



Residential Review Project Phase One Findings Report



THE FEDERATION
of COMMUNITY SOCIAL SERVICES of BC



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Residential Review Project

Phase One - Findings Report

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Executive Summary

The Ministry of Children and Family Development (MCFD) and the Federation of Community Social Services of BC (Federation) are undertaking a joint review of residential care services provided by MCFD. The Residential Review and Redesign Project (Project) is consistent with the directions set in MCFD's *Strong, Safe and Supported Operational Plan*. The desired outcome of the Project is to improve the experience and outcomes for children and youth who must, for some reason, be placed in a residential care setting. The Project crosses all service streams: child welfare and children with special needs (CYSN) residential services provided under the auspices of the *Child, Family and Community Services Act (CFCS Act)*, youth justice custodial and residential services delivered under the federal *Youth Criminal Justice Act (YCJA)* and provincial *Youth Justice Act*, and child and youth mental health (CYMH) services delivered under the *Mental Health Act*. It also includes, although to a lesser degree, other types of residential services that are accessed by children and youth who are concurrently served by MCFD and health authorities, such as residential services for problematic substance use and hospital-based mental health facilities.

The Project scope encompasses the full range of residential services including kinship care, foster care, contracted/staffed residential care and tertiary care. It is not restricted to an identification of what resources are available or insufficiently available but also includes how those resources are developed, supported, and accessed. Matters such as policies and procedures, recruitment and procurement practices, training, human resource supports and related concerns that directly support the operation of the residential care system are in scope.

The Project has three phases. The purpose of Phase One is to describe the current residential services system for children and youth, collect and reflect what diverse stakeholders and researchers have to say about residential care, including what works well and what does not work well, and ways that services and care might be improved or enhanced. The results will set the stage for Phase Two which will identify key opportunities for residential redesign and develop short and longer-term recommendations for action. In Phase Three, MCFD will review the findings and recommendations from four reports – the over-arching joint report of the Federation and MCFD, a more specific report resulting from Aboriginal consultations, and more focused kinship care and tertiary care reports – to inform the development of a MCFD five-year strategic plan for redesign of the residential services system, from kinship care through to tertiary care.

This report summarizes the results of Phase One of the Project. Included are findings from stakeholder and community consultations, and from reviews of relevant literature on residential services for children and youth, previous reviews and reports that have addressed residential services in BC in some way, similar reports and initiatives undertaken in other jurisdictions, and available data on residential services in BC. Although the Project is inclusive of the full range of residential care, this report primarily focuses on foster care and staffed residential care as this is where the

majority of children and youth are served.

A substantial amount of information has been collected in phase one, and diverse perspectives have been reflected in consultations, the academic literature and through a multi-jurisdictional review. However, four key themes emerged:

Achieving Permanency – As the Project progressed it became very clear to the Project Team and Advisory Group that a strong emphasis needed to be placed on achieving permanency for children and youth (i.e., maximizing family, community and cultural connectedness and stability) as the framework or organizing principle around which residential services are provided. Within the child welfare system, which accounts for 95% of all residential services, placement in residential care is often viewed as a solution to concerns about a child's need for protection (i.e., a goal of "ensuring safety") rather than a means to achieving security, stability and lifelong connections (i.e., a goal of "ensuring permanence"). For the purposes of this review, the Project Team drew on the work done by the BC Federation of Youth in Care Networks (FBCYICN)¹ and others that describe three dimensions of permanency: relational permanency, legal permanency and physical permanency.

Delivering an Accessible Array of Residential Care Services – There was general consensus that a diverse and comprehensive array of residential services and supports are needed along some type of a continuum, based on level of intervention required or style of care, for example, from kinship care to facility-based or tertiary level care, or from normative care and nurturing to intensive treatment and rehabilitation. Access to diverse options was seen to be particularly important due to the complexity of needs that many children and youth have and the efficacy of matching their needs to the characteristics and skills of the residential placement.

Access to an array of residential care options and supports was approached from various angles, including geographic access (especially in rural communities), timeliness of access, the "gatekeeping" of access through referral processes and eligibility criteria, and access to non-residential supports such as mental health counselling or substance withdrawal management (detox) in order to sustain residential placements such as foster care. There was also considerable discussion about access to emergency care, respite for birth families, and relief for foster caregivers.

Strengthening Foster Care – Participants in the consultation sessions were particularly interested in and concerned about foster caregivers.² Recruitment and selection, education and training, supervision, support, recognition and compensation

¹ See Federation of BC Youth In Care Networks 2010 report, *Belonging 4 Ever – Creating Permanency for Youth In and From Care*, p. 6. and Stott and Gustavson, 2010.

² The most commonly used terms in the system referring to people who provide alternative family-based, residential care to children and youth are 'foster parent' and 'foster family' and the majority of consultation session participants used these terms. However, in the findings report, we have used the term 'caregiver' to be consistent with the term used in the CFCS Act as well as MCFD standards and policies. This also serves to distinguish between the parental status of birth and adoptive parents and that of foster caregivers who take on a care giving, nurturing, temporary or shared parental role in looking after children and youth in care, but who are not the child's parent.

were identified as key factors in the development and retention of a strong and diverse range of foster caregivers.

The findings suggest that the supply of skilled foster family care homes needs to be increased. Enhanced supply would enable better matching of the child or youth's needs and the foster caregiver's skills and circumstances, as well as prevent the "overloading" of foster homes – both of which can be key factors in placement disruptions and breakdowns. To increase the supply, strategies to both recruit new foster caregivers and retain or re-engage approved foster caregivers were considered. Foster caregiver training and education was frequently discussed in consultation sessions, and while acknowledged as being very important, there were diverse views on how best to design, deliver and monitor training.

A broad range of meaningful "direct support" for foster caregivers was described both by consultation participants and in the literature. Direct supports ranged from basic courtesies such as having MCFD workers return phone calls promptly, to including caregivers in case planning meetings and valuing their input, to managing the number of children in homes, to sharing information and offering situation-specific training or counsel, to providing relief resources. "Indirect support" was also discussed; by ensuring that the child/youth in their care is receiving the specialized supports that he/she needs, such as mental health counselling or treatment for problematic substance use, the foster caregiver is more likely to feel supported.

Working Together – All sources of information spoke to the value of diverse parties working together in the interests of children and youth. Healthy and productive relationships in the caring systems appear to make a positive difference on a number of fronts. This includes relationships between: MCFD staff, foster caregivers and community service providers; MCFD staff and young people in residential care and their birth families and kin; caregivers and birth families; and amongst service delivery partners in communities.

The topics of respect and value, communications and information sharing, collaboration and teamwork, and systems coordination are addressed in this report. Healthy relationships were characterized by: mutual respect and appreciation for diverse roles, responsibilities and contributions; respectful and timely communications between and amongst the parties concerned about children and youth in residential care, including the youth themselves; willingness to have difficult conversations and work through challenges together; openness to "not knowing" and to figuring things out together when difficult situations arise; the absence of fear or concern about judgments or repercussions (e.g., withdrawal of funding or support); and a sense of "being in this together" and of "not being alone".

All of the phase one sources of information touched on how the residential care system is designed or structured and how it relates to other systems. The findings relating to systems design and coordination address the roles and responsibilities of the personnel involved, the organizational structure of the system and the roles undertaken by MCFD and the community social services sector, how different parts of the residential care

system are linked (e.g. child welfare/protection, child and youth mental health, youth justice and addictions), how residential services are supported by or interact with other systems both within and external to MCFD, and how the notions of “wraparound” services are expressed.

There were also **Other Issues** which arose, albeit less frequently that are also discussed in this report, notably funding, legal and court services, and accountability.

The Project Team also met with youth in each of the five regions to incorporate **Youth Perspectives** in this review. The themes that arose in these conversations were consistent with those arising in the general focus groups and stakeholder sessions. However, the intensity of experiences – both positive and negative – and the detailed descriptions and analysis provided by the participants was remarkable. A section of the findings report aims to share the youth perspective on the key themes in the youths’ own words. The Project Team also reviewed a number of BC reports prepared by the Federation of BC Youth in Care Networks that speak to residential care issues and opportunities for improvements.

This detailed findings report will be complemented by a shorter summary report, both of which will be broadly distributed. These reports set the stage for phase two of the Project, which will encompass key informant interviews, an online survey and working sessions, leading to the identification of prospects and opportunities for improving the experience and outcomes for children and youth in residential care.

Part One – Overview of the Residential Review and Redesign Project

A. Introduction

This report summarizes the results of Phase One of the Residential Review and Redesign Project (the Project), which is a joint effort of the Federation of Community Social Services of BC (the Federation) and the Ministry of Children and Family Development (MCFD). Included in this report are findings from stakeholder and community consultations, and from reviews of relevant literature on residential services for children and youth, previous reviews and reports that have addressed residential services in BC in some way, similar reports and initiatives undertaken in other jurisdictions, and available data on residential services in BC. These findings describe the current residential services system for children and youth and what diverse stakeholders and researchers have to say about it, including what works well and what does not work well, and ways that services and care might be improved or enhanced. The report sets the stage for Phase Two of the Project, which is to identify key opportunities for residential redesign and develop short and longer-term recommendations for action.

Part One of the report includes the following:

- Background information – Describes the context, purpose and scope of the Project.
- Approach – Describes how the information that is presented in this report was gathered.
- Statistical Overview – Presents descriptive and statistical information about the current system of residential care in BC.

Part Two provides an overview of key themes – highlighting the key issues and ideas that arose during phase one, including some issues that are important to, but beyond the scope of, this review.

Parts Three through Eight present detailed findings organized by theme. Within each of the parts, the findings from community and stakeholder consultations, and the reviews of academic literature, reports and plans from BC and other jurisdictions are summarized. The Project Team's commitment in each of these sections is to share what was learned without judgment, debate or prioritization. The sections are:

- Achieving Permanency – Presents findings related to maximizing family, community and cultural connectedness and stability. To more successfully achieve permanency for children and youth in residential care became the over-arching systemic goal for the residential review and redesign project.
- Delivering an Accessible Array of Residential Care Services – Presents findings pertaining to the array of residential services and the adequacy of and access

to that array, (e.g., the residential care options that are and should be available, availability of those options across BC, gaps in service, the quantum of and balance between residential options).

- Strengthening Foster Care - Presents perspectives on how foster caregivers can be more effectively recruited, trained, supported and retained.
- Working Together - Presents findings on the challenges of working together across disciplines, service streams and ministries and how diverse practitioners and systems might work better together to deliver high quality residential care and service.
- Other issues - Addresses findings related to funding, legal and court services and accountability.
- Youth perspectives - Presents findings from consultation sessions with youth, noting how they align with, enhance or diverge from the key themes noted above. Key reports on the experience of youth in care, particularly in relation to residential services and permanency, are highlighted.

Part Nine describes our next steps, Phase Two of the project and how the report will be used.

Appendices provide more detailed information on Project approach and methodology, participant demographics, articles and reports reviewed, etc. to supplement the findings reported in the body of the report.

B. Background

1. Origins of the Project

This Project arose out of the government endorsement and release in 2008 of *Strong, Safe and Supported: A Commitment to B.C.'s Children and Youth*, a document that sets out guiding principles for MCFD and the child, youth and family service system. These principles state that services, and the way services are provided, are to be strengths-based, rights-based, child-focused, family and community centered, transparent and accountable, holistic and needs-based, the latter specifically stating that: "A continuum of integrated supports and services will be available and accessible to vulnerable children, youth and families."

Intervention and Support, which is Pillar #3 of the *Strong, Safe and Supported* framework and which includes residential services, provides that: "Government will provide intervention and support based on the assessment of individualized needs."

The foundation for the assessment of individualized needs is being laid through the implementation of practice changes which include a developmental assessment (and where appropriate, additional specialized assessments such as mental health or FASD) of the child or youth, the development of a plan to address basic and developmental

needs, and evaluation of progress in achieving specifically identified outcomes set out in that plan.

The concurrently released *Operational Plan 2007-2012 for Strong, Safe and Supported* identified a number of key actions in relation to each of the five pillars, specifically identifying "redesign of residential care services" under Pillar #3. The *Operational Plan* also identified two other key actions that directly relate to residential redesign: a review and revision of the kinship care program and an increase in recruitment and retention of foster caregivers and other caregivers.

Concurrent with MCFD's identification of residential redesign as a priority, the Board of Directors of the Federation identified residential services as one of the top priorities for Federation review and action based on concerns raised by member organizations, which include foster caregiver associations and agencies that provide staffed residential services. Given the alignment of shared interests, MCFD and the Federation agreed in the spring of 2010 to enter into a partnership to jointly review residential services. (See Appendix A for Project Description)

2. Scope

Residential redesign crosses all service streams: child welfare and children with special needs (CYSN) residential services provided under the auspices of the *Child, Family and Community Services Act (CFCS Act)*, youth justice custodial and residential services delivered under the federal *Youth Criminal Justice Act (YCJA)* and provincial *Youth Justice Act*, and child and youth mental health (CYMH) services delivered under the *Mental Health Act*. It also includes, although to a lesser degree, other types of residential services that are accessed by children and youth who are concurrently served by MCFD and health authorities, such as residential services for problematic substance use and hospital-based mental health facilities.

The Project scope also encompasses the full range of residential services that are broadly categorized into four types:

- Kinship Care - includes the Extended Family Program under Section 8 of the *CFCS Act*, other kin-related Out-of-Care Options available under the *CFCS Act* such as transfer of guardianship to relatives, as well as placements of children in care with relatives through "restricted foster care" (i.e., all circumstances where children in need are assessed and placed with relatives with funding and supports through the *CFCS Act*).³
- Foster Care - includes foster care placements of children in care under the *CFCS Act* (excluding restricted foster care, which is included with kinship care).
- Contracted/Staffed Residential Care - includes contracted, agency-based and staffed residential services such as group homes and shelters but also includes

³ The Child in Home of a Relative Program, which was "capped" in April, 2010 and is being phased out over time through attrition of the current client population, is not included as it is strictly a privately arranged financial assistance program without assessment and support services.

contracted family care-based models of residential services where, for example, agencies recruit, train and provide ongoing support to the family-based caregivers and the child or youth through supplementary staffing and programming.⁴

- Tertiary Care - includes mental health hospital-based facilities designated under the *Mental Health Act* and youth custody centres as well as any future safe care or secure care services that may be developed, all of which are (or would be) directly operated by MCFD or Health Authorities.

The Project is not restricted to an identification of what resources are available or insufficient but also includes analyzing how those resources are developed, supported, and accessed. Accordingly, matters such as policies and procedures, recruitment and procurement practices, training, human resource supports and related concerns that directly support the operation of the residential care system are in scope.

One of the challenges of such projects is clarifying the scope of the inquiry. No system of services can ever be understood or delivered in isolation. The residential services system is, in effect, a sub-system of a complex and much broader cross-ministerial and cross-governmental system of social services supports to children and families. Residential services are, for example, directly affected by the availability of non-residential support services and by other program and practice change initiatives of MCFD, the increased use of collaborative practices such as Family Development Response and Family Group Conferencing, and the increasing devolution of services to and development of services by Aboriginal agencies. Residential services are also affected by systems and services managed by other ministries or entities such as legal and court services managed by the Ministry of Attorney General, income assistance and employment services managed by the Ministry of Social Development, addictions and mental health services offered by Health Authorities, federal funding of on-reserve services to First Nations communities, and adult services delivered by Community Living BC. Decisions made at any governance level – municipal, provincial, federal, First Nations, organizational – can have a direct, indirect or even unintended effect on children, youth and families, and residential services.

Given the inter-connectedness and complexity of systems, it is understandable that issues and ideas were raised in stakeholder and community consultations that are beyond the scope of this review and/or MCFD's jurisdiction. As the Project Team made a commitment to reflect back what was heard through the phase one consultations, these issues and ideas are included in the findings, with notations about what is in scope for this review, and what may need to be addressed through other processes.

3. Residential Services to Aboriginal Children and Youth

Services to Aboriginal children and youth must obviously be addressed in a review of residential services and are crucial to development of any redesign plan. While Aboriginal children comprise about 9% of the BC child population under age 19,

⁴ MCFD defines a contracted/staffed resource as involving a non-family based rotational staffing arrangement (e.g., group home) or placement with a family caregiver in conjunction with at least one FTE of additional staff support to that placement.

they comprise more than one-half of all children in care under the *CFCS Act*, which accounts for the vast majority of the residential services system. There is similar disproportionate over-representation amongst youth in custody under the *YCJA* – 49.8% were Aboriginal in 2009/10.

Stakeholder and community consultations reflected considerable concern and discussion about services to Aboriginal children and youth, especially in relation to over-representation and the cultural appropriateness of services. Broadly speaking, consensus emerged from discussions that urged further movement in the following general directions:

- Aboriginal families and communities need to be much better supported through prevention and early intervention services so that the circumstances that now give rise to the need for child protection and other types of measures that lead to removal from family and community, are avoided.
- Family and community support services and programs for Aboriginal families need to be enhanced and improved so that, when safety and/or other concerns arise, Aboriginal children can be supported within their families and communities instead of being removed from them.
- Services to Aboriginal children and youth should, as much as possible, be provided by Aboriginal peoples themselves including, when placement outside of the family and/or community is required, through Aboriginal kinship placements, Aboriginal foster homes, contracted residential services that are operated and staffed by Aboriginal agencies, and Aboriginal family reunification services.
- When services to Aboriginal children and youth are unable to be delivered by Aboriginal peoples, they should be delivered in culturally appropriate ways that facilitate attachment to Aboriginal culture and community.

Actions along these lines are being taken through initiatives related to Pillar #4 of *Strong, Safe and Supported* (i.e., the Aboriginal approach) as well as Pillars #1 and 2 (i.e., prevention and early intervention).

Representatives from Aboriginal agencies and services were invited to the consultations and many participated, however, the consultations were not exclusively focused on services to Aboriginal children nor limited to only Aboriginal agency and community representatives. Nor would it have been appropriate to do so, given that Aboriginal community leaders themselves should lead such targeted consultations. Accordingly, MCFD, with support from the Federation, has commissioned separate Aboriginal consultations with Aboriginal stakeholders that will be led by Caring for First Nations (on behalf of Delegated Agencies), the BC Association of Aboriginal Friendship Centres and the Metis Commission. The results of these consultations will be reported separately at a later date.

4. Developing a Five-Year Strategic Plan

The joint project of the Federation and MCFD includes the full range of types of residential services but principally focuses on foster care and contracted/staffed residential care provided through the child welfare system. The rationale for this is that the child welfare system accounts for the vast majority of residential care services (see data below) and foster care associations and the majority of agencies that provide residential services are members of the Federation.

MCFD has also established two small teams to more closely examine kinship care and tertiary care services. Kinship care has a distinct plan, process and audience. MCFD started earlier in this area with the announcement of the Extended Family Program in April, 2010. For example kinship arrangements are made directly with extended families without (necessarily) the mediating involvement of foster care or agency services. Similarly, tertiary care services are small in number, highly specialized and all are directly delivered by MCFD or Health Authorities rather than by foster caregivers or contract service providers.⁵

Accordingly, four reports will be produced – the over-arching joint report of the Federation and MCFD, the more specific report on Aboriginal consultations, and the more focused kinship care and tertiary care reports.

These reports, and their attendant recommendations, will inform the development of a MCFD five-year strategic plan for redesign of the residential services system, from kinship care through to tertiary care. The expectation is that the five-year strategic plan will, given the current fiscal climate, involve no-cost and low-cost improvements in the initial years of plan implementation. This may include changes to policies and procedures, training, practices, and communications, enhancements to collaborative work, realignment of existing resources, and the like, before proceeding to address service and resource gaps in the later years of the plan.

C. Approach

1. Guiding Considerations

Foundational considerations that guided the Project included:

- The belief that all children need permanent families who provide safe, stable, nurturing homes and lifelong relationships.⁶
- The view that out-of-home residential placements are critical bridges between the time a child has to live away from their parents and when they return to them, or if reunification is not in a child's best interests, until the child is in a permanent home with relatives or another family.

⁵ The term 'service providers' as used in this report generally refers to staff from community-based service agencies that act in the interests of children and youth who are in residential care.

⁶ The term 'families' (as used in this report) encompasses a diverse array of caring, nurturing relationships that support healthy child and youth development and lifelong connections.

- The intention to ensure that children and youth receive high quality residential care, experience as few placement disruptions as possible, achieve permanence as soon as can be safely arranged, and when necessary, are prepared and supported for the transition to adulthood.

Collectively, the Federation and MCFD have a number of concerns and questions about residential services and believe that services can and must be improved. Available data and reports, including from young people receiving residential care, raised questions about where and how children and youth are placed, the frequency of changes in placements, the length of time they spend in residential care, what their experiences are while in residential care, how they fare as a result of the interventions, how permanent family connections are built, and what outcomes are, and are not, being achieved. The Federation and MCFD agreed that in order to determine how best to improve care and services, the team needed to delve into these questions, gather information from diverse sources, reflect on the information about what works and doesn't work, identify opportunities to improve services and then build a vision and plan for the development and delivery of a high quality, comprehensive and effective residential services system for BC's children and youth.

2. Project Team and Advisors

The Federation and MCFD agreed that this review needed to be guided by people who were very knowledgeable about residential services. A Residential Review Advisory Group was established to provide overall advice and feedback on the project and findings. The Advisory Group is comprised of representatives from MCFD and from the community services sector, across regions and areas of practice. A Project Team was established to carry out the day-to-day work of the review, as is described below. This team is comprised of staff from MCFD and the Federation, working as equal partners, and is co-led by Jennifer Charlesworth, Executive Director of the Federation and Alan Markwart, Senior Executive Director from MCFD. (See Appendix B for list of Project Team and Advisory Group members)

3. Sources of Information

The Project Team and Advisory Group agreed that the review needed to start by building a comprehensive understanding about what is currently available and provided within residential services, how it works, how it fits with the characteristics and needs of children and youth who come into residential care, what the research suggests is effective, and what lessons can be learned from others who have endeavoured to improve residential care. (See Appendix C for methodology details)

Information for Phase One was gathered from six sources as described below:

a. Community and stakeholder consultations

Over 600 people participated in 43 facilitated focus groups held across the province between March and December 2010 (see Appendix D for list of sessions and participant

demographics). Participants included youth, foster caregivers, community service providers, MCFD staff, and community partners such as practitioners from Aboriginal organizations, health authorities, schools and police. In addition, Project Team members met with stakeholder groups such as the Federation of BC Youth in Care Networks, BC Federation of Foster Parent Associations, Provincial Association of Residential and Community Agencies (PARCA), Child and Youth Mental Health and Substance Use Care Advisory Network, and parents from the Provincial Family Council for Child & Youth Mental Health.

The objectives stated for all of the consultation sessions were to:

- Gather information about the aspects of the current residential system that are working well and areas that need to be improved upon.
- Discuss ideas for change that will contribute to improved outcomes for children and youth over the next two to three years using available resources (e.g., changes to policy, practice, training and contracting).
- Identify longer-term strategies for strengthening residential services including future financial investments.

Guided by two questions – “What is one thing you would change to improve the experience and outcomes for children and youth in residential care?” and “What is working well in the system now?” – participants engaged in conversations about issues and possibilities which helped to define the key themes presented in this report. Summaries of each of the discussions were prepared and distributed to participants for feedback and any subsequent contributions.

b. Academic literature

A systematic review of academic databases was conducted in order to identify articles of relevance to the Project. The themes that emerged during the community and stakeholder consultations helped to guide the selection of articles. The review examined a period of five and a half years, from January 2005 to July 2010. More than 400 abstracts were screened, and 110 articles were selected for review. A total of 32 articles were selected as being highly relevant to the initial findings from the consultation process. Where possible and appropriate, research conducted in Canada or published by Canadian researchers was given priority. The majority of the studies chosen were published in the last three years, reflecting the fact that research is cumulative and that recent studies often reference and expand upon previous studies. A summary of each of these articles was provided to the Project Team and Advisory Group. The relationship between the article and the emerging themes from the consultation process as well as the substantive relevance was noted for each article. (See Appendix E for annotated bibliography)

c. British Columbia reports and initiatives

Twenty-five reports that had been prepared by MCFD or other provincial government

entities in the past decade, that addressed residential care for children and youth in some way, were reviewed. The relationship between each report and the emerging themes from the consultation process was assessed and presented to the Project Team. (See Appendix F for cited Reports and Initiatives)

d. Canadian reports and initiatives

All provincial and territorial child welfare ministries or departments in Canada were contacted to determine if they had recently undertaken any research, evaluations, and/or reviews of their residential services for children and youth, and whether reports or other documents had been produced as a result of that work. For the purposes of this review, residential services were defined as “placements for children and youth who cannot live with their parents and therefore live somewhere else for a period of time, including extended family, foster care and staffed residential resources.”

All but one jurisdiction (Nunavut) responded to the request for information. Eight other provinces had conducted or were currently conducting a similar residential review and reports and documents were obtained from Newfoundland & Labrador, Prince Edward Island, Nova Scotia, Quebec, Ontario, Manitoba, Saskatchewan, and Alberta.

Over 20 reports from Canadian jurisdictions were reviewed and organized by consultation themes. A summary was prepared for the Project Team noting the relevance of the findings to the Project. (See Appendix F for cited Reports and Initiatives)

e. Reports and initiatives in other jurisdictions

A web-based search was conducted to locate government reports, reviews and initiatives pertaining to residential care for children and youth. Documents from the United States, Australia and the United Kingdom were reviewed and summarized for the Project Team. (See Appendix F for cited Reports and Initiatives)

f. Caseload and service delivery data

MCFD's Research, Analysis and Evaluation team was asked to provide data to address a series of questions prepared by the Project Team. Given the limitations of MCFD's information systems, some of the questions could not be addressed. However, provincial and regional information was obtained on the following: current and projected child and youth population for BC; child protection investigations; characteristics of entries into and exits from care (e.g., age distribution, reasons for coming into care, legal status); children in care by residential placement types (2005-2010); placement changes/moves and comparisons over time (2005-06 to 2009-10); length of time in care of children leaving Temporary Custody Orders (TCO) and Continuing Custody Orders (CCO); and educational special needs of children and youth with a CCO.

Additional data was obtained on the characteristics of youth in custody under the *Youth Criminal Justice Act*.

This data assisted the Project Team to better understand the characteristics of the population being served in the residential services system and note shifts over time and is presented in the following section.

D. Statistical Overview of the Residential Services System

There are an estimated 10,171 children and youth receiving residential services on any given day in BC. Table 1 (below) describes the total number of children and youth served by the residential services system on any given day, organized by service stream and type of residential service (e.g., kinship care, foster care, contracted/staffed residential care, tertiary care).⁷ The number of youth under Youth Agreements (YAG) under section 12.2 *CFCS Act* and children in care in independent living arrangements are also included (together). Inclusion of this data completes the picture because, although not residential services per se, they are placements that arise under the *CFCS Act* that are the result of assessment and planning. Since they typically engage additional support services (e.g., youth support worker, day program), they involve much more than simple financial housing and living assistance.⁸

⁷ Numbers given for all residential services provided under the *CFCS Act* reflect December 31, 2010 data, youth custody centres data reflect average daily population and the numbers given for mental health facilities, addictions services, and community youth justice residential services reflect bed capacity. It is reasonably assumed that the latter, much smaller number of residential/facility beds are typically fully occupied. The Ministry of Health, through six health authorities provides adult and youth substance use community and residential programs including withdrawal management (detox) assessment and treatment; child and youth mental health in patient adolescent psychiatric units and tertiary; MCFD shares responsibility for community-based child and youth mental health services for concurrent disorders with health authorities.

⁸ Agreements with Young Adults (former children in care or on YAG) are not included because they do not involve children or youth.

Table 1 - Residential Service System

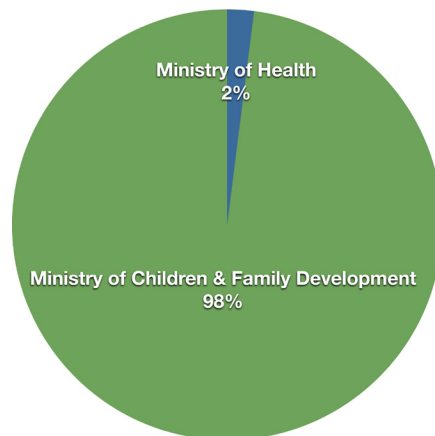
Service Stream	Resource Type	Number
Child Welfare (CFCS Act)		
	Kinship Care	1,755
	Foster Care	5,140
	Contracted/Staffed	1,019
	Independent Living	1,029
	Adoption Residency	356
	Other*	318
	CFCS Act sub-total	9,617
Youth Justice**		
	Youth Custody	130
	Contracted//Staffed Residential	44
	Contracted Family Care Model	100
	Youth Justice sub-total	274
Child & Youth Special Needs**		
	Sunnyhill Hospital (Health)	36
	Provincial Assessment Centre (CLBC)	1
	Victory Hill (MCFD)	25
	Special Needs sub-total	62
Child & Youth Mental Health**		
	Psychiatric Hospital Based Services (Health)	73
	Youth Supported Independent Living (MCFD)	20
	Maples Adolescent Treatment Centre (MCFD)	22
	CYMH sub-total	105
Youth Substance Use Treatment-Health**		
	Residential Treatment	62
	Detox-Community Based & Family Care Homes	35
	Supported Housing & Support Recovery	16
	Youth Substance Use sub-total	113
Total Residential Placements		10,181

*MCFD Data systems also tracks children & youth who are not coded, missing, in an institution or other temporary place

** CFCS Act numbers are children/youth specific while the other Residential Resources are bed specific whereby children/youth supported in a given year could be several different children/youth per bed.

Figure 1 (below) illustrates how MCFD is responsible for the vast majority of the residential services system: 98% of all residential services are funded and/or directly delivered by MCFD, with the remaining 2% being directly delivered by Health Authorities.

Figure 1-Residential Services Placement Funding Breakdown by Ministry



Similarly, Figure 2 (below) illustrates how child welfare residential services under the *CFCS Act* account for the vast majority (95%) of all residential services. In this regard, it should be noted that residential services for children and youth with special needs are primarily delivered under the auspices of the *CFCS Act*. Aside from a 10-space independent living program that is available in one region, children's mental health residential services are entirely hospital-based with a total of 95 beds. There are currently no intermediate, community residential mental health programs and, if such residential services are required, the child must be brought into care in order to be placed in a foster home or contracted/staffed resource.

Figure 2- Residential Resources by Service Stream

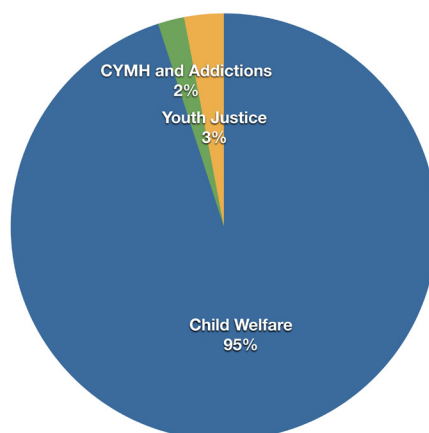
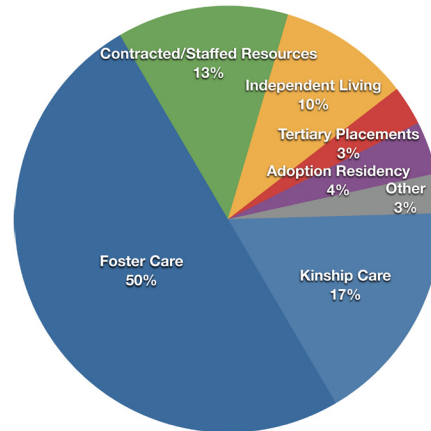


Figure 3 (below) illustrates the breakdown in the types of residential services: 17% of all children are in kinship care placements, 50% are in foster care, 13% are in contracted/staffed residential care, 3% are in tertiary care and 10% are in independent living.

Figure 3- Breakdown by Type of Residential Services



The overwhelming prevalence of child welfare services and very large proportion of children and youth in foster care explains why child welfare services, and especially foster care, were of primary interest to participants in the consultation sessions, and why they are a principal focus of this report.

Figure 3 and Table 1 (above) are striking in illustrating how small, both in proportion and in volume, the contracted/staffed residential care and tertiary care components of the residential services system are, especially tertiary care. The largest component of tertiary care is youth custody yet there is only an average of 130 youth in custody in BC.⁹ In this regard, BC has the lowest per capita rate of youth incarceration in Canada (tied with Quebec). Alberta has a youth incarceration rate that is 50% higher than BC, Ontario's rate is 75% higher, and Saskatchewan's rate is 650% higher.¹⁰ Moreover, the number of youth in custody is now less than one-third of what it was fifteen years ago; there was an average of 400 youth in custody in 1996/97 compared to only 130 in 2010/11.

Mental health facilities are the other key component of tertiary care services, comprising a total of 95 beds province-wide. Although there has been some enhancement to mental health facility capacity for children and adolescents in recent years (e.g., the Kelowna Adolescent Psychiatric Unit), there has been an overall decrease in reliance on tertiary mental health facilities through re-allocation of tertiary care resources. This shift reflects recognition of the limitations of facility-based treatment and the efficacy of addressing the needs of youth while they live in the community during critical periods of social and emotional development. Both the Maples Adolescent Treatment Centre in Burnaby and the Ledger House program on Vancouver Island have shifted their model of practice to reduce the number of facility beds in favour of providing shorter stays, specialized assessments, care plans, and supports to community-based care to a larger number of youth.¹¹

⁹ 2010/11, year to date to December 2010.

¹⁰ Canadian Centre for Justice Statistics, *Corrections Key Indicator Report, January, 2011*.

¹¹ For example, the Maples had 60 youth in residence in the late 1980's compared to only 22 today, while Ledger House has reduced its facility capacity from 16 beds to 8 beds.

Contracted/staffed residential services comprise a total of 1300 beds, or 13% of the residential services system. It should be noted that “contracted/staffed residential care resources” are not solely “group homes” but include a range of staffed residential care models of service delivered by agencies or individuals under contract, for example:

- The traditional “group home” (4 to 6 beds with 24/7 rotational staff).
- Smaller, more individualized staffed placements (one or two high needs children in a non-family care placement with rotational 24/7 staff).
- Staff supported, family-based care models where, for example, an agency contracted to provide services to high needs adolescents, recruits, trains and provides ongoing support to those families (one-to-one family support, one-to-one youth support workers, emergency call-out support, complementary specialized day treatment/intervention services). These types of family-based care programs have elements of, but are not the same as, Multi-Dimensional Treatment Foster Care (MTFC) and are more common in the community youth justice and addictions treatment sectors.
- Hybrid models of family-based caregivers bringing on substantial additional relief and support staffing to assist with the care and management of high needs children.

