behavioral and emotional problems requiring the expertise of highly trained professionals
- clear and imminent danger to the child, others, or to society
- an inadequate fit between the needs of the child and the resources available in the environment
- self-perpetuating cycles of dysfunctional behaviors resistant to less intensive treatment (Whitaker and Pfeiffer, 2001, p.591).

Additional characteristics may include chaotic behavior; poor impulse control, which includes a tendency to harm others, destroy property, and make physical threats; persistent school problems; poor self-concept (Frensch et al., 2003); heightened emotional reactivity; and extreme difficulty making and maintaining human connections (Small et al., 1991). It is quite aptly pointed out by Small et al. (1991) that "the expectation of a "cure" in residential treatment implies lack of continuity between pre-residential and post-residential environments. It must be understood that most youngsters in residential treatment require ongoing supports. Most of them will need continuing affiliations with mental health and social services long after their discharge from out-of-home care. A realistic appraisal of the long-term needs of these children and their families will serve them better than wishful expectations of dramatic transformation...Progress is a reasonable goal: cure, however, is not" (p. 337).

As noted earlier, residential care takes place, itself, along a continuum, from "a traditional house with minor modifications, as in the case of smaller group homes, or larger structures built specifically for housing residents and equipped with child proof windows and secure time out rooms" (Frensch et al., 2003, p.9). The latter represents the most extreme end of the continuum, secure treatment.

According to Brian Raychaba (1992), a former youth in care who has written extensively about his experiences, and the experiences of other young people in care, there are times when secure treatment can be positive and necessary. He cautions, however, that "secure treatment and restraining is justifiable only in cases where young people are clearly in immediate danger of harming either themselves or others" (p.4). This opinion is shared by others.

On the web site for Children's Services in the province of Alberta, secure treatment is defined as the following:

Secure treatment is a group of services provided to a child who needs to be confined in a restricted and highly supervised place. It is the most restricting protective service provided for by the Child Welfare Act.

There is legislation in place that governs the use of secure treatment to ensure that it is used appropriately. The reasons for admitting a child to secure treatment in Alberta are given as:

- the child has a severe mental or behavior problem that severely affects the child's ability to deal with life;
- because of this problem, the child has done something that placed herself, himself or others at immediate risk of serious bodily harm;
- this harmful act happened within the past few days or has happened repeatedly over the past few months;
- secure treatment can likely reduce the problem;
- less restrictive services can't meet the child's needs;
- the child won't accept other services or won't stay under adult supervision.

Other provinces have similar provisions for secure treatment.

In Nova Scotia, a model for secure treatment services has just been developed. This Province has chosen to view secure treatment as "a construct which involves much more, and sometimes much less, than a "securable" facility" (Province of Nova Scotia, 1998, p.8). They have developed a Secure Treatment Services Program which consists of a range of services for young people and families.

On one end of this spectrum of services is the situation where the youth might spend the majority of his or her time within a secure or secureable facility. On the other end of this spectrum of services is the situation where the youth, while benefiting from secure treatment services, resides within another program with the "security" being provided by the legal status of the youth, the availability of the Secure Treatment bed as an option should it be temporarily necessary, the structure and clear expectations of the youth's individual treatment plan, the support, involvement, and availability of the Secure Treatment Services staff in the youth's daily life, and the consistency of approach among all the professionals involved (p.9-10).

Secure treatment services in Nova Scotia are designed primarily for youth ages twelve and up. There are, however, secure treatment centers for children as young as four years (Falberg, 1990; L. Fox, personal correspondence, January 21, 2003), and some evidence to suggest that secure treatment is more effective when provided to children prior to the age of twelve (James, 1994; B. Hardy, personal correspondence, February 22, 2003).

While secure treatment is, perhaps, considered the least desirable of all treatment options because of its severely restrictive nature, it is a necessary resource for children and youth requiring such an intense level of intervention. As Falberg (1990) has stated, "if a youth's behavior can not be contained within safe limits by the most potent tools an organization has at its disposal, then the child does not belong in that program" (p.150). Appropriate services must be available to children and youth who can not be safely maintained in less restrictive programs.

### Diagnostic Labels

The literature on residential care is riddled with diagnostic labels, such as conduct disorder, character disorder, abuse-reactive, personality disorder, bi-polar disorder, and attachment disorder, to describe the children requiring treatment. While these labels are used to illustrate how certain programs or approaches work best with certain "diagnoses," it also appears, more often than not, that the labels are used interchangeably. What one author describes as "conduct disorder" is clearly referred to as "attachment disorder" by another author. While there are staunch supporters of the need for accurate psychiatric diagnoses, there are also many who oppose the practice of labeling children. Some of their comments are as follows:

Diagnostic labels are primarily a bureaucratic data collection for carework. It's a waste of time and a false reliance on useless information. (H. Maier, personal correspondence, cyc-net, March 18, 2003)

Conduct disorder is an unfortunately vague label that means nothing except that a child won't do as he or she is told. (Ungar, 2002, p.27)

When it comes to children, most of the routine problems of growth and development have been translated into disorders and catalogued in the DSM IV. (Fewster, 2001, p.124)

Whether in agreement with or against the use of diagnostic labels, there is clearly a need to be careful, when designing programs, to ensure that the program actually meets the needs of the child and not the label assigned to him or her.

### Staffing

Residential treatment centers are usually staffed by multidisciplinary teams, which can be comprised of administrators, psychiatrists, psychologists, social workers, teachers, and child and youth care workers. (This will vary depending on the size and mandate of the program). The use of a generic teamwork model, in which all team members share in the decision-making and have equal say in the development and implementation of treatment plans and other program related activities, is widely supported (Krueger, 1986 & 1990; Falberg, 1990; Roley, 1997).

Further to the concept of the team is the fact that, in most residential settings, the primary treatment providers are the child and youth care workers. The success of any program, therefore, is directly related to the quality and qualifications of the youth care staff. There has been considerable progress made over the last decade towards the professionalism of the field of child and youth care (Stuart, 2001), and work is ongoing in this area. A large body of information is available with regard to the necessary knowledge, skills, and aptitude required of

child and youth care workers, and there are diploma and degree (including Master's and PhD) programs in child and youth care available across the country. There is not yet, however, any means of regulating the profession or ensuring that those who are practicing are actually qualified to do so. The onus for this still rests with individual agencies.

The importance of ongoing and effective supervision for child and youth care workers is also well documented. (Gilberg and Charles, 2002; Delano, 2002; Phalen, 2003; Magnuson and Burger, 2002).

### Attachment Disorder

The controversy on labels notwithstanding, there has been considerable interest, in the past several years, on the treatment of children diagnosed with attachment disorder. A large amount of literature has been devoted to this topic.

Children with attachment disorder are often viewed as the most difficult to treat, and pose numerous challenges for foster care and residential treatment. According to Brendtro et al. (1990):

In the most severe cases of care-less parenting, children fail to internalize moral values. Lacking a conscience, seemingly incapable of concern toward others, such youth are given labels like "psychopathic" or "affectionless." They are among the most difficult to teach or treat, because they are cut off from the bonds that make one human (p.31).

