



Residential Review Project

Final Report



THE FEDERATION
of COMMUNITY SOCIAL SERVICES of BC



BRITISH
COLUMBIA
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and Family Development

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Residential Review Project Final Report



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Introduction

The Ministry of Children and Family Development (MCFD) and the Federation of Community Social Services of BC (Federation) project team has completed a joint review of residential care services provided by MCFD and is pleased to submit the *Residential Review Project Final Report* to MCFD and the Federation. This report builds on the *Residential Review Project Phase One Findings Report*, released in June 2011, and reflects work undertaken in Phase Two of the project, between January and October 2011. During this phase, the project team convened a series of intensive working sessions and consultations that lead to the development of 7 Strategic Directions, 32 recommendations and over 90 supporting actions aimed at enhancing the child and youth residential care system in BC. The next step is for MCFD and the Federation to consider this report and, as appropriate, develop plans to implement the recommendations and supporting actions.

The purpose of the Residential Review Project (the project) is to identify opportunities to improve the experience and life outcomes of children and youth who, for some reason, must live for a period of time in MCFD operated or funded residential care placements.

On any given day in BC, there are over 10,000 children and youth in some form of MCFD-funded residential care. There are many strengths in this system: experienced, skilled and committed caregivers; quality practices that are supported by research and evidence; accountable, accredited organizations; and strong working relationships between MCFD, community agencies and caregivers. However, there are also weaknesses within the system that can compromise the experience and outcomes of children and youth in residential care. These were documented in the *Residential Review Phase One Findings Report*. This Final Report aims to recommend a course of action for both MCFD and service providers that will build on strengths, address gaps and weaknesses, and achieve a planned system of residential care that better meets the care and treatment needs of children and youth and thereby supports more positive life outcomes.

This report sets the stage and identifies key opportunities for residential redesign as outlined below.

Part One – Setting the Stage includes the following:

1. Background - Describes the intention, context, and scope of the project.
2. Approach - Describes how the information that is presented in this report was gathered.
3. Statistical Overview of the Residential Services System – Presents descriptive and

statistical information about the current system of residential care in BC.

4. Residential Services to Aboriginal Children and Youth – Describes the importance of and progress in identifying the needs of Aboriginal children and youth within the residential care system.

Part Two – Envisioning a Planned System of Residential Care describes key findings from Phase One of the project and presents the context and rationale for each of the Strategic Directions and accompanying recommendations and supporting actions. The sections are organized according to the Strategic Directions:

1. Achieving Permanency
2. Enhancing Kinship Care
3. Strengthening Foster Care
4. Planning and Developing an Accessible Array of Residential Care and Treatment Services, which addresses three sub topics:
 - a. Building a Planned System of Residential Care and Treatment Services Based on Research & Best Practices
 - b. Building a Planned System of Intermediate Residential Care and Treatment Based on Research & Best Practices
 - c. Addressing the Key Gaps in Tertiary Care and Treatment
5. Addressing Youth Interests in Permanency and Transitions
6. Working Together Effectively
7. Enhancing Accountability in Residential Care

Part Three – Moving Forward proposes the steps for acting on the directions, recommendations and supporting actions detailed in this report.

Supporting materials on the project approach and methodology, participant demographics, survey findings, listing of articles and reports reviewed, and selected promising practice references that supplement the body of the report are posted on the Federation's website <http://www.fcssbc.ca/CoreBC/projects/residential-review>.

Part One - Setting the Stage

This report is the second from the Federation of Community Social Services of BC (Federation) and the Ministry of Children and Family Development (MCFD) Residential Review Project Team (the project team). The first report, *Residential Review Project Phase One Findings Report*, presents 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 or referenced residential services in BC, similar reports and initiatives undertaken in other jurisdictions, and available data on residential services in BC.

The Phase One report describes the current residential services system for children and youth and what diverse stakeholders and researchers have to say about it, including what works well, what doesn't, and how services and care might be improved or enhanced. Background and methodological information, and findings from the Phase One report are not repeated in the Final Report. However, readers are encouraged to review the previous report as it sets the context for this new report. It can be retrieved from the Federation's website at <http://www.fcssbc.ca/CoreBC/projects/residential-review>.

1. Background

Purpose

The purpose of the Residential Review Project (the project) is to identify opportunities to improve the experience and life outcomes of children and youth who, for some reason, must live for a period of time in MCFD operated or funded residential care placements.

At the outset, the intention was for this joint project of the Federation and MCFD to inform MCFD's development of a five-year strategic plan for the redesign of residential care services. MCFD also intended to draw on three other sources as they developed the plan: a consultation with Aboriginal stakeholders as described below, and internal reviews of kinship care and tertiary care undertaken by MCFD staff. However, as the work progressed, several shifts took place. First, MCFD concluded that it was wise to integrate the findings from the Aboriginal consultation and the kinship and tertiary care reviews into this report, to better describe the full range of a 'planned system' of residential care. Second, the new MCFD Minister and Deputy Minister expressed a keen interest in residential care and agreed to build upon the analysis and act on the project's recommendations within the context of the ministry's new three year Operational and Strategic Directional Plan that was being developed in the winter of 2011/12. Third, the Federation Board of Directors decided

that the community social services sector, as reflected in Federation membership, also had a responsibility to review the findings and proposed Strategic Directions, recommendations and supporting actions and develop a plan for action, within its scope of influence.

As a result of these shifts, this Final Report addresses the full spectrum of residential care options, from kinship to tertiary care, and makes recommendations that call for action from both MCFD and the community service sector.

MCFD Operational and Strategic Directional Plan

MCFD's Operational and Strategic Directional Plan released in May 2012 includes the following Key Action:

"Work with partners across the sector (MCFD staff, Aboriginal and mainstream agencies, foster parents, children and youth in care, and the Representative for Children and Youth) to design and implement a more integrated community-based service system for children in care, building from the analysis and acting on the recommendations of the Residential Review Project."

The expectation is that the Operational and Strategic Directional Plan will, given the current fiscal climate, involve improvements in the initial years of plan implementation within existing ministry resources and then address service and resource gaps requiring additional funding in later years. It is important to note that although progress can be made through better utilization of current funding, the full development of the residential care system that is envisioned in this report will require additional investments of funding over time.