Generally speaking, contracted/staffed residential resources are intervention/treatment focused and as such have fixed program lengths; in other words they are interventions not placements *per se*.

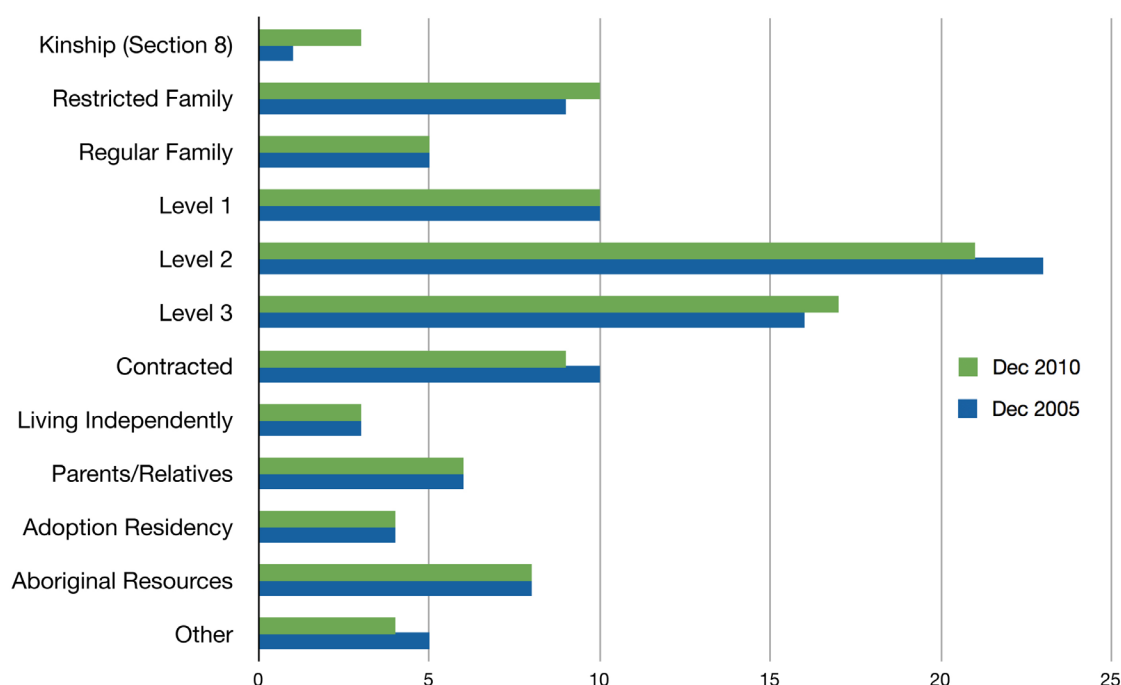
In the absence of a reliable breakdown in the number of contracted/staffed resources by different sub-types, estimates have been developed. There is a general consensus, however, that there has been, over the past decade or more, a marked reduction in reliance on the traditional staffed group home model of service, with increasing reliance on contracted/staffed family care models as well as on specialized level 3 foster care placements. This systemic trend, in combination with a relatively low and reducing reliance on tertiary care services noted above, raises questions about whether staff-supported/contracted family-based models of service and specialized level 3 foster homes have sufficient supports in place to meet the needs of challenging children and youth who might have been in tertiary or group home care in the past.

Returning to children in care, who are the principal recipients of residential services, available statistics indicate that:

- The children-in-care population has been decreasing since December 2001 when the caseload was 10,291 compared to 8,384 in December 2010.
- While the children-in-care caseload has decreased since 2001, the proportion of Aboriginal children in care has increased from 38% in 2001/02 to 55% in 2010. Further, the actual number of Aboriginal children in care has increased from 3,876 to 4,576 in the same time period.

- The average duration of stay in care, for a child leaving a CCO in 2009/10 was 7 years and 6 months compared to 6 years and 8 months in 2005/06.
- Forty percent of children who left continuing care in 2009/10 had 4 or more moves, and 12% had 10 or more moves, compared to 44 % who had 4 or more moves and 15% that had 10 or more moves in 2005/06.
- The average duration of stay of a child who left care while under a TCO was 1 years and 3 months in 2009/10, compared to 1 years and 2 months in 2005/06.
- Six percent of children who left temporary care in 2009/10 had 4 or more moves and 1% had 10 or more moves, compared to 7% who had 4 or more moves in 2005/06 (no child in a TCO had 10 or more moves in 2005/06).
- The high proportion of children in care who move frequently - 4 or more times, and as many as 10 or more times - is especially concerning, as is the considerable length of time in care without a permanent arrangement being achieved.
- As Figure 4 (below) illustrates, there has been little change in the relative use of specialized levels 1, 2, and 3 foster care and contracted resources for children in care between December 2005 and December 2010.

Figure 4 – Residential Child in Care Placements Type Usage % Comparison



With regard to the youth custody population, available statistics indicate that 731 unique youth were admitted to custody in 2009/10 and that on any given day, 49.8% were Aboriginal, only 17% were girls, and 74% were 16 years old or older (24% were 18

or older). As well, 52% were held in remand custody while awaiting trial or sentencing, with the remainder held in sentenced custody. As noted previously, there has been a very marked decline in the number of youth in custody during the past two decades.

Part Two – Overview of Key Themes

At several points during the consultation process the Project Team reviewed the findings and identified emerging themes. These were shared with the Advisory Group to determine if the team was “on track” with their analysis and to assess whether any modifications to the questions or processes needed to be implemented.¹² Upon completion of the consultations, literature and jurisdictional reviews, the contents were once again reviewed to pull out key organizing themes, determined as follows:

A. Achieving Permanency

As the Project progressed it became very clear to the Project Team and Advisory Group that a strong emphasis needed to be placed upon achieving permanency for children and youth as the framework or organizing principle around which residential services are provided. Within the child welfare system, which accounts for 95% of all residential services, placement in residential care is often viewed as a solution to concerns about a child’s need for protection (“ensuring safety”) rather than a means to achieving security, stability and lifelong connections (“ensuring permanence”). For the purposes of this review, the Project Team drew on the work done by the BC Federation of Youth in Care Networks (FBCYICN)¹³ and others that describe three dimensions of permanency:

- Relational permanency - requires “strong, long lasting connections with a biological family member/siblings, school staff, foster caregivers, social workers, youth workers, community members and organizations like the Federation of BC Youth in Care Networks – anybody who gives you positive, unconditional commitment.”
- Legal permanency - “where the responsibility of guardianship for a young person rests (e.g., parents, adoptive parent).”
- Physical permanency - “involves creating a safe, stable, healthy and lasting living arrangement.”

Within this section, information is included about what people believe should be the aims and priorities of a residential care system in BC, as well as what clinical, service delivery and professional practices and standards might need to be reviewed and developed in order to achieve the aims. Of primary interest are the practices and standards that promote the goal of “ensuring permanence” for children and youth who come into the residential care system. This section also considers professional practices, including what standards or expectations might be held for the professionals involved in the design and delivery of residential care.

In every consultation undertaken, practices pertaining to assessment, case planning,

¹² The Project Team initially identified 21 themes. Over time, interconnections between many of the themes were noted and they were clustered into the key themes described in this report.

¹³ See Federation of BC Youth In Care Networks 2010 report, *Belonging 4 Ever – Creating Permanency for Youth In and From Care*, p. 6 and Stott and Gustavson, 2010.

and placement matching and planning were raised. Assessment was of great interest to many participants as it establishes a basis for effective planning, placement matching, and monitoring that are tied to the unique needs and capacities of the young person in residential care. Given that MCFD has embarked on practice changes to improve assessment and planning and as assessment is not unique to residential care, the discussions about assessment have been limited in this report.

B. Delivering an Array of Accessible Residential Care Services

Across all sources of information reviewed, the issue of what types of residential services should be offered, where the services should be provided, and how access should be managed was considered. There was general consensus that a diverse and comprehensive array of residential services and supports are needed along some type of a continuum, based on level of intervention required or style of care (e.g., from kinship care to facility-based or tertiary level care or from normative care and nurturing to intensive treatment and rehabilitation). Access to diverse options was seen to be particularly important due to the complexity of needs that many children and youth have and the efficacy of matching their needs to the characteristics and skills of the residential placement.

Many of the participants in the consultations suggested that MCFD needed to consider how best to prevent children and youth from coming into residential care through such things as increasing financial supports for birth families, developing out-of-care support options for families such as respite care, or providing “whole family” care in which foster or mentor caregivers coach the family to improve their functioning and ensure safety. The Project Team was impressed by the interest that many people had in exploring ways to prevent children and youth from coming into some type of residential care in the first place. However, for the purposes of this review, discussions in this section are focused on residential services. Other transformation initiatives within MCFD are addressing prevention, early intervention, family intervention and support services that help to prevent children from being placed in residential services.

Access to an array of residential care options and supports was approached from various angles, including geographic access (especially in rural communities), timeliness of access, the “gatekeeping” of access through referral processes and eligibility criteria, and access to non-residential supports such as mental health counselling or substance withdrawal management (detox) in order to sustain residential placements such as foster care. Some participants spoke about the challenges faced in accessing specialized residential and non-residential services for children and youth with complex or concurrent concerns, especially mental health concerns, problematic substance use (addictions), FASD, autism and other developmental challenges and special needs. There was also considerable discussion about access to emergency care, respite for birth families, and relief for foster caregivers.

C. Strengthening Foster Care

Skilled, committed, and engaged foster caregivers, service providers and MCFD staff enhance the capacity of the system to meet the needs of vulnerable children and youth. Participants in the consultation sessions were particularly interested in and concerned about foster caregivers. Recruitment and selection, education and training, supervision, support, recognition and compensation were identified as key factors in the development and retention of a strong and diverse range of foster caregivers.

It was consistently suggested that the supply of skilled foster family care homes needs to be increased. Enhanced supply would enable better matching of the child or youth's needs and the foster caregiver's skills and circumstances, as well as prevent the "overloading" of foster homes – both of which can be key factors in placement disruptions and breakdowns. To increase the supply, both the recruitment of new foster caregivers and the retention or re-engagement of approved foster caregivers, needs attention. Foster caregiver training and education was frequently discussed and while acknowledged as being very important, there were diverse views on how best to design, deliver and monitor training.

Discussions about support were also rich and varied. A broad range of meaningful "direct support" for foster caregivers was described both by consultation participants and in the literature. Direct supports ranged from basic courtesies such as MCFD workers returning phone calls promptly, to including caregivers in case planning meetings and valuing their input, to managing the number of children in homes, to sharing information and offering situation-specific training or counsel, to providing relief resources. "Indirect support" was also discussed; when MCFD workers ensure that the child/youth in care is receiving the specialized supports that he/she needs, such as mental health counselling or treatment for problematic substance use, the foster caregiver is more likely to feel supported as well.

D. Working Together

In this section the reported findings relate to how individuals and systems work together in the interests of children and youth in residential care. The topics of respect and value, communications and information sharing, collaboration and teamwork, and systems coordination are addressed. All sources of information spoke to the value of diverse parties working together in the interests of children and youth. Healthy and productive relationships in the caring systems appear to make a positive difference on a number of fronts. This includes relationships between: MCFD staff, foster caregivers and community service providers; MCFD staff and young people in residential care and their birth families and kin; caregivers and birth families; and amongst service delivery partners in communities.

Healthy relationships were characterized by: mutual respect and appreciation for diverse roles, responsibilities and contributions; respectful and timely communications between and amongst the parties concerned about children and youth in residential care, including the youth themselves; willingness to have difficult conversations and work through challenges together; openness to "not knowing" and to figuring things out together when difficult situations arise; the absence of fear or concern about

judgments or repercussions (e.g., withdrawal of funding or support); and a sense of “being in this together” and of “not being alone.”

Communication and information sharing was identified as being critical to effective assessment, planning and decision-making. Of particular interest was how and when information is gathered and shared, and who is involved in the process. Collaboration and teamwork was also seen as essential, especially given the complex needs that many young people in care have. A number of approaches and mechanisms that support collaboration and teamwork were reviewed and are described in this section.

All of the phase one sources of information touched on how the residential services system is designed or structured and how it relates to other systems. The findings relating to systems design and coordination address the roles and responsibilities of the personnel involved, the organizational structure of the system and the roles undertaken by MCFD and the community social services sector, how different parts of the residential care system (e.g. child welfare/protection, child and youth mental health, youth justice and addictions) are linked, how residential services are supported by or interact with other systems both within and external to MCFD, and how the notions of “wraparound” services are expressed.

E. Other Issues and Interests

A number of other issues and interests were raised less frequently than those addressed for each of the key themes noted above, but are nonetheless of significance in the residential review and redesign project. They are presented in this section of the report and include funding, legal and court services, and accountability.

F. Youth Perspectives

The Project Team met with youth in each of the five regions. The themes that arose in these conversations were consistent with those arising in the general focus groups and stakeholder sessions. However, the intensity of experiences – both positive and negative – and the detailed descriptions and analysis provided by the participants was remarkable. This section of the findings report aims to share the youth perspective on the key themes in the youths’ own words. The Project Team also reviewed a number of BC reports prepared by the Federation of BC Youth in Care Networks that speak to residential care issues and opportunities for improvements.

Part Three – Achieving Permanency

A. Consultation Findings

1. Permanency as a Priority

The notion of “permanency” for vulnerable children and youth was a recurring and compelling theme throughout the community and stakeholder consultations. As the Project Team and Advisory Group reviewed the findings from consultations and the inter-jurisdictional and academic literature, permanency for children and youth became a unifying idea and priority for our work.

When participants were asked to describe “one thing they would change to improve the experience and outcomes for children and youth who need residential care” many participants referenced permanency, for example:

- “Make permanency the top priority.”¹⁴
- “Recognize each child’s right to good care and permanent relationships.”
- “There are too many 14 year olds that have been in care for years and have no plans or long term relationships – figure out how to make sure they have permanent connections.”
- “We should never give up on legal permanency for a child regardless of their age.”
- “We need to be asking, where will kids go for Christmas dinner, and where will they feel connected as they grow older? We need to be thinking about relationships long term.”
- “Positive changes would mean that kids are spending less time in care; there is more emphasis on family finding and permanency planning [and it is] integrated throughout the system and from the child’s first contact with the system on.”
- “We have to reduce the number of youth who are ‘aging out’ as CCO’s [Continuing Custody Orders] with no permanent connections and family involvement. By the time a youth reaches age of majority they should have positive long term connections.”
- “MCFD needs to be open to some other arrangements to ensure permanent connections are built for these kids at an earlier age.”
- “From the first time a child comes into care, there should be a time limit by which a permanency plan needs to be in place.”

¹⁴ Throughout the report and particularly in the sections reporting on the consultation findings, quotes from participants in the consultation sessions have been included to illustrate and reinforce the themes arising from the consultations. These are presented within quotation marks but are not attributed. Where quotes are included from reports or articles, the sources are noted.

And in the words of one youth who grew up in care and is now a young adult, “I would love to have an adult that I could call up and just have coffee with, to go through ideas I have, or give me feedback on my resume, or just be concerned about how I am doing and what I am up to. But I have no parent, no family and no one else that I am connected to. Every youth that grows up in care should have some adult that is there for them.”

As a result of the consultation session feedback and the previously noted FBCYICN report on permanency, the Project Team adopted a multi-dimensional understanding about permanency, including relational, legal and physical permanency.

2. Barriers to Permanency

Many participants shared concerns about:

- Length of time that children and youth remain in care without a long-term connection and the reported increases to this length of time over the past years.¹⁵
- Number of times children and youth cycle in and out of care or in and out of different residential care arrangements and systems (e.g., youth custody, mental health facilities, addictions treatment facilities, special needs homes, supported independent living homes and child welfare residential placements) prior to either aging out, reunifying with their family, or moving into a more permanent family arrangement.¹⁶
- Length of time that court proceedings take, especially when trying to secure a CCO to allow for more permanent family arrangements to be planned.¹⁷
- Number of youth who are in care under a CCO and who leave care at the age of majority without any long term connections or ties.¹⁸

Participants noted that there are no simple answers to the question of how to create permanency for children and youth who are served in the residential care system,

15 As previously noted in Part One of this report, MCFD data indicates that the provincial average for length of time in care for children and youth leaving a Continuing Custody Order (CCO) was 6 years 8 months in 2005/06 and this average rose to 7 years and 6 months in 2009/10. These numbers alone do not paint a definitive picture as there will be considerable variation in the experience of individual children and families and possibly different sub-groups of children and youth (e.g. young children, youth, children of Aboriginal heritage, etc). Many of the children and youth will be in stable long-term foster placements. Nonetheless, this is a significant period of time and long term fostering is not an adequate replacement for a permanent ‘forever’ family and community connections.

16 MCFD data indicates that there are a significant number of children and youth who, for a variety of reasons, experience multiple moves between placements during their time in residential care. For example, in 2009/10 of the children who left CCO care at age of majority or to a placement with adoption or another permanent living arrangement, 40% had experienced 4 or more moves during their average 7 years and 6 months in residential care while 12% had experienced 10 or more moves.

17 Participants from several regions identified court delays and processes as a significant issue. There appear to be some regional differences.

18 Stories were shared by youth and caregivers about foster families and community service practitioners who continue to be an important ‘touchstone’ for a young person after they leave the formal care system - providing a place to go for holiday celebrations, someone to call for advice and assistance, someone who demonstrates an ongoing interest in the young person’s well-being, etc. Although not a ‘permanent’ legal or binding commitment, these long-term connections are very important and make a significant difference in the lives of many young people. Participants spoke about how these important connections arise because of the commitments that the caregivers, service providers and young people make to sustain a connection, rather than as a result of anything that the care system does to encourage connections: “they happen by default rather than design.”

and that there are challenging and often conflicting needs and interests in decision-making and planning processes that require a delicate balancing act. For example, some families need more time to stabilize and learn how to provide a safe environment for their children, which means that the children may need to come in and out of care several times before reunification is sustained. If the system moves too quickly to a CCO and another family alternative, such as adoption, the birth family may be prevented from achieving a healthy reunification. On the other hand, a child who is in and out of care, and consequently in and out of his or her family, for a number of years may miss out on key developmental opportunities and healthy family attachments, and may face more difficulties in establishing permanent connections by the time a lengthy court process concludes with a CCO.

3. Opportunities to Achieve Permanency

Participants identified the following opportunities to achieve permanency:

- Prior to residential placement:¹⁹
 - Work with birth families more intensively to develop their capacity to provide appropriate and safe care.
 - Locate and engage extended family members who may be able to offer care or support (through programs such as Family Finders and Roots).
 - Engage the extended family and community in planning processes aimed at finding alternatives to out of home placements such as family development response or family group conferencing.
- In the early stages of a child or youth coming into residential care:
 - Continue to work intensively with birth families where there is a possibility that they will be able to provide appropriate care within a reasonable period of time, and ensure that the child/youth and family members maintain regular contact where possible. Set expectations for residential caregivers to support child and family contact and provide resources to facilitate the child's visits home if needed (e.g., travel to home Aboriginal community).²⁰
 - Plan for the long term; build plans with the intention to achieve permanency for the child or youth within a reasonable period of time.
 - Introduce concurrent planning soon after child is first placed; develop a plan for reunification, while also establishing a contingency plan with extended family or other alternate permanent family: "Don't wait to plan for the long term."

¹⁹ The actions taken prior to a child or youth coming into a residential placement are beyond the scope of this review however, as they were mentioned by many participants, they are noted in the findings report.

²⁰ Existing MCFD policies and standards will support a number of the suggestions made by participants. For example, several Child and Family Service, Children in Care and Caregiver Support Service Standards stress the importance of maintaining continuity of lifelong relationships and support ongoing collaborative planning with the child's birth and extended families.

- Identify children and youth for whom a return to birth family is unlikely and “fast track” them to CCO legal status to open up new options for permanency at an earlier age.
- When child or youth returns home:
 - Provide enhanced supports to family to stabilize and support reunification and healthy family functioning. Supports might include respite care, individual or family counselling (e.g., mental health or substance use concerns), child care, or parental coaching.
 - Coordinate and provide the child/youth with the services they need (e.g., mental health care, substance use counselling, developmental supports for children with special needs, anger management and other behavioural interventions). If their needs are being addressed, the family may be better able to cope with parenting.
- When youth in care is approaching the age of majority:
 - Work with the youth wherever possible – “even if we have to push ourselves into their lives” – to plan for his or her transition out of care and ensure that the young person has life skills and at least one permanent and healthy connection with a supportive adult (see below re: transitions and supports).

Participants identified a number of shifts in awareness, training, practice, programs, and service delivery organization that could be made to make permanency a stronger priority and possibility, including:

- Make a system commitment to permanency (ensuring lifelong relationships); make it a clear priority for MCFD and an expected focus for practitioners. Integrate a “permanency mindset” into assessments, planning processes, clinical supervision, training, etc.
- Offer joint training for all MCFD professional staff (protection social workers, guardianship workers, resource workers, mental health workers, probation officers, etc), community service providers and foster caregivers on diverse ways to achieve permanency. “There are many different ways to create permanency for a child – we need to be open to and creative with the alternatives.”
- “Define and operationalize concurrent planning.” Be clear about what concurrent planning is, how it can be done, and how to make it work.
- Co-locate MCFD’s guardianship, resources and adoptions staff and create an environment that supports more information sharing and integrated long term planning: “By the time a child becomes a CCO, the adoptions staff should know all about him.”²¹

21 Co-location of guardianship, resources and adoptions staff is in fact in place in some areas of the province.

- Establish and enforce time limits by which a permanency plan needs to be in place for a child, and how long the child or youth will be in temporary residential care placements: "Be willing to make the difficult decisions to get to permanence sooner."
- Cover travel costs for children and youth to stay connected or forge new connections with family, including extended family in other jurisdictions.²²
- Work with family justice system partners to raise awareness about the impact of court delays on children and youth, and change practices that are resulting in the "cycling of children and youth in and out of care" and delaying permanency and stability for young people. "Explore other ways [with the courts] to balance the diverse interests [of parents and systems] while keeping the child's needs for permanent relationships foremost" and "get court cases heard so that permanency planning can happen more intentionally."
- Reduce social worker turnover and the number of file transfers between workers to prevent "case drift" where no one has a sustained interest in and knowledge of the child. Address caseload sizes so that workers have more time to address permanency.
- "Prevent 'tween to teen placement breakdown." Recognize that the developmental period between the ages of 10-14 can be challenging for both youth and caregivers, and be aware that this is a period in which foster caregivers are more likely to end the placement either because they "don't work with teens" or caregiving is more difficult. "We need to figure out how to support these kids and foster parents through these times" and make it clear that "it is not OK to stop fostering a child just because they hit a certain age."
- Encourage foster caregivers to stay connected with children and youth after placements have ended, where appropriate.²³ While not the child's parent, foster caregivers can be key supportive adults long after the foster placement ends.
- Stay open to, and supportive of, adoption throughout a young person's time in care, and after the age of majority. Several participants described situations where they arranged adoptions for 18-year-olds in care, with one being approved by the courts just prior to her 19th birthday. This was difficult for them to achieve given court delays but was extremely important to the youth and their adoptive family. Current legislation and policy allows for post-majority adoption although this option is not well-known and legal and administrative conditions and costs may hamper post-majority adoption plans.
- Work with Aboriginal organizations and communities to identify ways to achieve permanency for Aboriginal children. A number of participants noted cultural

²² Existing policy allows for travel costs to be covered for children and youth in care to establish or maintain connections with family members living in other communities, however, funding within local/regional guardianship and resources budgets may not be sufficient to support all requests.

²³ This is an existing expectation in Caregiver Support Service standards.

concerns about adoption as well as poverty, housing and access to specialized services in rural and remote areas as significant challenges.

4. Role of Assessment

As noted previously, MCFD has embarked on a new approach to assessment and planning that will eventually apply to all areas of ministry practice and services. Since assessment and planning is being addressed separately through this practice change process, assessment is beyond the scope of this review. However, there was such a strong and consistent assessment thread in the consultations that it is noted as a theme within the findings and the concerns and suggestions are briefly described below.

Participants consistently noted that good assessments set the foundation for good planning and decision-making, thoughtful placement matching, and appropriate practice. Many participants felt that improvements needed to be made to assessment approaches and processes, and that consideration should be given to what assessments are done, when, by whom, how, who learns about the results, and what the expectations are for acting on the findings and any recommendations. There was considerable discussion about:

- Timing of assessments.
- Comprehensiveness of assessments (whether all children and youth should have a holistic assessment including developmental, physical, health and medical, psychological, educational and cultural perspectives).
- Assessment tools and approaches used (including assessments that recognize multi-faceted or concurrent issues and needs).
- Access to specialized assessments (aimed at special needs, mental health, problematic substance use, autism, occupational and physiotherapy, speech, language and hearing, etc).
- Information sharing around assessments (i.e., who receives what information).
- The system's responsibility and capacity to act on any suggestions or recommendations made as a result of the assessment.

The information and concerns about assessment gathered through the residential redesign consultations will be communicated to parties in MCFD who are responsible for the development and implementation of practice change.

5. Placement Planning and Matching

Participants discussed many aspects of planning and planning processes that have an impact on residential services, including:

- **Planning processes** for plans of care that include residential placement and

permanency plans, including how these plans are developed, who is involved, etc.

- **Placement matching** and planning for placements that incorporate matching the young person's needs with the attributes and capacities of the residential placement, pre-placement preparation, and monitoring of the placement and plan.
- **Transition planning** and preventing unplanned placements and moves (including transitions between placements, between the family home or community and placements, and from placement to independent living or adulthood at age of majority).
- **Concurrent placement planning** that attempts to shorten the length of time that children stay in residential care before returning home or finding a new permanent home by making efforts towards adoption that are concurrent with reunification efforts.

Each of the above is discussed in detail below.

a. Planning processes

Primary considerations in the design and delivery of planning approaches that lead to the development of effective plans of care include:

- Who is involved - There was a general preference for more widespread use of inclusive planning processes and particularly the inclusion and full participation of the child or youth (as appropriate). Some participants suggested that every child that is in need of a residential placement should have a "care team that includes all the key players - youth, family, foster caregiver, social worker, resource worker, mental health worker, school counselor, etc." While care team inclusiveness is addressed in current MCFD policies and standards, broad-based planning processes are time-consuming and challenging to convene and facilitate.

It was also suggested that efforts must routinely be made to find extended family members or community members who are willing to play a role in the child's life. *Family Finders* and *Roots* programs can support this as can creative use of social networking. MCFD worker turnover and frequent file transfers were seen as problematic and having a consistent "convener" for planning sessions was suggested (i.e., someone who will stay with the child and manage the planning processes and implementation over time). It was suggested that the convener or key worker could be someone from MCFD or a community agency.

- How planning is done - Participants considered what approaches are being used or could be used to bring key people together to generate comprehensive plans, and placement plans in particular. Suggested approaches included more widespread and routine use of family group conferences (FGC) and integrated case management (ICM) meetings, both of which are supported by current

MCFD policies and standards. The use of technology, tele- or video-conferencing or Skype for example, could make planning with other people spread across the province (or beyond) more feasible and timely. Participants suggested it was very important to ensure that the people involved in planning have the information they need to make informed plans and that a strong effort is made to "get everyone involved and working on the same page from the early stages." Some noted that, "too often there are no conversations held between people and [plan development] is just a paper exercise...we need to build a more integrated approach that starts right at the beginning" and "get people together to share information and think things through."

- The timing and timeliness of planning - Participants noted that plans are often not developed in a timely way and/or timeframes attached to key actions are prolonged so that children and youth are left "in limbo" which increases their vulnerability. Participants proposed early, as well as sustained and regular, planning processes, and that workers or care teams be required to prepare and review plans within certain timeframes that are set in standards and policy.²⁴
- Scope of planning - Including what is considered and what goals are set, participants expressed a general preference for more comprehensive plans that consider the "whole child" and include physical, social, emotional, developmental, cultural and special needs, as well as the development of plans that have clear goals, timelines and back up plans (e.g., concurrent planning). Participants suggested that monitoring is required at different points to assess whether the plan is being implemented as intended, if it is working, and if it is still relevant, as a basis for review and revision (see Other Issues section regarding monitoring). Supervisors have a key role in taking a "second look" at plans and asking questions or making suggestions to enhance the quality of plans.
- Plans that engage or coordinate between services, ministries and sectors - Given the complex needs that many children and youth who come into residential care have, planning approaches will need to include practitioners from other sectors and ministries, including health, education, housing and social development.

b. Placement matching

Participants in every consultation session commented on the importance of carefully matching children and youth with the residential placement. For example, "Match children with appropriate placements based on an assessment of their needs and the capacity of the caregivers. Plan placements rather than just placing kids wherever there is an opening."

Although there was agreement about the need for placement matching, a significant number of participants (particularly MCFD staff) described the difficulties of achieving this because of the limited number of placement options available.

²⁴ Expectations and timeframes for plan development and review are established in current standards and policies, although practice does vary.

Some participants also noted that when a child or youth first comes into care it might be difficult to achieve a suitable match if the workers have little knowledge about the child, their needs and interests. Additionally, when the need for placement arises suddenly, the options for such an immediate placement may be limited. In such circumstances, some participants suggested that placement in a “receiving, emergency or assessment home” may be the most appropriate first placement, even though this will result in another move for the child or youth in the short term. Such homes are in place in a number of communities, with experienced and skilled caregivers who are able to provide care to stabilize or settle the child, inform and support assessment of the child’s needs and placement requirements, and assist the child through transition to a planned and matched placement.

To facilitate better matching, participants suggested that the supply of foster homes needs to be increased, particularly specialized homes that have certain characteristics and caregiving interests and expertise such as Aboriginal homes, youth-friendly homes, homes that are willing to care for sibling groups, specialized homes for medically fragile children, or for young parents and their babies.²⁵

It was also suggested that the scope, diversity and numbers of residential placement options beyond foster care should be enhanced. Foster homes are not always the most appropriate placements for children and youth in every circumstance, and other residential options need to be available and accessible in a reasonably timely way, including staffed residences, short-term assessment and stabilization placements, and therapeutic homes.

Some participants suggested that given MCFD’s fiscal pressures, decisions about where to place or move a child sometimes can be unduly influenced, directly or indirectly, by cost considerations. Participants consistently reinforced that decision making about placements should be driven by “fit” between the child’s needs and the resource’s capacity to meet the needs and realize the goals and outcomes established in the plans, rather than by costs and budgets.

There is a built in tension within the system that arises from defined and limited available budgets as well as the lack, or insufficient availability of, some resources. On the one hand, there is agreement, backed by research evidence and supported by MCFD policy and standards, that the best course of action is to minimize the number of moves and transitions and to keep placements as stable and consistent as possible. However, if a child or youth is in a placement that is more specialized and more costly, and has been succeeding within that placement, there may be indirect systemic pressures to move the young person out of that successful but high cost placement into a less specialized and lower cost alternative in order to “free up” the specialized resource for another needy young person requiring that higher level of support and care. Or, from the perspective of prudent management of limited resources, it can become difficult to justify paying substantially higher costs for continuing in a placement that provides a level of service that is no longer required, especially when there are other needy

²⁵ This issue is more fully considered in the section on supporting foster caregivers.

children waiting for that service. In some cases, such as when a placement is designed to serve a short term, therapeutic or rehabilitative intent, the move may be appropriate and can be planned. However, in other situations, it may be more appropriate to sustain a placement and relationships but try to find means to “step down” the intensity and cost of care.

c. Transition planning

Consultation participants spoke about two distinct types of transitions that need to be well managed: transitions that take place between placements or living situations such as between a child’s family and a residential placement or between two residential placements; and transitions that take place when a youth in care moves to an independent living arrangement, reaches the age of majority, or is starting or ending a Youth Agreement (YAG).

Changes in living situations may be disruptive for a young person at the best of times, and may be confusing or damaging if there are frequent or multiple changes, or they are unplanned or inappropriate. As one participant said;

“Confusion and detachment set in when children are frequently moved in and out of care and between different homes. The child’s needs become more serious and complex and more difficult to meet with each subsequent change.”

A significant number of the youth who contributed to this study talked about having 10, 20, and even more than 30 placements during their time in care. They noted that once they had a few placement breakdowns, it became a repetitive cycle of disruptions as they were placed in homes or facilities that weren’t good matches. This phenomenon is also borne out in the research literature. As one youth said:

“Packing and having to move 37 times has given me horrible anxiety. I cut off relationships with people before I start to like them because I know I am going to lose them. Can you imagine moving 37 times yourself?”

Participants suggested that the following needed to be worked on:²⁶

- Improve the quality of the placement matches made for a child or youth to prevent placement breakdown.
- Reduce the number of times a child is moved and set goals such as was suggested by one team: “The first planned placement we make after a child comes into care, is the last time we will move her until we find her a permanent family.”
- Focus on transitioning well between a child’s family home and a residential care placement, and vice versa. As family reunification is a goal for most families, children may be cycling in and out of care a number of times before a long-term solution is established. Participants discussed how this could be done so that it is

²⁶ Existing MCFD policies and standards are consistent with and support many of the practices noted below, however, the ability to act on these is affected by a number of factors such as the supply of placements, availability of funding for supports, caseload sizes and the time that workers have to coordinate and act on plans.

less disruptive to the child. For example, efforts could be made to place the child in the same residential care placement each time or services and supports the child has received while in care could be continued through transitions.

- Improve communications and planning to prevent placement breakdowns, abrupt transitions and relationship disruptions. If a child is at risk of being moved, participants suggested that this was the time to invest more time, effort and caution into the planning and decision-making process.
- Avoid overloading residential care placements so that they become unstable and be prepared to add extra supports into a placement to stabilize the situation.
- When a transition between placements is necessary:
 - Plan the transition
 - Recognize emotional impact for everyone involved
 - Plan pre-placement visits
 - Ensure the process is transparent (e.g., explain the reason for the move)
 - Prepare for the move
- When transitions between distinctly different types of residential assessments and placements are required (e.g., from hospital or adolescent psychiatric unit to community resource or from youth custody centre to community resource), ensure they are coordinated and that communication between the sectors and practitioners is open and transparent.
- Coordinate transitions to adult placements (e.g., to CLBC community living services or to adult mental health services) more proactively and effectively.
- When transitions between foster homes take place, ensure that the caregivers share information with the intent to provide continuity for the child. This could include maintaining activities and routines or setting similar rules and expectations, etc.
- When a placement has ended abruptly or poorly, recognize that the child or youth may experience shock and grief. Some services may be needed to support the child through the loss.

Foster caregivers also noted that transitions are difficult on their families, and their own children may experience grief and loss. A number of caregivers suggested that foster caregivers should have access to counselling supports.