There is a need to distinguish between children and youth with attachment issues, and those with a DSM-IV diagnosis of reactive attachment disorder. It is commonly accepted that many troubled youth are struggling with issues related to attachment, and further postulated that attachment issues may be a contributing factor in the development of other disorders, such as conduct disorder (Whittaker and Pfeiffer, 2001) and personality disorders (Rayment, 2003). Intervention strategies for these children and youth must, therefore, be based on the nature of their particular attachment issues.

The attachment disorder literature focuses primarily on younger children (Falberg, 1990, 1991; James, 1994; Steinhauer, 1991). "Treatment focuses on breaking down the child's need to control his/her relationship with a primary caregiver, and having the child learn to trust that this adult can meet his/her needs. The literature recognized that this process takes a very long time, is very difficult to achieve, and requires an extensive support system for the primary caregiver. All too often the stress involved in dealing with these children, and the inability of these children to engage in emotional reciprocity with their adult caregivers, results in burn out for the adult and multiple placements for the child, further exacerbating the attachment difficulty" (Rayment, 2003, p.1). In fact, it has been stated that if real bonding does not occur in the first adoptive or foster family, it may never occur (James, 1994).

It has been proposed that successful treatment of a child with attachment disorder may take up to five to seven years (James, 1994; Steinhauer, 1991), and the younger the child is at the onset of treatment, the greater the chances of success. As stated by Ziegler (1994):

Without someone reaching them while they are still more connected to family than peer group (usually under the age of twelve), these children may well become the criminals and delinquents of tomorrow (p.248).

Treatment for attachment disorder involves education; developing self-identity, affect tolerance and modulation; relationship building; and mastering behavior (James, 1994; Amherst H. Wilder Foundation, 2003). Further work on exploring trauma and mourning losses can take place only when the child has developed enough security in the relationships with caregivers and the clinician to safely address these issues (James, 1994). Specific treatment conditions include the provision of a safe and protecting environment; therapeutic parenting; appropriate clinical skills; and a therapeutic relationship. Traditional treatment techniques are usually not effective with these children. The treatment milieu "may be a combination of outpatient therapy with therapeutic parenting in the home and school, or it may be a residential or institutional treatment program that provides a strong transitional bridge between the residential setting and the child's home" (James, 1994, p.91). Wherever the setting, it is imperative that treatment pervade the child's total environment - inconsistencies in approach or a lack of teamwork between the adults involved will undermine the treatment process.

Many treatment programs for attachment disorder advocate the use of coercive holding, which may be referred to as "holding therapy", "attachment therapy", or "rage therapy", among other things. This process usually involves prolonged restraint of the child by several adults for the purpose of providing a "multi-sensory experience that refines attunement, facilitates emotional reciprocity and honesty, enhances empathy responses, allows the child to experience emotional openness in a safe way, and reenacts the holding, nurturing experience of infancy; all of which provide a corrective cognitive-emotional experience" (ATTACH, 2003, p.8). This practice has been strongly criticized by James (1994) and others, who describe it as cruel, unethical, abusive, terroristic, and potentially dangerous to the child.

Rayment (2003) has cautioned that all "quick fix" solutions to attachment disorder should be met with skepticism. He is currently researching the use of equine therapy with attachment disordered children and youth, and has proposed that "when young people learn to be effective horsepeople they of necessity must learn all the non verbal signals which the horse uses to communicate. This language is very similar to the dyadic interactions that go on between infant and primary caregiver.... and this experience might have a similar effect on neuronal production in the brain" (personal correspondence, January 22, 2003). It is hoped that horses might be able to help children re-program some aspects of the brain in a way that makes emotional learning possible. This theory, if successful, will then be utilized to examine other kinds of interventions which might be likely to facilitate positive attachment experiences for youth with different interests.

### Dual Diagnosis

It is clear, through a cursory review of the literature, that young people with cognitive delays and psychiatric disorders, or "dual diagnosis," are housed and treated separately from other emotionally disturbed adolescents. This group requires specialized care and treatment that can not be easily provided in a residential setting for troubled youth.

According to Bongiorno (2003):

Though recognized as such only since the 1970's, these patients have long been the subset of the developmentally disabled most resistant to integration into the community. The maladaptive behavior or mental illness often prevents training for the retardation or other developmental disability. Because these patients are no longer placed in the back wards of state institutions, the modern expectation is that even this most difficult group can be influenced by positive behavior support directed by a psychologist and medication treatment prescribed by a psychiatrist. In addition, program specialists structure the work, play, and learning environment of the patients. These activities, living conditions, and peer relationships will form a dynamic interaction with the behavior therapy and the medication. The challenge of adapting to this interaction is met by an interdisciplinary team. Subject to bizarre behavior and difficult to diagnose and treat, patients with both mental retardation and mental illness are best directed to providers trained for these patients (p.1).

There are organizations that operate group homes and other residential programs specifically for young people who are dually diagnosed. Furthermore, there is a National Association for the Dually Diagnosed, which is located in New York and has chapters in Canada, Europe, and Australia. The Canadian chapter is in Sudbury, Ontario and is called the Habilitative Mental Health Resource Network (NADD, 2003). This organization provides a newsletter, workshops and conferences on dual diagnoses, and provides knowledge about effective treatment approaches and models of services. There is also a Dual Diagnosis Resource Service located in Toronto, which has a similar mandate (CAMH, 2003).

It appears that the recommended treatment for dually diagnosed individuals includes behavioral interventions, medication (Pyles et al., 1997), a positive systems approach, individual counseling, group therapy, and environmental configuration (Benner and Walker, 2001). It is emphasized throughout the literature that treatment must be multi-disciplinary (CAMH, 2003; Pyles et al., 1997; Biasini et al., 2003). It is further recommended that an essential component of treatment is the creation of individual crisis plans for each client, which should include support from health and social service providers and law enforcement, and access to specialized treatment programs when needed (Benner and Walker, 2001).

**APPENDIX 4**



## Provincial Committee on the Residential and Treatment Needs of Children and Youth

### The Children and Youth Served by the Child, Youth, and Family Services "In-Care" System in Newfoundland and Labrador.

#### Introduction

To conduct an adequate review of the residential and treatment needs of children and youth in Newfoundland and Labrador, it is essential to know, first of all, just who these young people are. What are the demographics and characteristics of children and youth being cared for by the province? How are they doing? Are there differences between young people requiring foster homes and those requiring residential care? Does the latter group have more challenging and complex needs than other young people in care and, if so, how are we currently responding to these needs?

To obtain the desired information, surveys were designed that asked specific questions about the children and youth in care of the province of Newfoundland and Labrador. Targeted areas included child's history; presenting problems/diagnoses at the time of initial placement and in present placement; length of time in current placement and in the care of the province overall; placement history; treatment planning and use of the ISSP model; and other services provided to the child and family. These surveys were then forwarded to the Directors in all regions, who distributed them to the appropriate social workers to complete on all children and youth, between the ages of 0 - 18, in the care of the Director of Child, Youth and Family Services. All surveys were completed between April 10 and May 26, 2003.