Scope

This residential review 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 much 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 options for placing a child or youth with relatives or someone who has a significant relationship with him/her through Extended Family Program Agreements and court orders under the *CFCS Act* without the

child or youth being in the Ministry's care (Out-of-Care Kinship Options). As well, kinship care includes 'restricted foster care' where a child or youth who is in the Ministry's care is placed with extended family or other significant adults.¹

- Foster Care - includes foster family-based care homes offering placements for children in care under the *CFCS Act* (excluding restricted foster care, which is included with kinship care). The vast majority of foster family-based care homes are directly recruited, assessed, approved and supported by MCFD staff. Approved foster caregivers are remunerated for their services via a Family Care Home Agreement with the director under the *CFCS Act*.
- Contracted/Staffed Residential Care - includes contracted, agency-based and staffed residential services such as group homes and shelters but also includes contracted family-based care 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.²
- Tertiary Care - includes mental health hospital-based facilities designated under the *Mental Health Act* and youth custody centres directly operated by MCFD or Health Authorities, as well as any future safe care or secure care services that may be developed.

The project is not restricted to an identification of what resources are available or insufficient but also analyzes 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 fall within the scope of the project.

One of the challenges that the project team faced was defining the scope of the review. 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 and supports to children, youth and families. Residential services are directly affected by the availability of non-residential services and supports, access to funding and resources, and by program and practice change initiatives within MCFD. For example, 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 are significant developments that contribute to an ever-changing context for residential care.

1 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 support services.

2 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.

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 Justice, income assistance and employment services managed by the Ministry of Social Development, substance use treatment 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 and working sessions that are beyond the scope of this review and/or MCFD's jurisdiction. Some of these issues and ideas are noted in this report and will be shared with the MCFD Leadership Team and others for their consideration.

2. Approach

Guiding Considerations

Foundational considerations that have guided the project include:

- The belief that all children need permanent families who provide safe, stable, nurturing homes and lifelong relationships.³
- 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.
- The intention to ensure that children and youth receive high quality residential care and treatment, 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.

The Federation and MCFD began this process with a number of concerns and questions about residential services and a shared belief that services can and must be improved.

Project Team and Advisors

A project team was established to carry out the work of the review as described below. This team was comprised of staff from MCFD and the Federation working

³ 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.

as equal partners and was co-led by Jennifer Charlesworth, Executive Director of the Federation and Alan Markwart, Senior Executive Director from MCFD. The joint review was guided by the Residential Review Advisory Group, established to provide overall advice and feedback on the project process and findings and comprised of representatives from MCFD and from the community services sector, across regions and areas of practice. (See Appendix A for list of project team and advisory group members)

Project Phases and Sources

The project has completed its two phases – *learning* and *generating* – and proposes next steps for moving forward – *acting* – which will be the responsibility of MCFD and the Federation.

Phase One was focused on *learning*. 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. Information for Phase One was gathered from five sources:

- Community and stakeholder consultations and focus groups
- Academic literature
- British Columbia reports and initiatives
- Canadian reports and initiatives
- Reports and initiatives in other jurisdictions
- Caseload and service delivery data

This *learning* phase enabled the project team to describe the current residential services system for children and youth, and collect and reflect what diverse stakeholders and researchers had to say about residential care, including what works well, what doesn't, and how services and care might be improved or enhanced.

The findings from all sources were analyzed for themes and these were presented in the *Residential Review Project Phase One Findings Report* and a *Summary Report*, released in June 2011 available at <http://www.fcssbc.ca/CoreBC/projects/residential-review>. This work set the stage for Phase Two.

Phase Two was designed to build on the collected findings and engage caregivers, service providers, Aboriginal organizations, MCFD staff, youth and field experts in *generating* the Strategic Directions, recommendations and supporting actions to enhance the quality and effectiveness of residential care in BC. Seven sources and

processes informed this work.

- *Community Feedback Report completed by the BC Association of Aboriginal Friendship Centres, the Metis Commission and Caring for First Nations Children Society* - The three participating organizations engaged their respective communities (First Nations, Urban Aboriginal and Metis) in discussions about how to improve residential care for Aboriginal and Metis children and youth and presented their findings in a companion report. Each constituency's distinct context and unique challenges are reflected in the information gathered and solutions proposed. And yet many of the ideas and solutions are similar to and consistent with those that arose in the other consultations as they are grounded in beliefs about what children and youth need to be healthy: positive, stable and consistent relationships with caring adults; connections to family, community and culture; access to effective support, care and treatment when needed; and access to education and learning opportunities. Key findings are summarized below and the full report may be viewed at <http://www.fcssbc.ca/CoreBC/projects/residential-review>.
- *Stakeholder working sessions* - Two intensive two-day working sessions were hosted by MCFD and the Federation to review the findings pertaining to achieving permanency, strengthening foster care, and delivering an accessible array of residential care services. Each session brought together between 50 and 60 MCFD staff, foster caregivers, community service providers and community partners (e.g. health authority representatives) from diverse roles and all regions to review the findings, identify opportunities for action, debate options and select those that they collectively believed would make the greatest difference in the experience and outcomes for children and youth in residential care. Fact sheets, agendas, presentations and proceedings from each session are available at <http://www.fcssbc.ca/CoreBC/projects/residential-review>.
- *Youth consultation* - A working session was also held with youth at the Federation of BC Youth in Care Network's Fall 2011 Steering Committee Meeting (SCM) at Zajac Ranch. This engaged many youth from throughout BC who have had extensive personal experience with residential care. A summary of the discussions and suggestions is available at <http://www.fcssbc.ca/CoreBC/projects/residential-review>.
- *Key informant interviews* - Key informants with specific experience and expertise in the primary areas of concern and interest were identified and interviewed. The purpose of the key informant interviews was to determine if the proposed directions made sense based on available evidence, to refine them as necessary, and to identify promising practices in other jurisdictions that could be referred to.