Youth who are in youth custody centres and transitioning back into the community at the end of their (typically) short sentence or period of detention present another transition challenge. One youth described his situation that is perhaps not typical but

illustrates the challenge:

"I was released and the only *plan* was for me to stay at Kiwanis Youth Shelter for 5 days, when I really should have been sent to treatment [for substance misuse]. There was no plan to help me find a place to live, find work, apply for income assistance, or anything that would have helped me move back into the community."²⁷

Some of the youth suggested that the apparent lack of planning (or available resources) set them up for re-offending. Most of the youth in youth custody centres are older adolescents who are not concurrently in care and, while they are typically eligible for Youth Agreements, they are not usually eligible for protection services under the *CFCS Act* and are therefore not, for example, able to be placed in foster homes. The need for supported and transitional housing services for this older adolescent population is a typical refrain amongst youth justice service providers.²⁸

A significant number of participants discussed transitions for older youth in care. Youth in particular had a great deal to say about how they were prepared (or not) for independence and adulthood, with the general consensus being that a great deal more should be done, starting at an earlier age (e.g., 13-14 years of age). This implies that youth are going to spend their adolescent years in care, which was an assumption that a number of people challenged, as noted in the section on achieving permanency. However, given that many young people are in residential placements during their adolescent years, more intentional preparation for independence was called for. This preparation may include:

- Life skills education ranging from how to cook, clean, and budget, to how to open a bank account, negotiate a rental agreement, arrange utilities and get along with roommates.
- Work skills preparation.
- Assistance or guidance for the youth to set goals, apply for and participate in school or the workforce, locate and sustain a safe and affordable place to live, etc.
- Establishing connections with adult systems to facilitate transitions (e.g., mental health, addictions services, community living, housing).
- Arranging for post-majority supports such as educational bursaries,²⁹ an Agreement with Young Adults (AYA), or facilitating transitions from a Youth

27 Examples such as this reinforce the importance of coordination of services across ministries and authorities that deliver key services such as income assistance, employment development, health care and substance use treatment services, adult community living supports, etc. Protocols are in place across some service streams, and in some regions, and further consideration of how best to encourage multi-system coordination is required.

28 Youth custody services have some contracted community placements in family care settings, as does community youth justice services delivered by the regions, however, there is limited availability. There are extensive intensive support and supervision services (e.g., one-to-one workers) available to assist with community transition.

29 Educational scholarship and bursary programs are in place for young people who have been in care, including the Youth Education Assistance Fund (YEAFF) available from MCFD, the Dream Fund bursaries available from the Federation of BC Youth in Care Networks, and the Youth in Care Bursaries available from the Federation of Community Social Services of BC. Despite availability, a number of the youth participants who transitioned out of care did not recall being advised of these educational supports.

Agreement (YAG) to an AYA.

- Ensuring that the youth have some positive adults in their life who are willing to be available for the long-term.

As it is very difficult for many young people to find safe and affordable housing, a number of youth suggested that transitional housing would make a significant and positive difference for them. Several interesting examples of successful transitional housing arrangements in some locales were described.

d. Concurrent placement planning

Concurrent planning is evolving as an option for children and youth for whom family reunification is desirable but may not be achievable. It attempts to shorten the length of time that children stay in care before achieving permanency by making efforts towards adoption that are concurrent with reunification efforts. The caregiver selected for the child or youth undertakes to actively support reunification or placement with extended family while also being willing to adopt the child or youth should these efforts fail. While the adoption of foster children by their foster caregivers is not new, concurrent planning is a very intentional process. By working simultaneously on both reunification and on preparation for adoption, the length of time that a child or youth remains in an impermanent family situation can be reduced; should reunification not be achieved an adoption process can be quickly expedited.

Effective concurrent planning is complex. Recruitment is challenging as many caregivers are not well suited to, or willing to be in, an ambiguous or dual role as both a facilitator of reunification and a prospective adoptive parent. Similarly, not all children and their families are well suited to such an arrangement. Careful screening and matching of child/family and caregiver is key, as is being open and transparent about the intentions and expectations. Several participants noted that resource workers may be reluctant to support concurrent planning as there is a risk that the foster caregiver will not be eligible to or interested in continuing to foster should they adopt the child or youth.

Despite the challenges, a number of focus group participants suggested that concurrent planning is a promising practice that should be more intentionally developed within the residential care system. Further consideration needs to be given to:

- Who is best suited to being a concurrent caregiver? How might concurrent caregivers be recruited? What are the attributes, attitudes and skills that are effective? How might this be assessed and determined?
- What supports should be provided to the child or youth, his/her family and the caregiver in order to achieve a successful permanency outcome as soon as possible?
- What criteria should be applied to select the child or youth most suited to a

concurrent planning arrangement?

- What are reasonable timeframes and parameters for decision-making? How might courts be informed and invited to support concurrent planning and timely decision-making?

B. Research Findings

An article by Stott and Gustavsson (2010) looks specifically at research on permanency and stability for older youth in foster care but their conceptualization of permanency is broadly applicable. They draw on a permanency perspective that includes three specific aspects: relational permanence, physical permanence, and legal permanence. The authors point out that the majority of youth that enter foster care after the age of 13 end up emancipating from the care system i.e., they “age out” of care. The authors provide an extensive review of the poor life outcomes for these youth, including health, legal, housing, and relationships outcomes. These poor outcomes are compounded by the fact that youth are often moved around in the care system, sometimes due to efforts to seek legal permanence with potential adoptive parents or with foster caregivers that might consider adopting.

The authors make the argument that the primary focus on legal permanence results in a lack of attention being paid to relationship and physical permanence. The loss of relationships and connections to school and community can be damaging and further alienate youth who already have significant difficulties in forming and maintaining relationships. The authors suggest that the youth's voice and desires should be respected in the process of identifying long-term plans and that relational and physical permanence should be considered in the planning process. While legal permanency is a desirable outcome for children and youth in care, research suggests that a more balanced strategy for youth entering care may be more effective.³⁰

The Annie E. Casey Foundation has supported the *Family to Family* initiative and identified several key themes to incorporate into permanency planning approaches, including: every child, no matter how old, can achieve permanence and should have a case plan for permanence; kinship families are an underused resource; and older youth should be involved in their own permanency planning. Their findings are consistent with other research findings.

A study by Pine et al., (2009) looked at variables that seem to make a difference to the rate and success of reunification and then examined the outcomes of a family reunification program operated by a non-profit organization under contract to a state child welfare agency. Previous studies have found that children coming from two parent households are more likely to reunify and that children placed with kin are less likely to reunify and remain in care twice as long. Lower rates of reunification are also related to length of time in care, number of prior removals, and number of previous placements. Children with multiple caseworkers experienced significantly longer

³⁰ It is this balanced view that has been adopted both by the Federation of BC Youth in Care Networks and this project, as previously noted.

stays and were less likely to reunify, whereas those with more qualified (Masters level) caseworkers reunified more quickly.

Previous studies of intensive home-based services have shown positive associations with rates of reunification. The family reunification program model examined by the researchers targets families experiencing a first time removal and receives referrals within 15 days of placement. The service is intensive, home-based, and tailored to the family's needs. It includes frequent visits, group work, and individual, couple and family therapy delivered by a team that includes a Masters level social worker, a family support worker, and the caseworker from the state agency. Caseload size is between five and seven families. The study looked at a sample of 135 families that received the program and a matched sample of 135 families that received regular reunification services. The families were matched on eight criteria and all had first time removals.

Interestingly, the rates of reunification were similar for both groups. There were also no significant differences in rates of other placement outcomes, such as adoption or permanent foster care. However, families in the program experienced greater stability and safety once they were reunified. They experienced fewer re-referrals to authorities and less likelihood that any reports to authorities would be substantiated. Program children also spent significantly less time in care than the comparison group regardless of the placement outcomes and experienced fewer moves in care. In terms of time to adoptive placement, comparison group children spent a considerably longer period of time in care (94 weeks compared to 54 weeks) prior to placement. The authors suggest that although intensive services and low caseloads require more resources, they may be more cost effective in the long run if children spend less time in care and are less likely to return after reunification.

This research highlights the importance of intensive, targeted supports to children in out-of-home care and their families in order to successfully reunify or move quickly to another permanency option and to minimize the length of time spent in care.

Several studies looked into the variables that contribute to or detract from achieving permanency. For example, Cushing and Greenblatt (2009) found that children who were successfully adopted were more likely to be younger and female, have fewer behavioural problems, have had a consistent case worker and have had fewer placements. On the other hand, children who were not adopted had more behavioural challenges, had experienced placement disruptions and multiple moves, had been placed in an institutional or group home setting and had inconsistent caseworkers. Youth who experienced a change in caseworker were 44% less likely to be adopted than those who did not experience a change in caseworker. The authors note that the importance of having a consistent caseworker has seldom been examined in previous research; despite that staff turnover is an all too common challenge for many child welfare organizations. For each year that a child spent in foster care after the termination of parental rights, the likelihood of adoption was reduced by 80%, highlighting the importance of early and effective case and concurrent planning.

A study undertaken by Snowden and Sieracki (2008) also looked at predictors of

children in foster care being adopted. A child's age at removal was determined to be the strongest predictor of whether or not the child would be adopted. Children removed under the age of 5 were significantly more likely to be adopted. Age of the child was the second strongest predictor, with children under the age of 12 years being significantly more likely to be adopted. These findings reinforce the importance of timely decision-making and action where it is likely that a child will not be reunified with their birth family.

Cushing and Greenblatt (2009) also looked at cases where a foster caregiver was identified as a potential adoptive parent, and ambivalence was a key factor in lowering rates of adoption. The reasons for that ambivalence were primarily lack of resources to meet the child's needs, loss of financial support, loss of casework and services or support, the family not being ready, and child behaviours. Supporting placement stability and providing supports for foster caregivers considering adoptions appear to be key. Regardless of whether it is a foster caregiver that adopts or another family, the authors suggest that a key component of enhancing permanency through adoption is the provision of high quality support and therapeutic services both before and after adoption.

A paper by Avery (2010) offers a new and compelling conceptualization of youth permanency, reframing permanency for youth in terms of lifelong connections to kin and fictive kin. The author highlights a demonstration project that used a Social Capital Building model for youth aging out of care called *Permanent Parents for Teens*. The project sought to find permanent adoptive parents or committed permanent parents that would "morally adopt" youth. Specialized casework activity focused on a child-specific recruitment approach called *Permanency Action Recruitment Teams (PART)*. *PART* meetings brought together all parties involved in the permanency planning process for the older youth, including the youth and individuals in the youth's life who could potentially be a permanency resource for them. The process included scouring the case files for potential names of individuals who previously had been foster caregivers, friends, teachers, etc. Throughout the life of the project, 98 of 199 youth referred were successfully placed in permanent situations. The authors argue that the pursuit of enduring relationships, alongside the delivery of support services, is essential in "permanency-oriented" child welfare services. The article highlights the potential of targeted, team-based interventions for finding permanent arrangements for youth in their late adolescence preparing to exit formal care.

Concurrent planning is another practice that is often considered in discussions about permanency. Concurrent planning attempts to shorten the length of time that children stay in care before returning home or finding a new permanent home by making efforts towards adoption that are concurrent with reunification efforts. There is little research on the effects of concurrent planning, although findings from the few published studies have shown some promise. Recent qualitative studies on concurrent planning suggest that effective planning is complex and involves skillful social work and intensive service provision as well as systems changes such as structured collaboration between adoption and reunification workers.

Concurrent planning practice has a number of distinctive elements including:

- Development of a concurrent plan – an alternative plan for permanency for the child.
- Reunification prognosis – a determination of the likelihood of reunification of a family.
- Full disclosure – explaining to parents the process of concurrent planning and the consequences of failing to complete their case plans.
- Discussions of voluntary relinquishment as an option for parents.
- Foster-to-adopt placements – placement of the child in a foster home willing to adopt the child should reunification fail.

These elements are intended to reduce time in care and confront parental ambivalence. This approach requires a redefining of success in child welfare to include a broad array of permanent outcomes. The development of “plan B” serves as a constant reminder of an alternative goal and the means to attain it.

D’Andrade (2009) studied 885 children entering out-of-home care in six counties in California, comparing children who received elements of concurrent planning with children that did not receive these elements. The concurrent planning element of “full disclosure” was associated with a lower likelihood of reunification. It may be that the practice of full disclosure is difficult to do well and that it disheartens parents and hinders reunification. The concurrent planning element of discussion of voluntary relinquishment was associated with an increased likelihood of adoption. Discussing relinquishment almost doubled the likelihood of adoption, supporting the idea that specifically discussing this option with parents facilitates their best use of it. In this study, the articulation of a concurrent plan was not associated with either reunification or adoption. However, because the source of this data was court reporting, this may not reflect true engagement in a concurrent planning effort.

The mixed results from this study suggest that implementing concurrent planning should be undertaken cautiously. The elements that should be included, the timing of their use and the level of training and support needed to effectively utilize the practice should all be considered.

C. BC Reports and Initiatives

The MCFD *Draft Permanency Framework in British Columbia* (2005) was developed to assist each region in designing and delivering effective child welfare services with a focus on obtaining appropriate permanent families for children in ministry care. The draft framework promotes using strategies to achieve permanency through reunification, kinship care, transfer of guardianship, custom adoption, adoption, or the development of lifelong connections to significant adults and to the child’s community.

In the fall of 2010, the Central Okanagan Network in the Interior Region began the implementation of their Permanency Planning Model (PPM). The PPM promotes practices that recognize permanency as starting at first contact. The model focuses on communication, information transfer and clinical supervision. PPM orientation sessions were delivered to MCFD staff (across all service streams) and community members including: Aboriginal agencies, health authority, school district staff, foster caregivers and a variety of contracted agencies. The sessions help to engage and inform participants about the importance of permanency and the range of options available to children and youth who come in contact with the ministry.

Also, the Fraser Region of MCFD supports an ongoing "Permanency and Adoption Planning Table" where representatives from all program areas from mental health, protection, resources, guardianship and adoptions meet to discuss timely permanency planning. This year the Table convened an all day meeting with community partners including: Aboriginal agencies, Adoptive Families Association and licensed adoption agencies to talk about permanency planning.

As well, the Adoptive Families Association has a Youth Speak Out Group that is mentoring young people in care to be public speakers and advocates regarding timely permanency planning for youth in care. Youth have made presentations at conferences, training sessions and team meetings with ministry social workers. A "tween" group has also been formed to carry out similar initiatives.

As previously noted, the Federation of BC Youth in Care Networks has prepared a report titled "Belonging 4 Ever – Creating Permanency for Youth In and From Care." Youth delegates have made a number of presentations based on this report within the province as well as nationally.

D. Canadian Reports and Initiatives

In Canada, the National Children's Alliance, in its desire to become more knowledgeable about the status of children in care in Canada, commissioned the Child Welfare League of Canada to develop an informative position paper addressing the subject of children in care to: answer broad questions; highlight some current statistics and gaps in data; highlight key issues and trends; and identify recommendations future research. The 2003 position paper reported a number of key issues and findings:

- The number of children in care in Canada is increasing each year.
- Children experience significant placement disruptions.
- Family based care is the primary resource utilized for children in care.
- Legislation, policies and standards of care vary between provinces, territories and First Nations.
- Aboriginal children are an overrepresented population amongst children in care.

- Many children in care have special needs requiring specific attention.
- Canada does not have a national strategy to address issues of permanency, leaving a significant number of children in care in a state of “limbo”.
- Attention to the two central organizing principles of *Permanency Planning and Outcome Measurement* “in all future research endeavours” will contribute to positive development in the resolution of many key issues identified.
- Further research in determining best practices in the provision of family based care is needed.³¹

As recognized by CWLC, there are inherent problems in comparing individual provincial and territorial and First Nations responsibility for service provision in child welfare, as there is no body of research that considers children in care nationally, either through statistical data or comparative program data. However, in alignment with the CWLC recommendations, a number of provinces are also recognizing the need to have a variety of approaches to achieving permanency. Some noteworthy jurisdictional findings are described below.

The Ontario government released the *Pillars to Permanency Framework* in 2006, reporting that it is “a more infused approach to permanency planning for our children and youth by engaging the community.” The expanded permanency planning options include: admissions prevention, kinship out of care, kinship in care, customary care, legal custody, foster care, adoption and youth leaving care. Ontario also defined permanency as every child having emotional certainty, legal certainty, meaningful ties for life, healthy attachment, enduring family relations, resilience and hope, stability, and a sense of belonging.

The province of Saskatchewan released two reports in the past two years that focused on their child welfare system. The first report reviewed the overcrowding of foster homes in Saskatoon, and the second one was conducted by a Child Welfare Review Panel in response to the first report. Fifty-seven recommendations flowed from the reports which focused on many of the same thematic issues currently identified in the BC Residential Review Project. One of the key recommendations regarding permanency was the creation of a *Special Committee on Foster Care and Permanency Planning* to address the development and implementation of a plan that would focus on creating a safe and nurturing foster care system, dedicated to promoting the best interests of children and to expanding the range of permanency options for both alternative out of care and in care placements, so as to reduce the increasing compression in foster care, while producing better and sustainable outcomes for vulnerable children.

E. Reports and Initiatives in Other Jurisdictions

³¹ CWLC (2003). *Children in Care in Canada: A summary of current issues and trends with recommendations for the future research.*

In the United States, federal law provides a framework for developing policies, strategies and practices at the state level regarding permanency. The recently enacted *Fostering Connections to Success and Increasing Adoptions Act* of 2008 provides new opportunities to effectively and safely reduce the number of children in foster care. Descriptions of several initiatives being implemented in the states in response to federal requirements are provided below.

1. Kinship Guardianship Assistance Payment Program

A variety of “strengthen kinship initiatives” have demonstrated that children in foster care who are placed with relatives have more stability, have a positive perception of their placement, are more likely to be placed with their siblings, and demonstrate fewer behavioural problems. A number of State initiatives have evolved that focus on reducing children’s length of stay in foster care, as a means to improve outcomes for children, youth and their families. For example, the *Kinship Guardianship Assistance Payment Program (Kin-GAP)* was implemented in 2000 in California, as a new permanency option for children in appropriate, long-term foster care placements with relative caregivers. The payment program provides relative caregivers who are unable or unwilling to adopt a child in foster care with another option for exiting the child welfare system, provided that permanent placement in the relative’s home is in the best interests of the child.

2. Permanency Roundtables

In Georgia, *Permanency Roundtables* were created (supported by Casey Foundation) to seek more permanent family and living arrangements for children and youth who had been in care for an extended period of time. Five hundred children-in-care cases were reviewed by teams of five to eight caseworkers, supervisors and experts from inside and outside of government. The ground rules for the roundtables were simple: no idea was a bad idea, and every possible idea was put on the table. The fresh perspectives ushered in new possibilities as each roundtable addressed a series of straightforward questions:

- What will it take?
- What can we try that we’ve never tried before?
- What have we tried before that we can try again?
- How many of these things can we try at the same time?
- How can we involve the youth in permanency planning?

The process was intense – 10 roundtables convened simultaneously each day for five consecutive weeks until every case had been securitized. Each roundtable drafted precise permanency action plans and firm deadlines for each case. Five months after the completion of the roundtables, 82 (17%) of the children had achieved positive legal permanency (33 reunifications, 13 in custody of a fit and willing relative, 15 adoptions

and 21 guardianships). There were also 28 emancipations, with 27 signing voluntary agreements to remain in foster care.

3. Specialized Youth Permanency Units

Using federal funds, the Los Angeles County's Department of Children and Family Services (DCFS) funded a comprehensive five-year reinvestment plan. DCFS initially focused its efforts on reducing the number of children in long-term foster care, especially those living in group homes and other institutionalized settings. *Specialized Youth Permanency Units* were developed that gave caseworkers fewer cases to manage as well as intensive training and support to work with youth at risk of aging out of foster care without a permanent family. DCFS invested the savings resulting from reduced foster care caseloads into comprehensive community based prevention services.

In the UK, the Department for Children, Schools and Families (DCSF) commissioned extensive government funded research (1998-2009) that resulted in a series of publications that focus on quality of care and outcomes: *Quality Matters in Children's Services*. From the *Quality Protects* report in 1998 to *Care Matters* and the recent *Children's Plan* (2010), the UK government's vision has put children at the centre of a system designed to nurture them, linked by the *Every Child Matters (ECM)* framework.

Out of a series of publications cited in *ECM*, one, the *Pursuit of Permanence*, explores the core issues of children's services by presenting their research on the following: what the children need and want; their movement into, out of, and within the care system; the nature and quality of their placements; and the outcomes (whether the children are settled and happy). It analyses the reasons for movements and outcomes in different groups of children, and the relative impacts of the departments, social work teams and placements.

The fundamental philosophy underpinning this research was:

- Children should have "permanence" which is understood as a lasting experience of family that gives them opportunity to attach to adults.
- Attachment should underpin better outcomes, particularly in education.
- There should be a choice of high quality services.
- Both the services provided and the systems around the services should be well managed.

Part Four - Delivering an Accessible Array of Residential Care Services

A. The Current Residential Care Array

As noted in the introduction, the residential services system can be broadly categorized into four types: kinship care, foster care, contracted/staffed residential care and tertiary care. Considerable detail about the number and types of residential services by category, service stream and ministry responsibility is provided earlier in Section IV (Statistical Overview of the Residential Services System). More descriptive detail about the foster care system is provided in the subsequent section, Supporting Foster Caregivers.

B. Consultation Findings

Many participants commented that the needs of children who are requiring a residential care placement or residential therapeutic intervention/treatment now are “more complex and challenging” than in the past. This complexity was primarily attributed to shifts in MCFD policies and practices, such that more efforts are made to prevent a young person from coming into care or a specialized placement. Consequently, when children and youth are brought into the residential care system they have often experienced more disruptive life events and emotional and physical trauma. Many of the children and youth who are receiving residential care have multiple needs (e.g., mental health concerns, problematic substance use, attachment disruption, special needs such as FASD).

Given this complexity of needs, a coordinated or integrated and comprehensive response across various services and systems is often required to meet the developmental needs of the children and youth who come to our attention.

Complexity also raises questions about whether an appropriate array of residential resources needed for the children and youth who require residential care is in place. Many consultation group participants suggested that increased availability of specialized placements were needed to ensure timely assessment, treatment or respite. Participants also raised questions and concerns about whether the residential placements that are currently in place are being used most appropriately; given that the supply of resources is limited, the ability to match a child or youth’s needs with a placement that has the capacity to respond to those needs is often not easy or possible.

There was extensive discussion in all consultation sessions about what residential options are currently available and what options should be included within a continuum of residential services. Participants consistently reinforced the need for a range of residential care and treatment options so that appropriate matches can be made between the needs of the young person and their residential situation.

This range included:

- Kinship care, extended family care.
- Shelters to provide temporary housing in times of crisis (e.g., when a youth and his/her family need a break from one another, when a youth's living situation has broken down and they need time to arrange appointments and sort out options).
- Receiving homes for stabilization and assessment and to allow time for planning and placement matching.
- Safe houses that provide emergency housing and support to youth who are being sexually exploited, are homeless or experiencing problematic substance use or mental health issues that have destabilized their usual living situation.
- Foster homes of different types that have different family compositions, skill levels, interests, experience, etc.
- Specialized foster homes that support children and youth with special and complex needs.
- Concurrent planning foster homes (i.e. foster families that are able to both support the child/youth and their birth family in reunification efforts, while also being committed to adopting the child should the family not successfully reunite).
- Respite and relief homes of different types including those with areas of specialty.
- Treatment foster care (e.g., Multi-Dimensional Treatment Foster Care).
- Staffed resources, particularly for intensive assessment, stabilization, support, and treatment.
- Specialized "step up" and "step down" residential resources as an alternative to placements in tertiary care services for young people who do not or no longer require intensive treatment services such as the Maples or adolescent psychiatric units. These intermediate residential resources could serve as a bridge between institutional/facility care and family-based options.
- Supported independent living.
- Supportive housing for older adolescents and youth transitioning to adulthood.
- Substance withdrawal management (detox) and residential treatment for problematic substance use.
- Regional and provincial "tertiary care" services, such as the Maples and Ledger House, providing intensive and specialized assessment and treatment.

Generally speaking, participants were not identifying the need for a wider range of residential service options *per se* but rather enhanced accessibility of service options so there is a capacity to respond to needs in a timely and appropriate way. Participants also called for more locally available and accessible specialized services so children

and youth do not have to seek care long distances away from their home communities. That said, some residential options that were recognized as being necessary to provide a full spectrum of services are either not available (e.g., specialized step up/step down resources) or in scant supply (e.g., supported housing for youth).

As described earlier (see Table 1), residential services for children with severe mental health problems are almost entirely tertiary care hospital-based services, and if alternate family care or staffed residential care services are required, the child or youth must be brought into care under the *CFCS Act* if eligible. In this regard, the primary concern of workers and service providers in the child and youth mental health service sector was the lack of specialized intermediate care, such as step up/step down residential services, for children and youth with severe mental health problems.

This concern about intensive, intermediate level response capacity similarly arose for children and youth with special needs, especially developmentally disabled adolescents who have very challenging behaviours and “dual diagnosis” youth (e.g., developmentally disabled and mentally disordered youth or those with both substance abuse and mental health concerns). These children and youth often cannot be accommodated in family care settings and, given the complexity of needs and challenges, may require specialized, short term tertiary care responses such as a dedicated Provincial Assessment Centre for youth.³²

The other major concern raised in relation to special needs children was the need for better availability of specialized family caregivers who are able to care for medically fragile children.

Recognizing that youth custody services are mandated and required by federal criminal law, the principal concerns raised in relation to services to youth justice clients were the needs for improved access to substance use treatment resources and supportive housing for older adolescents who are transitioning to adulthood.³³

Although the need for Safe Care (or Secure Care) services for the involuntary committal of, for example, sexually exploited or addicted youth, was raised by a few participants, the issue was not frequently raised and did not appear to be a priority.

Regardless of the type of residential placement arranged, many participants reinforced that the orientation or aim of the system needs to focus on “safely ensuring permanence” for the child/youth, be that with birth parent, extended family members, an adoptive family, or some other arrangement that ensures a lifelong connection for the young person with caring and competent adults.

In addition to having access to a range of residential placements as described above,

32 The Provincial Assessment Centre in Burnaby, which is operated by Community Living BC, is a designated mental health facility for short-term (i.e., up to 3 months) assessment, stabilization and planning for dual diagnosed clients. It is principally for adults but does accept admissions of youth. There is an average of 4 youth admitted per year.

33 Although Health Authorities are responsible for problematic substance use assessment, treatment and withdrawal management (detoxification) for the general adolescent population, MCFD youth justice services funds four contracted community residential substance use treatment programs for youth justice clients.

participants identified a number of other services and supports that children and youth in residential care may require, ranging from general to specialized supports:

- Transportation (e.g. to school, specialized services, etc)
- Special educational services
- Inclusive recreation
- Day programs (including for children not accommodated in school)
- Community-based support groups (e.g., youth in care, foster caregivers, parents of children with special needs)
- Special needs services (e.g., behavioural consultants)
- Family counselling
- Physical, occupational and speech-language therapy
- Mental health services
- Problematic substance use assessment, treatment and withdrawal management (detoxification) services and supports
- Autism services
- FASD services
- Forensic psychiatric assessment and treatment
- Violence prevention/intervention

While these may be recommended in assessments or plans of care, access is often limited due to geography and lack of services in the area, waitlists, restrictive eligibility criteria, etc. Of all of the above, access to mental health and problematic substance use services was most frequently noted as being insufficient or inaccessible.

C. Research Findings

Consultation participants reinforced the importance of having a diverse array of residential placement options and support services in order to match children and youth with appropriate resources and sustain out-of-home placements while working on a permanency plan. The research reinforced the value of diverse options, but also examined what interventions and approaches seem to be more or less effective. In other words, it is not enough to just have foster caregivers or staffed group homes in the array of services – consideration must also be given to *how* caregiving is done within these different options if the outcomes for children and youth in residential care are to be improved.

Fisher et al., (2009) prepared a framework of potential intervention options to improve

the lives of children in foster care. The options span from low to high intensity. Option one is to screen and refer. This option includes ongoing systematic assessment at the time of placement and active (as much as daily) monitoring of placements to determine where extra supports are warranted. The authors point out that researchers in the child welfare field have called for systematic screening to address the physical, mental and developmental wellbeing of children in care. They suggest that combining this with active monitoring and support may be a cost-effective way to identify children who are unlikely to benefit from conventional foster care and/or may need additional services, and to reduce the likelihood of extremely expensive events, such as foster placement disruption and the loss of available foster caregivers. They also believe that this approach is likely to yield significantly better outcomes for the children. The second option in the framework is enhanced foster care where workers have lower caseloads and receive higher salaries, and foster caregivers have access to enhanced support and behavioural consultation. Option three is targeted foster care interventions to address specific needs and issues. This includes *Project KEEP (Keeping Foster and Kin Parents Skilled and Supported)* and *KITS (Kids in Transition to School)*, both of which show promise based on available evidence. The fourth option is *Multi-dimensional Treatment Foster Care (MTFC)*, which has an extensive evidence base. The authors conclude by suggesting that one of the greatest areas of need is a systematic approach for implementing a comprehensive set of interventions on a wide scale basis in the context of foster care. This article highlights the availability of evidence-based models for supporting children and youth in out-of-home care and that using such models should be undertaken within a comprehensive and systematic approach to addressing their needs driven by early, universal assessment.

Several articles questioned the effectiveness of group home care, inpatient treatment and independent living services, however others suggested that these settings could be successful. As noted above, these inconclusive results may be attributable to other variables including the practices and approaches used within the placement. For example, Bettmann and Jasperson (2009) determined that residential treatment and inpatient psychiatric care appear to be effective interventions for certain youth. The challenge in utilizing this form of intervention appears to be effective targeting, maintaining family involvement, and having access to comprehensive after-care supports.

A growing body of literature supports the use of specialized care models for higher needs children and youth, such as *Multi-Dimensional Treatment Foster Care*, *Wrap-Around* programming, *Safe Babies*, and *Treatment Family Homes*. These models are intended to target the specific needs of the populations they serve and have demonstrated positive outcomes. There was little evidence in the available literature to support the use of non-specialized community-based group care models serving multiple high needs children and youth.

A number of research articles addressed the importance of timely mental health assessments and services for children and youth in care. For example, James et al., (2008) looked at risk factors for placement breakdowns, especially during early and

mid-adolescence. They concluded that the significant role of behavior problems in placement breakdowns stresses the need for comprehensive mental health assessments at time of entry into out-of-home care in order to effectively match a child or youth's needs with their placement. They further stated:

"Results from our study suggest mental health services early in the out-of-home episode may decrease the likelihood of placement into an RCS [restrictive care setting], but that these services are less effective over time in treating the types of problems that ultimately propel children into an RCS." (p. 356)

This underlines the need for early, targeted mental health services at point of entry into residential services.

D. BC Reports and Initiatives

A continuum of care for BC was clearly defined in the *Systems of Care in British Columbia* (2002) discussion document. Although the document was not formally endorsed by MCFD, it was disseminated to regions as a potentially useful guide to planning. The purpose of the framework outlined in the document was "to provide a clear articulation of what the types of resources should be, what supplementary services they might need (to help with planning for more effective use of those services), and the reason for using and not using a residential service in order to address a need or a problem. Most importantly, the framework would *ensure that children, youth and families benefit to the greatest extent possible from the available resources.*"

The key themes of the proposed system of care were:

- Building on the capacities of families and communities.
- Greater emphasis on early and ongoing assessment and planning.
- Separation of services and placements, and bringing services to placements.
- Emphasis on wraparound/integrated case management to support full participation of children, youth and their families.
- Improved access for families seeking help.
- A "gate" or access to services that does not require the involvement of the child protection system.

The *System of Care* document emphasized the importance of working from a strengths-based, community development approach and improving assessment and planning particularly to help reduce the number of moves for children in care. In addition, the proposed system of care conceptually and functionally separated services from the placement, or where the child lives, meaning that the services a child or youth receives are not dependent upon where he or she lives, rather they are brought or made available to the child where he or she lives.

Safe Care for British Columbia's Children: A Discussion Paper, released in May 2004, outlined a proposal for replacing the widely criticized *Secure Care Act* that was passed by the Legislative Assembly in July 2000 but not proclaimed into force, with legislation that focused on sexually exploited youth, utilized a court-based adjudication process and limited detainment to a maximum of 30 days. This discussion paper provided the basis for consultations during the summer and fall of 2004 that involved over 500 participants in 57 consultation meetings across the province. The overarching messages from the Safe Care consultations were that the existing system of voluntary community services needed to be strengthened to avoid unnecessary reliance on involuntary services and that improvements must be made to enhance voluntary aftercare supports. Aboriginal communities also raised a number of issues about the proposed legislation, given the anticipated impact on Aboriginal youth.

While government still considers Safe Care legislation to be a potentially useful part of a future continuum of responses to children and youth who are at serious risk of harm to themselves, there are no plans in the immediate or near future to proceed with such legislation.

E. Canadian Reports and Initiatives

Other Canadian provinces are also recognizing the need to have a continuum of service options for children who need to be placed outside their parental home. Several jurisdictions report that work to strengthen their array or continuum of residential options for children and youth is underway or planned.

In December, 2010 the Ontario government released the report, *Future Directions for In-Care Services in a Sustainable Child Welfare System*. They note that there is "a broad consensus that in almost all circumstances, family-based care offers the best environment in which to realize the goal of enabling kids to be kids." They suggest that, as children and youth differ greatly in their needs, family-based care should take a variety of forms. This requires ongoing availability of range of family-based settings across the province.

In the past two years, the Saskatchewan government has released two reports pertaining to their child welfare system (see note above). One notable recommendation proposed that the ministry, "conduct mandatory education and performance management for Ministry personnel whose job duties include the assessment and placement matching for children in the care of the Minister and foster homes."

F. Reports and Initiatives in Other Jurisdictions

As previously noted, federal law in the United States provides a framework for developing policies, strategies and practices at the state level regarding stability in placements and continuum of services that focus on moving children into family-based settings and out of group homes and institutions. This framework has informed the development of a range of residential care services that aim to provide family-style care while also delivering treatment care to better meet the complex needs

of the children and youth in the system. Most notable among these options are *Treatment Foster Care (TFC)*, *Multi-Dimensional Treatment Foster Care (MTFC)* and the *Mockingbird Family Model*.