The results of these surveys have yielded a considerable amount of data about the young people currently in care in Newfoundland and Labrador. Some of it will be reported here and used as a reference point for recommendations emerging from the Provincial Committee on the Residential and Treatment Needs of Children and Youth. Data that is not presented or analyzed in this report will be useful for future research and activities conducted by the province.

#### Demographics

Overall, surveys were completed on 589 children and youth. Table 1 on the next page outlines the specific numbers of children in each region. According to the Directors in Region, the response rate for completion of surveys was high and surveys were returned for most young people in each region. There is every reason to assume, therefore, that the data received is accurate and complete.

Table 1: Numbers of Children Surveyed by Region

Region	Total	0 - 5 years		6 - 11 years		12 - 15 years		16 - 18 years	
		M	F	M	F	M	F	M	F
Grenfell	7	0	0	1	2	1	2	1	0
Western	127	14	8	17	12	20	21	14	21
Central	48	4	5	5	6	5	10	9	4
Eastern	74	3	1	15	8	19	11	11	6
Labrador	78	5	7	13	12	21	18	2	0
St. John's	260	11	14	27	20	47	32	54	55
<b>Totals</b>	<b>594</b>	<b>37</b>	<b>35</b>	<b>78</b>	<b>60</b>	<b>113</b>	<b>94</b>	<b>91</b>	<b>86</b>

The above table is presented in absolute numbers and includes all categories related to age and sex that were included in the surveys. In all following tables, the numbers are presented as percentages and the data has been blended for males and females and across age groups. Data is simply reported in two categories: 0 - 11 years and 12 - 18 years.

#### Child/Youth Profile

Data collected on child history and, to some extent, family demographics, reveals a disturbing picture. The children and youth in care of the province are coming from a range of unhealthy backgrounds with high incidences of neglect, abuse, violence and substance abuse in the family. While this is certainly not unique to Newfoundland and Labrador, it does provide a window into the lives of these children and families and the issues with which they are struggling. It also has ramifications for service delivery and resource allocation, which will be discussed later. The characteristics of child history, as gathered from the surveys, are presented in Table 2:

Table 2: Characteristics of Child History (%)

<i>History</i>	<i>0 - 11 years</i>	<i>12 - 18years</i>
Sexual Abuse	14	18
Physical Abuse	44	35
Neglect	81	57
Emotional Abuse	58	50
Witness to Family Violence	45	37
Family Breakdown	40	53
Family Violence	42	32
Medical Concerns	20	21
Family Substance Abuse	60	39
Family Criminal Involvement	33	26
Family Psychiatric Disturbance	28	28
Other	14	9

Children enter into care for a number of reasons. Usually, the reason for initial placement can be found in elements of the history of the child and family and the presenting problems identified at the time of placement. Therefore, in addition to the information reported above, specific information was gathered on the presenting problems/diagnoses at the time of the child's initial placement. This same information was also gathered for the child's present placement. As with the child history results, this data revealed that children coming into care are dealing with significant issues, both prior to initial placement and while in care, and are exhibiting a multitude of disturbed and disturbing behaviors. Of particular note are the high percentages of children, in both age groups, entering care with special education needs and developmental delays. For the 12 - 18 age group, the prevalence of negative peer involvement, violence towards others, irregular school attendance, and severe parent-child conflict is noteworthy. On the positive side, there are many young people who do not present with any behaviors upon admission or in their current placement and who appear to be doing well in care. The results are shown in Table 3:

Table 3:

## Presenting Issues at Admission (%)

Issue	0 - 11	12 - 18
Developmental Delay	33	21
Substance Abuse	4	13
Depression-Anxiety	11	19
Self-Harming Behavior	8	15
Negative Peer Involve.	16	30
Violence Toward Other	20	25
Running Away	8	16
Prostitution	0	2
Age-Inappropriate Sexual Behavior	11	16
Attachment Disorder	2	2
ADD/ADHD	6	10
Conduct Disorder	.5	1
Other Psychiatric	2	5
YOA Involvement	0	17
Special Education Needs	29	30
Irregular School Attendance	13	36
Language-Speech Concerns	24	8
Extreme Defiance-Oppositional Behavior	10	13
Verbally Abusive	13	18
Severe Parent-Child Conflict	14	37
Severe Sibling Conflict	9	13
Other	15	8

## Current Presenting Issues (%)

Issue	0 - 11	12 - 18
Developmental Delay	31	21
Substance Abuse	1	13
Depression-Anxiety	10	14
Self-Harming Behavior	5	7
Negative Peer Involve.	10	28
Violence Toward Other	12	22
Running Away	5	11
Prostitution	0	1
Age-Inappropriate Sexual Behavior	10	8
Attachment Disorder	3	3
ADD/ADHD	7	13
Conduct Disorder	.5	1
Other Psychiatric	6	6
YOA Involvement	0	19
Special Education Needs	33	37
Irregular School Attendance	2	20
Language-Speech Concerns	26	9
Extreme Defiance-Oppositional Behavior	5	10
Verbally Abusive	5	14
Severe Parent-Child Conflict	7	13
Severe Sibling Conflict	8	6
Other	16	12

"When young people come into care, they do not change immediately, nor does being in care eliminate all of the problems of living of the young person and family, or how those difficulties are manifest" (Garfat & Charles, 2000, p.19). This is clear from the data above. At the same

time, there do appear to be some reductions in behaviors from admission to current placement which may cautiously be interpreted to reflect progress. It is not possible to make a direct comparison, however, because there are too many extraneous factors, such as social worker interpretation of the questions, differences in perception and assessment at different points in time, and differences in reporting methods, that must be taken into consideration.

### **Placement Experience**

This section of the survey examined the current placement experience of the young people. Table 4 presents the length of time spent in the current placement:

**Table 4: Length of Time in Current Placement (%)**

<b>Length of Time</b>	<b>0 - 11 years</b>	<b>12 - 18 years</b>
Less than one month	5	9
One to six months	20	26
Seven to twelve months	18	14
More than one year	55	50

Interestingly, half of all young people have been in their current placement for more than one year. This would, ideally, be indicative of some level of stability for these young people. However, the stats in the following two tables indicate that this may not be the case:

**Table 5: Anticipated Length of Stay in Current Placement (%)**

<b>Length of Stay</b>	<b>0 - 11 years</b>	<b>12 - 18 years</b>
Less than one month	1	1
One to six months	4	7
Seven to twelve months	5	4
More than one year	44	42
Unknown at this time	46	44

Table 6: Planned Future Placement (%)

<i>Placement</i>	<i>0 - 11 years</i>	<i>12 - 18 years</i>
Home	8	7
Extended Family	1	1
Foster Care	3	2
Independent Living	0	13
Remain with Caregivers	12	6
Adoption	13	2
Other	4	2
Unknown	58	65

The most striking feature of both of the above tables is the percentage of "unknowns" for the anticipated length of stay and planned future placement. This would appear to indicate that many young people are living their lives in a state of limbo, not knowing with any certainty how long they will be maintained in their current placement or where they will be going when they leave. This runs contrary to the concept of permanency planning.