- *Online surveys* - Three surveys were developed to invite feedback from a broad audience on draft directions and actions that had been determined through the working sessions. The surveys addressed achieving permanency, strengthening foster care, and delivering an accessible array of residential care services and supports. Invitations to contribute were extended to all MCFD staff, Federation member agencies and their networks including the Federation of BC Youth in Care Networks, the BC Federation of Foster Parents Association the Federation of Aboriginal Foster Parents, and Aboriginal provincial organizations including the BC Association of Aboriginal Friendship Centres, Caring for First Nations Children Society and the Metis Commission. These surveys set out a series of possible actions and asked respondents to rate importance and indicate their highest priorities for change. Respondents were also asked to offer suggestions for other actions and suggest examples of strong practices in their community or other jurisdictions. A total of 421 surveys were completed with close to 70% offering additional comments and suggestions. The survey contents and the results are available at <http://www.fcscbc.ca/CoreBC/projects/residential-review>.
- *MCFD reviews of kinship care and tertiary care* - In response to a review of kinship care in April 2009, MCFD established a Kinship Care Provincial Advisory Table in October 2010 to identify strategies for increasing the use of out-of-care kinship placements. MCFD also conducted an internal examination of directly delivered tertiary care services, defined as including youth custody services, hospital-based mental health services and safe/secure care - services which were discussed during the course of consultations, stakeholder engagement sessions and online surveys. The actions recommended by the Kinship Care Provincial Advisory Table are included in this report under **Strategic Direction #2 - Enhancing Kinship Care** while the actions that directly or indirectly relate to tertiary care services are incorporated under **Strategic Direction #4 - Planning and Developing an Accessible Array of Residential Care and Treatment Services**.
- *Project Team and Advisory Group planning sessions* - The project team met frequently to sift through the findings, consider options, and seek out additional information about promising practices that might inform the recommendations and supporting actions. The advisory group also met to provide advice about how best to engage stakeholders in the development of recommendations. This work lead to the development of a series of 'fact sheets' for broad distribution and a plan for working sessions.

Upon completion of the steps noted above, the project team collectively reviewed all of the results from the above processes over five one- or two-day sessions while team members did additional independent work on key areas. The team drafted strategic directions, recommendations and supporting actions and then hosted a two-day working session with the full advisory group (comprised of representatives

from MCFD, the Federation, Foster Parent Federations and the Federation of BC Youth in Care Networks) in which each element was discussed, debated and refined as necessary. The project team then revised the recommendations and supporting actions and submitted them to the advisory group for final review and endorsement.

Moving forward, we propose that MCFD and the Federation develop plans for acting on the recommendations and supporting actions in this report. As noted earlier, the three year Operational and Strategic Directional Plan released in May 2012 includes as a Key Action: "... design and implement a more integrated community-based service system for children in care, building from the analysis and acting on the recommendations of the Residential Review Project."

Although it was the project team's original intention to publish the Final Report before moving into implementation planning, it became apparent that it was in the best interests of children and youth to move into discussions about priorities and next steps in the Fall of 2011. The MCFD members of the project team established a Strategic Plan Working Group comprised of Regional and Provincial office staff and a Federation advisor to organize the draft recommendations and supporting actions into a three year plan for moving forward. This plan will be considered by MCFD in their implementation planning process.

The Board of Directors of the Federation has also established a Residential Care Advisory Committee comprised of representatives from each region and from diverse aspects of residential care practice. The committee has initiated a review of this report and will develop a plan to act upon recommendations and actions that are within the scope of the community social services sector and amongst the 140 member organizations. These actions may address education and training, accountability and continuous quality improvement, care practices and practice-based research and service delivery pilots.

As was noted above, while a number of the proposed recommendations and actions can be addressed with existing financial and human resources, the project team has concluded that an analysis of additional investment and resource requirements will be necessary in order to develop the system of residential care that is envisioned in this report.

3. Statistical Overview of the Residential Services System

There are an estimated 10,200 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).⁴ 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 only housing and financial assistance.⁵

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	115

⁴ For consistency with data provided in the June 2011 *Findings Report*, the 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.

⁵ Agreements with Young Adults for 19-24 year olds (former children in care or on YAG) are not included because they do not involve children or youth under 19.

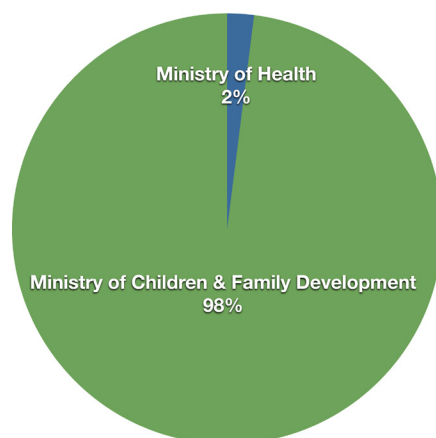
Service Stream	Resource Type	Number
Youth Substance Use Treatment-Health**	Residential Treatment	62
	Withdrawal Management (Detox)-Community Based Residential & Family Care Homes	35
	Supported Housing & Support Recovery	16
	Youth Substance Use sub-total	113
Total Residential Placements		10,181

*MCFD Data systems also track 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

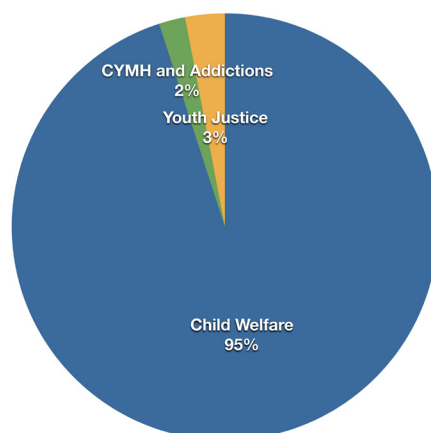
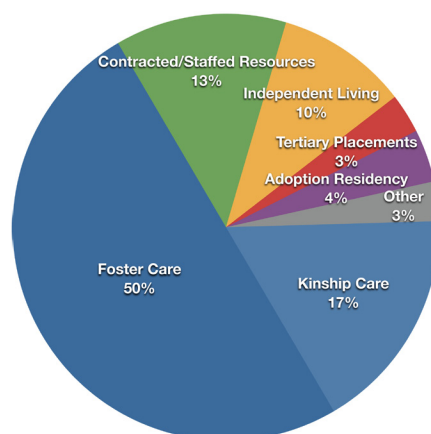


Figure 3 (below) illustrates the breakdown in the types of residential services: 17% of all children are in kinship care placements, 50% are in foster care, 13% are in contracted/staffed residential care, 3% are in tertiary care and 10% are in independent living.⁶

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 even though there is only an average of 101 youth in custody in BC. In this regard, BC has the lowest per capita rate of youth incarceration

⁶ The Independent Living statistics include youth with Youth Agreements.