1. Treatment Foster Care

Treatment Foster Care (TFC) aims to provide children and youth with a combination of the best elements of traditional foster care and residential treatment centres. The approach combines the positive aspects of a nurturing therapeutic family environment with an active and structured treatment program. Proponents of *TFC* suggest that it is a clinically strong and cost-effective way of providing individualized, intensive treatment for children and youth who would otherwise be placed in institutional settings. This program is community-based allowing children to remain in their home communities. This program allows children and youth to maintain a large degree of normalcy - maintain relationships with family and friends, attend the same schools, and continue extracurricular activities - which is an important factor in healthy development. The research and evaluative findings have demonstrated that children and youth in *TFC* experience more stability, have a positive perception of their placement, and that these home based interventions are more cost effective than tertiary care.

2. Multi-dimensional Treatment Foster Care

Multi-dimensional Treatment Foster Care (MTFC) is an intervention designed for children and youth who display emotional and behavioral difficulties. The model emerged as a result of work undertaken at the Oregon Social Learning Centre (OSLC) during the 1970's and early 1980's, as a cost effective alternative to group and tertiary care. It is based on social learning and attachment theories and provides intensive support in a family setting. A multidisciplinary team of professionals works with *MTFC* caregivers to change behaviour through the promotion of positive role models. Placements are intensive and tailored to the child's specific needs, with 24-hour support from supervisors. *MTFC* has been implemented in a variety of jurisdictions in Canada, USA, UK and Sweden and is being implemented over 60 sites spreading across the world.³⁴

3. Mockingbird Family Model³⁵

The *Mockingbird Family Model (MFM)* developed and implemented in Seattle Washington, offers a comprehensive support structure for families and children across the continuum of the child welfare experience - from preventative strategies to transitional and permanency solutions. The *MFM* was designed to help improve safety, permanency and well-being and to mitigate the effects of trauma by restructuring and normalizing the way foster care services are delivered. The *MFM* structure allows for an integrated and holistic approach to foster care service delivery and acts as a vehicle for practice change.

³⁴ For further information see <http://www.mtfc.com/currentsites.html>

³⁵ For further information see <http://www.mockingbirdsociety.org>

The model incorporates:

- Children and youth ages birth to 21 years.
- Birth families
- Formal and informal kinship caregivers
- Foster families
- Foster-to-adopt families
- Adoptive and chosen families

The *MFM* offers innovative solutions for some of the most frequent problems facing children in the foster care system, notably:

- Relationship-based planned and crisis relief care that prevents placement disruptions, provides a safe space for relationship pacing, and reduces caregiver burnout.
- Peer mentoring and coaching to eliminate the feeling of isolation caregivers often experience, facilitate conflict resolution and problem solving, and increase placement stabilization.
- Support for children to maintain connections with siblings and birth families while experiencing the safety, stability, and well-being associated with an extended family.

Outcome evaluations conducted on 11 active *MFM* constellations in Washington State, Washington D.C and Kentucky have reported that, "*Child safety* is improved because caregivers are supported in a myriad of ways and there is a larger community looking out for the needs of the child. *Permanency* is facilitated through effective efforts to stabilize placements, foster birth family connections, and support the participation of birth and future families before and after permanency is achieved. *Child well-being* is enhanced through the opportunity to place siblings together in the same Constellation when it is not possible to place them in the same home, through providing culturally sensitive care and through enhancing community engagement."³⁶

³⁶ Reference: *Mockingbird Family Model: 2008 Management Report on Program Outcomes*.

Part Five – Strengthening Foster Care

A. The Current System of Foster Care

As described in best practice research on foster care and residential care models, the foster family care model is an out-of-home care living arrangement that most closely replicates a family living situation – with adults in the caregiving parental role and sibling type relationships with the caregivers' own children or other children placed in the home. Consistent with this research and practice experience, BC has developed a comprehensive range of foster family care homes to meet the diverse needs and situations of children and youth who are in the care of the director under the *CFCS Act*.³⁷ The definition of a family care home that is used in MCFD Standards is:

"A family or person approved by and funded by a director to care for children who are in the care of the director. Persons who provide family care home services are referred to as caregivers. Family care home services are provided from private homes where caregivers reside."

There are three types of family care homes:

- Restricted (Kinship) family care – director-approved family that provides care for a child known or related to them. Approval is restricted to the specific child placed in the home and terminates when the child leaves or is discharged from care. A restricted home may be re-approved if the child previously in care at that home returns to it, or to provide respite or relief services for that child.
- Regular family care – a director-approved family that provides care for children and youth of varying ages and needs. Unlike restricted family care homes, the child placed in the home is not normally known by the caregiver.
- Specialized family care home – director-approved family that provides care and support for a child or youth that may present complex health needs and/or challenging behaviours that interfere with the quality of his/her social interactions. Each of the three levels of specialized family care homes has specific caregiver assessment, approval, experience and training requirements. Level 2 and 3 homes may also provide specialized assessment and intervention services. The following describes the child development needs, care and service intensity:
 - Level 1 family care homes provide care for children with multiple developmental needs who present average to moderately challenging behaviour and an average to moderate risk to self, others and/or property.

³⁷ The services, caregiving intensity and service system expectations present foster caregivers with both challenges and rewards. BC is very fortunate to have a considerable number of long serving foster caregivers who have been looking after BC's most vulnerable, fragile and high needs children and youth for 20, 30, and 35 years. Their knowledge and experience is vast, their capacity to care for and nurture children and youth of all ages who have a diverse variety of strengths and needs is substantial and their patience with a service system that may be slow to make necessary changes knows no bounds. This demographic among MCFD's foster caregivers is one of the emerging challenges on the horizon as many of these highly experienced caregivers will be retiring and ongoing recruitment and retention of new groups of caregivers who have very different family and economic situations and expectations is becoming more of an emergent need.

- Level 2 family care homes provide care for children with more complex needs and behaviours, who present moderately to severely challenging behaviours/ developmental delays and a moderate to severe degree of risk to self, others and/or property. Assessment and intervention is usually required.
- Level 3 family care homes are for children who require the most extensive daily care, including health related care and/or interventions related to mental health concerns, and who present extremely challenging behaviour and/or lack of developmental progress and an extreme degree of risk to self, others and/or property. Assessment and intervention is usually required.

Caregivers providing family care home services are provided with compensation through a contract known as a *Family Care Home Agreement* that covers the maintenance costs of caring for the child in their care. In the case of specialized family care homes levels 1 – 3, a service payment is also provided to reflect the skill level and additional service expectations. In some circumstances where a *Family Care Home Agreement* and ongoing supplementary payments are not considered sufficient to meet the care and intervention service needs of the child, another type of contract known as a *Client Service Agreement* may be used to support and augment the family care home setting with a limited number of support staff working with the primary caregiver.

Approved family care homes provide relief services to other foster caregivers as well as receive relief services when they need to take scheduled breaks in caregiving or when they are experiencing a personal crisis or emergency situation. This is considered one of the vital support services for caregivers and in the case of level 2 and 3 caregivers funding for up to 3 days of relief per month is provided for within the service payment. All other foster caregivers can make arrangements for relief through their MCFD resource worker and provide invoices for payment of their relief services.

Distinct from the relief care provided for and by approved foster family care homes, foster caregivers may also provide respite services to families (birth, adopted, kinship) who are receiving respite supports under a *Support Service Agreement*. Respite services are typically used as part of a range of services that support birth, adoptive or kinship families to continue looking after their children, prevent family breakdown, cope with a family crisis or emergency situation or provide a rest from dealing with the high needs of their children.

MCFD recognizes that in order to keep foster caregivers engaged, confident and competent in their caregiving role, a whole range of supports need to be in place to sustain and successfully retain foster caregivers. The ministry has partnerships and funding relationships with a number of agencies and organizations that have a primary focus on supporting, training and advocating for foster families including: the BC Federation of Foster Parent Associations (BCFFPA), the Federation of Aboriginal Foster Parents (FAFP), and, since 2002, regional foster parent agencies and contractors that provide a range of support and training services including the delivery of the current *BC Foster Care Education Program*.

In addition, MCFD provides the *Foster Parent Support Line* which is available after office hours, on the weekends and statutory holidays to provide advice, support, referral and follow up in situations where a caregiver is experiencing a very challenging, crisis or emergency situation with a child in their care. During the development of ministry standards and policies which have a direct impact on foster caregivers, such as the *Caregiver Support Service Standards* (2006), policy staff worked with ministry resources team leaders and managers as well as representatives from the BCFFPA, FAFP, foster caregiver support agencies regional groups and individual foster caregivers throughout the province. The aim of this process was to ensure that the standards reflected the supports and services foster caregivers needed to fulfill their challenging care giving roles.

The *Caregiver Support Service Standards* were developed to provide a framework for:

- Consistent, timely and high quality service delivery involving caregivers to enhance the safety and well-being of children in care.
- Development of collaborative plans to return children to their families wherever possible.
- Promotion of stability and continuity of lifelong relationships for children, including adoption.

In order to achieve excellence in the provision of support for caregivers and the provision of services by caregivers, the standards focus on key areas relating to caregiving, including:

- Planned recruitment and retention of caregivers.
- Supportive practice to sustain caregivers.
- Inclusion of caregivers and resource staff in the child's team using integrated case management practice.
- Collaborative assessment and planning for children.
- Promoting and maintaining stability and continuity of lifelong relationships for children.
- Keeping Aboriginal children connected with their families and communities, and strengthening collaborative working relationships with Aboriginal communities.

While the *Caregiver Support Service Standards* are comprehensive and innovative in terms of best practice policy, it is clear in the feedback from some consultation participants that there have been challenges in communication, training, practice supervision and funding that may have impacted implementation. Although many of the ideas, issues and concerns raised in the consultations are already addressed and supported in several sets of current ministry standards and policies – including the *Child and Family Service Standards*, the *Children in Care Service Standards*, and the

Caregiver Support Service Standards - the broader knowledge, full understanding, communication about and application of the content of these standards appears to be lacking in some areas and will be considered in phase two of the Project.

B. Consultation Findings

1. Caregiver Recruitment

Participants in most of the community consultations (inclusive of MCFD staff, caregivers and service providers) spoke to a need for more foster family care homes. The primary value in increasing the supply of placements is to create more choice so that better placement matches can be made. Participants suggested that this will result in less placement disruptions due to inappropriate placements that have a higher likelihood of breaking down due to mismatch between child's or youth's needs and the skills and attributes of the caregiver.

More specifically, participants indicated that there was a need to recruit and retain more:

- Aboriginal homes.
- "Youth-friendly" homes and caregivers that welcome and are skilled in meeting the needs of adolescents.
- Specialized care homes and caregivers that are knowledgeable and skilled in supporting young people with a history of significant trauma, attachment challenges, problematic substance use, mental health concerns, FASD, co-occurring conditions (e.g., mental health concerns, developmental delay and/or problematic substance use), dual diagnosis (e.g., co-occurring mental health and developmental delays), and other special needs.
- "Birth-family friendly" homes that are willing and able to work more intensively with birth families to achieve reunification.
- "Multi-generational care" homes that are willing to take a youth in care and their child, or a parent and child.

The extent of recruitment challenges varied from community to community and was influenced by a number of factors, ranging from the amount of time the local and regional offices and supporting agencies had been able to invest in recruitment and assessment of interested families, to the cost of housing and the capacity of families to offer care for extended family members or foster children. Challenges seemed to be greater in some rural and/or remote communities and urban communities with higher housing costs.

The *CFCS Act* and MCFD policies and standards direct staff to place children and youth requiring residential placement close to their birth families, home communities and support systems (including schools, activities, supportive peers and neighbours,

etc) wherever possible. Some offices have established operational procedures requiring close-to-home placements to reinforce policies and standards and support permanency planning and reunification practices. This creates a challenge in some communities where there are few caregivers. When close-to-home placement options are limited or non-existent, children and youth are placed wherever appropriate caregivers are located, including in communities that may be a considerable distance away from the child's birth family and community. It was suggested that community-by-community assessments of caregiving capacity and child and youth placement need to be done on an ongoing basis in order to identify which communities are most in need of targeted recruitment and retention.³⁸ The principle of placing children close to their birth family, other caring and involved adults, and their circle of connections/ supports (such as school, recreation, etc) is important to consider when assessing community capacity for residential care.

Not all communities face a shortage or limited supply of caregivers however, and some foster caregivers raised concerns that due to an over-supply in their area, children were not being placed and their financial sustainability was affected. This points to a dilemma or tension within the foster care system. The system was developed when the majority of families had one stay-at-home parent and housing was relatively affordable. Foster care payments were originally structured to cover only the basic costs of caring for a child including food, shelter, clothing, recreation, transportation and some supplementary costs; therefore, families did not depend upon an income from fostering. Family compositions and economic and employment requirements have changed over the past 50 years, housing costs in many urban and suburban areas have escalated, and the needs of the children within residential care have become more complex. Consequently, foster care payments have increased and in many cases, one or both of the foster caregivers are full time care providers and fostering is a primary source of family income. As such, if the supply of foster or extended family placements increases and/or the demand for placements diminishes, some caregivers that are not working outside of the home or have extra housing costs, for example, will not have sufficient income to sustain their current situation. Accordingly, retention of these caregivers may be compromised. On the other hand, it is in the best interests of the children and youth needing residential care that supply exceeds demand so that a strong fit between the young person's needs and caregiver skills and attributes can be achieved.

Participants identified the need for more concerted and consistent efforts to recruit and retain foster and extended family caregivers. Short-term foster caregiver recruitment campaigns have had some success in raising interest and increasing the number of applications. However, participants noted that in some cases, MCFD's capacity to review and process the applications within a reasonable time period has been limited and prospective foster caregivers have become disillusioned and withdrawn their applications or moved on to other caregiving opportunities such as "homestays" for

³⁸ Existing MCFD standards require the development of a resources plan for the community that assesses resource needs and capacity and establishes action steps. Many MCFD resource teams have prepared plans, however, fiscal and other challenges can limit the action taken, particularly for long term planning that requires action over multiple years (and funding cycles).

foreign students or “care homes” or “homeshares” for adults in community living. Participants suggested that strong applicants have become lost to the system and the need for a more sustained and sustainable recruitment approach was identified.

Participants reinforced the importance of recruiting people who will be effective and successful caregivers and suggested that better screening tools at the beginning of the recruitment process would help MCFD staff to discern those most appropriate for fast-tracking or to go forward for the comprehensive assessment and home visits. The value of having contracted foster caregiver services – that have as their primary function to recruit, train, support and retain foster caregivers – was noted in a number of communities that have had access to these services. However, it was also noted that the array of services offered by these programs varies considerably and it was suggested that some analysis be done to determine what is most beneficial and effective in foster caregiver support practice.

Once foster caregiver applicants are contacted, interviewed and screened as appropriate for assessment and home study, participants urged MCFD to expedite the process. Stories were shared about people having come forward (often recruited by other foster caregivers) only to have to wait for periods of time upwards of 6-12 months, before being contacted for follow up.

The value of having “surplus capacity” in the foster care system is clear: there is less need to overload existing foster homes, more choice for matching child needs and caregiver strengths, etc. However, this would necessitate some re-thinking of compensation. While vacant “leveled” homes may receive payments for a specific period of time, to sustain them in between placements, some homes with vacancies may not receive payments, making it difficult for them to meet their costs and sustain their home for future placements. The greater the surplus capacity, the more likely that vacancies will exist in homes, which presents challenges to funding and sustainability, and retention of caregivers.

The level system for classifying and compensating foster caregivers, and recruitment into levels appears to be inconsistently applied across regions and sub-regions. The growing number of specialized family care homes with additional support staff that are recruited and contracted for outside of the level system, is a further indication that the current family care home contracting model is not meeting the needs of all concerned and should undergo a comprehensive review.

Participants identified an array of barriers to effective foster caregiver recruitment. Negative public perceptions about fostering, foster children and MCFD were a frequently cited barrier. A number of participants suggested that caregiver recruitment and retention would be enhanced if foster caregiving was positively “re-branded” through a broad and creative public awareness campaign. Other barriers to recruitment included:

- High cost of housing and utilities in some communities.

- Lack of accessible and affordable family housing in some communities. (This was noted as a significant barrier for many Aboriginal families who cannot secure housing that will allow them to take in extended family or community members).
- Internal government delays and impediments in developing and launching communications materials.
- Lack of capacity (time and resources) amongst MCFD or contracted staff to build community awareness, share information about fostering, follow up with people expressing interest, review applications, complete home studies, and prepare new foster caregivers for their first placements.
- Perceived and real inequities or inconsistencies in the ways in which specialized levels are assigned and compensation and exceptional payments are determined.
- Competition from other caregiving arrangements including, for example, foreign student homestays and the CLBC home share program.

2. Caregiver Training and Education

Participants in all community consultations discussed foster caregiver training and education including curriculum, mandatory and discretionary contents, mode of delivery, timing, accessibility and supports to participate, expectations and incentives for professional development, and consequences if foster caregivers don't participate in training.

There was general agreement that foster caregivers should be expected or required to participate in orientation and basic core training prior to having the first child or youth placed with them. However, there was less agreement on how *core* training beyond the basic level should be handled. Those familiar with the work done a few years ago on the new foster caregiver training curriculum felt that it was a valuable framework and should be revisited and implemented. Others suggested that training should be more individualized and "opportunistic" (e.g., foster caregivers who are specializing in caring for infants with special needs should have training relevant to their unique role, and not be expected to participate in general training on adolescents). The pedagogical principle reflected in these conversations was to offer the more detailed or advanced training when it is most likely to be relevant and applicable to the foster caregiver. For example, a foster caregiver who is supporting a child who has FASD and consequent special needs will find the curriculum on FASD relevant at that time, but might not absorb the content as well if it was offered out of context as part of a general training program.

Foster caregivers suggested that they would be more willing to engage in training when the subjects covered were more relevant to their specific situation and/or the specific child or children placed with them (e.g., caring for sibling groups, caring for adolescents with problematic substance use issues, caring for children with FASD).

In addition to discussions about *what* should be included in foster caregiver training

and when it should be offered, there were discussions about *how* it could be offered. A number of participants familiar with foster caregiver education suggested that a significant number of foster caregivers do not complete the mandatory 53-hour training.³⁹ Reasons cited include: the fact that training is not offered at times that make it accessible; training is difficult to attend training unless child care or relief care for the children in the home is made available; the mode of delivery (i.e., classroom style groups) does not work for some foster caregivers; caregivers do not find the curriculum to be relevant to their circumstances and thus decide not to attend; and the lack of incentives to participate and consequences for not attending.

Discussions pertaining to foster caregiver education and training suggested five types or levels of learning:⁴⁰

- **Orientation** - Offered prior to or shortly after an application is received, orientation training introduces prospective foster caregivers to the field of fostering – what they can expect, how they might prepare themselves and their family, what skills and attributes will be beneficial, etc.
- **Basic training** - Offered after a home has been approved but prior to the first placement, basic training will deepen the orientation information and help prepare people for their first placement. Information about how placements will be arranged, who does what in the system, what they can expect from the MCFD staff, what other organizations, authorities or ministries might be involved in a foster child's life, where they might go for support, what training is available, etc.
- **Core training** - Offered after a home has been approved, core training has traditionally covered a broad range of topics delivered through a series of specific modules offered over time (approximately 50 hours). Foster caregivers have been expected to complete all modules within a 2-year time frame, although, as noted, a significant number do not appear to complete the training for a variety of reasons. Participants in the community consultations felt that core foster caregiver training was very important, particularly given the complexity of needs of the children being supported and the desire of foster caregivers to be treated as "professionals". However no consensus emerged on what contents should be covered, how long the training should be, how it should be delivered (e.g. classroom style groups or via internet) and what incentives and consequences should be in place.
- **Specialized** - As foster caregivers often develop specific areas of interest and expertise in fostering over time (such as caring for infants with special needs,

³⁹ In order to assess the extent of this challenge, further information will be gathered on participation and completion rates for mandatory training across regions.

⁴⁰ The first three levels of education and training (orientation, basic and core training) are currently in place. Feedback and suggestions for curriculum contents, delivery approaches, pace and timing of delivery have been gathered from caregivers and further review is pending. The latter two components of education and training, specialized and situation/child-specific, are not formally in place, however they were also recommended by participants in the *Caregiver Support Services Framework* forums held in 2006 and 2007. Some situation/child specific advice or coaching is provided in some areas of the province by community service agencies offering foster care support services. Existing MCFD standards would support all five levels of caregiver education and training.

caring for adolescents with mental health concerns, etc), participants suggested that foster caregivers should have access to specialized training that would assist them to be more effective in their practice.

- **Situation/child-specific** - Participants noted that knowledge is more likely to be absorbed when it is timely and relevant to the learner's situation. It was suggested that some training be provided to address specific situations or needs of children once placed within a home, possibly as an alternative to or as one way to deliver some of the core training. For example, training on how best to respond to children and youth who have limited impulse control (often associated with FASD or other developmental challenges) and are at risk of harming themselves, would be more relevant and meaningful at the time when a foster family is actually caring for a young person who has difficulty managing their impulses and places himself at risk of harm. For this type of learning there is a blurring of the lines between training and support.

Participants generally agreed that ongoing learning is important – foster caregivers should be required to continually build their base of knowledge and skills. There was also general agreement that orientation and basic training should be completed prior to a child being placed within a new home. Beyond this however, there were a variety of viewpoints expressed about:

- What the structure of training should be (e.g., orientation, basic, core, specialized or some other configuration).
- When training should be offered within a foster caregivers "life cycle" (e.g., at the beginning of fostering, during or after first placements, after a placement breakdown, when taking in a sibling group or increasing the number of children being cared for).
- What should be required or mandatory and what should be discretionary.
- How training could be delivered (e.g., classroom style groups, online, self-study).
- Who should deliver the training (e.g., MCFD staff, other foster caregivers, community agencies, post-secondary institutions)?
- Who should participate in the training (e.g., one or both foster caregivers, joint training with MCFD staff and service providers)?
- Whether foster caregivers with relevant education or work experience should be required to attend all core training.
- Whether incentives to participate should be offered and/or consequences for not participating should be established and enforced.
- What specialized training should be offered.

Another issue raised addressed what specifically should be required of MCFD staff

so that they can be better prepared to work effectively with foster caregivers and community service providers. Some participants suggested joint training on selected topics. In addition, cross-training of MCFD staff with different job functions and roles was suggested as a means to encourage and support greater understanding about the different responsibilities carried by staff; for example child protection social workers, resource workers, and guardianship workers could train together with foster caregivers on such topics as case planning, supporting connections with birth families and permanency planning.

Suggestions for foster caregiver training and education included:

- Joint or cross-training for MCFD staff and foster caregivers.
- Practicum placements for new foster caregivers (i.e., new foster caregivers would be placed with experienced foster families to observe and learn prior to receiving a child or youth in their home).⁴¹
- Developing a mentorship program that would complement organized training.
- Specialized training to raise caregiver understanding and skills to support children and youth who are experiencing or have experienced such things as significant trauma, mental health concerns, problematic substance use, family violence, sexual exploitation, health concerns, developmental delays, learning disabilities and school failure, loss of cultural connections to homeland (frequent in refugees and immigrants).

3. Caregiver Retention and Support

Many participants reinforced that foster caregiver recruitment is important but not in isolation from the other aspects of training, support and retention. If skilled caregivers are not retained then recruitment becomes a significant (and costly) concern. Retention has many facets including the intangibles such as feeling respected and valued, and the tangibles such as placement matching, compensation, access to relief care, supports, etc.

Participants spoke about what causes foster caregivers to leave or be less effective in their role. Key concerns included children being placed inappropriately (e.g., the foster home being a poor fit, not being prepared for the transition, a lack of information and guidance provided to the foster home at the time of placement) and lack of support and assistance provided both to the child/youth and to the foster family, particularly during the first few weeks of placement, when challenges arise, and at the conclusion of a placement.

Retention of foster caregivers is strongly connected to placement stability and continuity. If supports are not provided to assist in retention, then the foster caregiver is more likely to request that children or youth in their care be moved, or leave fostering

⁴¹ Interestingly, some experienced specialized foster caregivers offer practicum placements for social work and child and youth care students, creating a valuable opportunity for cross-training.

altogether. As a result, the young person in their care experiences a disruption in their placement and relationships.

Many participants spoke to the need for strong and comprehensive supports for foster caregivers to enhance retention and sustain placements. Many different aspects or facets of support were described – from how caregivers are treated, to what services are available, to what compensation is offered. In general, “support” encompasses anything that could help to sustain caregivers, enhance their capacity, and reduce the likelihood of crisis or placement breakdown for a child or youth.

Many caregivers spoke about the importance of interpersonal supports. Being respected and valued by the MCFD staff was very important. Respect is conveyed in a variety of ways – from MCFD staff promptly returning phone calls, to including caregivers in planning meetings and respecting their input and knowledge, to taking their concerns seriously and responding to requests for advice or help without judgment. Networking with other foster caregivers and community partners was identified as another key interpersonal support. Given the nature of the work, foster caregivers can feel isolated and alone. Considering the complexity of the needs of the children in their care this sense of isolation can be overwhelming, especially when crises arise. Caregivers who were connected to existing networks and supports such as the community partnership tables, local events such as family picnics, family drum-making workshops, local and provincial foster parent associations, contracted foster caregiver support services and after-hours supports offered by MCFD, noted the value of these connections, while also acknowledging that a significant number of foster caregivers are not participating. More information is required to understand why caregivers are not engaged in the current networking opportunities and what other options might need to be developed.

Caregivers suggested that their capacity to deliver quality care is enhanced when the following relationship-based supports are in place or available:

- Respectful, positive and constructive working relationships with MCFD staff. One foster caregiver described a situation when a sibling group was placed in her home close to dinner time: “The social worker could have just dropped the kids off and been on his way, but instead he came into the house and stayed for a few hours to help me settle the children and make dinner. He appreciated that it would be hard for all of us and did his best to bring some calm to the situation. I felt that we were a team.”
- Access to other foster caregivers for mutual support, advice, mentorship and counsel.
- Clear understanding about roles and expectations, including what is expected of the foster caregiver and what the caregiver can expect and “count on” from MCFD staff and community partners. Consistency of expectations was also important – caregivers find it difficult when dealing with multiple MCFD workers each of whom have different expectations and approaches.

- Opportunities to prepare for new placements such as meeting the child/youth beforehand, easing them into the home, receiving key information, etc.
- Appreciation and acknowledgement of the strain that fostering can place on the caregiver's own family particularly during key points of time – at time of placement, during crises, at conclusion of placement (whether planned or unplanned).
- Appreciation and acknowledgement of the challenges inherent in fostering in rural or isolated communities (e.g., limited access to supports and services, risk of strained relationships with friends, neighbours or colleagues when caring for children and youth whose families are connected to them) and/or fostering children and youth of diverse cultural backgrounds and traditions.
- Opportunities to be involved in planning processes. Demonstrated respect and value for the caregiver's knowledge and perspective about the child or youth and their needs.
- Feedback and conflict resolution protocols to ensure that information is shared, issues are raised appropriately and differences of opinion are addressed in a respectful and constructive way.⁴²

Caregivers described their frustration with the lack of time some MCFD workers are able to invest in building relationships and getting to know the foster caregiver and their family, and the children and youth who are being placed within their homes. It was suggested that this could compromise the sustainability of placements. For example, when workers are not familiar with the needs of the child, the capacity and strengths/limitations of the caregiver, and the needs of the children already living in the home, then the matching of child and placement is not well informed. Inappropriate placements escalate the likelihood of crisis and breakdowns. In addition, when there are several unrelated children placed in the home – sometimes each with a different MCFD worker – the expectations set by the workers can be incompatible or unrealistic if the workers have not been able to coordinate their efforts and take the time to understand the dynamics and diverse needs of all the children in the home.

When the children and youth in their care receive the supports and services that they need, the caregivers in turn feel supported. Caregivers suggested that their effectiveness and longevity as foster caregivers is enhanced when the children and youth in their care have timely access to the following services and supports:

- Specialized and therapeutic services such as specialized assessments (to identify learning disabilities or other special needs), mental health and problematic substance use services, behavioural interventions, and autism services.
- "Normalizing" resources such as financial supports to participate in typical child

⁴² Several participants shared local/regional conflict resolution agreements that foster caregivers and MCFD staff had developed together, noting that these had been helpful tools to address difficult situations. Existing MCFD standards also address conflict resolution.

and youth activities like sports teams, music and art classes, driving lessons, school trips, birthday parties, and family vacations.⁴³

- Transitional supports, especially when the child or youth is moving to another setting (e.g., birth family home, adoptive home, new residential care placement), preparing for an independent living arrangement or for independence at age of majority, or when significant life events are unfolding (e.g., when a CCO is granted or when a parent dies).
- Wraparound services. Given the complex needs of many young people in residential care a more comprehensive array of services that “wrap-around” the child or youth may be required.
- Resources to act on any recommendations arising from assessments and plans.

In addition to supports for the children and youth in their care, foster caregivers described a number of concrete supports that they have found helpful to receive (or would like to receive) in order to be effective caregivers, including:

- New caregiver orientation and support.
- Access to relevant and timely education and training.
- Information about the children and youth being placed in their home.
- Quick access to knowledgeable advice, ideas and assistance including during “after hours” – evenings, weekends and holidays.
- Timely access to relief care.
- Cultural guidance.
- Assistance and supports to include and involve birth family members where this is in the interests of the child or youth (which can be challenging for caregivers).
- Counselling services for self and family, such as grief and loss counselling.
- Adequate and fair compensation.
- Managing the number of children and youth placed in a home.

A number of participants spoke about the importance of providing extra supports to new caregivers. Regardless of the preparation offered in training sessions the “reality of fostering 24/7 can be overwhelming for new caregivers.” It was suggested that a significant number of new recruits leave fostering in the first few years and this loss could be prevented if more efforts were made up front to support and guide new caregivers. Mentorship or “buddy” programs were suggested, with experienced foster

⁴³ Existing MCFD standards and policies allow for financial and other supports to be provided for these types of activities, however, budgets are limited.

caregivers being paired up with new caregivers to serve as advisors and “sounding boards.” It was also suggested that MCFD staff be supported to pay more careful attention to the needs of new caregivers, ranging from carefully matching the child to the caregiver, to facilitating pre-placement visits, to visiting the home more frequently during the first weeks and months of a placement.

Many participants spoke to the importance of having timely access to advice, counsel and assistance so that caregivers did not have to deal with challenging situations in isolation. While MCFD staff may have the expertise necessary to offer advice and counsel, their time is limited due to caseload demands. Caregivers with access to a person or team (such as foster caregiver support services or support networks) that assisted them to work through difficult situations reported that this made a significant difference and helped them support the children and youth in their care.

The support provided by community agencies to family caregiver-based specialized programs in, for example, youth justice, was contrasted with ministry-provided supports to foster caregivers and was frequently praised:

“Agency-affiliated caregivers get a lot more support than what is provided to other foster homes; there is a dedicated support worker for every 3-4 homes.”

These specialized family caregiver programs are different from foster caregiving in that community agencies (instead of ministry staff) recruit, train and support family caregivers – often in combination with day programs and/or one-to-one worker supports – who provide the residential component of a treatment/intervention program.

In particularly challenging situations, it was suggested that access to a worker who could come into the foster home at any time of the day or night to assess the situation and make recommendations or establish a plan, intervene, or provide relief care would help to stabilize placements. Those caregivers who did have access to this type of support (including caregivers within the youth justice system) reported that it made a significant and positive difference in their home.

Participants in many of the consultation sessions suggested that it was essential for caregivers to have access to relief from time to time in order to sustain placements. Two aspects of relief were addressed: financial support and eligibility, and access to and availability of relief caregivers. Regarding financial support, there was a perception amongst a number of the participants that access to relief care was restricted to level 2 and 3 homes only and that all other homes were not eligible for relief. Participants who were more familiar with the supports available to foster caregivers suggested that all caregivers needed more information about what is available to them for relief care.⁴⁴ Regarding eligibility, some foster caregivers who were not level 2 or 3 homes reported that they were reluctant to disclose that they needed relief or request reimbursement

44 Under existing MCFD policies, level 2 and 3 homes receive funds to cover up to 3 days of relief per month in their service payment. Exceptional payments are used to pay for additional relief if required. All other groups of caregivers can invoice for their relief costs or be paid via exceptional payments.

for relief care as they felt they might be judged by MCFD staff and were left feeling that they were inadequate as caregivers if they needed relief support.

Access to, and availability of, relief care was also cited as a significant challenge by a number of foster caregivers and MCFD staff. Caregivers noted that it was very difficult for them, working on their own, to locate suitable relief caregivers. They suggested that, instead of each individual caregiver having to locate relief care, MCFD contract directly with an individual or agency for this service, which caregivers could then access. While most regions have homes that specialize in providing relief services to other foster families and respite services to birth/kinship families, the concerns and suggestions raised indicate that there are still capacity and access issues to be addressed.

The issue of foster caregiver compensation was raised in a number of the consultation sessions. While being clear that no amount of compensation will make fostering more desirable if the other supports noted above are not in place, participants did suggest that compensation should be reviewed and enhanced.

The general view expressed by consultation participants is that the current foster care level system requires revision or re-design. However, no clear alternatives were proposed. Other jurisdictions have wrestled with how best to structure foster care services but weaknesses have been identified for all systems in use. Attaching a level to a foster home serves several purposes:

- Establishes the level of experience, education, skill and/or capacity that the foster caregivers/home have such that practitioners are better able to match the level of care needs that a young person has to the capacity level of the foster caregivers.
- Generally describes the complexity of need that the foster family is willing to accept into their care.
- Ties the above to different compensation levels so that there is some equitable approach to determining service payments.

Concerns were noted about the current level system including that:

- It is administered differently across sub-regions and regions which create inequities.
- It does not adequately account for different regional characteristics and costs (e.g., high costs of housing in the lower mainland, Victoria and the Okanagan, high utility and transportation costs in the North and the Kootenays).
- It does not account for the fact that almost all children requiring foster care have complex needs requiring specialized foster care.
- Cost of living increases have not been built into the system.

Participants suggested that a review of the level system should be undertaken and, that whatever approach is taken to determine compensation, it should consider and address the following questions:

- What is the role of foster caregivers in the system and what expectations are they being asked to meet? Are they “professionals” and expected to have or attain qualifications and provide services as other community practitioners are expected to do?
- Are the maintenance and service payments adequate given the complexity of the work and needs of children in care?
- What is necessary to ensure that compensation is equitable and fair across communities and regions and that interpretation and application of the level system is more consistent and fair?
- Does a graduated compensation approach make sense so that more experienced caregivers receive higher compensation?
- How will differential costs of living and annual increases in costs be factored into a compensation model?
- How might funds be made available to caregivers to support typical family activities for foster children, such as recreation, transportation, lessons, and family activities?
- How might the high costs associated with placement of a new child in care be compensated (e.g., clothing, personal items/toiletries, medical and non-medical treatment)?
- Should caregivers be compensated for a vacant bed when a child or youth who had been in their care is temporarily living elsewhere (e.g., in an assessment facility or detention) though the intent is for the child to return to their care? Should caregivers receive a modest retainer (or “sustainer”) to stay in fostering even when there is no immediate need for their services?⁴⁵

A number of participants, including youth, raised questions about the number of children and youth who may be placed within a single foster home. Some youth reported that they preferred being placed in homes where they were the only child. For example, youth who had experienced the family caregiver model of service developed in youth justice and delivered by Boys and Girls Club Services of Greater Victoria, PLEA, the John Howard Society, and others, consistently spoke very highly of their experience, and some youth attributed part of this to being the only child placed within the home so that they could receive more supervision and care from the parent(s) in the home.