The very low percentage of children and youth returning home is perhaps most surprising. It is impossible to ascertain the exact reasons for this without going through the files of each young person. Speculation could lead in a number of directions, from the idea that only those children who absolutely can not live at home, under any circumstances, are coming into care; young people are being left at home so long that by the time they come into care it is too late to preserve the family; or the possibility that there is a need to place much more emphasis on family reunification while children are in care and allocate more services and resources in that direction.

Given the early traumatic experiences of many children who end up in care, it is imperative that all young people have treatment or intervention plans that focus not only on their current presenting issues, but their presenting problems at intake and issues related to the early experiences in their family of origin. There must also be a co-ordinated effort on behalf of all professionals and agencies involved with each young person to work together in the best interests of the child. To that end, the survey looked at the number of young people with treatment plans and ISSPs in place. The results are depicted in Table 7 and Table 8:

Table 7: Treatment Plan in Place (%)

	<i>0 - 11 years</i>	<i>12 - 18 years</i>
Yes	70	65
No	30	34

Table 8: ISSP in Place (%)

	<i>0 - 11 years</i>	<i>12 - 18 years</i>
Yes	30	56
No	59	42

While the majority of young people do have treatment plans, a large percentage do not. Furthermore, most young people in the care of the Director of Child, Youth and Family Services do not have an ISSP in place. This data raises the question as to whether or not there is a correlation between the percentage of young people with treatment plans and/or ISSPs and the number of "unknowns" identified for planned length of stay in current placement and future placement plan.

Table 9 indicates the degree to which the model of co-ordination of services (ISSP) is working for each young person, as determined by the social worker. The percentages in this table are based on the number of respondents to this question, which was only applicable to those young people with ISSPs in place. The results are as follows:

Table 9: Satisfaction with ISSP (%)

<i>Satisfaction Rating</i>	<i>0 - 11 years</i>	<i>12 - 18 years</i>
1 (not at all)	4	3
2	4	9
3	20	25
4	48	46
5 (very)	25	17

*\* ratings based on number of respondents, n = 303*

It appears that the Coordination of Services Model is working at least fairly well for the majority of young people in care who have an ISSP. There are some young people, however, for whom this process has been rated as completely unsatisfactory. Closer examination of the data has revealed that there are differences in the satisfaction ratings of the ISSP process for young people who are in foster homes versus those in residential placements. These differences will be explored in a later section.

In addition to the placement itself, children and youth in care are often provided with a variety of additional services. Table 10 outlines the ancillary services provided to young people while in care:

Table 10: Other Services Utilized by Child (%)

<i>Services</i>	<i>0 - 11 years</i>	<i>12 - 18 years</i>
Psychiatric	11	15
Psychological	11	7
Counselling	27	40
Speech-Language	19	5
Recreational	32	24
Special Education	20	20
Specialized Medical	15	8
Respite	39	28
CMS/BMS	23	16
Tutoring	13	23
Other	16	8

The most commonly provided services are counseling, recreational services, and respite. Many young people are receiving multiple services. It is interesting to note that only 20% of all young people are receiving special education services, while 29% of 0 - 11 year olds and 30% of 12 - 21 year olds had special education needs at intake, and 33% of 0 - 11 year olds and 37% of 12 - 21 year olds have current special education needs. Perhaps there is a correlation between these statistics and the percentage of young people with irregular school attendance.

The last question in this section ranked the impact of the current placement, as determined by the social worker. The results are in Table 11:

Table 1: Impact of Current Placement (%)

<i>Impact</i>	<i>0 - 11 years</i>	<i>12 - 18 years</i>
1 (negative change)	0	1
2	0	3
3 (no change)	10	15
4	31	37
5 (positive change)	57	41

The majority of placements were ranked as having a positive impact on the young person, particularly in the younger age group. It is difficult to interpret the data further without more information, although these figures do seem to correlate with previous stats that indicate the occurrence of progress or positive change for some young people while in care. The ranking of 3 (no change) is the most ambiguous; in some cases, it meant that the needs of the young person could not be met in the placement and there was no progress noted; in other cases, it

meant that there were no issues or behaviors at intake and no change required. It must be pointed out that this question was subjective in nature, and open to interpretation by each social worker. What one worker considered to be a positive impact could have been considered no change by another worker. There was not always a correlation, on individual surveys, between the response to this question and the child's current presenting issues.

Social workers were asked to indicate a more appropriate placement for the child, if applicable. Following are examples of the responses to this question:

- "Adoption or permanent caregiving home"
- "Caregiver home with no other children, with caregivers specially trained to deal with child"
- "Placement within the province"
- "Placement until age 16"
- "Secure custody"
- "Group home"
- "Caregiver home trained in attachment"
- "Extended family"
- "Supportive residential placement with staffing"
- "Semi-independent living arrangement"
- "Home with parents"

The above responses indicate a lack of appropriate placement resources for some young people and, to some extent, the frustration of social workers in having to place young people in situations that they do not deem to be most suitable.

#### **Placement History**

As outlined in the literature review, the more placements a young person must endure, the more difficult it becomes for him/her to develop meaningful attachments and the more resistant he/she becomes to future interventions. It is important, therefore, to know how many placements the children of Newfoundland and Labrador are experiencing while in care, and where they are being placed. Table 12 shows the placement history by type of placement, ranging from foster homes to out-of-province treatment. This covers all current and previous placements and includes open and closed custody.

Table 12: Placement History (%)

<i>Type of Placement</i>	<i>0 - 11 years</i>	<i>12 - 18 years</i>
Foster Home	98	67
EPU	7	13
Group Home	0	9
ILA	1	2
Out of Province Treatment	1	2
Custody (Open & Closed)	0	11
Relative Placement	9	13
Board & Lodging/Bedsetter/ Apartment	0	13
Other	1	3

Clearly, foster homes are the most prevalent placement option for young people in care. While this is generally recognized as the most appropriate placement for the majority of young people, problems arise when young people who are not necessarily suitable for a foster home must go there anyway because it is either perceived as the preferred placement option, or because there is nothing else available. This can lead to young people having multiple foster home placements and racking up continuous failures until the appropriate resources are provided. The number of placements experienced by young people in care is presented in Table 13:

Table 13: Number of Placements (%)

<i>Number of Placements</i>	<i>0 - 11 years</i>	<i>12 - 18 years</i>
One	42	41
Two to five	50	47
Six to eleven	7	10
Twelve to eighteen	.5	1
More than eighteen	0	0

It is encouraging that many young people have only experienced one placement while in care. Unfortunately, the majority have had multiple placements, with some young people experiencing up to 18 moves. While, in many of these cases, the movement appears to be related to the behaviors of the young person, and the quest to find a suitable placement, in other cases, it is unclear why the child has moved so many times. For example, a four month old baby has been in four foster homes; a one year old child has been in three foster homes; and a thirteen year old boy, with few behaviors, has been in eight foster homes in less than two years. These are statistics that can not be ignored. What will be the presenting issues of the four month old and one year old in ten years, and will they be the result of family history, or experiences in care?