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.⁷ Moreover, the number of youth in custody is now only about one-quarter of what it was fifteen years ago; there was an average of 400 youth in custody in 1996/97 compared to only 101 in 2011/12.

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.⁸

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 substance use 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.

⁷ Canadian Centre for Justice Statistics, *Corrections Key Indicator Report, January, 2011*.

⁸ 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.

Generally speaking, contracted/staffed residential resources are intervention/treatment focused and are intended to be time-limited; 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. However, there is a general consensus that over the past decade or so there has been a marked reduction in the reliance on the traditional staffed group home model of service, with increasing reliance on contracted/staffed family care models and specialized level 3 foster care placements.

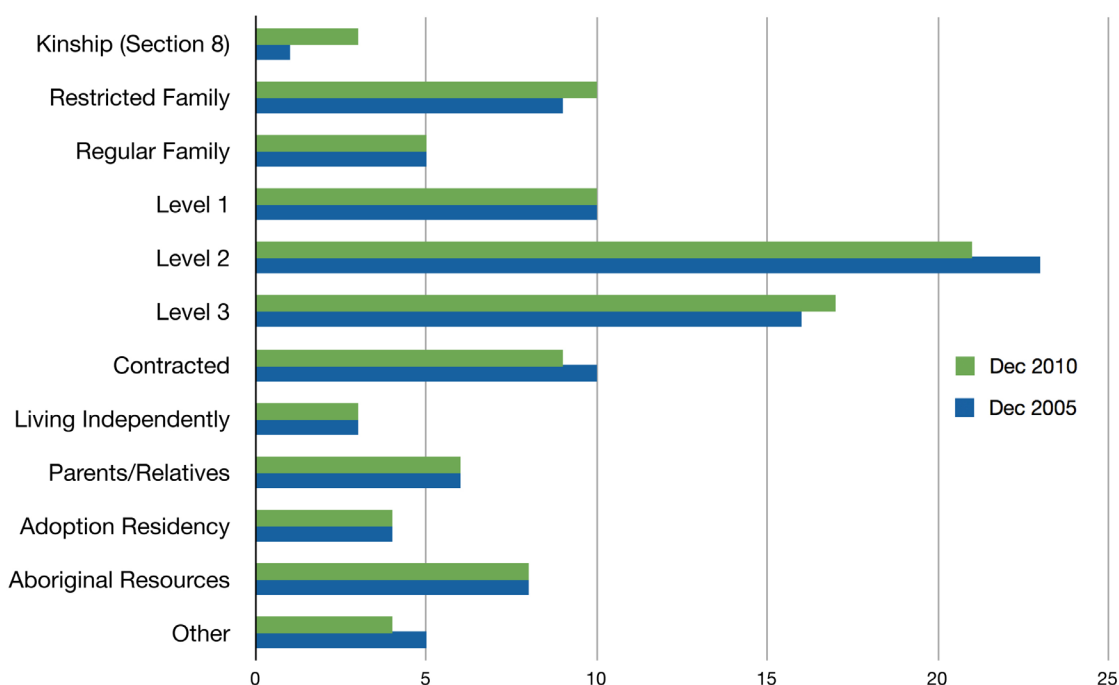
Regarding children in care, who are the principal recipients of residential services, available statistics indicate that:

- The children-in-care population has been decreasing since December 2001 when the caseload was 10,291 compared to 8,052 in March 2012.
- The proportion of Aboriginal children in care has increased from 38% in 2001/02 to 56% in March 2012. The actual number of Aboriginal children in care increased from 3,876 to 4,528 while non-Aboriginal children declined from 6415 to 3524 in the same time period.
- Children in care admissions went down from 5025 in 2001/02 to 3645 in 2011/12.
- The proportion of Aboriginal children admitted to care went up from 31% in 2001/02 to 40% in 2011/12 while the actual number of Aboriginal children admitted to care decreased from 1550 to 1468.
- The average duration of stay in care for a child leaving a CCO in 2011/12 was 7 years and 10 months compared to 6 years and 8 months in 2005/06, and 5 years and 5 months in 2001/02.
- Aboriginal children leaving a CCO in 2011/12 were in care 43% longer than non-Aboriginal children.
- Forty percent of children who left continuing care in 2011/12 had 4 or more moves, and 11% had 10 or more moves, compared to 44 % who had 4 or more moves and 15% who had 10 or more moves in 2005/06, and 48% who had 4 or more moves and 15% who had 10 or more moves in 2001/02.
- The average duration of stay of a child who left care while under a TCO was 1 year and 3 months in 2011/12, compared to 1 year and 2 months in 2005/06 and in 2001/02.
- Five and a half percent of children who left temporary care in 2011/12 had 4 or more moves and no children had 10 or more moves, compared to 7% who had 4 or more moves and no children with 10 or more moves in 2005/06, and 10% had

4 or more moves and less than 1% had 10 or more moves in 2001/02.

- The considerable and increasing length of time in care for children in CCOs without a permanent arrangement is especially concerning, as is the high proportion of children in care who move frequently (more than 4 moves or up to as many as 10).
- As Figure 4 (below) illustrates, between March 2006 and March 2012, there has been an increased use of kinship care agreements but little change in the relative use of specialized levels 1, 2, and 3 foster care or contracted resources for children in care. Comparison between March 2002 and March 2012 shows a significantly lower use of contracted resources and greater use of Level 3 foster care in 2012.

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



With regard to the youth custody population, available statistics indicate that 716 unique youth were admitted to custody in 2010/11 and that on any given day, 48% were Aboriginal, only 17% were girls, and 79% were in the 15 to 17 year old age range. 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.

4. 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, they comprise more than one-half of all children in care under the *CFCSA*, which accounts for the vast majority of the residential services system. There is similar disproportionate over-representation amongst youth in custody under the *YCJA*: in 2010/11, 48% of those youth were Aboriginal.

Representatives from Aboriginal agencies and services were invited to the Phase One consultations and many participated. Stakeholder and community consultations conducted in Phase One of the project 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 cannot be delivered by Aboriginal peoples, they should be delivered in culturally appropriate ways that facilitate attachment to Aboriginal culture and community.