⁴⁵ There is provision in existing MCFD policies and standards to continue to pay for a placement while vacant when there is a reasonable likelihood that a child or youth will return in a reasonable period of time. There is also a 60-day notice requirement within Family Care Home Agreements, so that payments will continue to be made to a foster caregiver for 60 days after notice is given.

There were also a number of stories shared about “too many unrelated children and youth” being placed in homes, resulting in the overloading of otherwise competent foster caregivers, leading to poorer quality care or breakdown, and unhealthy mixes of young people. On the other hand, foster caregivers raised concerns about having “vacant beds” and consequently “no income” for periods of time. This issue ties into concerns raised above about the level system, as foster caregivers noted that when challenging, high need level 3 children do well within their care they may be “downgraded” and receive a lower level of compensation for that young person.⁴⁶ As a significant number of foster families are dependent upon income from fostering, the reduced compensation becomes an issue for the family and may affect the stability and continuity of the placement or the care offered.

C. Research Findings

There are many references in the research literature about foster caregiving and what might make a difference in terms of training and support, although little mention of recruitment practices.

Dorsey et al., (2008) prepared a comprehensive research synthesis on training of caregivers for children and youth in out-of-home settings. The paper reviews the literature from both treatment foster care and regular or traditional foster care due to the fact that there is significant blurring of these models in real life application. Professional standards for foster caregiver training have been largely operationalized through training curricula developed by professional associations in the child welfare arena. The article points out that two curricula - *Model Approach to Partnerships in Parenting Group Preparation and Selection of Foster and/or Adoptive Families (MAPP/GPS)* and *Foster Parent Resources for Information, Development, and Education (PRIDE)* - are widely used and viewed as the “gold standards” for the field. MAPP was developed by the Child Welfare Institute (Mayers-Pastzor, 1987). PRIDE was developed by the Child Welfare League of America. Both are similar in length. MAPP focuses on 12 key skills and PRIDE focuses on five competencies. Both have been criticized for being overly focused on policies and procedures and not paying enough attention to meeting the needs of emotionally troubled youth, and, despite MAPP and PRIDE's widespread use, the authors found virtually no evidence to support their effectiveness.

The paper goes on to look at a range of other caregiver training approaches, some of which are tied into specific intervention approaches. Most studies looked at foster caregiver knowledge and attitudes following training as the primary outcome with little or no assessment of skill or behavior changes at later points in time. Studies in the last five years using interventions originally developed for other populations do however show promising results, including *Multi-Dimensional Treatment Foster Care (MTFC)* for pre-school age children, *The Incredible Years*, and *Parent-Child Interaction Training (PCIT)*. A recently developed intervention called *Attachment and Biobehavioral Catch-up (ABC)* showed positive results with infants and toddlers residing in foster care.

⁴⁶ Although MCFD standards support placement stability, fiscal pressures and the demand for particular caregivers may influence decisions about caregiver compensation.

More recent directions in foster caregiver training and support hold promise, including the *Keeping Foster Parents Trained and Supported (KEEP)* program. This 16-week training program accompanied by weekly homework and telephone calls focusing in tailoring behavioral interventions showed significant improvements in parenting skills child behavioral problems, placement stability and family reunification.

The authors conclude their review by suggesting a two pronged approach that includes the basic messages about expectations and preparation for being a foster caregiver delivered prior to taking a child and providing skills-based training for managing difficult and wide ranging behaviors. Two critical characteristics of the second prong appear to be providing the training and support after the child is placed in the home (not before) and providing opportunities to receive coaching and feedback on the skills that are being practiced. This research points to the importance of both content and timing of training and support.

A study undertaken by Nash, et al., in 2009 used cross-sectional data from a larger study of child welfare outcomes in Ontario to explore whether various types of foster caregiver training would be associated with foster child outcomes. The *PRIDE* foster caregiver training program has been incorporated into the new Ontario practice model so the researchers were curious to examine the impact this might have on child outcomes. The researchers looked at the foster caregiver training programs in widespread use (*MAPP* and *PRIDE*) and concluded that training interventions did not improve foster caregivers' behaviour management skills, attitudes or psychological functioning, and did not enhance the foster children's psychological functioning, extent of behavioural problems or interpersonal functioning. The authors did note however that the *KEEP* program appears to be the only foster caregiver training intervention that has shown positive impact on child behaviors and placement stability.

Barth, et al., (2009) also looked at *Project KEEP* and noted that children who were placed with foster caregivers who were trained and participated in *Project KEEP*,

"... Were almost twice as likely to leave foster care for reunification or adoption, while children whose foster parents were not using Project KEEP were more likely to run away, have their placement disrupt, or have another negative exit from care" (p. 155).

This suggests that there is some value in providing specialized training for specific practice approaches.

With regards to support, research undertaken by DeGarmo, et al., (2009) looked into the effectiveness of the support component of *Project KEEP*. Participants in the study group received 16 weeks of training, supervision and support in behaviour management methods. Subsequent to delivery, the number of placement disruptions and reports of negative child behaviours were monitored. Evidence suggested that children cared for in *Project KEEP* connected homes had better outcomes, however there were differences across homes that could not be attributed to the characteristics of the children and their needs. The researchers concluded that the successful delivery of *KEEP* was impacted by the degree to which foster caregivers were engaged, which suggests that

gaining their buy in and support as well as providing incentives or other motivational strategies, might serve to further increase the effectiveness of this intervention.

James, et al., (2008) noted the risks of placement disruption for children moving into adolescence as the nature of the foster caregiver–child relationships shift. They suggest that significant effort should be directed toward supporting caregivers with foster children who are transitioning into adolescence in order to prevent placement breakdowns.

D. BC Reports and Initiatives

The *Systems of Care* (2002) discussion paper highlighted the following essential components of effective support for foster caregivers from the research and consultations: relationship building with the social worker; respectful and positive decision making process; pre-service and in-service training; crisis intervention services; concrete supports including relief, liability insurance, day care and financial reimbursement; support groups, mentors, buddies, peer support; access to services to meet the child/youth's needs such as for mental health and education; and appreciation and recognition.

MCFD launched the *Caregiver Support Services Framework Project* in May 2006 with a provincial forum attended by 170 participants including foster caregivers, regional resources staff, regional foster caregiver support agencies, delegated Aboriginal agencies, the BCFFPA, the FAFP, the FBCYICN and provincial office policy and program areas. The key themes from the forum included: developing and maintaining trust and respect; building relationships and improving communication; strengthening supports for caregivers including relief; ensuring each child has access to other support and treatment services, education and ongoing skill development; focusing on innovative recruitment and retention; addressing service gaps particularly for children and youth with complex needs; providing after care services for young people leaving care including adequate preparation for adulthood; and the need for a range of residential settings for children and youth to augment family-based care.

Following the forum, a provincial steering committee and four sub-committees were established to develop recommendations related to caregiver recruitment, retention, education, and Aboriginal caregivers. In May 2007, a second provincial forum attended by 135 participants reported out on progress made by the various sub-committees and confirmed plans for further work. In 2008, project activities were put on hold pending development of a new practice framework and initiation of residential redesign. The Residential Redesign Project Team has reviewed the reports and recommendations prepared by the committees.

Despite the initiative being put on hold in 2008, several positive actions can be linked to the *Caregiver Support Services Framework Project* including: the development and distribution of recruitment materials and supports; extensive input and advice on the development and implementation of the *Caregiver Support Service Standards* published in December 2006; the development of a framework for caregiver education;

and, starting in March 2007, the implementation of the increase to the monthly maintenance payment for the child and the increase to service payments for caregivers along with an increase in the mileage rate.

E. Canadian Reports and Initiatives

In Canada, other provinces are also recognizing the need to better recruit, train and support foster caregivers. Most provinces have determined that it is essential to have a comprehensive and consistent approach to caregiver training and most have opted to use or build on *PRIDE* training. The government of Ontario recently released the *Future Directions for In-Care Services In a Sustainable Child Welfare System* (December 2010) acknowledging that, "foster parents are the backbone of an effective in care system" and suggesting that the province's goal of delivering family-based care hinges on the system's ability to recruit, develop and retain individuals who can bring the kind of specialized parenting skills essential to supporting vulnerable children and youth. The report also suggested that more value be placed on the special contributions made, and challenges faced by, children of foster caregivers.

In 2008, the government of Alberta began to implement recommendations stemming from an in-depth examination of the province's foster care system. The proposed changes focus on improving the assessment process for potential foster caregivers, improving information sharing amongst staff and providing more support for new foster caregivers. The *Foster Care Review Report* includes eight recommendations to strengthen Alberta's foster care program and a vision for fostering in Alberta. Of the eight recommendations, four were related to improvements in the foster caregiver home assessment process. For example, it was recommended that a provincial process be developed to clarify expectations and improve consistency in the home assessment process. A winter 2009 status report noted that the *Structured Analysis Family Evaluation (SAFE)* model was already being implemented across the province to enhance foster home assessments.

F. Reports and Initiatives in Other Jurisdictions

In the United States, a number of foundations have been supporting improvement in the foster care system by conducting research initiatives. Most notable and prolific amongst these is the Casey Foundation, whose mission is to provide and improve – and ultimately prevent the need for – foster care. With a focus on high-quality foster care, kinship care and transition services to improve the lives of children and families across the country, the Foundation works with "children, families and communities to ensure that all children can be raised in a safe and permanent family." The Foundation provides strategic consulting services to: help public child welfare agencies improve their services; educate state and federal lawmakers on the need for public policy changes that will help child welfare systems provide effective services for children and families; and, provide nonpartisan research so that child welfare professionals and lawmakers can make informed decisions based on data and evidence.

Part Six - Working Together

A. Consultation Findings

1. Respect and Value

Regardless of where and with whom the Project Team consulted, the topics of “respect” and “valuing” were raised. Participants spoke about the importance of respect between people working in the system and of valuing the role and contributions that each person has and makes. Although most frequently raised in relation to dealings between MCFD staff and foster caregivers, the concepts were also applied to relationships between service providers and MCFD staff, service providers and foster caregivers, caregivers and specialists and between MCFD staff in different roles (e.g., between social workers and guardianship workers or guardianship workers and resource workers as well as between professionals and families).

Where present, it was described as a contributing factor to the individual’s, team’s or community’s capacity to meet the needs of children and youth. It contributed to a sense of being in a “team” or partnership. As one long time foster caregiver said, “I still recall working with [the social worker] years ago and how positive that was. He really valued my input. We worked together as a team on a really difficult case and it made a huge difference to the young person, and kept me going as a foster parent.”

When respect was not demonstrated, participants described negative consequences for the quality of residential care provided to children and youth, including less commitment to the work, less participation in and effectiveness of planning, higher likelihood of placement instability and breakdown, increased conflict and/or avoidance of the necessary “difficult conversations”, and greater challenges to retention of skilled staff and foster caregivers.

When asked to describe what respect and valuing looked like, participants in the community consultations shared the following:

- **Basic courtesies and responsiveness to the interests and needs of others** – such as returning phone calls and emails from caregivers, service providers, youth and family members within a reasonable period of time, answering questions, taking questions and concerns seriously and endeavouring to respond in a helpful way.
- **Communication** – sharing important information with caregivers and service providers about a child or youth or system (“treating us as members of the team”), sharing assessments and recommendations, inviting caregivers and service providers to contribute information, and respecting their unique perspectives on the child/youth and families.
- **Inclusion** – inviting caregivers and service providers to be involved in and contribute to assessment and case planning processes.

- **Action** – such as responding to requests or concerns raised by caregivers or service providers to meet the needs of the child or youth in their care or to sustain the placement through provision of supports and assistance.
- **Collaboration** – such as working with the caregiver or service provider to ensure necessary supports are in place for the child/youth and caregiver, engaging in problem solving and solution-finding.
- **Resolving differences and conflicts in healthy ways** – reflected in a commitment to identify and work through differences in a fair and transparent way.

Barriers to achieving respectful and effective working relationships that were identified by participants included:

- **Worker changes in MCFD** – many caregivers, service providers and youth reported that they did not have a consistent supportive relationship with MCFD workers. Foster caregivers also expressed frustration that when workers for the children and youth in their care change, the new workers can come with different interpretations of the young person's needs and set new expectations and "rules" upon the young person and caregiver, sometimes without consultation.
- **Attitudes** – some people working within the system convey a lack of respect and regard, particularly for foster caregivers and community based service providers and the work that they do.
- **Multiple children, multiple workers** – when a number of children are placed within a foster home, each child may have a different worker, such that the foster caregiver is expected to work with and accommodate diverse worker interests and expectations within their home.
- **Lack of MCFD staff time** – to engage with caregivers and services providers due to high caseloads and system crises and reactivity: "It takes time to build healthy working relationships and if MCFD staff don't have time to invest in connecting with caregivers and sharing information and ideas then we can't build the foundation for respect and value."

A number of suggestions were made to enhance the quality of relationships between parties in the residential care system, including:

- Offering joint training and learning opportunities.
- Enhancing informal and formal networking opportunities.
- Reducing caseloads and/or administrative demands for MCFD staff so that they can invest more time in relationship building and collaborative practices.
- Establishing standards and performance measures that reinforce relationship building.

- Orienting new MCFD workers to relationship building, the roles and responsibilities of caregivers and understandings of service providers as being “members of the team.”
- Improving continuity of MCFD staff with caregivers.

2. Communications and Information Sharing

Consultation participants consistently spoke about the importance of timely communications and information sharing between the diverse parties involved in a young person’s life. Foster caregivers and community service providers indicated that it made a significant difference to their ability to provide residential care if they had access to key information about the child/youth that is coming into their care. This was particularly key for children and youth coming into a residential care placement for the first time.⁴⁷ The kind of information that they said was helpful to receive included:

- General information about the child/youth and their situation (including family background, strengths and interests, needs, risks, where else they have been placed and how they fared, concerns, timeframes, etc).
- The child/youth’s plan of care, legal status and any police, court or probation involvement.
- The extent of involvement of the birth family and any expectations and guidance on how best to involve family members.
- Assessment reports and recommendations, including what actions are being taken in response to findings and recommendations.
- Medical information and school information and reports, including key contacts.

In addition, they found it helpful to have information about what was expected of them in terms of caring for a particular child (e.g., what involvement they should have with the birth family, what specialized supports they need to arrange or offer, what connections and activities they need to maintain for the child).

Some foster caregivers reported that they did not consistently receive sufficient information about the children in their care, either at the beginning of the placement, or in the course of the placement. This affects them in various ways, from feeling less able to meet the needs of the child/youth, to unknowingly accepting young people that may not be appropriate for the home, to feeling like they are not valued as a member of the “care team” for the child. On the other hand, some foster caregivers described their experiences with communications that were respectful, transparent, timely, responsive, consistent and ongoing, and which contributed to positive experiences for all those involved.

⁴⁷ It was acknowledged that the workers might have little information about a child or youth when they first come into care and that mutual information sharing between foster caregivers and MCFD staff (and other service providers who may be familiar with the child and family) are particularly important in the early weeks and months of a new placement.

The need for information and timely communications is particularly acute for newer foster caregivers – they need “practical information” about what they are likely to experience with the children and youth in their care as it may bear little resemblance to their prior parenting experiences:

“In the absence of information about things like safety, relationship to food, activities, hygiene, medical conditions, behaviour, etc it can be overwhelming for them and for their family.”

If caregivers and practitioners are armed with information and knowledge, they are better able to cope with what arises and sustain the placements and quality of care.

In addition to information sharing and communications about children and youth, caregivers and service providers discussed the importance of receiving specific information and communiqués about the following:

- **Roles, responsibilities, standards and expectations** – A significant number of consultation participants spoke to the importance of knowing more about the “other players” in the care system. What are the roles and responsibilities of the various people and positions in the system? Who is expected to do what in the interests of children and youth? What expectations can people have of each other? Some foster caregivers felt that greater clarity about roles and responsibilities would reduce confusion and frustration and contribute to better teamwork and collaboration. Some suggested that guidelines and expectations about information sharing between MCFD staff and caregivers and service providers should be more clearly defined and prescribed.⁴⁸
- **Services in the community and how to access services** – Caregivers suggested that they needed more information about services that are available and how they might access resources to support the children and youth in their care and/or themselves as caregivers.⁴⁹ They also requested information about access challenges (such as wait lists) and alternate options.
- **Cultural information and guidance** – Caregivers, service providers and MCFD staff spoke to the value of having access to information, resources and guidance when working with and caring for children and youth from cultural backgrounds that are unfamiliar to them. The current reality is that there are more children of Aboriginal heritage needing care in the system than there are Aboriginal foster families, workers and resources to serve them. Therefore, participants in

48 This suggestion reflects a challenge or tension within the system: a considerable amount of the information that caregivers suggested was important for them to know is addressed in the existing core training modules. However, as a number of caregivers are not completing core training, key information is not being transmitted. This raises the question of how best to ensure caregivers receive key information, who is responsible for this, and should this be a shared responsibility, i.e., MCFD, caregiver and the caregiver support/networks?

49 The BC Federation of Foster Parent Associations (BCFFPA), the Adoptive Families Association of BC (AFABC), and the Federation of Aboriginal Foster Parents (FAFP), with funding from MCFD, Gaming Commission and Victoria Foundation, created a regional and provincial database of available community resources. The *In Your Grasp* website (see www.inyourgrasp.bc.ca) was developed to address requests from foster caregivers for access to information about a broad range of services and supports in their community.

the consultations reinforced the importance of having access to information and resources about Aboriginal culture, traditions and connections applicable to the individual child or sibling group in their care. They wanted to know how and when to contact the child/youth's home communities and extended family in order to build or sustain cultural connections.

- **Systems information and notification of changes** - Caregivers, service providers and MCFD staff spoke about the value of having current information about the systems that they work with and within, and being apprised of any shifts that might have an impact on their work with young people and families. This included foundational or background information about ministerial structures, roles and responsibilities, legislation, policies and procedures, and program areas, as well as timely information about changes that are being planned or implemented.

It was suggested that communication systems and processes could be improved to support timely follow up when new information is available (e.g., assessment recommendations), when plans have to be enacted, and/or at transition points (e.g. when a child's TCO is being reviewed or when a CCO is being sought in court).

Discussions also touched upon the need for both formal and informal networking amongst foster caregivers, and between foster caregivers, MCFD staff, community services staff and other community partners in all areas of the province. Examples of successful formal and informal networking opportunities were shared by participants such as foster caregiver, support agency, and MCFD Partnership Tables and gatherings and joint training initiatives, that helped to build relationships and capacity. However, a number of participants noted that such opportunities are limited or not available within their communities and areas, and they suggested that these opportunities needed to be further developed and supported. Still other participants described situations in which there was limited uptake when events were offered in their area, suggesting that there is "not a one-size-fits-all" approach to networking. Tied to this were suggestions that there needs to be communication systems that will enable the dissemination of critical systems and service delivery information quickly and broadly.

The youth that participated in the consultations had a great deal to say about communications and information sharing, including what is shared, with whom and how. Youth consistently said that they wanted to be given information about:

- **Rights** - Including what they can expect in the system, how to raise concerns or make complaints, how to ask for a new worker and how to find adults that will advocate for them.⁵⁰
- **"What's going on and why"** - Young people want complete and timely information about their legal status and legal proceedings, plans for their care, placements that have been established or are being considered, assessments that are being

⁵⁰ The *Right to Success* pilots as well as the Child and Youth Advocacy, youth complaints, and youth quality assurance processes currently underway or in development by MCFD should help to address these concerns. Foster caregivers are often advocates for the children and youth in their care.

arranged, transition plans, etc. Many youth said that they were often “in the dark” about what was happening to them and this contributed to feeling powerless, angry and defiant.

- **Options** – Beyond simply receiving information, youth said they wanted to be more actively involved in planning for their care. They wanted to “be asked, not told” and included in the planning processes, noting that, “If we have no say about what is happening to us and where we are going to live, then it is more likely that the placement won’t work out.”
- **Their family** – A number of youth spoke about not having received information about their family (including deaths of family members), and not having their questions about their family answered. Even children and youth who have limited or no contact with their birth families described their curiosity and “need to know” about their family and its history and challenges – even when it is not flattering.

Many youth spoke about *how* information sharing and communication happens with their workers. It makes a positive difference when their phone calls are returned, their perspective is taken into account (“the social worker doesn’t immediately side with the foster parent against me”), their concerns and requests are taken seriously, and the worker is willing to talk things through and explain what is going on.

The importance of having, and the ways in which, the different “systems” share information was also discussed by youth participants. On the one hand, they felt it was helpful when workers in different systems and programs shared information so that those who were involved in their care had pertinent background information and they didn’t have to repeatedly tell their story. On the other hand, they cautioned that too often information is used to form judgments and conclusions about them that may not be accurate. They urged social workers and caregivers to “spend time getting to know us”, and to be curious about and responsive to what they have to say, and what their ideas are about what they need and what they want to achieve.

3. Collaboration and Teamwork

Respectful communications and information sharing is an important foundation for effective practice yet consultation participants suggested that this alone is not enough. When participants described experiences of working as a team or in collaboration with others, they became more engaged and animated and reported feeling more positive about the work. When it wasn’t present, people reported feeling frustrated, disenfranchised, devalued and less effective. Given the complexity of needs of many children in residential care, participants reinforced that a collaborative approach is essential to mobilize diverse resources and expertise for each young person:

“All of us need to share responsibility for the well-being of children in our care – the ministry, the courts, community agencies, police, physicians, teachers, foster parents... How can we work and plan together?”

Participants spoke about *who* should be included in the “team”, with a preference for

more inclusion of foster caregivers, community service providers, specialized workers (such as addictions or mental health workers), youth, family members and others who have (or might have) positive connections with a child or youth (such as teachers, child care providers, coaches). While including such diversity of perspectives can be “messy” at times (and take more time than many practitioners feel they have available), it can lead to new and innovative solutions and/or result in the relatives of the child taking a more active role.

Participants also spoke about *how* a sense of team and a collaborative spirit can be developed, starting with how people treat each other (see Respect and Value section above), how relationships are developed and nurtured, how diverse input is taken into account and how differences of opinion and concerns are addressed. A number of participants spoke about the importance of investing time to build relationships that will in turn support teamwork and collaboration:

“Relationships between us don’t just happen – we have to build them carefully and invest time and energy in getting to know each other.”

Time is a precious commodity and many participants – particularly MCFD staff – reported that they have little time to stay as connected with their colleagues, and even with the children and youth that they are responsible for, as they would like to. Caseload demands and administrative requirements were cited as being barriers to relationship building and to collaborative practices.

Service providers, caregivers and youth also cited staff turnover in MCFD as a significant barrier to relationship building, teamwork and collaborative planning. Youth were particularly concerned about staff changes, with some noting that they could have as many as three or four different ministry workers in the course of a year and rarely have an opportunity to get to know the worker or to feel that the worker has an opportunity to know them. It was not clear from the conversations whether these changes were due to turnover, or due to the internal transfer of files to workers with different roles in relation to the plans for and placement of the child. Nonetheless, youth suggested that frequent changes compromise their experience in care. Youth called for greater continuity and consistency in the MCFD staff that they work with. In several sessions youth talked about having developed long term, trusting relationships with a community service practitioner, foster caregiver, or MCFD worker and cited this as being very important to them and contributing to their ability to cope with challenges:

“Sometimes [my youth worker] was a pain because she kept checking in and asking how I was doing, even after I was no longer in the program. I’d get a call on my cell phone from her and sometimes I didn’t want to answer because things weren’t going well. But this was just what I needed – someone who cared enough to stay connected, to care about how I was doing, to help me out when I needed it and to just have coffee with. [She] made all the difference – she is like a surrogate mom to me now.”

Participants also spoke about the mechanisms and processes that support collaboration and teamwork, citing *Integrated Case Management (ICM)*, *Family*

Group Conferencing (FGC), plans of care reviews, transitional planning meetings, and other family and group planning processes, as examples of mechanisms that can facilitate collaboration and better decision-making. Benefits of these processes include that diverse perspectives are taken into account so more thorough, creative and accountable plans can be developed and implemented.

Other processes that were encouraged by foster caregivers included: the local and regional foster caregiver Partnership Tables (a number of which are in place around the province); joint training events for MCFD staff and caregivers; and, social or cultural events that include the caregivers, MCFD staff, children and birth family members where appropriate. Protocols and defined procedures to help address concerns between caregivers and MCFD staff were also cited as helping to maintain respectful, clear communications and working relationships, especially when there are risks for the parties involved (e.g., complaints or concerns about decisions, practices or quality of care).

4. Systems Coordination

Many participants spoke about the importance of coordination, collaboration and flexibility across the “diverse systems” that are involved with the children and youth who need residential care, and their families. It was noted that many children and youth who enter into the residential care system, and their families, have complex needs that cross over programs and ministries. For example, a youth in a staffed resource might also be dealing with a substance use problem and fetal alcohol syndrome and have dropped out of school, while their primary parent may have a mental health condition that makes it difficult for them to sustain stable housing and employment. In this small family there are potentially seven different systems involved. If they happen to be of Aboriginal heritage there are even more potential players. Participants spoke about the need to better coordinate efforts across systems and services to bring about better outcomes for children and youth.

Sometimes “systems” were understood as the types of services provided (such as mental health, substance use treatment, housing, etc) and other times participants tied the “systems” to organizational structures such as MCFD and other ministries, health authorities and health care institutions, educational institutions, police departments, courts, correctional services, Aboriginal and First Nations organizations, etc. Regardless of the way in which “systems” were defined, participants were clear that too often there is a lack of communication, collaboration and coordination across systems and a lack of flexibility with mandates and resource sharing, for example, that results in children and youth “falling between systems.” Participants suggested that this lack of communication and coordination increases risks and may ultimately add to the complexity, challenge and costs of providing care to young people when timely collaborative action doesn’t take place.⁵¹

⁵¹ In the past, MCFD and other ministries/service streams have established protocols to establish how and when the different streams would cooperate or collaborate. Some proved to be quite helpful and brought services and providers together to address shared concerns and/or client interests and service. It was noted that many of these are outdated and need to be reviewed.

Steps that participants suggested could be taken to enhance practices across systems included:

- Establishing a shared focus - Adopting a shared focus on child/youth needs rather than on the mandates or needs of the systems.
- Learning more about each other - Developing a shared understanding of the roles, mandates, preferred practices and terminology used in different systems and having more knowledge about the strengths and limitations of each system; in other words, "what they can and cannot bring to the table when trying to create solutions for a child or youth."
- Looking for common ground around what success is - Developing a shared understanding about how "effectiveness" and "success" is defined and measured in each of the systems, and then finding ways to create shared success.
- Establishing mechanisms, structures, and approaches that compel systems to communicate, share information and work together - Approaches such as ICMs, FGCs, Child and Youth Committees, Community Partnership Tables and other inclusive individual and community planning processes serve to bring people representing different systems together to focus on a child, youth, family or community.
- Encouraging innovation and creativity across systems and sectors - Some participants suggested that incentives be offered to practitioners to be more collaborative and coordinated and to develop innovative and creative solutions together. These could be monetary incentives such as development grants, training opportunities, or other forms of recognition.
- Encouraging and supporting locally generated solutions - Where gaps between systems are identified within a community, the players should be encouraged to develop ways to reduce or eliminate the gaps rather than waiting for "others" to address the problem. Participants encouraged local action and accountability and encouraged us to "explore the spaces between our systems and build bridges across these spaces."
- Thinking long term - "We have to look beyond what we immediately see and are dealing with, such as tight budgets, restrictive mandates, pressing challenges and talk about what outcomes we want over time." What are the skills, attitudes and knowledge that are required collectively to achieve better outcomes for children and youth?

B. Research Findings

The research literature that was reviewed did not speak to aspects of "working together" that have been described here. This is understandable given the difficulty of defining and measuring "respect" or "feeling valued". However, a number of articles spoke to the issue of collaboration, teamwork and coordination and these findings are

briefly described below.

Holden et al., (2007) noted that when community agencies were required to create collaborative networks of services and coordinate care across community partners, the outcomes for the children and youth being served improved. Most notably, the collaborative approach was more effective in returning children home within 12 months and reducing the length of stay in restrictive placements. Case management, crisis stabilization and family support were also reported to be more effective.

Another study demonstrated the benefits of teamwork, collaborative planning and the inclusion of caregivers in *Team Decision-Making (TDM)* processes (Crea et al., 2009). *TDM* is a facilitated group process that emphasizes input from family and community members to inform decision-making. One of its purposes is to connect family members to supports. This American study, supported by the Casey Foundation, specifically examined the association between attendance at meetings by current caregivers and family members, and placement decisions that are made during the meetings. The attendance of a caregiver at the meetings reduced the likelihood of a placement change recommendation by more than 40%. For each additional friend or neighborhood support person in attendance, teams were 25% less likely to recommend a placement change. In other words, inclusion of caregivers and family members in structured planning processes leads to less placement disruption, and more stability of care for the child or youth in the placement.

A study undertaken Pennell et al., (2010) examined the outcomes of an expedited family group engagement process called *Family Team Meetings (FTMs)*. Considered a hybrid of family group conferencing and team decision making, *FTMs* are "structured planning and decision-making meetings that use skilled and trained facilitators to engage families, family supports, and professional partners in creating plans for children's safety and in laying the groundwork for permanency" (p. 1013). They are used to create plans shortly after an emergency placement in care but before the court hearing on whether the children should remain in care. Cases where *FTMs* were held were compared with cases where *FTMs* were not held and it was determined that:

"When family groups take part in child welfare decisions, the plans tend to keep children at home or with their relatives" (p. 1013).

Children who had received an *FTM* had a higher percentage of kinship foster care placements than either of the other groups. Almost 70% of the *FTM* group ended up with family-type permanency goals, such as return to home, while less than half of the non- *FTM* groups had such goals. Those with a *FTM* spent less time in care, with 35% exiting within six months in comparison to 12% for the non-*FTM* group. The researchers noted that their findings were consistent with the results reported in other international research.

The key principles in the *FTM* approach are:

- Meaningful family participation in planning and decision-making.

- Promoting the involvement of the “community of origin” in planning with families and children.
- Honest and direct communication about the issues to be addressed.
- Affirmation of the family's strengths as partners in change efforts as communicated by workers, kin and community.

Another model for collaborative planning and decision-making was studied in Pennsylvania (Ruaktis, et al., 2010). The *Family Group Decision Making (FGDM)* model appears to be a common sense approach to working with troubled families. However, the authors of the study discovered that it actually requires a tremendous “practice paradigm shift” in that it alters the power differential. Families (rather than the professionals) describe their needs and design and implement the solutions. The authors view this as:

“... A move away from child saving, the historical role of child welfare, to partnering with and empowering families” (p. 733).

The authors found that the implementation of the *FGDM* approach was challenging and “messy” and that consistent leadership throughout the adoption and implementation process was needed for success. Caseworker attitudes were a significant barrier to successful implementation as was the lack of resources available to invest in the approach such as money, time or staff. The authors concluded that additional resources in the form of training and funding are helpful at the start of an implementation process.

There is strong evidence that collaborative practice approaches such as *FGDM* and *TDM* can have positive outcomes, especially when utilized at key points in the care process such as immediately following placement and when a placement change is being considered. A team-based approach coupled with meaningful engagement of birth parents, family members and alternate care providers appears to support permanency through successful return home, placement with kin, or adoption, as well as prevent placement breakdowns. Implementing such approaches requires an acknowledgement of: the time and resources required; the impact of existing organizational cultures and need for strong leadership; and the challenges for case workers who remain responsible for the outcomes of arrangements that come out of the group-based collaborative processes.

C. BC Reports and Initiatives

The reviews and reports undertaken in BC, other Canadian jurisdictions and particularly international jurisdictions, were relatively silent on the topics of information sharing and communications. As with the review of the literature, this may be due to the challenge of describing how to “be respectful” and “value others” and the difficulty of implementing and measuring the effectiveness of recommendations that are essentially about personal attitudes and behaviours. A number of reports in BC do however speak to the topics of collaboration, teamwork and systems coordination.

The BC Children and Youth Review completed by the Honourable Ted Hughes in 2006 devoted a chapter to communications and information sharing. Although primarily focused on cross-jurisdictional sharing of information in child welfare and for death reviews, the Hughes Review did identify a number of barriers to the appropriate and timely sharing of information and called for increased coordination and collaboration in the interests of vulnerable children and youth.

One of the more ambitious initiatives in BC was undertaken in the Fraser Region. In March of 2007, the MCFD Fraser Region *Residential Resources Transformation Project: The Conceptual Framework for the Delivery of Residential Services to Children and Youth (FRTTP)* report and plan was released. The FRTTP was the outcome of a comprehensive and inclusive consultation process held in twelve communities in the Fraser Region. The framework weaves together input from youth and caregivers, community priorities, successful practices in other jurisdictions, and recommendations from stakeholder advisory groups and focuses on key components of residential service provision, including:

- Community partnership and collaboration.
- Recruitment of caregivers.
- Training and assessment.
- Placement of children and youth.
- Support to children, youth and their caregivers.

Each community involved in the consultation process developed a *Community Action Plan for Residential Services Delivery* specific to their community needs. A number of communities identified strategies and actions that supported enhanced collaboration and community partnerships including:

- The establishment of a resource table with representatives from Child and Youth Mental Health, Family Development, Guardianship and Resources and with agencies providing services to ensure a more collaborative planning process.
- Joint training events (including resource workers, foster caregivers and service providers) organized by MCFD to encourage collaboration and relationship building.

Other MCFD regions have also reported taking steps to improve working relationships with foster caregivers and service providers in areas such as:

- Collaborative planning approaches.
- Joint education and training.
- Formal and informal networking opportunities and assistance to enable participation in these opportunities (e.g., partnership meetings, special events,

assistance to enable participation such as child care and transportation allowances).

- Communication initiatives and protocols (e.g., e-mail communication that protects confidentiality and privacy while enhancing timely exchange of information, timely telephone follow ups, communiqués on practice or procedure shifts).
- Following up with caregiver when child/youth leaves home to help deal with loss.
- Making mutual agreements to check in with each other.
- Provision of specialized relief homes.
- Funding of specific foster caregiver support services.