The status of young people in care is presented in Table 14 below:

**Table 14: Care Status (%)**

<i>Status</i>	<i>0 - 11 years</i>	<i>12 - 18 years</i>
Child Welfare Allowance	.5	2
Permanent Care	52	46
Temporary Care	36	9
Voluntary Care	2	4
Interim Care	6	1
Youth Services Agreement	0	34

The majority of young people are in permanent care. The difference between this percentage and the percentage of young people who are being adopted or remaining with current caregivers, which is much lower, is noteworthy. Although only a small percentage of children are in interim care, this figure is somewhat concerning because it mostly pertains to children under five and appears to be holding up the process of permanency planning. In some cases, children were in foster homes for more than two years, in interim care, and long term planning was not possible. Although this is an issue related to Family Court and, as such, out of the jurisdiction of Child, Youth and Family Services, it must still be addressed at some level.

A very small percentage of children and youth were reported to be in a Child Welfare Allowance placement. This is not an accurate reflection of the situation. Although the survey was intended to include these children, this was not stated clearly enough and some regions did not provide the information for these young people.

The total amount of time that young people have spent in the care of the province is presented in Table 15:

**Table 15: Length of Time in Care (%)**

<i>Length of Time</i>	<i>0 - 11 years</i>	<i>12 - 18 years</i>
1 - 6 months	17	18
7 - 12 months	12	10
1 - 2 years	24	13
2 - 5 years	30	19
5 - 10 years	16	20
More than 10 years	1	15

Children and youth who enter care appear to stay there for extended periods, with the majority in care for one year or more. They also appear to leave in less than five years - only 35% of young people ages twelve and up have been in care for more than five years. These figures

appear to go hand in hand with the data from Table 14, Care Status. The percentage of young people in permanent care is similar to the percentage of young people in care for more than two years. It would be interesting to know at what ages all of these young people entered care. For example, if a young person entered care at twelve years, and was granted permanent care status because issues in the family precluded his returning home, should he have entered care earlier? What is the impact of taking children into care at a younger age versus an older age? Where do young people go when they leave permanent care? It is difficult to interpret this data further without other correlate information.

### Family and Community Contact

The involvement of family and the presence of community supports have been found to be critical elements of post-discharge success. It is therefore important to know the status of family involvement and community support for young people in care in this province. This information is presented below in Table 16 and Table 17:

**Table 16: Optimal Family Involvement in Case and Treatment Planning**

<i>Family Involvement</i>	<i>0 - 11 years</i>	<i>12 - 18 years</i>
Yes	68	61
No	31	37

**Table 17: Support System in the Community for Child**

<i>Support System</i>	<i>0 - 11 years</i>	<i>12 - 18 years</i>
Yes	91	92
No	7	7

The question on family involvement referred to "optimal" family involvement. In some cases, social workers who answered "no" to this question indicated ways in which family involvement could be increased. In other cases, the answer "no" was followed by explanations such as "the child doesn't want contact" or "the child has been in permanent care since birth, there has been no contact." These situations could technically constitute optimal family involvement, given the circumstances, and may have been interpreted as such by other workers. Both questions pertaining to family involvement and community support were subjective in nature.

It is encouraging that so many young people were viewed as having a support system in the community, although in some cases this support appeared to be comprised mainly of professionals.

In addition to services provided to the young people while in care, services are provided to their families. This is outlined in Table 18:

Table 18: Services Provided to Families

<i>Services Provided</i>	<i>0 - 11 years</i>	<i>12 - 18 years</i>
Parent Coach	18	5
Respite	30	21
Behavioral Aid	1	1
Family Support	47	29
Child/Behavior Management Specialist	17	7
Counselling	37	29
Babysitting	24	7
Other	37	23

This question was designed to get at services provided to the natural families. The wording of the question was not specific enough, however, and it appears that many workers answered the question as it pertained to the foster family. Regardless, a significant number of services are being provided to natural and/or foster families.

Percentages in the "other" category were high in this section. The items identified for this category primarily included transportation, access funding, and tutoring.

The last question in the survey asked about services the family receives from other agencies. The most common response included all services provided by the Janeway.

### **Young People in Residential Placements**

It is generally assumed that young people who require a residential placement have more challenging and complex needs than those who can be successfully maintained in a standard foster home. To determine whether this is, in fact, an accurate assumption, data was pulled out of the overall data pool for young people who are currently in, or had previously been in, a residential setting. Placements considered to be "residential" were group homes, open and closed custody, individual living arrangements (ILAs), and out-of-province treatment. Emergency placement units were not included, because young people enter these programs for a variety of reasons and do not necessarily require long-term residential care.

Open and closed custody were included because, even though they are provided through Youth Corrections, they are residential placements that are utilized by young people in care. The frequent use of these placements may, in fact, indicate the need of some young people for programs with a higher level of structure and containment than that currently provided by Child, Youth and Family Services.

Once the data was gathered for the group of young people with residential placements, it was then further delineated to look at the demographics of young people who have been, or are currently in, ILAs or out-of-province treatment.

In total, there were 64 young people in the residential placement group (11% of the in-care population), and 16 of these (3% of the in-care population) were pulled out for the ILA/out-of-province treatment group. A breakdown by region is provided below:

<i>Region</i>	<i>Residential Placement</i>	<i>ILA/Out-of-Province Treatment</i>
Western	4	2
Eastern	2	1
Grenfell	0	0
Central	2	2
Labrador	10	5
St. John's	46	7

*\* n = 64, all young people in the second group are included in the first group*

A comparison was made between the three groups: all young people in care, those in residential placements, and those in ILAs or out-of-province treatment. It must be kept in mind that these are not pure comparisons, since the data from each sub-group is also included in the larger group. Any differences noted would be even greater if all three groups were completely distinct.

Table 19 on the next page outlines the child history for each group:

**Table 19: Characteristics of Child History (%)**

<i>History</i>	<i>Residential Placement</i>	<i>ILA/Out-of-Province</i>
Sexual Abuse	19	25
Physical Abuse	41	50
Neglect	61	81
Emotional Abuse	52	63
Witness to Family Violence	36	56
Family Breakdown	53	44
Family Violence	39	56
Medical Concerns	14	25
Family Substance Abuse	41	63
Family Criminal Involvement	42	31
Family Psychiatric Disturbance	33	44
Other	9	13

Since the age range of these young people is from 11-17, the most accurate comparison is with the 12 - 21 age group. There do not appear to be any significant differences between the young people in the residential placement group and those in the overall in-care population in this area. Young people in ILA's and out-of-province treatment, however, scored higher than the other two groups in many areas, most notably sexual abuse, neglect, witness to family violence, family violence, family substance abuse, and family psychiatric disturbance.