While these findings provide some useful direction, the Phase One 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, commissioned separate Aboriginal consultations with Aboriginal stakeholders led by Caring for First Nations Children Society (CFNCS – on behalf of Delegated Aboriginal Agencies), the BC Association of Aboriginal Friendship Centres (BCAAFC) and the Metis Commission. The full report from the three parties is available from the report authors or on the Federation's website at <http://www.fcssbc.ca/CoreBC/projects/residential-review>. The findings from this joint review have informed all of the strategic directions, recommendations and supporting actions included in this report. They also stand up as a specific call for action in residential care services and supports for Aboriginal children and youth and an Aboriginal-specific plan of action may also be required.

The consultations conducted by the Aboriginal stakeholders reinforced and enhanced many of the seven Strategic Directions, particularly:

Strategic Direction #1 - Achieving Permanency

Participants reinforced the need to shift from a focus on safety to a focus on safety and permanency, with an emphasis on sustained connections with extended family and cultural community. Relationship consistency was cited by all three constituencies as being vital for healthy child development. Greater consistency and continuity of relationships with social workers, foster caregivers, staff in residential care settings, and other professional staff, as well as sustained relationships with parents, siblings and extended family, and cultural community were seen to be very important: "the roots need to be established and the plant will grow" (p. 64).⁹

As one participant suggested:

"Educate social workers to understand that the mental health needs of children involve the stability of their placement. Rather than focusing on mental illness and labeling children as 'depressed' and/or 'anxious', use a holistic perspective and view the child as part of the context in which they are existing. The physical, emotional, spiritual and mental needs of the child require stability and consistency. Children need to maintain relationships over time to develop healthy attachments. It is important that these factors are understood by social workers so that actions are not reactive. An outside advocate should monitor the number of placements, and require a review when there appears to be a high number of placements, such as a review after 3 placements" (p. 55).

Strategic Direction #2 - Enhancing Kinship Care

Participants from all three constituencies reinforced the importance of kinship care and early identification of opportunities for out of care placement with extended family or 'cultural kin'. Kinship care may prevent removal or, in the event of removal, help facilitate reunification or an alternative 'permanent' family that sustains cultural connections.

⁹ All references in this section are from the aforementioned Aboriginal stakeholder report

Strategic Direction #3 - Strengthening Foster Care

While removal of a child from their family and cultural community is not desirable, it was acknowledged that for a variety of reasons some children and youth will need residential care and that many will be placed in foster care. Participants emphasized the need to recruit and support more Aboriginal and Metis caregivers in order to match children to caregivers who reflect their heritage. Some participants suggested that Aboriginal and Metis agencies should undertake recruitment as they can better engage and assess prospective caregivers. Recruitment could be done collaboratively by MCFD and Aboriginal or Metis agencies.

"In First Nations communities, it's hard to recruit anybody [as foster caregivers] because of the impact of residential schools. A lot of people don't feel ready to take in children. Although culturally it's something we've always done. A lot of the paper work that comes along with it, people don't want to fill out because they don't want people knowing their business. There's no way around that. We'll keep providing opportunities for healing and increasing their knowledge, and by increasing their knowledge we're increasing their sense of knowing that 'Hey, I can do this, maybe there's stuff that I do know.' Building their capacity by providing training and increasing opportunity, they will be ready to take on having children" (p. 68).

As the number of Aboriginal and Metis caregivers do not meet the current needs, children and youth should be placed with caregivers who are open to learning about the child's background and are culturally attuned and skilled at connecting the children and youth in their care to extended family and cultural communities. It was suggested that mandatory pre-placement orientation and training for foster caregivers be enhanced to cover Aboriginal and Metis culture and history, and that this be delivered by people of Aboriginal and Metis heritage within a cultural context (e.g. location, ceremony, circle work).

While a child or youth is in foster care, the stability and continuity of care is of great importance. Participants noted that too often placements break down repeatedly due to inappropriate matching of child and caregiver, lack of support for the child and/or caregiver to work through challenging times, lack of specialized treatment or care for the child (e.g. mental health care), and lack of assistance to the caregiver to support the child's connections with their family and community. This results in "continued trauma and upheaval for children/youth in foster care" (p. 11).

To prevent breakdown it was suggested that a more plentiful and diverse array of caregivers needs to be recruited so that more appropriate matches can be made between the caregiver and child and so that placements are less "crisis-driven" (p. 42). Direct knowledge by the social workers about the characteristics of the foster home and the strengths of the caregivers would also support matching. Ongoing training and supports for caregivers and the children in their care was also suggested (see pp. 42-43).

The need for fair and consistent compensation of foster caregivers was noted by some participants, while also suggesting that kinship care providers should have access to a similar level of support, particularly for children and youth with special needs for whom the costs of support and care are typically higher. The need for resources to follow the child when the young person leaves residential care and goes back to the family home was also suggested (i.e. if the residential care provider receives funding to provide the child/youth with specialized supports, respite care or access to recreation, cultural or other activities, this funding should flow to the birth or kin family to ensure continuity of care during times of transition).

Ongoing clinical supervision and support, respectful involvement of the foster caregivers in planning processes as "valued members of the team" (p. 54), clear communications from MCFD, responsiveness of social workers to requests from caregivers, regular visits by the resource workers to the home, and peer to peer training and mentorship, were all suggested as ways to ensure that foster caregivers are given the support that they need to deliver continuous quality care.

Strategic Direction #4 - Planning and Developing an Accessible Array of Residential Care and Treatment Services

Participants reinforced the need for timely and accessible care and treatment for Aboriginal and Metis children and youth who need specialized care and service due to special needs, mental health concerns, substance use, behavioural and learning challenges as a bridge back to family, community and school (see p. 37). It was also suggested that specialized out of care services and supports need to be made available to vulnerable children and youth upon return to their family or community to sustain reunification or alternative family placements.

Strategic Direction #5 - Addressing Youth Interests in Permanency and Transitions

While the intention is that youth will not 'age out' of care without having some stable and significant connections with caring adults and their cultural community, it was acknowledged that many Aboriginal and Metis youth are leaving care without these connections and supports. As a result, they are at an increased risk of homelessness, school incompleteness, unemployment, poverty and dependence on income assistance, and persistent and unresolved trauma.

Stakeholders suggested that greater support is required to prepare 16-18 years olds for transition to adulthood, including trying to establish some familial, cultural and community connections and supports, ensuring that they have basic life skills and that someone has discussed "relationships, career options and other things that youth will require when they go out on their own for the first time" (p. 47). "Professionals involved in their planning need to be accountable for these children's futures" and build in supports and opportunities with a long term view – much as parents do for their older youth (p. 47). Foster caregivers were seen as key resources

to help young people prepare for transition and to “take on more of an advocacy and proactive role to assist the youth close to aging out” (p. 48).