The *YouthSpeak Reports* prepared by the FBCYICN in 2007, 2008, and 2010 reinforce many of the issues and suggestions brought forward by youth during the consultation process, such as the need to advise children and youth coming into residential care of their rights and access to complaints processes and advocates. They also spoke to the importance of placing siblings together and that lines of communication are kept open between children and youth and their birth families wherever possible.

D. Canadian Reports and Initiatives

Other provinces are also recognizing the need to work collaboratively to achieve better outcomes for children entering the child welfare system. The Ontario government's recently released *Future Directions for In-Care Services In a Sustainable Child Welfare System* report (2010) identified the need to address barriers for children and youth in accessing services in other sectors. In response to the frustrations expressed by youth in care, foster caregivers and Children's Aid Society workers about the barriers they have encountered in accessing services in other sectors, particularly relating to education, children's mental health and health care, the Ontario government is in the process of implementing legislative, policy and procedural changes to improve services and inter-ministerial coordination.

Prince Edward Island's *Residential Services Review* (2009) led to recommendations calling for regular communication sessions, regular meetings and the establishment of stronger working relationships between the people involved in planning for and delivering services to a child or youth in care.

Alberta's *Foster Care Review Report* (2010) referenced the need to improve communications and information sharing between foster caregivers, resource social workers and guardianship social workers. It was also suggested that the *Case Management Practice Model* could serve to increase and support information sharing between foster care support workers and child intervention workers.

Saskatchewan's investigation into foster home overcrowding in a Saskatoon service centre (2009) led to the suggestion that the Ministry and Foster Parent's Association

develop a frequent and consistent feedback and mediation mechanism for foster caregivers and Ministry personnel.

Communications and collaboration were major themes in Manitoba's *Changes for Children Initiative* with a specific call for improved communications in support of youth engagement and staff engagement.

Part Seven - Other Issues

In addition to the major themes developed above, participants raised several other topics: funding, legal and court services and accountability.

A. Funding

Participants discussed the adequacy, effectiveness and flexibility of funding for child and youth services and supports.

MCFD staff members were most likely to raise concerns about the adequacy of funding for the residential care system. Some suggested that the overall funding envelope was inadequate given the complex needs of the children, youth and families needing support and care. Their comments were not restricted to residential care. They suggested that more "front-end" funding was needed to support vulnerable children and youth within their birth or extended families in order to prevent placement in the residential care system. They also spoke about the need for more funding for support services, such as mental health and substance use counselling and respite and relief care, in order to prevent breakdowns in the child's living situation – be that in the child's birth family, kinship care or residential care.

Enhanced funding for transitional supports was called for, especially for youth who "age out" of care and for whom the "state was the last parent."⁵² Reflecting on their own experience as parents, some participants noted that our society expects parents and families to continue to provide supports for education, housing and employment development for their offspring into early adulthood and suggested that the state has a similar responsibility for the young people raised in its care.

Some participants suggested that there was an issue with the perception residential services funding (i.e., residential care is often "blamed" for creating budget challenges within the regions, and consequently subjected to fluctuations, restrictions or reductions which affect the capacity of the resource workers to meet residential care needs which results in further strains within the system). Community service providers noted that there has been a significant reduction in the number of staffed residential care homes in the province, often driven by fiscal pressures. Traditionally these staffed resources have provided more intensive, therapeutic interventions for children and youth with significant needs. Service providers and some MCFD staff suggested that the diminished capacity in staffed resources has led to the development of "one-off" one and two bed homes that are often developed in times of crisis when there is no available resource. These alternatives can be costly and they may not be able to deliver the experienced, skilled, therapeutic services that these young people need in order to prepare for moves into more stable, permanent living situations:

"When you cut, staffed residential programs are the hardest to buy back; you lose

⁵² Agreements for Young Adults (AYA) provide financial and other assistance to former children in care and those on Youth Agreements (YAG) when they age out.

housing, licensing, skilled staff with an interest in residential care, and community support that has been built up over years."

While acknowledging that residential care is inherently costly, participants also reinforced that it is essential and suggested that more funds are required to develop a comprehensive array of options and to increase the number of available placements. Enhanced supply and array of placement options would support placement planning and matching, leading to more effective care and intervention, stability, and ultimately better outcomes for children and youth.

Some participants suggested that increased and dedicated funding for foster caregiver recruitment, training and support was required. In particular a number of participants spoke to the need for "targeted supports" for children and youth with special needs, mental health concerns, substance use concerns and behavioural issues to maintain continuity of care. It was also suggested that service payment levels for foster caregivers and "special needs homes" needs to be reviewed, as there is considerable diversity in how levels and fees are determined.

Youth participants and others noted that the budget for Youth Agreements (YAG) appears to be insufficient to meet demand in some regions or locales; some youth reported that they had requested an agreement mid-way through a fiscal year and had been advised that there were no more funds available to support a YAG.

While not frequently raised, some contract service providers raised concerns about sustainability in light of rising operating costs (e.g., housing, utilities, fuel) and staffing costs in relation to collective agreement provisions. They suggested that contracts have not kept pace with increased costs over the years, and with increased requirements, expectations and restrictions being set by the funder, some contracted residential care options are not sustainable at current rates.

Some participants wondered whether funds could be allocated more effectively: could the resources that are available be used to greater effect and should funding practices and priorities shift? There was no clear consensus on where or how available funds should be allocated, however, a number of participants suggested that if the focus of attention shifts to the longer-term permanency interests of children and youth and accountability for outcomes, then funding priorities and allocations will likely need to shift. It was noted that an increased emphasis on permanency could reduce the length of time children and youth spend in residential placements resulting in resources being made available to reinvest in strengthening the residential care system. Similarly, if a youth has significant concerns and is disengaged from family, school and community, yet kinship care is a viable option in the future, then the focus might shift from "providing care" (i.e., ensuring that the youth's basic residential and care needs are safely met) to "providing treatment" (i.e., assessing and stabilizing and enhancing the youth's capacity for connections in family and community). From this perspective, while a treatment oriented placement (e.g., a multi-dimensional treatment foster care placement, a staffed resource or a tertiary care facility) may be more costly in the short term, the longer term outcomes may be much better for the youth if the interventions

establish conditions for a successful kinship placement.

Related to comments about effectiveness, some participants suggested that the flexibility of funding streams, guidelines and criteria should be enhanced, to allow for more effective, creative, child/youth-centred planning and decision-making. Some MCFD workers suggested that if they had more discretion on how funds could be used, they could address needs and emerging issues more quickly and appropriately to, for example, create a placement, or support a placement to prevent breakdown. Participants noted that there is an inherent challenge with flexibility – on the one hand it creates options, but on the other hand it can create perceived or actual inequities in funding across care providers.

The comments about funding flexibility extended beyond MCFD to other ministries, with participants suggesting that the ministries and authorities that have responsibility for parts of the care system need to work more holistically and flexibly and use their resources to “wraparound” children and youth to meet their needs.

B. Legal and Court Services

Participants in a number of community consultations raised concerns about legal and court delays, resulting in children and youth being left in temporary situations for considerable periods of time, and delayed action on permanency planning. They commented on the negative impact that this can have on children and youth. While not an issue expressed in every community, it seems that this is a significant concern in some communities. Although legal and court services are outside MCFD’s jurisdiction, and beyond the scope of this review, it is a strong example of how the residential care system is interconnected with other systems and how the capacity of the MCFD system to meet the needs of young people requiring residential care can either be hampered or enhanced by practices and procedures in other systems.

Three primary issues with legal and court services were noted:

- Lack of court personnel leads to delays in hearings and longer timeframes to reach decisions that can be acted upon.
- Diverse attitudes, beliefs and practices of judges result in different courses of action and timelines. Some seem to want to provide the birth families with significant opportunities and time (years) to address the issues that have contributed to their children coming into care whereas others seem to move more quickly towards a CCO to set the stage for alternative permanent arrangements.
- Within the context of youth justice, some families who are dealing with parent-teen conflict and violence, are being advised and encouraged to seek restraining – or “no contact” – orders against their son or daughter. As a consequence, when the youth completes his sentence/placement and is able to move back into the community, it is not possible for him to return to his family. As these youth are not, in most cases, “in need of protection” and are no longer within the youth

justice residential system, they are in limbo and unable to connect with family and community. This places them at risk of re-offending, exploitation and conflict.

Ideas put forward by participants included:

- Engage judges and legal counsel in joint training or learning to increase awareness about child development and perspectives on time and permanency planning options.
- Give greater consideration to timelines and delays from a child's perspective. A six-month delay in a hearing may not necessarily be significant from an adult's perspective, but it is a large disruption for a 3-year-old.
- Establish tighter timeframes for permanency-driven decisions.

C. Accountability for Quality Care and Positive Outcomes

While not a frequently discussed topic in the consultation sessions, accountability-related comments were made by some participants and are also addressed in both the academic literature and in reports from BC and other jurisdictions. Participants were most likely to speak about accountability in the contexts of: quality and continuity of relationships; case planning and plan implementation; and reporting, monitoring and quality improvement processes, each of which are discussed below.

1. Quality and Continuity of Relationships

Consultation participants, particularly youth, frequently noted the importance of stable, positive, ongoing relationships in any child or youth's life. They suggested that the system should be held accountable for what it does (or does not do) to create, support and sustain relationships or to facilitate and ease transitions should a relationship not be sustained. The significance of stable relationships between MCFD staff, service providers and caregivers was also noted; where strong relationships existed, the participants felt that they had greater capacity to "work through challenges and find solutions because we understand and respect each other."

Concerns were raised about the lack of time some MCFD staff have to develop relationships with the children and youth that they are responsible for, and with the caregivers, service providers and partners in their community. Caseload size, court requirements, staff turnover and movement to other roles, and administrative/documentation requirements were cited as being impediments to relationship building. It was suggested that administrative and reporting requirements could be streamlined, and functions could be reconfigured, in order to increase the time available for workers to stay connected with children and youth, within currently available resources. For example, foster caregivers suggested that a considerable amount of time is spent both by MCFD staff and themselves to arrange approvals for basic developmental and family activities such as authorizations for school trips and swimming lessons. They suggested that more decision-making could be delegated to foster caregivers. A review of caseloads was also suggested.

Several participants proposed accountability for “preserving and sharing” information about a child’s life. Use of life books, treasure boxes and other concrete items should be expected of workers, service providers and caregivers to maintain elements of a child/youth’s identities and connections.

2. Case Planning and Implementation

Case planning and placement matching is discussed in an earlier section. Within the context of accountability, however, other aspects were raised by participants including planning for positive outcomes, following through on plans and monitoring progress.

Some participants emphasized the importance of an outcomes orientation: what is the long-term plan for the child and how might residential care be used to support attainment of healthy outcomes? While noting that in crisis situations, workers, caregivers and service providers may need to focus on short term interests such as finding a resource that can care for and stabilize the child or youth, participants suggested that in some cases the planning processes stop once the immediate needs have been addressed. Good planning takes time and to be responsive and accountable, the “system must be prepared to invest time in the planning process” to ensure that key information is gathered and available, key people are involved (including youth and family members where possible), thoughtful reviews can take place, options are fully explored and a strong plan is developed.

Some participants noted that the plans established are only as strong as the system’s capacity for implementation and follow-through. For them, being accountable meant being able to deliver the recommended or agreed upon services in a timely way, monitor progress and revise plans as needed to reflect emerging needs, interests and capacities of the child or youth.

3. Reporting, Monitoring and Quality Improvement

It was suggested by some participants that accountability is tied to answering three key questions: are we planning well and for the long term; are we implementing the plans appropriately; and, is what we are doing making a positive difference to the child or youth? In order to answer these questions, expectations for recording and reporting, monitoring and reviewing need to be clear and mechanisms to share information and adjust plans, programs, services and practices must be in place.

The ministry’s new *Integrated Quality Assurance (IQA)* framework is expected to provide some structure and processes to support accountability. Participants also suggested some concrete actions including:

- Entry and exit interviews with children, youth, caregivers and service providers at the outset and conclusion of a placement to learn what was helpful and not helpful.
- Annual (or more frequent) sessions with MCFD staff, caregivers and service providers at a community level to discuss the needs of the children and youth who

are requiring residential care, the strengths of and challenges facing their local residential care system, and what might be done to better serve the children/youth and their families to achieve desired outcomes.

Part Eight - Youth Perspectives

The perspectives and contributions of youth who participated in consultation sessions are incorporated into every section of this report on findings. However, the Project Team believed that it was also important to highlight youth views in a defined section of the report, and incorporate the findings from other consultations with youth undertaken by the BC Federation of Youth In Care Networks (FBCYICN) that speak to many of the same issues and interests.

A. In Their Own Words

Many of the comments and suggestions made by youth were consistent with those raised by other participants, but with a more personal sense of urgency and importance:

- **Family support and connections:**

- "I wish someone would have helped my family figure out how to cope so I wouldn't have to go into care."
- "Keep siblings together."

- **Inclusion in planning:**

- "Ask me what I want and include me when you make plans for me."
- "Provide choices and ask me what I think would be best. If I have no choice, then there is a greater chance that the arrangement will fail."

- **Long term planning and outcomes:**

- "Think long term about my future; help me think about my future and help me get there."

- **Information sharing:**

- "Help foster [caregivers] understand what is going on for us and how to support us when we come into their home...going from a chaotic home and life to something really organized in foster care can make you go crazy and they don't understand."
- "Tell me more about the foster home before I get there – help me prepare for moving there."

- **Child/youth centered:**

- "People should not pre-judge me; get to know me and who I am, what's happened to me, what I like and where I want to go."

- "Take our complaints and concerns seriously – don't just side with the foster [caregiver] and not check things out."
- **Stable and meaningful relationships:**
 - "Relationships are important; having a different worker every week, or a different foster parent makes me not care, so I can protect myself."
 - "Having [my youth care worker] stay connected with me long after I finished the program has made a huge difference. Even when I haven't wanted her around she has been there. I can figure things out with her help."
- **Access to services and supports:**
 - "A shelter should be in place in every community to provide housing when a family is in crisis. And they should be more flexible – not kick you out after 7 days. You can't even get an appointment with a worker in 7 days!"
 - "Regardless of which community you run to, when you ask for help, the ministry should give you help and not tell you to go home or wait for 3 months."
 - "I must have called 40 different numbers trying to get some help."
 - "I kept asking for help but didn't get anything [from the MCFD intake worker] because he wouldn't believe me. Finally I broke the law and got the help I needed."
 - "What I really needed was treatment for my Meth addiction, and I couldn't get it. Finally I broke free myself when I realized I was going to die if I didn't do something, but that took three years."
- **Youth Agreements:**
 - "Figure out who can be successful on Youth Agreements – they are being used with kids that have too many problems and they are being set up to fail. I was told I was "too together" to be eligible for a Youth Agreement but this was just what I needed to be successful. I finally had to figure it out myself."
 - "When the money runs out, you can't get a Youth Agreement, even if you are eligible. There needs to be more money."
- **Quality of care:**
 - "Make sure you get really good foster [caregivers] – they have a really important job."
 - "Make sure they [foster caregivers] get training and help and watch what they are doing – are they doing a good job?"
- **Transitions between placements and services:**

- "Transition plans should be in place for everyone leaving detention. I was released and the only plan for me was to go stay at [a youth shelter] for 5 days, when I really should have been sent to treatment [for addictions]."
- **Preparing for adulthood:**
 - "Start helping us get ready for independence at 13-14 years old."
 - "Don't wait until 3 months before I turn 19 and then ask me if I know how to live on my own – get involved to help me get ready because I don't even know what to ask for."
 - "At 18-19 years old, you begin to think about your future so you are more ready to accept treatment – but this is just when we are pushed out of care."
- **Transitions into adulthood:**
 - "Four days before the meeting I had to arrange my AYA (Agreements with Young Adults) the worker told me there was no more money. So, I lost my medical coverage [when I turned 19] and couldn't afford my medications and housing. The worker said I was eligible, but there was no money left."
 - "There should be more supports for youth aging out, like youth mentor housing programs."
- **Flexibility:**
 - "Youth forensics told me to come back for assessment when I was off drugs, but I couldn't get any help to get off drugs so I couldn't get the assessment I needed."
- **Permanency:**
 - "Make sure someone is there to stick by me for the long term."

Part Nine - Next Steps

As noted in Part One, this report summarizes the results of Phase One of the Residential Review and Redesign Project. These findings – presented without analysis, judgment or priority setting – describe the current residential services system for children and youth and what diverse stakeholders and researchers have to say about it, including what works well and what does not work well, and ways that services and care might be improved or enhanced. The report sets the stage for Phase Two of the Project, which is to identify key opportunities for residential redesign and develop short and longer-term recommendations for action.

In Phase Two, the following actions will be taken:

- Prepare a summary report of the Phase One findings (by April 15, 2011).
- Release and broadly distribute the summary report as well as this detailed report and appendices (by June 30, 2011).
- Broadly distribute an electronic survey inviting feedback on potential enhancements, shifts and changes in residential care (June-July, 2011).
- Initiate key informant interviews with leading scholars, practitioners and change-makers in the field of residential care, to obtain ideas and suggestions for residential care redesign (May-July, 2011).
- Convene two 2-day working sessions with representatives from MCFD staff teams in each region, foster caregivers, community service providers and youth, to review findings, identify prospects and opportunities for action, and suggest and prioritize short, medium and longer term strategies for change. (March –April, 2011).
- Draft a report reflecting the findings from the online survey, key informant interviews and working sessions, with recommendations for action (by August 31, 2011).

In addition to the over-arching joint report of the Federation and MCFD, the more specific report on Aboriginal consultations, and the more focused kinship care and tertiary care reports (as described in Part One) will be completed within the same timeframe. These reports, and their attendant recommendations, will inform the development of a MCFD five-year strategic plan for redesign of the residential services system, from kinship care through to tertiary care. As noted in Part One, the expectation is that the five-year strategic plan will, given the current fiscal climate, involve no-cost and low-cost improvements in the initial years of plan implementation, such as changes to policies and procedures, training, practices and communications, enhancements to collaborative work, realignment of existing resources, etc. before proceeding to address service and resource gaps in the later years of the plan.

For further information on the Project and the resulting reports, please refer to the

Initiatives section of Federation's website:

www.fcssbc.ca

Appendices

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The Consultative Process for Residential Services Redesign is a joint planning initiative between the Federation of Community Social Services of BC (FCSS) and the Ministry of Children and Family Development (MCFD). This work is an extension of the "Engagement Process" agreement between the Ministry and the Federation signed in November 2009 that identifies the redesign of residential care services as a shared priority.

An extensive community based consultation process intended to be inclusive of a broad spectrum of stakeholders will be conducted between March and December of 2010 with the aim of delineating the issues and concerns facing residential services for children and youth served by the Ministry and identify potential strategies for improving residential care services. These strategies – which may include proposed changes to policy, practice, training, human resource management, contracting/procurement, information systems and service gaps/realignment – will inform the development of the Ministry's five year strategic plan for redesign of residential services that will enhance the quality and stability of care and therefore result in better outcomes for children and youth served by the Ministry. The principal focus of the consultation will be on the foster care system and staffed residential care programs. MCFD will address issues related to extended family care (kinship care) and highly specialized care through distinct but linked processes.

The consultation process will include the opportunity for stakeholders to participate in focus groups being held in each region across the Province. Stakeholders will also be invited to provide input through electronic submissions and may request that project staff meet individually or attend scheduled events that might help in ensuring that comprehensive and meaningful input is gathered. The initiative will also include collection of information from research, previous Ministry reports, publications from other jurisdictions and any existing evaluations of practice.

A report and recommendations will be provided to Ministry Leadership in March of 2011 which will then be used to inform the development of a five year strategic plan. The intention is to structure that plan so that the focus of the initial years will be on implementation of policy and practice changes, and improvements to infrastructure supports such as training, contracting/procurement, and information systems. These changes will provide the foundation and inform potential future investments in the latter years of the plan.

For more information about the project, please contact either of the Project Coordinators:

Warren Helfrich (FCSS) – 250-486-8840
Phil Schwartz (MCFD) – 250-953-3118

Appendix B

Residential Services Redesign Advisory Committee and Project Team Membership - February 2011



Name	Organization	Role
Alan Markwart	MCFD, Senior Executive Director Provincial Services	Co-Chair
Jennifer Charlesworth	The Federation of Community Services of BC	Co-Chair
Melanie Filiatrault	BC Federation of Foster Parents Association	Federation Member
Heather Bayes	BC Federation of Foster Parents Association	Federation Member
Laurie Birdsall	Pacific Community Resources Society	Federation Member
Gary Mavis	Federation of Aboriginal Foster Parents	Federation Member
Michele Fortin	Watari Youth and Family Alcohol and Drug Counselling Service	Federation Member
Nanette Taylor	Hollyburn Foster Parent Support Services	Federation Member
Shane Picken	ARC Programs	Federation Member
Jocelyn Helland	Federation of BC Youth in Care Networks	Federation Member
John Belfie	North Okanagan Youth and Family Services Society	Federation Member
Rob Parenteau	MCFD, Director of Operations, Services to Aboriginal Children & Families	MCFD Member
Robert Watts	MCFD, Executive Director Of Integrated Practice, North	MCFD Member
Mark Armitage	MCFD, Regional Executive Director, Vancouver Island	MCFD Member
Sandy Wiens	MCFD, Child, Youth and Family Policy	MCFD Member
Dennis Padmore	MCFD, Regional Executive Director, Vancouver Coastal	MCFD Member
Phil Schwartz	MCFD, Provincial Services	Project Coordinator
Warren Helfrich	FCSSBC	Project Coordinator
Jackie Behrens	MCFD, Provincial Services	Project Team
Ken Moore	Executive Director of Maples (seconded to Project Team)	Project Team
Annette Harding	MCFD, Provincial Services	Project Team

Appendix C

Methodology and Handouts Shared in Community Consultation on the Redesign of Residential Services



What is "Residential Redesign"?

The Federation of Community Social Services of BC (FCSS) and the Ministry of Children and Family Development (MCFD) have come together to conduct consultations on the redesign of residential services for children and youth in BC. Our intention is to address significant challenges facing the current system of residential resources for children and youth including:

- **Improving outcomes** for children and youth receiving residential services, especially those with complex needs
- **Addressing gaps** in the system
- **Addressing difficulties** in finding and keeping qualified foster parents/caregivers
- **Increasing consistency** in how residential resources are provided or contracted in different regions of the Province

Our focus will be on the foster care system and staffed residential care programs (MCFD will be addressing extended family care and highly specialized care through distinct but linked processes). The feedback we receive from the consultations, along with information from previous MCFD reports, research material, publications from other jurisdictions, existing evaluations of practice and submissions made by stakeholders will provide the basis for a report and recommendations to MCFD Leadership in March 2011.

What are the focus groups about?

We are making every effort to include a broad range of key stakeholders in the consultations. Their input is critical for understanding what currently exists and what is possible in the future. In order to gather this input, there will be an opportunity for stakeholders to participate in focus groups being held across the Province as well as opportunities for giving input through written submissions and web-based conferences. MCFD's "Strong, Safe and Supported: BC's Commitment to Children, Youth and Families" and the Ministry's Service Plan will provide context for stakeholder discussions about residential care. The aim of the focus groups is to:

- **Gather information** about what's working in the current system and what needs to be improved
- **Discuss immediate changes** that could result in improved outcomes for children and youth over the next two to three years using available resources

- **Identify long-term strategies** for strengthening residential services including future financial investments

What kinds of questions are going to be asked?

The following are proposed questions for focus group participants and for the overall consultation process:

- What's in place now? What's working well? What are the strengths of the current residential system? What needs improvement?
- What residential services are necessary to meet the needs of children and youth of your community? What's missing from or insufficient about the existing residential system?
- What can we do to improve transitions to and from placements?
- How can we reduce unplanned placement moves?
- What can be done to reunify more children with their families or extended families?
- Where reunification is not possible, how can we establish permanent lifelong relationships for children and youth sooner?
- How can we make best use of specialized residential resources and services?
- What Changes Can Be Made Over Next 2-3 Years Within Available Resources?
 - Changes in policy?
 - Changes in practice?
 - Changes in training or human resources practice?
 - Changes in contracting or procurement?
 - Changes in system structure or alignment?
 - Changes information systems?
- What Financial Investments Should We Be Planning for the Longer Term?
- How Will We Know Whether the Needs of Children and Youth Are Being Better Met?

For more information about the Residential Redesign Consultation, please contact:

Warren Helfrich (FCSS) – 250-486-8840 or
Phil Schwartz (MCFD) – 250-953-3118

Focus Group Presentation Slides

Slide 1

Slide 2

Slide 3

Image 1

Image 2

Appendix D

List of Community and Stakeholder Consultations and Demographics

#	Date	Location	Foster Caregivers	Service Providers	MCFD Staff	Youth
1.	Mar 4	Federation of Community Social Services-Victoria		10		
2.	Mar 25	Vancouver Island Foster Parent Partnership Committee-Nanaimo	7	6	6	
3.	Apr 13	PACE Transition Program Vancouver		3	2	
4.	Apr 13	Vancouver	1	13	3	
5.	Apr 14	Vancouver	1	5	9	
6.	Apr 15	Vancouver	3	1	6	
7.	Apr 16	Chilliwack Foster Parent Partnership Committee (teleconference call)	10		3	
8.	Apr 16	North Fraser MCFD Managers (Conference Call)			7	
9.	Apr 23	South Fraser MCFD Managers, Surrey			6	
10.	Apr 26	Sunshine Coast	2	2	3	
11.	May 4	Terrace	2	15	15	1
12.	May 5	Fort St. John	5	5	9	
13.	May 6	Prince George (am)	8	8	6	
14.	May 6	Prince George (pm)		3		5
15.	May 12	North Fraser Resources Team(Conference Call)			12	
16.	May 17	Victoria (am)	5	4	7	
17.	May 17	Victoria (pm)	3	5	8	
18.	May 18	Nanaimo (am)	15	2	4	
19.	May 18	Nanaimo (pm)	3	1	10	
20.	May 19	Campbell River (am)		10	11	
21.	May 19	Campbell River (am)	16			
22.	May 19	Campbell River (Lunch)		2		3
23.	May 19	Port Hardy (video conference)	7		1	

24.	May 20	PARCA, Abbotsford		9		
25.	May 28	BC Federation of Foster Parent Associations, Kelowna	50	4	5	
26.	May 30	Federation of BC Youth In Care Networks, Mission		2	1	15
27.	June 2	Vancouver Youth Session				11
28.	June 3	South Fraser Resources Team (Conference Call)			18	
29.	June 10	Penticton - Federation of Community Services		5		
30.	July 27	Vancouver Youth Session				14
31	July 27	Fraser Valley Foster Parent Association	12			
32	Sept 14	Castelgar	3	6	6	
33	Sept 15	Kamloops	1	12	10	
34	Sept 16	Penticton (am)	6	8	8	
35	Sept 16	Kelowna (pm)	1	11	12	
36	Sept 16	Kelowna Youth Session		2		2
37	Sept 17	Kelowna Permanency Planning			4	
38	Sept 22	Victoria Youth Session				6
39	Sept 30	CYSN am (Video Conference)			14	
40	Sept 30	CYMH & Substance Use Care Network (pm)			18	
41	Oct 4	CYMH Conference Call			4	
42	Oct 26	Provincial Family Council for Child and Youth Mental Health	4			
43	Dec 15	Fraser Service Providers		6	1	
		Totals (611 participants)	165	160	229	57

Introduction

A systematic review of literature was conducted in order to identify articles of relevance to the residential redesign project. It was conducted between April and July of 2010. The review was completed concurrent with an extensive consultation process that gathered input from stakeholders across the Province. The themes that emerged during these consultations helped to guide the selection of articles. The review utilized the following academic databases;

- Social Services Abstracts
- Psych Info
- Google Scholar

The search term combination of "Residential Care", "Children" and "Youth" as well as "Foster Care", "Children" and "Youth" were utilized. The review examined a period of five and a half years, from January 2005 to July 2010. Although this produced a very large number of results, the intent was to increase the likelihood of finding articles relative to the broad range of themes emerging from the consultation. More than 400 abstracts were reviewed. A total of 110 articles were identified and copies were accessed. The reference lists of the most recent and salient articles were also reviewed for potential articles missed in the database search. A total of 32 articles were selected as being the most relevant to the initial findings from the consultation process. Where possible and appropriate, research conducted in Canada or published by Canadian researchers was utilized. The majority of the studies chosen were published in the last three years, reflecting the fact that research is cumulative and that recent studies often reference and expand upon previous studies. A summary of each of these articles is provided below. The relationship between the article and the emerging themes from the consultation process as well as the substantive relevance is noted for each article. A brief summary of key points from this review is provided at the end of annotated bibliography.

Article 1:

Lyons, J., Woltman, H., Martinovich, Z., & Hancock, B. 2009. An Outcomes Perspective of the Role of Residential Treatment in the Systems of Care. Residential Treatment for Children and Youth, 26, 71-91.

Relationship to Emerging Consultation Themes:

Assessment, Systems Coordination, Comprehensive Continuum of Placement Options and Supports

Overview:

This article reports on an analysis of the treatment trajectories of 3170 children and youth served from 2004 to 2007 in New Jersey. A state-wide common assessment tool called CANS (Child & Adolescent Strengths and Needs) was implemented and used to plan treatment, make decisions about the level of care, and monitor outcomes. CANS is a functional assessment tool that looks at both risk and protective factors.

Results/Findings:

The average level of need for admissions into residential treatment became more acute for each year of the study, suggesting that the use of residential treatment became more targeted on those children and youth with the most severe needs. Over the same period of time, the number of children served as a percentage of all children served by the mental health care systems decreased. The scores at admission also become more distinct for each level of residential care within their system of care. The rate of improvement in residential treatment increased over the periods of time, though the average length of stay did not change. The authors suggested that the tightening of placements may also reduce the risk of peer contagion by diverting at-risk youth to a more appropriate level of care.

Relevance:

The use of a common assessment tool or process appears to allow for better targeting of mental health services and better results. Having a comprehensive set of services that matches different levels of client need appears to be critical for maximizing the potential of implementing a common assessment tool.

Article 2:

Holden, E., O'Connell, S., Liao, Q., Krivelyova, A., Connor, T., Blau, G., & Long, D. 2007. Outcomes of a Randomized Trial of Continuum of Care Services for Children in a Child Welfare System. *Child Welfare*, 86(6), 89-114.

Relationship to Emerging Consultation Themes:

Systems Coordination, Collaboration & Team Work, Information Sharing and Communication

Overview:

The article provides an evaluation of a demonstration project intended to evaluate whether the well-being of children could be improved and lengths of stay in residential treatment reduced by providing case rate payments to community agencies to provide continuum of care services. Community agencies were required to create collaborative networks of services and to coordinate care among community partners. Each agency received a case rate to serve the child for 15 months that was equivalent to the cost

of residential treatment for 12 months. Participants were children and youth involved in the child welfare system that had been approved for residential treatment based on mental health acuity levels. 157 children and youth were randomly assigned to a demonstration site or usual services. Structured interviews were used at entry and at 6 and 12 months.

Results/Findings:

The demonstration sites were more successful at maintaining children in non-institutional settings or home settings for longer periods of time. Both groups, regardless of service model assignment, demonstrated positive outcomes. The average expenditure per child was \$51,618 for the demonstration sites compared to \$62,000 for usual services (17% less). The demonstration program was more effective in 1) returning children to in-home placements in the first 12 months, 2) reducing the length of stay in restrictive placements, and 3) utilizing higher levels of case management, crisis stabilization, and family support.

Relevance:

The project combined a competitive and performance oriented funding strategy with provider authority to coordinate care. The results suggest that this combination has potential for reducing costs and improving outcomes.

Article 3:

James, S., Landsverk, J., Leslie, L., Slyman, D., & Zhang, J. (2008). Entry into Restrictive Care Settings: Placements of Last Resort? *Families in Society*, 89(3), 348-359.

Relationship to Emerging Consultation Themes:

Foster Parent Recruitment, Training & Support, Assessment, Mental Health & Addictions Resources, Systems Coordination

Overview:

This article reported on a study examining the relative risk of entry in residential care, the specific reasons for entry, and the clinical and non clinical factors that enhanced or reduced risk. A cohort of 570 children and youth in foster care were included in the study.

Results/Findings:

Roughly 70% of children entering residential care Restrictive Care Settings (RCS) did so due to behaviour problems and entered between 3 and 4 months after first coming into care. The remaining 30% of placements occurred due to system or administrative moves. While all placements in-patient psychiatric units were due to behaviour, only slight more than half of the placements in short term groups homes were due to

behaviour even though the length of stay for both groups was the same. The relative risk of entry seems to be greatest during the first two to three months following placement in out-of-home care. Older age of entry into care increased the risk of being placed in residential care. Behaviour problems and previous episodes of care also significantly increased the risk of entering residential care. Children who spent more time in kinship care had a slightly decreased risk of entering residential care.

Relevance:

The authors point to research on parenting skills of foster caregivers suggesting that changes in the foster caregiver–child relationships during adolescence are associated with higher rates of placement disruption (Lipscombe, Moyers, & Farmer, 2004). They further suggest that significant effort should be directed toward supporting foster parents with foster children that are transitioning into adolescence in order to prevent placement breakdowns. They also suggest that the significant role of behavior problems stresses the need for comprehensive mental health assessments at time of entry into out-of-home care in order to effectively match a child or youth's needs with their placement. Further, "Results from our study suggest mental health services early in the out-of-home episode may decrease the likelihood of placement into an RCS, but that these services are less effective over time in treating the types of problems that ultimately propel children into an RCS." (pg 356). This underlines the need for early, targeted mental health services at point of entry.

Article 4:

Stott, T., & Gustavsson, N. (2010). Balancing permanency and stability for youth in foster care. *Children and Youth Services Review*, 32, 619-625.

Relationship to Emerging Consultation Themes:

Permanency & Concurrent Planning, Transition Planning & Supports

Overview:

The authors examine research on permanency and stability for older youth in foster care. They draw on a permanency perspective that includes three specific aspects of permanency; relational permanence, physical permanence, and legal permanence. The authors point out that the majority of youth that enter foster care after the age of 13 end up emancipating from the care system. The authors provide an extensive review of the poor life outcomes for these youth, include health, legal, housing, and relationships outcomes. These poor outcomes are compounded by the fact that youth are moved in the care system, sometimes simply due to efforts to seek legal permanence with potential adoptive parents or foster parents that might consider adopting.

Results/Findings:

The authors make the argument that the focus on legal permanence results in a lack of

attention being paid to relationship and physical permanence. The loss of relationships and connections to school and community can be damaging and further alienate youth who already have significant difficulties in forming and maintaining relationships. The authors suggest that youth's voice and desires should be respected in the process of identifying long term plans and that relational and physical permanence should be considered in the planning process.