The data on presenting issues at intake and in current placement contain many differences between the groups, as shown in Table 20 and Table 21:

Table 20: Residential Placement

<i>Issue</i>	<i>Intake</i>	<i>Current</i>
Developmental Delay	17	19
Substance Abuse	30	25
Depression-Anxiety	19	25
Self-Harming Behavior	23	8
Negative Peer Involvement	53	44
Violence Toward Other	55	28
Running Away	41	17
Prostitution	2	5
Age-Inappropriate Sexual Behavior	25	11
Attachment Disorder	5	8
ADD/ADHD	16	19
Conduct Disorder	3	5
Other Psychiatric	5	8
YOA Involvement	42	52
Special Education Need	47	50
Irregular School Attendance	50	41
Language-Speech Concerns	3	5
Extreme Defiance-Oppositional Behavior	44	30
Verbally Abusive	53	39
Severe Parent-Child Conflict	53	30
Severe Sibling Conflict	19	9
Other	3	6

Table 21. ILA/Out-of-Province

<i>Issue</i>	<i>Intake</i>	<i>Current</i>
Developmental Delay	44	38
Substance Abuse	25	13
Depression-Anxiety	38	44
Self-Harming Behavior	50	6
Negative Peer Involvement	75	31
Violence Toward Other	69	31
Running Away	56	19
Prostitution	0	0
Age-Inappropriate Sexual Behavior	25	13
Attachment Disorder	19	25
ADD/ADHD	19	25
Conduct Disorder	0	13
Other Psychiatric	6	19
YOA Involvement	25	50
Special Education Need	81	83
Irregular School Attendance	63	38
Language-Speech Concerns	6	6
Extreme Defiance-Oppositional Behavior	75	44
Verbally Abusive	69	44
Severe Parent-Child Conflict	31	19
Severe Sibling Conflict	19	0
Other	13	13

Young people in residential care had much higher percentages at intake of substance abuse, self-harming behavior, negative peer involvement, violence towards others, running, inappropriate sexual behavior, special education needs, irregular school attendance, and verbal

abuse. Young people in ILAs and out-of-province treatment not only scored higher in these areas than the overall population, but were significantly higher than the residential group in many areas. The most noteworthy differences occurred in the areas of developmental delay, depression-anxiety, attachment disorder, negative peer involvement, violence towards others, special education needs, and irregular school attendance.

A comparison of current presenting issues continues to show differences between the three groups. Young people in residential care scored higher than the overall group on substance abuse, depression-anxiety, negative peer involvement, attachment disorder, ADD/ADHD, special education needs, and irregular school attendance. There was some reduction in behaviors from intake to current placement for this group, most notably in extreme defiant-oppositional behavior, verbal abuse, and severe parent child conflict.

Young people in the ILA/out-of-province treatment group show increases from intake in depression-anxiety, attachment disorder, ADD/ADHD, conduct disorder, and other psychiatric disorder, most of which are a result of increased diagnosis rather than behavioral change. In almost all other categories, there were reductions in behaviors from intake to current placement. The most significant were in the areas of self-harming behavior, negative peer involvement, violence towards others, running, age-inappropriate sexual behavior, irregular school attendance, extreme defiance-oppositional behavior, and verbal abuse. Although these were, in some cases, drastic decreases, the percentages for this group are still higher in most categories than for the other two groups.

The length of time in current placement is presented in Table 22 below:

**Table 22: Length of Time in Current Placement (%)**

<i>Length of Time</i>	<i>Residential</i>	<i>ILA/Out-of-Province</i>
Less than one month	19	25
One to six months	41	38
Seven to twelve months	14	6
More than one year	25	31

For both groups, there were a higher percentage of young people in the current placement for less than one month - 19% and 25%, respectively, versus 9% of all young people in care. Subsequently, a far lower percentage of young people have been in their current placement for more than one year - 25% and 31% compared to 50%. This could be indicative of an increased number of moves for these young people.

The anticipated length of stay in the current placement, and identification of where the young person will go when he/she leaves this placement, are shown below:

Table 23: Anticipated Length of Stay in Current Placement (%)

<i>Length of Time</i>	<i>Residential</i>	<i>ILA/Out-of-Province</i>
Less than one month	2	0
One to six months	13	6
Seven to twelve months	11	13
More than one year	23	19
Unknown at this time	50	63

Table 24: Planned Future Placement (%)

<i>Placement</i>	<i>Residential</i>	<i>Out-of-Province</i>
Home	11	6
Extended Family	2	0
Foster Care	3	0
Independent Living	6	13
Remain with Caregivers	2	0
Adoption	0	0
Other	0	0
Unknown	75	81

The most significant difference here, for both groups, is the lower percentages of young people who will remain in their current placements for more than one year, compared to 42% of all young people in care, and the higher percentage of "unknowns," both for length of stay in current placement and planned future placement.

Data on the presence of a treatment plan and ISSP is shown in Table 25 and Table 26:

Table 25: Treatment Plan in Place (%)

	<i>Residential</i>	<i>ILA/Out-of-Province</i>
Yes	83	100
No	16	0

Table 26. ISSP in Place (%)

	<i>Residential</i>	<i>ILA/Out-of-Province</i>
Yes	63	56
No	38	44

Interestingly, a much higher percentage of young people in both groups have a treatment plan in place, compared to 65% of all children and youth in care (ages 12 - 18), with 100% of young people in ILA's and out-of-province treatment having a treatment plan. This may be a reflection of the mandate of various residential programs to develop and implement treatment plans with the young people; the increased number of professionals involved in the case planning; or the need for more thorough documentation to justify the additional funding required in these situations.

A slightly higher percentage of young people in residential care have ISSPs in place, compared to the general in-care group. There is no difference, however, between the general group and those in the ILA group.

There are significant differences in how well the ISSP process is perceived to be working for young people in both sub-groups versus the larger group. The ratings are shown in Table 27:

**Table 27: Satisfaction with ISSP (%)**

<i>Satisfaction Rating</i>	<i>Residential</i>	<i>ILA/Out-of-Province</i>
1 (not at all)	5	0
2	24	56
3	22	11
4	34	22
5 (very)	15	11

**\* ratings based on number of respondents, n = 41 for residential, and n = 9 for ILA**

ISSPs were rated as not working for 29% of young people in residential care and 56% of young people in ILAs and out-of-province treatment. It appears that the ISSP process becomes increasingly less effective as the needs of children and youth become more complex and challenging. The cause of this is not clear. Does it result from a lack of resources? Is there a correlation between this data and the high rate of special education needs and irregular school attendance by the majority of these young people? Does this data support the commonly held belief that the ISSP process is controlled by the school system? This issue that must be explored further, given that these are the young people for whom effective co-ordination of services is most critical.