For older youth who have transitioned out of the residential care system at age 19, continued access to some supports and services to ease and facilitate the transition was proposed. “Services should not be cut off from youth that age out of care or for those that are returning back to the family home...These youth need a much longer transition time than typical youth. There needs to be persons still mentoring them until they have adequate supports in place” (p. 47). Participants in the CFNCS consultation proposed that services be provided to youth in care until the age of 25.

Strategic Direction #6 - Working Together Effectively

Improved trust, communication, cooperation and collaboration were seen by all three constituencies as being vital to improving the experience and outcomes of their children, youth and families. Leadership is required to build a “more sustainable, collaborative, innovative system...[and to create] a sense of mutual respect and trust” and prevent fear-based decisions (p.29).

Better communication, information sharing, collaboration and teamwork between MCFD, families and youth, cultural communities, caregivers and service providers is essential to ‘wraparound’ children, youth and their families to support better outcomes, achieve better plans, preserve cultural heritage, ensure that plans are implemented and regularly updated, and to enhance and monitor the quality of care.

Cross-ministry coordination and integrated systems and structures were also identified as being important, particularly the development of a single, comprehensive plan of care through an integrated case management approach (see p. 35). Even across the First Nations, Aboriginal and Metis service networks there is a lack of communication and information sharing and joint planning. For example, the Metis Commission proposed that “it is time to bring together everyone to the table – Metis community associations, Metis service providers, along with Aboriginal agencies that are working with Metis children and families...to clarify everyone’s role and rebuild lines of communication to better assist Metis families” (p. 38).

Strategic Direction #7 - Enhancing Accountability in Residential Care

Aboriginal stakeholders noted the very great differences in attitudes, practices and procedures across the province and the lack of mechanisms to share good and promising practices across communities and regions. Consistency coupled with some degree of flexibility to meet unique needs and contexts was cited as being important.

The education and preparation of staff and caregivers was noted by all constituencies as being part of accountability. It was suggested that they should be required to participate in cultural education and experiential learning (“see, learn, know and understand” p. 26). And they should be expected to demonstrate knowledge and

understanding in their practice e.g. through ensuring that planning processes include extended family and cultural kin, that plans ensure the child or youth's access to cultural activities, events and learning, etc. It was suggested that staff and caregivers should be supported to participate in ongoing cultural learning and be held to account if they are unable to practice in a culturally attuned way.

BCAAFC and CFNCS stakeholders stressed the need to improve accountability for services through greater evaluation of MCFD-delivered services, using evaluative processes and measurement tools developed and contributed by the Aboriginal community, including youth in care.

Metis Commission consultation participants noted that accountability has to start with ensuring that the experience of the child or youth in residential care is positive: "This means ensuring that homes are safe, adequate police checks [are] completed on staff, appropriate and comfortable environments [are provided], cultural representations from staffing [are] in the home, cultural representations adorn the home...cultural support and meetings [take place] right in the home, [and there is a] focus on healing the family" (p. 25).

CFNCS participants also suggested that it was important that all players in the system be expected to document their activities in relation to the child or youth's plan of care.

Many of the more specific concerns, ideas and solutions that were presented in the feedback report are reflected in the recommendations and supporting actions discussed later in this report. These set a strong foundation for residential care and treatment for all children, and it is also recognized that more specific and careful attention will need to be paid to translate these into unique First Nations, Aboriginal and Metis contexts.

The following key themes also emerged in the feedback report from the Aboriginal stakeholders and will need to be reflected in implementation plans for residential care:

Importance of cultural connection and opportunity

"Maintaining connection to his or her family, community and culture is paramount towards fostering a child's wellbeing. Workers and caregivers need to be more active and committed in connecting children to their culture. To support this need, the cultural rights of children in care should be defined" (p. 62).

Children, youth and families living off-reserve often experience "disconnection from elders, teachers, medicine and medicine people from home" and have "little or no access to family, culture and traditional practices, and may not be able to develop their cultural identity" (p.4) as a result of this disconnection. Despite stated intentions of the child welfare system, "this connection and/or opportunity for the culture and

spirit in the lives of urban Aboriginal foster children is not promoted enough" (p. 8) and thus "cultural plans should be enforceable" (p. 63).

Creative ideas to ensure that workers and caregivers have "experiential cultural education" and are able to thoughtfully guide children and youth into cultural activities were proposed (see p. 9, 26-27).

Even when children and youth are not able to live with their families, "the family still lives with the child in their hearts" (p. 10). Yet too often these connections are not facilitated or supported through visits home or with family members and provision of concrete and practical assistance (e.g. funds for travel or food). It was suggested that "a budget should be available to defray costs associated with travel and otherwise connecting children with their community and culture" (p. 63).

Ideally, services to Aboriginal and Metis children and youth will be delivered over time by Aboriginal and Metis people, however, in the meantime "through training, mentorship and other opportunities, the importance of cultural and familial connection must be clear to caregivers" (p. 63).

Importance of timely and thoughtful assessment, planning and matching of children and youth with suitable caregivers

Participants from all three constituencies identified the need for early and comprehensive assessment for children and youth in order to better determine what supports they might benefit from and what caregiving situation will best meet their needs.

Participants also noted a range of challenges and barriers to effective planning and matching for Aboriginal and Metis children and youth. These included: workers' lack of time or expertise to locate natural supports for the child and family; difficulty workers face trying to navigate within the Aboriginal community to identify sources of connection and support; lack of leadership support "to make creative and unique decisions that would align with Indigenous worldviews" (p. 12); reluctance of Aboriginal and Metis people to come forward and be foster caregivers or kinship homes given their lack of trust in, and ongoing trauma, stigma and fear of working with, MCFD; planning processes that are inflexible, inaccessible or intimidating to family members such that they are unable or unwilling to participate.

All proposed that more support be given to family-finding programs and services so that: out of care familial and cultural placement options may be identified prior to a child or youth's removal from their family and community; should removal be necessary, that the young person is placed with extended family, friends or acquaintances within the same cultural group wherever possible; and should placement with cultural kin not be possible, that focused and intentional work be done to ensure that the young person is able to recover or sustain their cultural connections and sense of belonging and identity.