Relevance:

While legal permanency is a desirable outcome for children and youth in care, research suggest that a different and more balanced strategy for youth entering care may be more effective.

Article 5:

Barth, R., Greenson, J., Zlotnik, S., & Chintapalli, L. (2009) Evidence-Based Practice for Youth in Supervised Out-of-Home Care: A Framework for Development, Definition and Evaluation. *Journal of Evidence-Based Social Work*, 6, 147-175.

Relationship to Emerging Consultation Themes:

Comprehensive Continuum of Placement Options and Supports, Foster Parent Recruitment, Training & Support, Permanency & Concurrent Planning

Overview:

This article provides an overview of research on evidence-based interventions for older foster youth, examining the evidence base for five current models. The review utilizes the California Evidenced-Based Clearinghouse for Child Welfare's Scientific Rating Scale for evidence-based practices.

Results/Findings:

Multi-dimensional Treatment Foster Care (MTFC) received the second highest possible rating – Supported Efficacious Practice. The authors also discuss interventions for the general population of foster care providers that appear to have promise. They point to a recent study on a training and support intervention for foster parents called Project KEEP that found that "Children whose foster parents participated in Project KEEP were almost twice as likely to leave foster care for reunification or adoption, while children whose foster parents were not using Project KEEP were more likely to run away, have their placement disrupt, or have another negative exit from care" (pg 155). The Teaching Family Model received a rating of Promising Practice. Small Group Home Care was given a rating of "Evidence Fails to Demonstrate Effects" based on available research evidence. Both Supervised Independent Living Programs (small apartments with on-site support and staffing) and Independent Life Skills programs were considered "Promising Practices". In the review of services for youth preparing to exit care, the authors suggest that "... the concept of permanency for older youth in foster

care can be thought of as the opportunity to have a lasting and irrevocable connection to at least one committed and caring adult who will provide lifelong support." (pg 149). They point to an initiative undertaken by the Annie E. Casey Foundation called Family to Family that identified several key themes to incorporate into permanency planning initiatives, including; every child, no matter how old, can achieve permanence and should have a case plan for permanence; kinship families are an underused resource; and older youth should be involved in their own permanency planning.

Relevance:

This article points to several models of providing care or supporting children and youth and their caregivers that hold promise and are worth considering in any redesign of residential services. The article also makes the argument that, at minimum, more research is needed to confirm whether or under what circumstances small community-based group homes should be utilized given the lack of evidence to support their efficacy. The principles identified by the Family to Family initiative for permanency planning are consistent with other research articles reviewed.

Article 6:

Fisher, P., Chamberlain, P., & Leve, L. (2009). Improving the lives of foster children through evidence-based interventions. Vulnerable Children & Youth Studies, 4(2), 122-127.

Relationship to Emerging Consultation Themes:

Foster Parent Recruitment, Training & Support, Assessment, Comprehensive continuum of Placement Options & Supports

Overview:

This article provides a framework of potential intervention options derived from the evidence base that are intended to improve the lives of foster children. The options span from low to high intensity.

Results/Findings:

Option one is to screen and refer. This option includes ongoing systematic assessment at the time of placement and active (as much as daily) monitoring of placements to determine where extra supports are warranted. The authors point out that researchers in the child welfare field have called for systematic screening to address the physical, mental and developmental wellbeing of children in care. They suggest that combining this with active monitoring and support may be a cost-effective way to identify children who are unlikely to benefit from conventional foster care and/or may need additional services, and to reduce the likelihood of extremely expensive events, such as foster placement disruption and the loss of available foster parents. They also believe that this approach is likely to yield significantly better outcomes for the

children. The second option in the framework is enhanced foster care where workers have lower caseloads and receive higher salaries, and foster parents have access to enhanced support and behavioural consultation. Option three is targeted foster care interventions to address specific needs and issues. This includes Project KEEP (Keeping Foster and Kin Parents Skilled and Supported) and KITS (Kids in Transition to School), both of which show promise based on available evidence. The fourth option is Multi-dimensional Treatment Foster Care, which has an extensive evidence base. The authors conclude by suggesting that one of the greatest areas of need is a systematic approach for implementing a comprehensive set of interventions on a wide scale basis in the context of foster care.

Relevance:

This article highlights the availability of evidence-based models for supporting children and youth in out-of-home care and that using such models should be undertaken within a comprehensive and systematic approach to addressing their needs driven by early, universal assessment.

Article 7:

Cushing, G., & Greenblatt, S. (2009). Vulnerability to Foster Care Drift After the Termination of Parental Rights, Research on Social Work Practice, 19(6), 694-704.

Relationship to Emerging Consultation Themes:

Permanency & Concurrent Planning, Professional Practices

Overview:

The paper examines the characteristics of children, their families and case practice that puts them most at risk for lingering in foster care after the termination of parental rights. A total of 640 children for whom parental rights had been terminated in Connecticut were examined.

Results/Findings:

The children who were adopted were more likely to be female and younger. Children who were not adopted were more than twice as likely to have significant behavioural problems. There were no statistical differences in the frequency of medical problems among the two groups. Changes in social workers were much more frequent among those children that had not been adopted. Youth who experienced a change in case worker were 44% less likely to be adopted than those who did not experience a change in case worker. The authors note that the importance of having a consistent case worker has seldom been examined in previous research. This had been a gap in the research given that staff turnover is an all too common challenge for many child welfare organizations. Children that were not adopted were more likely to have experienced a placement change. Placement stability was associated with more rapid

adoptions. Placement in an institution or group home was much more frequent among those that were not adopted.

In cases where a foster parent was identified as a potential adoptive parent, ambivalence was a key factor in lowering rates of adoption. The reason for that ambivalence were primarily lack of resources to meet the child's needs, loss of financial support, loss of casework and services or support, the family not being ready, and child behaviours. For each year that a child spent in foster care after the termination of parental rights, the likelihood of adoption was reduced by 80%, highlighting the importance of early and effective case and concurrent planning. The results of the study suggest that plans to continue relationships with birth families do not pose a barrier to adoptions.

Given the prevalence of emotional and behaviour problems and the reasons associated with foster parent ambivalence to adopt, the authors suggest that a key component of enhancing permanency through adoption is the provision of high quality support and therapeutic services both before and after adoption. They also point out that older youth do in fact get adopted and that "While continuing to work toward a permanency goal that is unreachable would not be advisable, all youth should receive the benefit of the enhanced efforts to recruit an adoptive family within their own networks and the broader community before agencies become resigned to "next best" alternatives" (pg 702).

Relevance:

The research points to factors and child characteristics associated with increased likelihood of adoption that could be used to more effectively design and target services. Supporting placement stability and providing supports for foster parents considering adoptions appear to be key. The research also underlines the importance of having consistency in case workers. Results indicate that consistency of staff makes a difference for children waiting for adoption, even after considering the impact of obstacles from multiple domains.

Article 8:

Crea, T., Wildfire, J., & Usher, C. (2009) The Association of Team Composition and Meeting Characteristics with Foster Care Placement Recommendations. Journal of Social Service Research, 35, 297-310.

Relationship to Emerging Consultation Themes:

Collaboration & Teamwork, Placement Planning & Matching, Information Sharing & Communication

Overview:

The study reported in this article examines the use of a Team Decision Making (TDM)

model as part of the Family to Family initiative supported by the Casey Foundation. TDM is a facilitated group process that emphasizes input from family and community members to inform decision making. One of its purposes is to connect family members to supports during the meetings. Although the model is used for meetings held at different points in the case management process, this study focused on meetings involving a potential decision to move a child to less, more or same restrictive placement. The study specifically examined the association between attendance at meetings by current caregivers and placement decisions that are made during the meetings. The authors discuss the fact that while better assessments and increased support to foster parents would likely promote more stable placements, systemic factors that promote instability would not be addressed. Research on placement disruption is reviewed. Placements are at the greatest risk of disruption early in the relationship. Most moves in care happen within the first six months. Children in kinship care are at a lower risk for disruption. Behaviour problems pose a risk for placement breakdown which in turn places the child at further risk for increased behaviour problems. Caseworker turnover is associated with multiple placements, longer stays in care, and a decreased likelihood of reunification.

Results/Findings:

The attendance of a caregiver at the meetings reduced the likelihood of a placement change recommendation by more than 40%. For each additional friend or neighborhood support in attendance, teams were 25% less likely to recommend a placement change. The number of family members and relatives in attendance significantly lowered the likelihood of same level or more restrictive placement changes. Older children were more likely to be recommended for more restrictive placements and the risk of placement disruption increased with the age of the child. The authors suggest that by distributing decision making control, TDM decreased the likelihood that caseworker turnover and lack of education would negatively impact placement decisions.

Relevance:

This research provides support for implementing or expanding upon collaborative decision making models that are systematically implemented at key points in the care process.

Article 9:

Street, E., Hill, J., & Welham, J. (2009). Delivering therapeutic wraparound services for troubled adolescents in care, *Adoption & Fostering*, 33(2), 26-33.

Relationship to Emerging Consultation Themes:

Comprehensive Continuum of Placement Options & Supports

Overview:

This article reports on the use of a multi-level intervention for youth with significant behaviour issues. The Multi-disciplinary Intervention Service (MIST) is a team that looks after youth aged 11-21 that are in care and who exhibit significantly challenging and risk taking behaviour such that their placements are at risk of breakdown. Its original purpose was to bring young people out of residential care and into foster or relative care. With that goal achieved, it now works pro-actively to prevent young people from being moved into care. MIST takes a multi-dimensional and multi-systemic approach, employing a variety of interventions concurrently with the young person and their network. Attachment based approaches are privileged. The program attempts to promote trust, self-esteem, self-value, autonomy, and emotional literacy. MIST jointly manages four therapeutic foster care placements and a small number of regular foster care placements where the young people live. Support to foster parents is similar to that provided in the Multi-Dimensional Treatment Foster Care model. Each young person is assigned a key worker with whom they meet up to five times a week. The focus is maintained in the child's agenda. Support is provided for family relationships and for dealing with the education system, including active support in the school where necessary.

Results/Findings:

Although this article does not include an evaluation of the effectiveness of this approach, the authors point to positive results in terms of achieving placement stability for high needs youth outside of staffed residential settings.

Relevance:

The article highlights a number of critical program elements that appear to be associated with positive outcomes for children and youth exhibiting significant behavioral issues. These elements are similar to those utilized in other multi-level approaches and could be effectively incorporated into existing or new program initiatives.

Article 10:

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

Relationship to Emerging Consultation Themes:

Comprehensive Continuum of Placement Options & Supports

Overview:

This article examines the outcome literature on both residential and inpatient treatment for adolescents. The literature for both types of services is considered

together due to similarities in the treatment modalities, often only distinguished by treatment duration. A total of 13 studies were identified and included in the review. The outcomes measured in the studies were symptom reduction (common in medically-based programs) and social & familial functioning (more common in programs run by social service agencies). The authors review and critique both approaches. Variation in theoretical orientation across programs made comparisons of outcome more difficult. The authors point out significant methodological issues, including lack of comparison or control groups and use of idiosyncratic measures. The available outcome literature fails to systematically define its samples by ethnicity and sexual orientation.

Results/Findings:

The authors argue that, overall, the outcome literature indicates that these settings can be successful interventions for many clients. Positive changes have been demonstrated in research looking at both behaviour changes and social/familial functioning. Factors such as parental engagement and certain client characteristics (e.g., no history of abuse) appear to positively influence treatment outcome. Methodological issues, the lack of research on specific elements of programming and the lack of a unified definition of residential treatment are deficits in the literature.

Relevance:

The results of this review support the results of previous studies and the results of the Lyons et. al article reviewed above. Residential treatment and inpatient psychiatric care appear to be effective interventions for certain youth. The challenge in utilizing this form of intervention appears to be effective targeting, maintaining family involvement, and having access to comprehensive after-care supports.

Article 11:

Avery, R. (2010). An examination of theory and promising practice for achieving permanency for teens before they age out of foster care. Child and Youth Services Review, 32, 399-408.

Relationship to Emerging Consultation Themes:

Collaboration & Teamwork, Permanency & Concurrent Planning

Overview:

This article examines current practice with regards to achieving permanency for teens in out-of-home care. The authors argue that Independent Living programs have proven inadequate to prepare youth for independence. Their review of the available research indicated that youth who age out of foster care to "independent living" are more likely to experience homelessness, unemployment, unplanned pregnancy, legal system involvement, substance abuse, and are less likely to have a high school diploma, earn enough to support themselves, or participate in post-secondary education or training.

They further suggest that little or no attention has been paid to well established theories of child development that shed serious doubt on the assumption that being 18 is an appropriate age for transitioning to adulthood and launching foster youth into independence. The authors point out that adolescents on the path to adulthood continue to rely on their families for supports that are critical to development and future life outcomes.

Results/Findings:

The paper reviews developmental literature examining the general population which suggests that transition into adulthood is a gradual process for the majority. The research suggests that young people in the US are not ready to assume adult roles and live independently until their mid twenties. Developmental trajectories are significantly influenced by familial relations throughout this period. Significant portions of youth in care have no or few relations of connections with parents or extended family members that can provide the needed social support. The authors argue that "The absence of strong "social scaffolding" in the lives of foster youth aging out of care is, no doubt, the critical predictor of the deleterious post-foster care outcomes that research has recently uncovered." (pg 401). The article then reviews research regarding the efficacy and adequacy of independent living programs for youth and calls into question the goal of independence for any youth in care. Evaluations of independent living programs have found few impacts on measurable outcomes. The paper then reviews a new conceptualization of youth permanency, reframing the concept of permanency for youth in terms of lifelong connections to kin and fictive kin. The authors highlight a demonstration project that used a Social Capital Building model for youth ageing out of care called "Permanent Parents for Teens". The project sought to find permanent adoptive parents or committed permanent parents that would morally adopt teens. Specialized case-work activity focused on a child-specific recruitment approach called Permanency Action Recruitment Teams (PART). PART meetings brought together all parties involved in the permanency planning process for the teen, including the teen and individuals in the teen's life who could potentially be a permanency resource for them. The process included scouring the case files for potential names of individuals who previously had been foster parents, friends, teachers, etc. Through the life of the project, 98 of 199 teens referred were successfully placed in permanent situations. There was no comparison or control group for this research. The authors argue that the pursuit of enduring relationships, alongside the delivery of support services, is essential in "permanency oriented" child welfare services.

Relevance:

This article argues for a re-thinking of how permanency is approached for youth, emphasizing life-long relationships and the need to ensure that family-based supports are in place for youth well into their early twenties. The article highlights the potential of targeted, team-based interventions for finding permanent arrangements for youth in their late adolescence preparing to exit formal care.

Article 12:

Landsverk, J., Burns, B., Stambaugh, L., & Reutz, J. (2009). Psychosocial interventions for children and adolescents in foster care: Review of research literature. Child Welfare, 88(1), 49-69.

Relationship to Emerging Consultation Themes:

Mental Health and Addictions Resources, Assessment, Systems Coordination, Access to Service

Overview:

The paper is a condensed and updated version of a technical report provided to Casey Family Programs in 2005 that looks at evidence based and promising interventions for the most prevalent mental health conditions found amongst children in foster care. Current research suggests that between one half and three quarters of children enter foster care exhibiting behaviour or social competency problems that warrant mental health care. The research has also found a high rate of developmental problems for children entering foster care prior to the age of seven.

Results/Findings:

Research suggests that the most prevalent conditions among children in foster care are PTSD and abuse related trauma, disruptive behavior disorders, depression and substance abuse. The authors suggest that providing individual therapy for most of these conditions has been shown to be of limited value. The article highlights research suggesting that there are effective interventions (both brief clinic-based and group-based models) to address commonly diagnosed conditions. Further, the available research on more comprehensive interventions for youth with more complex needs suggests that "... longer term and intensive interventions offer alternatives to institutional care for many youth in foster care." (pg 52). Three treatments emerged as best practice for PTSD. They are reviewed in the technical report, but not in this article. In general, treatment is more effective when it is brief and when parents are involved. Two models emerged for the treatment for disruptive behaviors – Parent Child Interaction Therapy (PCIT) and Multi-Systemic Therapy (MST). The paper points to the technical report for a review of the most strongly supported interventions for depression. Controlled trials using Selective Serotonin Reuptake Inhibitors (SSRI's) are also showing significant positive findings. Brief interventions including cognitive-behavioral therapy and family-based interventions have been successfully utilized in the treatment of substance abuse. Pharmacological interventions for addiction are not recommended for adolescent populations. The recommendations based on the review include "... (a) informing child welfare workers about the importance of early identification and treatment, (b) instituting a standard protocol for screening and assessment to identify need for mental health care on entry into the child welfare system, (c) educating child welfare workers about local resources and creating a liaison with mental health providers to facilitate rapid referrals into mental health services,

and (d) monitoring referrals and following up with foster parents to ensure that youth receive services." (pg 64). The authors suggest that the provision of specific mental health interventions within the child welfare system may be a more effective and innovative approach than accessing services through a separate mental health services system.

Relevance:

This article underlines the critical importance of early mental health assessment/screening for children and youth entering care. It also highlights the availability of effective interventions. Assessing and intervening early could have significant positive effects in terms of reducing placement breakdowns and supporting better long term health and mental health outcomes for children and youth. The fact that BC currently has mental health services and child welfare within the same administrative structure may provide a solid base for more integrated service delivery.

Article 13:

Dorsey, S., Farmer, E., Barth, R., Greene, K., Reid, J., & Landsverk, J. (2008). Current status and evidence base of training for foster and treatment foster parents, Children and Youth Services Review, 30, 1403-1416.

Relationship to Emerging Consultation Themes:

Foster Parent Recruitment, Training & Support

Overview:

The paper provides a comprehensive research synthesis on training of caregivers for children and youth in out-of-home settings. The paper reviews the literature from both treatment foster and regular or traditional foster care due to the fact that there is significant blurring of these models in real life application. Professional standards for foster parent training have been largely operationalized through training curricula developed by professional associations in the child welfare arena. The article points out that two curricula - Model Approach to Partnerships in Parenting Group Preparation and Selection of Foster and/or Adoptive Families (MAPP/GPS) and Foster Parent Resources for Information, Development, and Education (PRIDE) - are widely used and viewed as the 'gold standards' for the field. MAPP was developed by the Child Welfare Institute (Mayers-Pastzor, 1987). PRIDE was developed by the Child Welfare League of America. Both are similar in length. MAPP focuses on 12 key skills and PRIDE focuses on 5 competencies. Both have been criticized for being overly focused on policies and procedures and not paying enough attention to meeting the needs of emotionally troubled youth. MAPP, PRIDE and the training curricula used in Multi-Dimensional Treatment Foster Care (MTFC) were included in this review. MTFC's training includes 3 days of orientation followed by extensive supervision and in-the-moment problem solving.

Results/Findings:

Despite MAPP and PRIDE's widespread use, there is virtually no evidence to support their use. Two published evaluations of MAPP showed no or limited gains. There is little research in the literature on training of kinship caregivers and most of the research available is more than 20 years old. The types of training included in the 29 studies reviewed varied widely. Most studies looked at foster parent knowledge and attitudes following training as the primary outcome with little or no assessment of skill or behavior changes at later points in time. More recent studies examining the impact of training on child behaviors have shown mixed results. Studies in the last five years using interventions originally developed for other populations showed promising results, including Multi-Dimensional Treatment Foster Care (MTFC) for pre-school age children, The Incredible Years, and Parent-Child Interaction Training (PCIT). A recently developed intervention called Attachment and Bio-behavioral Catch-up (ABC) showed positive results with infants and toddlers residing in foster care. More recent directions in foster parent training and support hold promise, including The Keeping Foster Parents Trained and Supported (KEEP) program. This 16-week training program accompanied by weekly homework and telephone calls focusing on tailoring behavioral interventions showed significant improvements in parenting skills, child behavioral problems, placement stability and family reunification. The authors conclude by suggesting a two-pronged approach that includes the basic messages about expectations and preparation for being a foster parent delivered prior to taking a child and providing skills-based training for managing difficult and wide ranging behaviors. Two critical characteristics of the second prong appear to be providing the support after the child is placed in the home (not before) and providing opportunities to receive coaching and feedback on the skills that are being practiced.

Relevance:

The paper highlights characteristics of effective foster parent training and support interventions based on an emerging evidence base. This research points to the importance of both content and timing of education and support.

Article 14:

Crum, W. (2010). Foster parent parenting characteristics that lead to increased placement stability or disruption, Children and Youth Services Review, 32, 185-190.

Relationship to Emerging Consultation Themes:

Foster Parent Recruitment, Training & Support, Information Sharing & Communication

Overview:

The purpose of the study was to illuminate parenting characteristics of foster parents who successfully maintain long term placement. Foster parents recruited to the study

had to have been foster parenting for at least two years. The researcher hypothesized that high parental support (the emotional and social support a parent receives), effective communication, effective limit setting, high satisfaction with parenting and high parent alliance between foster parent couples would significantly predict long term placements. 151 foster homes were included in the study.

Results/Findings:

In the final analysis only two parenting characteristics – parenting support and limit setting – were significant. These two independent variables accounted for the most variance in placement stability. Communication, parenting satisfaction, and parenting alliance did not significantly predict the outcome. For limit setting, there was an inverse relationship where those parents that were more firm in their limit setting tended to have longer placements. The study did not account for characteristics of the foster child and relied on a voluntary sample.

Relevance:

The article reinforces other research findings that stress the need to provide effective emotional and social support in order to maintain placement stability. It also highlights the importance of firm limits-setting as a factor in maintaining longer placements. This appears to be consistent with fostering models such as Multi-dimensional Treatment Foster Care that focus intensively on the application of specific behavioral interventions.

Article 15:

Nash, J. & Flynn, R. (2009). Foster-parent training and foster-child outcomes: An exploratory cross-sectional analysis. *Vulnerable Children and Youth Studies*, 4(2), 128-134.

Themes:

Foster Parent Recruitment, Training & Support

Relationship to Emerging Consultation Themes:

The study reported in this paper utilized cross-sectional data from a larger study of child welfare outcomes in Ontario to explore whether foster parent exposure to various types of training would be associated with foster child outcomes. MAPP or PRIDE are used by 26 of 50 states and PRIDE has been incorporated into the new Ontario practice model. The evidence base for MAPP and PRIDE is sparse. A recent Campbell Collaborative review of controlled studies concluded that training interventions did not improve foster parents' behaviour management skills, attitudes or psychological functioning, and did not enhance the foster children's psychological functioning, extent of behavioural problems or interpersonal functioning. The authors note that the KEEP program appears to be the only foster parent training intervention that has shown

positive impact on child behaviors and placement stability. The sample included 603 foster children and adolescents aged 10-17 and their foster parents in Ontario. The data was gathered as part of the Ontario Looking After Children (OnLAC) study. Thirty different regression analyses were conducted examining the relationships between five foster child outcome variables (total child difficulties as rated by the foster parent, developmental assets scale as rated by the child welfare worker, child's relationship with foster mother and father and child's satisfaction with their placement as rated by the foster child) and 4 categories of foster parents training (agency specific, OnLAC specific, PRIDE training, and community college training).

Results/Findings:

In most (25) of the regressions, foster parent training was unrelated to child outcome variables. The authors suggest that, consistent with other findings in the literature, it is difficult to connect foster parent training that is mainly philosophical and procedural to child outcomes. While these elements may be essential to screening and orienting foster parents, they will likely need to be supplemented with specific interventions targeted at child behavioral difficulties that are common among children and adolescents in foster care. In the five analysis that were significant, the effect was opposite to what was expected. A foster parent's exposure to a greater number of different types of training predicted more foster child behavioral difficulties and fewer developmental assets. Exposure to a greater amount of OnLAC training predicted more child difficulties. Exposure to some (as opposed to no) OnLAC training or some (vs. no) PRIDE training predicted fewer child assets. The authors suggest that exposure to the training may have a sensitizing effect on foster parent's perception of their foster children. The effect may derive from heightened expectations of the child that are communicated during training, especially in the case of OnLAC training received by both foster parents and child welfare workers. The authors conclude that foster-parent training cannot simply be assumed to be effective and that it requires much greater research attention than it has received to date if it is to justify the considerable resources expended on it.

Relevance:

The finding that increased exposure to training for foster parents may be associated with a more negative view of foster child behavioral issues and developmental assets highlights the need for caution in how training curriculum is chosen and implemented. Implementation should be accompanied by evaluation to monitor for unintended negative consequences.

Article 16:

Osborn, A., Delfabbro, P., & Barber, J. (2008). The psychosocial functioning and family background of children experiencing significant placement instability in Australian out-of-home care. Children and Youth Services Review, 30, 847-860.

Relationship to Emerging Consultation Themes:

Permanency & Concurrent Planning, Assessment

Overview:

The study extends previous research to obtain a more comprehensive profile of children with high levels of placement instability in Australia. The previous study found that children who had experienced two or more placement breakdowns within a two-year period due to behavior challenges had a less than 5% chance of stability over the subsequent two years. Simple baseline measures of a child's behavioural adjustment and age in conjunction with a placement profile reliably predicted outcomes over a 2 year period and allowed the identification of the children particularly at risk of sustained placement instability. The study also found that "Although baseline behavioural problems were strongly predictive of placement instability over time, placement instability itself was found to have a separate or independent (and negative) effect on behavioural adjustment 18 months later, even amongst children who had entered care with few behavioural problems." (pg 848). The authors point out that whereas most children and foster caregivers only required monthly contact, children with long term patterns of instability required almost daily contact from caseworkers, significantly impairing their ability to support and plan for other children. The authors argue that successful solutions developed for higher needs children and youth may benefit the majority of children in care by freeing up resources that are currently concentrated in only a small number of children and youth. The sample for the current study included 364 young people between the age of 4 and 18 that had experienced two or more unplanned placement breakdowns due to child behavior in the previous two years.

Results/Findings:

Older children were found to have significantly more placement breakdowns than younger children. In terms of family history, there was a strong association between domestic violence, substance abuse, physical abuse and parental mental health problems, meaning that the existence of any one of these factors was a strong predictor for the others. Around two thirds of the sample were affected by five or more factors. Close to two thirds of the sample fell in the abnormal range for overall difficulties measured by the Strengths and Difficulties Questionnaire (SDQ). Children in the abnormal range were found to experience significantly more placement disruptions than children in the borderline or normal groups. Children from backgrounds of domestic violence, substance abuse and sexual abuse experienced significantly more placement disruptions. The highest levels of placement stability are for children between 12 and 13 years of age who have experienced 10 or more placements in their lifetime. The authors suggested that the existing foster care system in Australia is not appropriate or sufficient to provide care for these children and that additional supports and interventions are needed to prevent future placement instability. The authors suggest that given the high rates of conduct disorder and social problems in the sample, innovative interventions (such as MST and MTFC) and models that emphasize

stabilization and regulation of children's social environments may be useful.

Relevance:

The research highlighted previous findings that a placement move has a significant negative impact on children and youth in care even for youth with no or few pre-existing behavioral issues. It also confirmed that those children with behavioral issues, older children, and children with certain backgrounds are more likely to experience placement instability. This information could be used in helping to create appropriate assessment tools and targeting supports for children and youth entering out-of-home care.

Article 17:

Strijker, J., Knorth, E., & Knot-Dickscheit, J. (2008). Placement history of foster children: A study of placement history and outcomes in long term family foster care. Child Welfare, 87(5), 107-124.

Relationship to Emerging Consultation Themes:

Permanency & Concurrent Planning

Overview:

The research examined the relationship between placement history and age, duration of care, and problem behavior. The sample consisted of a cohort of 419 children and youth admitted to long term foster care in the Netherlands. In the Netherlands, children can be admitted to short term or long term foster care, the later of which is designed to provide continuity of care through to the age of 18.

Results/Findings:

In 45% of cases, the child's current placement was their first. First time placements are twice as common in kinship care as opposed to regular foster care. Children with attachment disorders experienced more than twice as many placements on average. Externalizing behavior was also associated with number of placements. Foster children who had previously experienced a breakdown precipitating their current placement had a higher mean number of placements. A model that included previous history of placements, age and behavior problems, was associated with placements that were identified as at risk of breakdown, explaining 14% of the overall variance.

Relevance:

This research adds to the evidence base regarding the relationship between mental health issues and experiencing a greater number of placements for children and youth in out-of-home care. Consistent with previous research in other jurisdictions, previous placement history, anger and behavioral issues are associated with greater risk of

placement breakdown. This information can support the development and targeting of interventions designed to prevent placement breakdowns.

Article 18:

Ryan, J., Garnier, P., Zyphur, M., & Zhai, F. (2006). Investigating the effects of caseworker characteristics in child welfare. Children and Youth Services Review, 28, 993-1006

Relationship to Emerging Consultation Themes:

Professional Practices

Overview:

Caseworkers in child welfare have considerable discretion over the nature, quality and amount of sanctions as well as eligibility for services. This study attempts to test a multi-level model regarding the association between key child welfare outcomes and caseworker characteristics. The study sample included 5726 children in foster care.

Results/Findings:

Caseworker turnover was associated with a significant increase in the length of stay in care and a significant decrease in the likelihood of achieving reunification. Children associated with MSW level caseworkers spent significantly less time in care than those with non-MSW workers.

Relevance:

While significant attention is paid to the characteristics of children, caregivers and the care process that are associated with placement instability, this study focuses attention on the critical importance of having consistency in the staff that are responsible for decisions regarding care. Efforts to minimize turnover and stress related absences, as well as designing the care process so that system generated transitions between workers are minimized, appears likely to support more positive outcomes.

Article 19:

Pennell, J., Edwards, M., & Burford, G. (2010). Expedited family group engagement and child permanency, Children and Youth Services Review, 32, 1012-1019

Relationship to Emerging Consultation Themes:

Collaboration & Teamwork, Information Sharing & Communication

Overview:

This article examines the outcomes of an expedited family group engagement process

called "family team meetings" (FTMs). They were used to create plans shortly after an emergency placement in care and before the court hearing on whether the children would remain in care. The findings are based on a comparison of cases where FTM's were held with cases where they were not held. The authors review international research and consistently find that "When family groups take part in child welfare decisions, the plans tend to keep children at home or with their relatives." (pg 1013). Policy in the jurisdiction where the study took place defined FTMs as "structured planning and decision-making meetings that use skilled and trained facilitators to engage families, family supports, and professional partners in creating plans for children's safety and in laying the groundwork for permanency." (pg 1013). Coordinators that were separate from caseworkers prepare participants in advance for a meeting facilitated by another worker and lasting between one and two and half hours. The principles include meaningful family participation in planning and decision making and promoting the involvement of the community of origin in planning with families and children. FTM is considered a hybrid of family group conferencing and team decision making. The authors discuss these models as well as the rapid response family case planning conferences used in Minnesota and the expedited family group conferences used in Nebraska as part of their review. The study sample included 789 children that had been removed from their home. Three study groups were established: a baseline group of cases that occurred before roll-out of the program, a no-FTM group for families that declined to participate, and an FTM group.

Results/Findings:

Children that had received an FTM had a higher percentage of kinship foster care placements than either of the other groups. Almost 70% of the FTM group ended up with family-type permanency goals such as return to home, while less than half of the other two groups had such goals. The length of stay in care measured up to eight months following placement found that those with an FTM spent less time in care, with 35% exiting within six months in comparison to 12% for the other two groups. Upon exit from care, there was no significant difference between the three groups in terms of likelihood to move home or with other relatives. This lack of differences is explained by the fact that nearly all of those that exited care during this initial period ended up moving home or with relatives. The authors discuss the importance of honest and direct communication with families by workers, kin and community about the issues to be addressed as well as affirmation of their strengths as partners in change efforts.

Relevance:

Consistent with the findings of the Crea et. al. study reviewed above, this research provides support for implementing or expanding upon collaborative decision making models that are systematically implemented at key points in the care process. These processes can reduce the length of stay in care and facilitate decisions resulting in increased kin placements which are shown to be associated with more positive outcomes for children and youth.

Article 20:

Ruaktis, M., McCarthy, S., & Krackhardt, D., & Cahalane, H. (2010). Innovation in child welfare: The adoption and implementation of Family Group Decision Making in Pennsylvania, *Children and Youth Services Review*, 32, 732-739.

Relationship to Emerging Consultation Themes:

Collaboration & Teamwork, Information Sharing & Communication, Systems Coordination

Overview:

This paper examines the adoption of Family Group Decision Making (FGDM) in Pennsylvania. The research looked at system level of need, characteristics of the child welfare agencies and neighborhood factors. A mixed methods design was utilized for the study, using geographic autocorrelation modeling and an analysis of qualitative information about adoption and implementation of FGDM. The authors believed that this approach would enable a more complete understanding of the factors that may be at play when child welfare agencies adopt new and innovative practices. The authors suggest that although FGDM appears to be a common sense approach to working with troubled families, it actually requires a tremendous paradigm shift in that it alters the power differential. Families (as opposed to professionals) describe their needs and design and implement the solutions. The authors view this as "... a move away from child saving, the historical role of child welfare, to partnering with and empowering families." (pg 733). Further, they suggest that FGDM may not be in the best interests of professionals because it shifts the power to the family yet leaves the child protection worker responsible for the outcomes (i.e., child safety). The article reviews research on the adoption of innovations in multiple contexts and concludes that the assimilation of new innovations is often organic and messy, with a shifting back and forth through stages of imitation, implementation, setbacks and surprises.

Results/Findings:

The level of child welfare need in a county (operationalized as poverty level, population density, children under 18, and reported maltreatment per 1000 citizens) had no impact on implementation of FGDM. However, all of the variables related to the characteristics of the child welfare agency (whether they had received a start up grant, whether they participated in a System of Care Initiative, population density of the county and number of case workers in the agency) were significantly associated with FGDM implementation. The authors suggest that a system of care approach is philosophically consistent with FGDM. System of Care philosophies support a strengths-based approach to care, something strongly promoted by the FGDM model. The level of implementation in neighboring counties also significantly predicted implementation. Established adopters were more likely to mention the importance of leadership in implementing FGDM than those that were new adopters. The qualitative findings support the need for consistent leadership throughout the adoption and implementation process.

Established adopters were also more likely to mention caseworker attitudes as a significant barrier to successful implementation. For new adopters, the most commonly identified barriers were lack of resources (money, time, staff). The authors conclude that additional resources in the form of training and funding are helpful at the start of an implementation process. The geographic autocorrelation data also suggested a more subtle approach to encouraging the adoption of an innovative practice that would involve targeting certain counties that may be “ripe” for adoption due to their locations.

Relevance:

The article points to the importance of considering the potential impact or influence of systems level factors in the implementation of any new or innovative practices. Regardless of the merit of the model, approach or intervention being implemented, factors such as resource availability, leadership, the level to which there is philosophical consistency between what is being implemented and the existing approach to service delivery, can impact success.