Table 27 outlines additional services provided to both groups of young people:

Table 27: Other Services Utilized by Child (%)

<i>Services</i>	<i>Residential</i>	<i>Out-of-Province</i>
Psychiatric	25	38
Psychological	11	25
Counselling	59	50
Speech-Language	3	0
Recreational	38	38
Special Education	27	38
Specialized Medical	5	6
Respite	11	13
CMS/BMS	3	6
Tutoring	13	6
Other	9	13

While the figures are similar for all three groups in many areas, it is worth noting that the provision of some services, such as Child/Behavior Management Specialist, respite, and tutoring, is much lower for the two sub-groups. This may be a result of services not being required because they are provided within the residential placement. Whatever the reason, this finding is an important reminder that the comparison of program costs; i.e., foster homes versus residential, must include all hidden costs and additional services to be truly accurate and reflective of the real costs of placement.

Table 28 below indicates the impact of current placement:

Table 28: Impact of Current Placement (%)

<i>Impact</i>	<i>Residential</i>	<i>ILA/Out-of-Province</i>
1 (negative change)	0	0
2	9	6
3 (no change)	27	31
4	25	19
5 (positive change)	31	50

There is a higher rating of, "negative change" (2) and a significantly higher rating of "no change" (3) for both of these subgroups, compared to the larger group. A higher percentage of placements were rated as "positive change" (4 & 5) for young people in the ILA group versus the residential group. It would be interesting to know if the young people for whom placements were considered to be unsatisfactory are those who had been in a residential placement through Youth Corrections rather than Child, Youth and Family Services. Some of the lower ratings were for young people who had previously been in residential placements and were

now living independently. The data in this section can not be interpreted to measure the impact of current residential placements, since many of the young people included are not in a current residential placement.

The placement history of these young people is depicted in Table 28, followed by Table 29, which shows the number of placements:

**Table 28: Placement History (%)**

<i>Type of Placement</i>	<i>Residential</i>	<i>ILA/Out-of-Province</i>
Foster Home	70	88
EPU	47	6
Group Home	61	50
ILA	16	75
Out of Province Treatment	14	63
Custody (Open & Closed)	63	56
Relative Placement	13	6
Board & Lodging/Bedsetter/ Apartment	9	13
Other	3	13

**Table 29: Number of Placements (%)**

<i>Number of Placements</i>	<i>Residential</i>	<i>ILA/Out-of-Province</i>
Ones	2	6
Two to five	53	63
Six to eleven	23	19
Twelve to eighteen	8	13
More than eighteen	0	0

Obviously, there are differences in the placement histories of these young people versus the overall group, since they were pulled out for that reason. The percentage of young people with foster care placements is about the same for those in residential care and the larger group but higher, at 88% compared to 67%, for those in the ILA/out-of-province group. This may be indicative of the younger age of some of the children in this group and the fact that there are no other alternatives to foster homes available to them. It is also interesting that, in the ILA group, 75% have had ILA placements and 63% have been in out-of-province treatment. The overlap indicates the percentage of young people who have been in both types of placements.

The statistics on number of placements are perhaps the most disheartening, and the most telling. These young people are experiencing a much higher percentage of multiple moves, with more than a third of those in both groups having more than six placements, and only one young

person (who represents the 2% and 6% in each group) having one placement. Our inability to effectively meet the needs of these young people in a timely manner, with the proper resources, has created a situation in which the system designed to help is actually causing further damage.

Table 30 shows the care status of these young people and Table 31 shows the total time they have been in the care of the province:

**Table 30: Care Status (%)**

<i>Status</i>	<i>Residential</i>	<i>ILA/Out-of-Province</i>
Child Welfare Allowance	2	0
Permanent Care	44	63
Temporary Care	13	13
Voluntary Care	9	0
Interim Care	0	0
Youth Services Agreement	30	25

**Table 31: Length of Time in Care (%)**

<i>Length of Time</i>	<i>Residential</i>	<i>ILA/Out-of-Province</i>
one to six months	13	6
7 - 12 months	14	0
1 - 2 years	14	19
3 - 5 years	23	50
5 - 10 years	13	19
more than ten years	11	6

A larger percentage of young people in the ILA/out-of-province treatment group are in permanent care than in the other two groups. Furthermore, the majority have been in care for more than two years. This would appear to even further emphasize the need to provide appropriate care to these young people, and to look at the long term costs of service provision over time, versus the cost of specific programs. A timely, appropriate placement early in care might prevent much more costly placements later on, when the likelihood of success has diminished.

Data on the level of family involvement and community support is presented below:

Table 32: Optimal Family Involvement in Case and Treatment Planning

<i>Family Involvement</i>	<i>Residential</i>	<i>ILA/Out-of-Province</i>
Yes	64	81
No	34	19

Table 33: Support System in the Community for Child

<i>Support System</i>	<i>Residential</i>	<i>ILA/Out-of-Province</i>
Yes	84	81
No	13	19

While community support is somewhat the same for both sub-groups (although lower than for the larger group), family involvement is actually higher for the ILA group than for the other two. The reasons for this are unclear.

Services provided to the family are tabled below:

Table 34: Services Provided to Families

<i>Services Provided</i>	<i>0 - 11 years</i>	<i>12 - 18 years</i>
Parent Coach	19	5
Respite	29	21
Behavioral Aid	1	1
Family Support	46	29
Child/Behavior Management Specialist	16	7
Counseling	37	30
Babysitting	24	8
Other	37	23

These figures are significantly lower for both groups in most areas, with the only exception being counseling for the residential placement group.

Overall, it is obvious that there are significant differences, in many areas, between young people who end up in residential care and those who do not. The data has clearly indicated that there are children and youth in our province with very complex and challenging needs who require a level of service that cannot be provided in the mainstream foster care system. Meeting the needs of these young people demands a coordinated response from all levels of government and government departments, particularly Health and Community Services, Education and Justice, and a thoughtful, long-term approach to placement planning.



**APPENDIX 5**



## Provincial Committee on the Residential & Treatment Needs of Youth

### Child Data Information Form

#### INTRODUCTION

A provincial committee has been established to look at issues related to the residential care and treatment of children and youth in Newfoundland and Labrador. The mandate of this committee is:

1. To develop a plan of action to broaden and improve the residential and treatment options available to children and youth with complex needs and behaviors.
2. To identify policy and program improvements that would lead to earlier identification and intervention of children and youth with complex and challenging behaviors.

In order for the committee to fulfill its mandate, it is necessary to have an accurate profile of all young people who are currently in the care of the Director of Child, Youth and Family Services in the province. The information gathered in this survey will provide a crucial snapshot of who is in care across the province, the services they need, and the resources that are currently dedicated to these young people. This information will also provide us with a way to accurately assess the gaps in services and provide recommendations for change and improvement.