The need for collaborative and culturally attuned planning processes that were inclusive of family members, extended family and cultural kin, elders and the youth as appropriate was emphasized. Family group conferencing and other traditional family decision-making processes were noted as having promise when used wisely. Tied to this was the need to create a “cultural plan” as soon as the child or youth goes into residential care (see p. 30).

Some participants also suggested that “children’s voices need to be heard around decisions that pertain to them. The circle can be a good way to engage children” (p. 67) and we must give them some choice amongst reasonable options for their care.

The lack of First Nations, Aboriginal and Metis caregivers was noted as being a significant barrier to matching children and youth with suitable caregivers. Focused recruitment of Aboriginal and Metis foster caregivers (and MCFD and community agency staff) was proposed, as was a re-consideration of the expectations of foster caregivers that may create barriers to approval, such as number of children sharing a room or living in the home. The lack of suitable and affordable housing was frequently cited as a barrier to both kinship care and fostering for many Aboriginal and Metis families (as well as being a challenge faced by birth families that contributes to a child’s removal in the first place).

Stability and consistency of caregivers was cited as being particularly important for many Aboriginal and Metis children and youth who have experienced trauma due to family upheaval.

Policies and procedures that reinforce cultural connection – and expectations that these be reflected in practice

Participants suggested that some policies should be amended or added to reflect the “voices” of the Aboriginal and Metis people, what they value, and what children and youth are entitled to have access to in terms of cultural connections and access to activities, events and experiences (p. 34).

It was proposed that MCFD and community agency staff and caregivers be better prepared so that they can work more effectively “with Indigenous people and [know] how to ensure that culture is incorporated appropriately into service delivery...[and] have a practical understanding of how to implement their own policies respecting Aboriginal people” (p. 12).

Support for healing

It was noted that the history of First Nations, Aboriginal and Metis people has resulted in successive generations affected by trauma, violence, shame, disconnection and exposure to substances. In light of this, it was suggested that removal of a child or youth from their family, extended family and cultural kin should be a “last resort” to prevent “perpetuating trauma by [MCFD’s] current processes of removals, services

and changes in homes for children" (p. 41). It was proposed that greater effort be taken to prevent removal through more intensive therapeutic and healing work with family members, identification of alternate family caregivers who are known to the child (e.g. extended family member or someone from their community), and mentorship of parents by Elders or other healthy adults who can support healing and growth.

Support for healthy transitions

Participants consulted by the BCAAFC suggested that the focus of the child protection system remains on removal and placement rather than on reunification and helping a child return home safely and successfully. Transitions to family and home could be better supported by facilitating visits through the provision of tangible support such as funds for travel (child to home or family members to child), funds for food for when child or youth is visiting (given that many families have limited resources), and sustained housing.

The Metis Commission consultation participants also spoke about the importance of planned transitions for Metis children into adoptive homes, including training the adoptive families in how to meet the special needs of the child or youth, and how to reinforce and facilitate cultural connection, and how they might manage ongoing relations with the child's extended family members.

Part Two - Envisioning a Planned System of Residential Care

In Phase One of the project, a number of Strategic Directions emerged and these were brought forward into Phase Two and shared with participants in the working sessions, through the online surveys, and in key informant interviews. As Phase Two progressed, these directions were expanded, revised, and refined and provide the scaffolding upon which the recommendations and supporting actions have been built.

The project partners and the many stakeholders that directly participated in the residential review process envision a system of residential care that is child-centred, well-planned, comprehensive, accessible, respectful, responsive, culturally attuned, effective and accountable. This system will meet the unique care and/or treatment needs of all children and youth who must spend time in residential care and will serve as a bridge to permanency and better life outcomes. This report proposes that such a system be built on a foundation of seven Strategic Directions.

These Strategic Directions are interconnected. All must be worked on together in order to achieve a strong, evidence-informed, effective and caring residential care system that provides children and youth with positive residential care and/or treatment experiences, enhances their well-being, and strengthens long term outcomes. Together they paint a full picture of what is required to create a strong and effective system of residential care. The seven Strategic Directions are:

- 1. Achieving Permanency** – Embed permanency as a key priority throughout the residential care delivery system. Achieving permanency through reunification or placement with an alternate permanent family needs to be the organizing principle around which residential services are provided.
- 2. Enhancing Kinship Care** – Give priority consideration to placement with relatives and other significant adults who have an established relationship with a child or have a cultural or traditional responsibility toward a child.
- 3. Strengthening Foster Care** – Realign and strengthen foster care services and supports to better achieve permanency and stability.
- 4. Planning and Developing an Accessible Array of Residential Care and Treatment Services** which addresses three sub topics:
 - a. Building a planned system of residential care and treatment services based on research and best practices.
 - b. Building a planned system of intermediate residential care and treatment services based on research and best practices.

c. Addressing the key gaps in tertiary care and treatment services.

5. Addressing Youth Interests in Permanency and Transitions – Pursue permanency options for youth aged 16-18 and improve preparation for transitions to adulthood including strengthening post-majority supports and services for 19-24 year olds.

6. Working Together Effectively - Enhance the working relationships within the residential care system as an essential foundation for implementing the recommended actions across all of the Strategic Directions.

7. Enhancing Accountability in Residential Care - Build accountability and continuous learning into the process of implementing the recommended actions across all of the Strategic Directions for residential services.

For each Strategic Direction, between 2 and 5 recommendations have been put forward. The combined 32 recommendations reflect what the stakeholders, key informants, and advisors identified as being critical to bringing about the desired change in residential care and improving the experiences and outcomes for children and youth. Each of these recommendations is also congruent with the body of knowledge on good practice that has been drawn from research and evaluation evidence. Each recommendation is supplemented by a series of supporting actions. These set out more specific steps, often addressing what should be done and by whom.

Strategic Direction #1 - Achieving Permanency

Embed permanency as a key priority throughout the residential care delivery system. Achieving permanency through reunification or placement with an alternate permanent family needs to be the organizing principle around which residential services are provided.

Intention: Ministry staff, service providers, and caregivers should organize and focus the delivery of all forms of residential care (kinship, foster, staffed and tertiary care) around the over-arching aim of achieving permanency – *safe, stable and enduring family relationships for children and youth through reunification, adoption, transfer of guardianship or other meaningful lifelong connections*. With that aim in mind, residential care should be viewed and valued as a crucial but temporary and transitional bridge to permanence. Planning for permanence must be a priority that starts from the point of first placement, with a focus on family reunification, and at the same time includes consideration of alternate legally permanent options such as adoption, custom adoption and transfer of guardianship. For youth where a permanent legal option is not possible, continuity of relational, cultural and physical connections that are meaningful to them is critical for their transition to adulthood. Particular attention must be given to ensuring cultural connections for Aboriginal children as a foundation for permanency planning and exploring culturally accepted permanency options.