Article 21:

Snow, K. (2009). The case for enhanced educational supports for children in public care: An integrative literature review of the educational pathway of children in care, Vulnerable Children and Youth Studies, 4(4), 300-311.

Relationship to Emerging Consultation Themes:

Access to Services

Overview:

The article examines educational and social outcomes of children transitioning out of child protective services. The purpose was to examine factors that might impact on educational pathways of children in care in order to demonstrate their need for enhanced educational supports.

Results/Findings:

Maltreated children are more likely to repeat grades and to experience disciplinary actions. Even children that experience exemplary care have educational lags, suggesting that early deprivation and maltreatment experiences can have lasting effects well into adulthood. Children living in foster care are five times more likely to require special education services. Research conducted by BC's Children's Representative and the Provincial Health Officer found that children in care were twice as likely to be scored as “not ready for school” and that 75% were identified as having special needs before the age of 16. Special education services were put in place mainly to address behavioural and mental health issues. Systems factors, including the lack of natural advocates, instability and placement type, all have an impact on educational achievement. Children in care change schools as much as 5 times more frequently

than their peers. Children who were placed in foster care showed improved attendance at follow up, but were also more likely to have a special educational placement and to have poor school performance which is a similar profile to non-placed children. In a study that matched children in care with maltreated children not in care, those in care were significantly more likely to be classified as emotionally disturbed. Children in care are more likely than their peers to repeat grades. A Swedish study found the worst educational outcomes for children placed in care in their teens. A study looking at children in care in Washington and Oregon found that high school completion rates were similar to the general population, but that a GED was more common and that post secondary education rates were less than the general population. In a similar study in North Carolina, money was the most common barrier to continuing education. However, a BC study found that 80% of children in care do not graduate. The author suggests that pathways for educational achievement be addressed from the point of contact with child protective services and included as part of long term planning. Services should make continuity, consistency and appropriateness the priorities for educational planning for children in care.

Relevance:

This review, which included research from British Columbia, points to the need to ensure that educational needs of children in care be addressed. This will likely require specific approaches or interventions and enhanced coordination with the public school system.

Article 22:

MacDonald, G., & Turner, W. (2007). Treatment foster care for improving outcomes in children and young people. Campbell Systematic Reviews, 9.

Relationship to Emerging Consultation Themes:

Comprehensive Continuum of Placement Options and Supports, Mental Health and Addictions Resources

Overview:

This review which was conducted utilizing a specific methodology articulated for systematic reviews published by the Campbell Collaborative and available in the Campbell and Cochrane libraries. It sets out to assess the impact of Treatment Foster Care on a range of outcomes for children and young people. The review looked at a number of treatment outcomes, including behavioural outcomes, psychological functioning, educational outcomes, interpersonal functioning, mental health status, the skill and interpersonal functioning of carers, and agency outcomes including placement stability, attainment of goals and level of restrictiveness of post-discharge placements. Information on costs and cost benefit was also reviewed where it was available. Three of the included studies were of Multi-Dimensional Treatment Foster

Care. Because only five studies met inclusion criteria and because four of the five were connected to the Oregon Social Learning Centre, the applicability of the evidence to other geographic areas and cultural contexts may be limited.

Results/Findings:

The authors found that Treatment Foster Care programs that had been studied varied greatly in terms of: children served; treatment parent selection, training, and supervision; staff expertise; involvement of children's families; and frequency and types of interventions used to help children adjust. The research was not able to clearly identify which treatment elements of the foster care programs contributed to the positive results. Although the inclusion criteria resulted in fewer studies being included than in previous reviews of treatment foster care, the results are similar to those reviews. The authors consider TFC a promising intervention for children and young people experiencing mental health problems, behavioural problems or delinquency and at risk of placement in more restrictive, institutional or group settings. The review was unable to come to any conclusions regarding the cost benefit because of the lack of reported available information in the included studies. Given the promising results shown for the MTFC model, the authors suggest that rather than doing more research into general models of Treatment Foster Care, research should seek to test the generalizability of MTFC findings. It would also be desirable to test it with other multi-faceted interventions.

Relevance:

While this review points to gaps in the research base for Treatment Foster Care, it is consistent with the findings of the evidence-based practice review conducted by Barth et. al. (2010) and discussed above, asserting that Treatment Foster Care, and specifically the MTFC model, is a promising practice for children and youth exhibiting challenging behaviors.

Article 23:

Snowden, J., Leon, S., & Sieracki, J. (2008). Predictors of children in foster care being adopted: A classification tree analysis. Children and Youth Services Review, 30, 1318-1327.

Relationship to Emerging Consultation Themes:

Permanency & Concurrent Planning, Mental Health and Addictions Resources

Overview:

Prior research on adoption has primarily investigated 'main effects' in regards to adoption rates. These studies have identified a number of variables that are significant in predicting adoption. Age is the most frequently studied variable in predicting adoption. In general, older children are the least likely to be adopted. Some studies

have also found an association between race/ethnicity and adoption though this research is inconclusive. The results of studies looking at mental and physical health status variables have also varied. Some studies have found that having a diagnosed disability lessens the likelihood of adoption, while others have not. Having a diagnosed emotional or behavioral disorder appears to lessen the likelihood of adoption. Increased levels of poverty in the birth family have been associated with lower likelihood of adoption and children who had been sexual abused also appear less likely to be adopted. Placement in a setting other than foster care appears to lessen the likelihood of adoption. Both the number of increased removals and increased length of time in care have been associated with lower likelihood of adoption. Foster parents who were specialized appear to be more likely to consider adopting. The current study utilizes national adoption data from the United States to examine and uses a Classification Tree Analysis to understand adoption rates in the context of youth and family demographic and clinical variables. This approach allows for a deeper understanding of the influence of multiple factors related to adoption, with the assumption that the decision or choice to adopt must be understood as an inherently contextual phenomenon.

Results/Findings:

A child's age at removal was determined to be the strongest predictor of whether or not the child would be adopted. Children removed under the age of 5 were significantly more likely to be adopted. Age of the child was the second strongest predictor, with children under the age of 11.7 years being significantly more likely to be adopted. The classification tree approach identified groups of variables that strongly predicted adoption status. The group identified as the least likely to be adopted were over the age of 11.7 at removal and had a Hispanic multi-racial foster parent who was part of an unmarried couple. The children classified as most likely to be adopted were between the ages of 5 and 11.7 at removal, have married foster parents, and were previously adopted prior to the age of 2 or over the age of 5. The State within the United States in which a child lived was a significant predictor in a number of the groupings of predictor variables. The family structure of the foster family also appeared in a number of groupings. It was the third highest predictor overall, with married and unmarried couples having the highest rates of adoption. The authors underline the importance of not viewing the factors that impede adoption in isolation and understanding that their impact varies by context.

Relevance:

The article adds to existing research on variables that influence adoption rates by identifying contextual factors. Knowing the marital status and family structure of foster parents may assist in case planning and decision making regarding placements for children that are or are likely to become available for adoption.

Article 24:

DeGarmo, D., Chamberlain, P., Leve, L., & Price, J. (2009) Foster parent intervention engagement moderating child behavior problems and placement disruption, Research on Social Work Practice, 19(4), 423-433.

Relationship to Emerging Consultation Themes:

Foster Parent Recruitment, Training & Support

Overview:

The goal of the article is to examine the differential effectiveness of a group based intervention for foster parents aimed at reducing foster child behaviour problems by examining the level of engagement foster parent achieved in the parent intervention groups. The intervention being examined was Project KEEP (Keeping Foster Parents Trained and Supported), a model based on Multi-dimensional Treatment Foster Care (MTFC) and Parent Management Training (PMT). The results from previous studies of KEEP found that having six or more child behaviour problems reported by foster parents during daily telephone interviews significantly increased the likelihood of a negative placement disruption and that KEEP significantly reduced the rates of reported daily behaviour problems. Families that reported more baseline behaviour problems reported benefiting more from the intervention. Although prior placement history was predictive of negative placement disruptions in previous studies, KEEP was able to buffer this effect. A sample of 700 foster child families (359 intervention and 341 services as usual, randomly assigned) was chosen in San Diego County, California. There were no significant differences in children's behaviour problems, prior risk factors, age or sex. No differences were obtained for caregivers with the exception of age; older caregivers were more likely to attend the groups. Participants in the study group received 16 weeks of training, supervision and support in behaviour management methods. The intervention was implemented by para-professionals with no prior experience with the MTFC model. Interventionists were trained during a five-day session and provided with weekly supervision. If foster parents missed a session, the material was delivered during a follow-up home visit. Incentives were provide to attend, including child care, credit towards annual licensing requirements, reimbursing travel expenses, and providing refreshments. A Parent Daily Report Checklist was used during repeated telephone interviews and assessed 30 different potential behaviour problems. Kin or foster parent engagement was rated after each session by group leaders.

Results/Findings:

For children with a number of previous placements, the KEEP intervention was more effective if foster parents had high levels of engagement and not as effective if they had low levels of engagement.

Relevance:

This article highlighted previous positive findings for the KEEP program and added to an understanding of variables influencing its effectiveness. The successful delivery of KEEP was impacted by the degree to which foster parents were engaged, which

suggests that gaining their buy in and support as well as providing incentives or other motivational strategies, might serve to further increase the effectiveness of this intervention.

Article 25:

Zinn, A. (2009) Foster family characteristics, kinship and permanence. Social Services Review, June, 185-219.

Relationship to Emerging Consultation Themes:

Permanency & Concurrent Planning

Overview:

The study reported in this article uses administrative data describing the out-of-home care histories of children in Illinois to examine the relationship between various foster family characteristics and the disposition and timing of permanence. The characteristics include foster parent age, race or ethnicity, wage income, and fostering history. The study also investigates the extent to which the relations between foster family characteristics and children's permanency outcomes for kinship foster family placements differ from those relations for non-kinship foster family placements. Studies to date indicate that children placed with kin exit to family reunification and adoption more slowly than children placed with non-kin. There have been no peer-reviewed studies of the relationship between family reunification and foster family characteristics. The final sample examined 22,311 foster family placements of 11,142 children in 15,845 distinct foster families. Slightly less than half of the sample of foster families were kinship foster-carers. Of the remaining, 40% were classified as traditional foster families and 13% were classified as treatment foster families.

Results/Findings:

Foster family wage income was considerably lower than the average in the State. Kinship foster carers differed on most characteristics, being older, more likely to be African American, more likely to be headed by single adults and more likely to have a lower wage income. Traditional and treatment foster families were similar on all characteristics measured. Children placed with kinship families were more likely to be African American and more likely to have been the subject of a substantiated allegation of substance exposure. During the five year period of time that the cohorts were observed, 70% of children exited to some form of permanency. The probability of reunification is highest in the first 12 months but is eclipsed by the probability of adoption by 24 months. The estimated rates of reunification and adoption were not statistically different for kinship care and traditional foster care, a result that differs from other studies of kinship care and permanence. This may be due to the fact that foster family demographics have been controlled for. The rates of reunification were found to be significantly lower for children placed in treatment foster care homes.

This may reflect differences in child characteristics not measured and accounted for in this research (i.e., treatment foster parents serve a higher needs population that is less likely to achieve permanency). Foster parent age was positively associated with reunification, suggesting that reunification may be facilitated by traits that accrue with age. Children placed with African American traditional and treatment foster families have lower rates of adoption than those placed with non-kinship white foster families. The number of adults in a foster home does not appear to be associated with permanency outcomes. As foster family wage income increases, the rate of adoption increases and the likelihood of reunification decreases. This held for all groups of foster carers. This suggests that as household income increases, the real and perceived ability of a family to assume long term responsibility increases. Neither foster family tenure nor rate of placements in a foster home (ie. turnover) was found to be associated with permanency outcomes.

Relevance:

The implication of this study is that child welfare agencies could potential affect the course and timing of children's permanency outcomes through a combination of selective placement decisions, foster family recruitment, and efforts to provide foster families with support as well as training.

Article 26:

Montgomery, P., Donkoh, C., & Underhill, K. (2006). Independent living programs for young people leaving care: The state of the evidence. Children and Youth Services Review, 28, 1435-1448.

Relationship to Emerging Consultation Themes:

Transition Planning & Supports, Comprehensive Continuum of Placement Options and Supports

Overview:

There is little evidence to gauge the effectiveness of Independent Living Programs (ILP's) for youth leaving care. Furthermore, the basic premise of ILP programs, that youth who acquire skills will experience a smoother transition to self-sufficiency, is unproven. A systematic review conducted through the Campbell Collaboration found no randomized or quasi-randomized controlled trials of such programs worldwide. Despite the lack of randomization, the available research may be useful. This paper reviewed available evidence on the effectiveness of ILP programs that met all of the criteria for inclusion in a Campbell Systematic Review apart from being randomized. These studies compared ILP programs to usual care or no intervention, or another intervention. The paper reviewed the literature on outcomes for children and youth emancipating from care. Young people leaving care are more likely than their counterparts to be homeless, unemployed and/or depending on public assistance. This is compounded by the fact

that young people in care transition earlier than their counterparts, and retain little or no financial, emotional or social support from their family. Independent living skills programs general employ skills training techniques to focus on personal development (e.g., communication skills, anger management, decision making) and independent living skills (e.g., job skills, budgeting, household tasks, seeking housing, utilizing community resources). In the years before transitioning to independence, ILP's often offer supervised living spaces. Eight studies were identified for inclusion – seven from the United States and one from the United Kingdom.

Results/Findings:

The study groups consistently differed in age, ethnicity, gender, placement history and support networks. This underlines the issue of external validity of the results. The studies relied on case records and self-reported data. Few studies measured program level outcomes and follow-up times varied. There was little information on implementation fidelity, making it difficult to assess which program or elements of program are effective. Notwithstanding the limitations, there were significant baseline differences between control or comparison groups and the study groups in most studies. All but one study reported favorable results for educational attainment, with participants being more likely to complete high school and to carry on to vocational, technical or college training. A number of studies also reported positive employment outcomes. Every study reported favorable outcomes for housing. The strength of the evidence in these areas must be tempered by the weak evaluation methodology. Although two of the studies showed that participants were more likely to be utilizing public assistance at follow-up, this could be considered a measure of ability to access available resources. The authors note that outcomes of the ILP participants compared favorably with the outcomes of the general population of youth exiting care. However, ILP participants still had extensively poorer outcomes when compared to the general population.

Relevance:

The lack of studies evaluating independent living programs that utilize random assignment or matched samples underscores the need for more research into the effectiveness of these commonly used programs. While there is some evidence of positive results, the methodological issues limit their applicability. The fact that even those youth achieving positive outcomes are lagging behind the general population suggests that more needs to be done to effectively plan and provide services to youth exiting care.

Article 27:

Cheers, D., & Mondy, S. (2009). Enhancing placement stability via a continuum-of-care approach: Reflection from the Australian context. Vulnerable Children and Youth Studies, 4(2), 148-153.

Relationship to Emerging Consultation Themes:

Comprehensive Continuum of Placement Options and Supports

Overview:

This article presents a brief overview of the nature of children in care in Australia. It focuses attention on a group of children with high and complex needs and reflects on the experiences of one agency – Centacare Broken Bay (CBB) in New South Wales (NSW) – in providing a continuum-of-care approach to reducing placement instability. In Australia, the rate of children in care is 5.8 per thousand children, a rate that had increased sharply between 1997 and 2000. Responsibility for children in care is at the State level in Australia. Although indigenous people make up only 3% of the population in NSW, they represent over 30% of children in care. In 2002, the NSW government announced additional funding of \$1.2 billion over 6 years to strengthen the NSW child protection system. A significant part of that initiative was directed at a subset of children in care (about 200) known as “High Needs Kids” (HNKs), who had significant and complex needs and for whom traditional residential and foster-care options had failed. Although these children and young people represented only about 2% of children in NSW care, they accounted for 26% of the children in care budget. These high needs kids were mostly adolescents with intellectual disabilities and serious challenging behaviors and most had at least one mental health diagnosis. However, this group of kids usually failed to meet the threshold for intensive long term intervention by any particular service delivery system (e.g., juvenile justice, mental health). Most have long histories of placement instability. Although at least one State in Australia has secure care options, NSW does not have any provision for secure care.

Results/Findings:

In NSW, the Department of Children's Services contracts with NGO's to develop a response for the HNK's. The Department retains responsibility for case management. CBB provided 12 residential placements in four homes along with six foster care placements. The residences provided care for a maximum of three young people and provided close supervision as well as structured activities to minimize negative peer interactions. Staff facilitated a staged entry into the placement. Residential staff with whom the children had made significant attachments were able to remain with them as they moved through the care system. Individualized treatment plans were overseen by psychologists that were exclusively assigned to each residence and foster placement. CBB maintained a close collaborative relationship with the department in order to present a consistent and united approach to young people. The authors argue that a continuum-of-care approach leads to enhanced placement stability which in turn offers "... the possibility of consistent, targeted therapeutic interventions that address trauma, lead to the establishment of better attachments and social functioning, and in turn stabilize behaviours contributing to placement breakdowns." (pg 152). The authors suggest that a policy implication of a continuum of care approach is that sufficient government funding is needed to enable youth to transition seamlessly within agencies. In terms of practice, they suggest that contracted providers need to have the flexibility

to adjust programs, staffing and resources to meet a youth's changing needs while still maintaining continuity in the relationships developed within their placements.

Relevance:

Although this paper does not specifically test a treatment intervention or explain in detail exactly how the continuum worked, the similarity to the context in BC and approach of contracting with one agency to provide a continuum of flexible supports to very high needs kids is noteworthy.

Article 28:

Pine, B., Spath, R., Werrbach, G., Jensen, C., & Kerman, B. (2009). A better path to permanency for children in out of home care. Children and Youth Services Review, 31, 1135-1143.

Relationship to Emerging Consultation Themes:

Comprehensive Continuum of Placement Options and Supports, Permanency & Concurrent Planning, Collaboration & Teamwork

Overview:

This study examines the outcomes of a family reunification program operated by a non-profit organization under contract to a state child welfare agency. The model targets families experiencing a first time removal and receives referrals within 15 days of placement. The service is intensive, home-based, tailored to the family's needs. It includes frequent visits, group work, and individual, couple and family therapy delivered by a team that includes a Masters level Social Worker, a family support worker, and the case worker from the State agency. Caseload size is between five and seven families. This review focuses on whether or not families are being reunified and whether or not the program is more effective in reunifying or achieving permanency than standard reunification services offered by other partner State agencies. Previous studies have found that children coming from two parent households are more likely to reunify and that children placed with kin are less likely to reunify and remain in care twice as long. Lower rates of reunification are also related to length of time in care, number of prior removals, and number of previous placements. Children with multiple caseworkers' experienced significantly longer stays and were less likely to reunify. Those with Master level caseworkers reunified more quickly. Previous studies of intensive home-based services have shown positive associations with rates of reunification. The study looked at a sample of 135 families that received the program and a matched sample of 135 families that received regular reunification services. The families were matched on eight criteria and all had first time removals. The data was collected through case record reviews.

Results/Findings:

The rates of reunification were similar for both groups. There were also no significant differences in rates of other placement outcomes, such as adoption or permanent foster care. However, families in the program experienced greater stability and safety once they were reunified. They experienced fewer re-referrals to authorities and less likelihood that new reports to authorities would be substantiated. Program children also spent significantly less time in care than the comparison group regardless of the placement outcomes and experienced fewer moves in care. In terms of time to adoptive placement, comparison group children spent a considerably longer period of time in care (94 weeks compared to 54 weeks) prior to placement. The authors suggest that although intensive services and low caseloads require more resources, they may be more cost effective in the long run if children spend less time in care and are less likely to return to care after reunification.

Relevance:

This research highlights the importance of intensive, targeted supports to children in out-of-home care and their families in order to successfully reunify or move quickly to another permanency option and minimize the length of time spent in care.

Article 29:

D'Andrade, A. (2009). The differential effects of concurrent planning practice elements on reunification. *Research on social work practice*, 19(4), 446-459

Relationship to Emerging Consultation Themes:

Permanency & Concurrent Planning

Overview:

Concurrent planning attempts to shorten the length of time that children stay in care before returning home or finding a new permanent home by making efforts towards adoption concurrent with reunification efforts. In the United States, some States require concurrent planning and some states allow concurrent planning. Concurrent planning practice has a number of distinct elements, including the development of a concurrent plan (an alternative plan for permanency for the child), a reunification prognosis (a determination of the likelihood of reunification of a family), full disclosure (explaining to parents the process of concurrent planning and the consequences of failing to complete their case plans), discussions of voluntary relinquishment as an option for parents, and "post-adopt placement" (placement of the child in a foster home willing to adopt the child should reunification fail). These elements are intended to reduce time in care and confront parent ambivalence. This approach requires a redefining of success in child welfare to include a broad array of permanent outcomes. The development of plan B serves as a constant reminder of an alternative goal and the means to attain it. There is little research on the effects of concurrent planning, although findings from the few published studies have been positive. This study

examines 885 children entering out-of-home care in 6 counties in California comparing children who received elements of concurrent planning with children that did not receive these elements. Although concurrent planning is mandated in California, a substantial portion of children entering care after the passage of the law did not receive it. The study utilized an observational design examining children who either had or had not received elements of concurrent planning. The model attempted to control for variables of social worker bias in choosing which cases they targeted for concurrent planning.

Results/Findings:

The concurrent planning element of “full disclosure” was associated with a lower likelihood of reunification. No other concurrent planning variables were associated with reunification. It may be that the practice of full disclosure is difficult to do well and that it disheartens parents and hinders reunification. The concurrent planning element of discussion of voluntary relinquishment was associated with an increased likelihood of adoption. No other concurrent planning variables were associated with this outcome. Discussing relinquishment almost doubled the likelihood of adoption, supporting the idea that specifically discussing this option with parents facilitates their best use of it. In this study, the articulation of a concurrent plan was not associated with either reunification or adoption. However, because the source of this data was court reporting, this may not reflect true engagement in a concurrent planning effort. A number of recent qualitative studies on concurrent planning suggest that effective planning is complex and involves skillful social work and intensive service provision as well as systems changes such as structured collaboration between adoption and reunification workers. The authors state that current State policy in California does not facilitate such practice.

Relevance:

The mixed results from this study suggest that implementing concurrent planning should be undertaken cautiously. The elements that should be included, the timing of their use and the level of training and support needed to effectively utilize the practice should all be considered.

Article 30:

Tarren-Sweeney, M. (2008). Retrospective and concurrent predictors of the mental health of children in care. Children and Youth Services Review, 30, 1-25.

Relationship to Emerging Consultation Themes:

Mental Health and Addictions Resources

Overview:

This study examines retrospective and concurrent predictors of children’s baseline

mental health problems and proposes some likely developmental mechanisms related to their mental health. Previous research has demonstrated that children in out-of-home care have an exceptional frequency and severity of emotional and behavioral difficulties that more closely resembles children and youth clinically referred through other means than children at large. Previous studies have been limited in their designs because they looked at mental health outcomes without reference to their developmental histories. The Children in Care Study in New South Wales, Australia was an attempt to address some of these limitations. The study data included carer-reported estimates of mental health for children in care as well as retrospective data on potential risk and protective factors. The study sample included 347 children aged 4 to 11.

Results/Findings:

Children in the study were reported to have exceptionally poor mental health and socialization, both in absolute terms and in comparison to their peers. More than half of both boys and girls had at least one score on the Child Behavior Check List (CBCL) in the clinical range. About one third were on prescribed medications of which psychotropic medications and asthma medication were the most common. Boys were prescribed psychotropic medications at a much higher rate than girls. In this sample, 22% of children were reported to have speech language difficulties, with the highest prevalence found among younger boys; 36% were reported to have reading difficulties. A third of children encountered formal disciplinary measures in school in the past year. There was a strong relationship with age of entry into care and the mental health of children who entered care beyond 7 months of age, with older age of entry related to increased mental health issues. Those entering care before the age of seven months enjoying substantially better mental health. Children with a history of sexual abuse had high scores on a scale of sexual behavior, but were not different on other scales or measures. Confirmed history of physical abuse was associated with attachment problems, anxiety problems, delinquency, and aggressive behavior. Exposure to emotional abuse was associated with a number of mental health issues including self-injury, social problems, anxiety problems, attention problems and aggressive behavior. Witnessing domestic violence and verbal assault/threats of violence were not associated with any measures of mental health. Developmental and pre-care histories predicted about two thirds of variance in mental health issues in this sample. The strongest predictors were age of entry into care, reading difficulties, reported intellectual disability, young maternal age at birth, and exposure to certain types of maltreatment or adverse life events in the year preceding entry into care. The mental health issues most strongly associated with pre-care adversity were attachment difficulties, aggression, defiance and age-inappropriate sexual behavior. The author proposed that the current study provides partial support for the cumulative risk model of psychopathology, with those exposed to longer periods of maltreatment likely to experience more and greater difficulties. The findings from the current study are also consistent with current knowledge on attachment development that suggests infants entering care are more likely to develop secure attachments to their foster or kinship caregivers. The study found that placement security was a strong predictor of mental

health when controlling for other confounding variables.

Relevance:

The findings regarding the mental health of children and youth in care add to the body of evidence documenting poor outcomes. The findings related to developmental impact of accumulated risk factors points to the need for courts and caseworkers to consider mental health implications of decisions relating to the care of children young people being exposed to adverse conditions.

Article 31:

Oosterman, M., Schuengel, C., Slot, N., Bullens, R., & Doreleijers, T. (2007). Disruptions in foster care: A review and meta-analysis. Children and Youth Services Review, 29, 53-76.

Relationship to Emerging Consultation Themes:

Placement Planning and Matching

Overview:

The purpose of the review was to provide a summary of factors that are associated with placement outcome in the form of placement breakdown in order to identify risk and protective factors. The review also examines the relative size of the effects based on multiple studies and the heterogeneity of the findings across findings. A total of 26 studies satisfied the inclusion criteria. They were published between 1960 and 2005. A meta-analytic approach was utilized to examine combined effect sizes of factors that were included in five or more studies. This included age, placement history (residential care, previous placements), behaviour problems and kinship care.

Results/Findings:

The results of the relation between age and placement breakdown revealed a small but significant effect. The effect sizes were small for multi-variate studies that controlled for other risk factors. It appears that children in care for reasons of abuse had more placement breakdowns than children in care for reasons of neglect. This may reflect the fact that children placed for neglect tended to be younger and have fewer behaviour-related issues. Most biological family and parent characteristics were not related to placement breakdown. There was a moderately strong association between a history of residential placement and placement breakdowns. In terms of time in care, the first six months of placement pose the greatest risk of placement breakdown. Behavior problems were a robust predictor of breakdowns when other factors are controlled for. The evidence reviewed did not support an association between mental or developmental disability and placement breakdown. There does appear to be a relationship between the presence of biological children in the family and placement breakdown, though other factors may also help to explain this finding. Placement with

siblings appears to be associated with fewer placement breakdowns.

Relevance:

Consistent with other studies on placement disruption, behavioral issues and a previous history of residential care are robust predictors. Combined the finding that placements are at greatest risk of breakdown in the first six months in care, this suggests targeting and front-loading intensive supports for care providers.

Article 32:

D'Angiulli, A. & Sullivan, R. (2010). Early specialized foster care, developmental outcomes and home salivary cortisol patterns in prenatally substance-exposed infants. *Children & Youth Services Review*, 32, 460-465.

Relationship to Emerging Consultation Themes:

Foster Parent Recruitment, Training and Support, Collaboration & Teamwork

Overview:

The paper reports preliminary findings on the developmental outcomes associated with the Safe Babies Program in prenatally substance-exposed infants. The purpose was to examine whether the postnatal environment provided by specialized early foster care would be associated with signs of positive developmental outcomes in the most vulnerable infants. The Safe Babies program is operated through the BC Ministry of Children and Family Development – Vancouver Island Region. The main component of the program is the recruitment of experienced and highly qualified foster parents, including people with relevant professional qualifications in social work, paediatric medicine and nursing in addition to their experience as foster parents. The emphasis of this program is on early admission to care and on the stability of care making these placements more like adoption placements. The other key component is the inclusion of various forms of support for the foster parents including an assigned community health nurse, resource workers assigned to the program, an advisory committee, and six sessions of training for prospective foster parents and their relief covering a range of care related topics such as understanding the impact of substance abuse exposure on the infant health, safety considerations, infant CPR, partnerships with birth parents, and care for the caregivers. Monthly meetings with a support group are facilitated for foster parents and a biannual newsletter is produced. Standardized measures of psychological development were compared among foster infants who were preterm or full-term. Basal cortisol levels were measured across two days in the prenatally-exposed foster infants. The research participants were volunteer foster families and 22 infants. All infants had been taken into care within four months of birth. None of the infants experienced placement changes or transiency.

Results:

The scores on the standardized measure of development did not indicate clinically significant atypical development for the study group. Preterm infants showed significantly lower fine motor skills than their full term counterparts but were at norm in all other developmental domains and sub-domains. The authors argue that the developmental assessment findings suggest an association between the Safe Babies Program and positive developmental outcomes in foster infants, especially on the preterm group. The cortisol level values of the prenatally substance exposed infants overlapped with the typical range comparison values. Infants who had higher cortisol levels in the evening also had higher receptive communication and interaction abilities. When average cortisol concentrations were corrected for number of months spent in foster care, the differences between preterm and full-term groups were no longer significant. This suggests that early specialized foster care may be associated with some correction of the adverse effects of prenatal substance exposure observed in these preterm infants. The authors suggest that the professional background of the foster parents supports more responsivity and communication in the infants. Early admission in care (within four months of birth) and careful screening and recruitment are also considered critical to success.

Relevance:

This BC-based research provides further evidence that having specialized and supported foster caregivers is associated with positive outcomes for children and youth in care.

Summary of Themes

- The literature firmly supports the use of common assessments for all children and youth entering care in order to identify potential mental health and developmental issues and to assist in the targeting of support services.
- Poor outcomes, high incidence of mental health issues, and an increased likelihood of placement breakdown in the first six months of care suggest the need to ensure early access to comprehensive support services for children and youth entering care, especially with regards to mental health services and services to support stability and achievement in the school environment. For mental health services, a body of literature on effective treatment approaches for the most common mental health concerns presented by children and youth in care exists and can be utilized in the creation of specialized supports.
- There is evidence that specialized and targeted reunification programs that work aggressively from the time of placement have positive outcomes for expediting a safe and stable return home or to another permanent option.
- A growing body of literature supports the use of specialized care models for higher needs children and youth, such as Multi-Dimensional Treatment Foster Care,

Wrap-Around programming, Safe Babies, and Treatment Family Homes. These models are intended to target the specific needs of the populations they serve and have demonstrated positive outcomes. There was little evidence in the available literature to support the use of non-specialized community-based group care models serving multiple high needs children and youth.

- For general or traditional foster care providers, there is evidence that ongoing, pro-active support combined with monitoring of child/youth behavioral issues can significantly enhance outcomes. Several models have shown promise, including KEEP and KITS. The current evidence base suggests that age (being older), having behavioral issues and a history of placement breakdowns increases the likelihood of future placement breakdowns and overall negative outcomes. This information can support pro-active targeting of support services. In general, ongoing social and emotional support for foster parents is associated with more positive outcomes. The current evidence regarding training for foster parents suggests that pre-service training, while necessary for administrative and procedural purposes, has no or potentially negative impacts on child outcomes and that more attention should be paid to active post-placement support and training.
- High rates of placement disruption for children in foster care during the transition to adolescence suggest that additional, pro-active supports are required during this period to reduce the likelihood of placement breakdown.
- Although the evidence-base for the effectiveness of residential and in-patient treatment has some limitations, there appears to be general support for this intervention, both in terms of outcomes and meeting a community need. There is evidence that it is most effective when it is targeted to the very highest needs children and youth and utilized as part of a more comprehensive system of care and support.
- An emerging body of literature on youth permanency suggests that permanency in the form of stable and secure connections/relationships with caring adults should always be an objective and that the approach must include the youth's voice. Focusing solely on legal permanency may result in damaging disruptions to the youth's existing relationships and their physical environment (neighborhood, school, etc.). There is some emerging research suggesting that targeted specialized interventions can be successful in achieving permanency for older youth in foster care.
- There is a lack of evidence firmly supporting the efficacy of Supported Independent Living Programs for youth emancipating from care. More research is needed in this area. Poor life outcomes for youth that have emancipated from foster care and the acknowledgement that youth in the general population remain reliant on their parents well into young adulthood has led some researchers to advocate for more extensive family-based supports available for foster youth into their mid-twenties.

- The prevalence of foster parents that ended up adopting and the research highlighting some of the barriers to such adoptions suggests a need for more comprehensive financial and social-emotional supports for foster parents considering adoption. There is also an emerging body of evidence on the characteristics of parents that are more likely to adopt that can be used in matching children with caregivers earlier in the care process, reducing the likelihood of placement disruptions.
- There is strong evidence that collaborative practice approaches such as Family Group Decision Making and Team Decision Making can have positive outcomes, especially when utilized at key points in the care process (e.g., immediately following placement and at any point when a placement change is being considered). A team-based approach coupled with meaningful engagement of birth parents, family members and alternate care providers appears to expedite a successful return home, placement with kin, or adoption as well as prevent placement breakdowns. Implementing such approaches requires an acknowledgement of the time and resources required; the impact of existing organizational cultures and need for strong leadership; and the challenges for case workers who remain responsible for the outcomes of decisions and/or arrangements that come out of group-based collaborative processes.
- Two of the articles reviewed highlighted situations where contracted providers took on greater responsibility for comprehensive care of high needs children and youth and were given some level of authority to create collaborative networks and to make decisions about how to best use resources and organize care. Positive child/youth outcomes and decreased costs were noted as benefits of this type of approach to contracting for services.
- Having a stable, consistent and well trained/educated child protective services workforce (i.e., case workers, resources workers, foster care supports) appears to be associated with more positive outcomes for children and youth in care. Research suggests that children and youth who have a consistent caseworker and/or Masters level caseworker move home or to another permanency option more quickly. Researchers studying foster care outcomes have suggested that enhanced foster care support through lower support worker caseloads is a critical aspect of a comprehensive framework to improve the lives of foster children. While discussing the specific strategies that would reduce worker turnover and absenteeism is beyond the scope of this review, any efforts to improve leadership, culture/work environment, and caseworker's perceived satisfaction with their job would likely yield positive results. In addition, reducing changes in caseworkers associated with work flow or administrative demands would increase consistency and improve outcomes.
- While there is research evidence that supports the positive impact of concurrent planning initiatives, recent research from California suggest that mandating and implementing concurrent planning should be undertaken with caution.

Comprehensive training and careful thought regarding which elements of this approach to use, as well as the timing and context of their use, would likely enhance the potential for positive outcomes.

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