#### INSTRUCTIONS

**Your completion of this survey is an essential part of assisting in the development of an effective and sustainable model of care for the children and youth of this province.**

1. Individual forms are to be completed on all young people, between the ages of birth to eighteen, in the care of Child, Youth and Family Services.
2. Please do not write a child or family name anywhere on this survey, as we want to ensure that the confidentiality of all individuals will be protected.
3. To further protect confidentiality of the individuals, results of the survey will only be presented in aggregate form on a regional or provincial basis.
4. Please write legibly using blue or black ink.
5. If you require extra space, please use the back of the form.
6. **Completed surveys are to be returned to the office of the Director in the Region no later than April 23, 2003.**

### 1. Demographics

Region: \_\_\_\_\_ Office/Site: \_\_\_\_\_

Age of Child: \_\_\_\_\_ Gender: M  F

- Ethno-Racial Group  
 White  
 Aboriginal  
 Other: \_\_\_\_\_

### 2. Child/Youth Profile

2.1 We are looking for information on the child's history prior to placement. Please indicate which of the following are applicable for this child, **checking all that apply**

- Sexual abuse  
 Physical abuse  
 Neglect  
 Emotional abuse  
 Witness to family violence  
 Family break-down  
 Family violence  
 Medical concerns  
 Substance abuse in the family  
 Criminal involvement in the family  
 Psychiatric disturbances in the family  
 Other (Please list): \_\_\_\_\_

2.2. We are looking for all presenting problems/diagnoses at the time of the child's initial placement with Child, Youth and Family Services. Please indicate which of the following are applicable for this child, checking all that apply:

- Developmental Delay  
 Substance abuse  
 Depression-Anxiety  
 Self-harming behaviour  
 Suicidal  
 Self-mutilation  
 Negative Peer Involvement  
 Violence towards Others  
 Running Away  
 Involvement in Prostitution  
 Age-inappropriate Sexual Behaviour  
 Psychiatric Disorder (Please list): \_\_\_\_\_  
 Criminal-YOA Involvement  
 Special Education Needs  
 Irregular School Attendance  
 Language-Speech Concerns  
 Extreme Defiance-Oppositional Behaviour  
 Verbally Abusive  
 Severe Parent-Child Conflict  
 Severe sibling Conflict  
 Other (Please list): \_\_\_\_\_

2.3. We are looking for all problems/diagnoses that currently exist with the child, in his/her present placement. Please indicate which of the following are applicable for this child, checking all that apply:

- Developmental Delay
- Substance abuse
- Depression-Anxiety
- Self-harming behaviour
- Suicidal
- Self-mutilation
- Negative Peer Involvement
- Violence towards Others
- Running Away
- Involvement in Prostitution
- Age-inappropriate Sexual Behaviour
- Psychiatric Disorder (Please list)
- Criminal-YOA Involvement
- Special Education Needs
- Irregular School Attendance
- Language-Speech Concerns
- Extreme Defiance-Oppositional Behaviour
- Verbally Abusive
- Severe Parent-Child Conflict
- Severe sibling Conflict
- Other (Please list) \_\_\_\_\_

### 3. Placement Experience

3.1 Please indicate the length of time the child has spent in his/her current placement:

- less than one month
- one to six months
- seven to twelve months
- more than one year

3.2 What is the anticipated total length of stay in the current placement?

- Less than one month
- One to six months
- Seven to twelve months
- More than one year
- Unknown at this time

3.3. Where will the young person be going when he/she leaves the current placement?

- Home
- Extended family
- Foster care
- Independent living situation
- Group care
- Other (Please list)
- Unknown at this time

3.4. Is there a treatment plan in place for this young person? Yes  No

3.5. Is there an ISSP? \_\_\_\_\_



**5. Family and Community Contact**

5.1. In your opinion, is the family optimally involved in the case and treatment planning for this young person?

Yes  No

5.2. If you answered **No** to #1, please indicate what you think could be done to further engage the family:

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5.3. Does the child have a support system in the community (which may or may not include family members)?

Yes  No

5.4. Please check any of the following services the program (H&CS) provides for the family:

- Parent Coach
- Respite
- Behavioral Aid
- Family Support
- Behavior Management Specialist
- Counseling
- Babysitting
- Other (please list): \_\_\_\_\_

5.5. List any known types of services the family receives from other agencies:

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**Thank you for taking the time to complete this survey!**



**APPENDIX 6**



**Provincial Committee on the Residential and Treatment Needs of Children and Youth****Regional Survey - Director in Region for CYFS****Introduction**

A provincial committee has been established to look at issues related to the residential care and treatment of children and youth in Newfoundland and Labrador. The mandate of this committee is:

1. To develop a plan of action to broaden and improve the residential and treatment options available to children and youth with complex needs and behaviors.
2. To identify policy and program improvements that would lead to earlier identification and intervention of children and youth with complex and challenging behaviors.

In order for the committee to effectively meet its mandate, a Child Data Information Form is being distributed to all regions to gather information on all young people currently in the care of the Director of Child, Youth, and Family Services.

At the same time, the Regional Survey is being distributed to the Directors in Region for CYFS for all Regional Boards in the province to gather information related to the prevalence of young people in each region who are considered to be the most challenging and complex, and the costs of providing services to this group.

Your participation in this survey will assist the committee to compile accurate information with regard to resources currently being utilized so that we may develop realistic recommendations for new program development based on current funding levels.

**Instructions**

**Your completion of this survey is an essential part of assisting in the development of an effective and sustainable model of care for the children and youth of the province.**

1. Please write legibly, using blue or black ink.
2. If you require extra space, please use the back of the form or attach an extra sheet.
3. **Completed surveys are to be returned to the Provincial Committee on the Residential and Treatment Needs of Youth, c/o Heather Modlin, no later than April 2, 2003.**

**\*\* Contact information for Heather Modlin is as follows: phone: 368-6101; fax: 368-6121; email: [j.modlin@roadrunner.nf.net](mailto:j.modlin@roadrunner.nf.net); mailing address: P.O. Box 632, St. John's, NL, A1C 5K8**

**General Questions**

Region: \_\_\_\_\_

1. What do you think is the biggest gap, **in your region**, in the continuum of services available to children, youth, and families?

2. What do you think is the biggest gap, **in the province**, in the continuum of services available to children, youth, and families?

3. Have you observed any trends in child welfare over the past five years that you would like to comment on?

**Financial Questions**

1. How many young people in your region are currently living in Individual Living Arrangements?  
\_\_\_\_\_  
\_\_\_\_\_
2. How many young people in your region are currently in out-of-province treatment?  
\_\_\_\_\_
3. What are the yearly costs of ILA's or out-of-province treatment in your region? (Please include all costs, including travel, long distance teleconferencing, etc.)  
\_\_\_\_\_  
\_\_\_\_\_
4. How many FTE's would you estimate are dedicated solely to the work of this group?  
\_\_\_\_\_  
\_\_\_\_\_
5. What are the yearly costs of other high need cases in your region, i.e. young people who are still at home or living in foster care, whose placements are considered tenuous and at risk of breakdown within the next twelve months?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
6. How many young people would currently fit in the above category in your region?  
\_\_\_\_\_

**Thank you for taking the time to complete this survey!**

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