Evidence and experience suggests that achieving permanency should be the over-arching strategic goal of the residential care system. When young people do not have healthy and enduring relationships with caring adults they are more likely to experience poor health, educational, economic, legal, housing and relationship outcomes (Avery, 2010; Stott and Gustavson, 2010). Conversely, research on risk and resilience suggests that prosocial behaviour and better life outcomes are more likely when children and youth have consistent, caring and enduring relationships with adult family members and/or friends. Children and youth who come into residential care have often experienced trauma and developmental disruptions and are therefore at greater risk of negative life experiences and outcomes. Therefore, it is essential that the residential care system be designed to reduce these risks by facilitating and supporting enduring, permanent connections.

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 as a means to achieving security, stability and lifelong connections (i.e. a goal of: ensuring permanence'). Perhaps as a result, the length of time that children and youth are in

residential care without having a permanent family connection has increased over time from 5 years and 5 months in 2001/02 to 7 years and 10 months in 2011/12 – a 45% increase.¹⁰ As well, Aboriginal children under CCOs who left care in 2011/12 were in care 43% longer compared to non-Aboriginal children. Research in other jurisdictions suggests that the majority of youth who enter foster care after the age of 13 end up ‘aging out’ of care. BC data indicates that, each year, a significant number of youth who are in care under a continuing custody order (CCO) leave the residential care system at age 19 without any clear, formalized long term connections to caring adults.¹¹ These are compelling metrics that point to the need to embed a permanency mindset into the system of care.

“Aging out of care is not good for kids. We need to reinforce that this is not something we ‘plan for’ but something we plan to avoid” (Survey respondent).

But what is permanency and what characterizes a permanency mindset? Throughout the project, this has been a dominant theme. Participants in one of the intensive working sessions spent two days discussing permanency, what it meant, what it looked like, and what it would take to establish a permanency mindset. The following is what emerged.

Dimensions of permanency

Four dimensions of permanency were identified: legal, relational, physical and cultural.¹²

- *Legal permanency* has been a primary concern within the child welfare system as reflected in efforts ranging from family reunification to guardianship transfer to adoption.
- *Relational permanency* has had less focus, but is often what youth say is most important to them. This was described by one youth as “strong, long lasting connections with a biological family member/siblings, school staff, foster caregivers, social workers, youth workers, community members or organizations like the Federation of BC Youth in Care Networks – anybody who gives you positive, unconditional commitment.”¹³

10 This reflects the number of children who left care from MCFD or a Delegated Aboriginal Agency under a Continuing Custody Order (CCO). In 2001/02, 791 children left care (e.g. turned 19, placed in adoptive home or more permanent guardianship arrangement); in 2011/12, 891 children left care and the average length of stay had increased by 29 months to 7 years/10 months.

11 In 2011-12, 547 youth under CCO left care at age 19.

12 The project team drew on the work done by the BC Federation of Youth in Care Networks (see FBCYICN 2010 report, *Belonging 4 Ever – Creating Permanency for Youth In and From Care*, p. 6), Stott and Gustavson (2010) and others that described three dimensions of permanency: relational permanency, legal permanency and physical permanency. Participants in the consultation and working sessions recommended adding the fourth dimension of cultural permanency.

13 Throughout this report, quotes from contributors in the Phase One and Two consultations, working sessions, and online surveys have been included to illustrate and reinforce the directions, recommendations and supportive actions. These are presented within quotation marks but are not attributed. Where quotes are included from reports or articles, the sources are noted.

- *Physical permanency* "involves creating a safe, stable, healthy and lasting living arrangement."
- *Cultural permanency* "means that you continue to be connected to your culture regardless of what else is changing in your life; it is a constant". The sense of belonging to one's heritage and cultural community is desired by, and a protective factor for, many young people. As previously noted in the section on Aboriginal and Metis interests, cultural connection and permanency is particularly important for children and youth of Aboriginal and Metis heritage.

Stott and Gustavson (2010) suggest that a more holistic and balanced approach to planning for permanency is necessary. This is especially true for older children and youth, or for Aboriginal children, youth and families for whom adoption may not be desirable but nonetheless seek permanency in relationships, living arrangements and access to culture.

Promoting and encouraging a permanency mindset

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." The question was also posed by participants: "Why does it have to be by default – could we not design a system to respect and reinforce these enduring relationships and commitments?"

Participants suggested that the orientation of the system needed to shift, or at least expand, to make space for a permanency mindset to take root both with practitioners and the teams and agencies within which they work. Accordingly, this Strategic Direction specifically calls for ministry staff, service providers, and caregivers to organize and focus the delivery of all forms of residential care (kinship, foster, staffed and tertiary care) around the over-arching aim of achieving safe, stable and enduring family relationships for children and youth (i.e. permanency).

With this aim in mind, residential care should be viewed and valued as a crucial but temporary and transitional bridge to permanence. Planning for permanence must be a priority that starts from the point of first placement, with a focus on maintaining family integrity and reunification, while including consideration of alternate legal permanency options such as transfer of custody to extended family, adoption, custom

adoption and/or continuity of relationships for youth transitioning to adulthood.

Contributors in Phase Two suggested that the permanency mindset and practice could be better supported within MCFD by policy shifts, introduction of a permanency framework, timely access to programs such as Family Finders and Roots, as well as the implementation and trial of evidence-informed permanency planning approaches such as 'permanency roundtables', the 'foster to adopt' model and 'concurrent planning' approaches used in other jurisdictions.^{14 15}

Contributors also suggested that staff and caregivers needed assistance to make this shift. Changes to post-secondary social work, child and youth care curricula, and foster caregiver training were suggested so that new practitioners and caregivers come into the system with knowledge about the importance of permanency and skills to support the challenging emotional dynamics that arise during permanency planning. Training of staff across MCFD (e.g. from intake staff to youth justice staff) with caregivers and community practitioners was also suggested. This would encourage the whole system to take responsibility for achieving permanency from the point of first contact with the child or youth and their family, rather than leaving the permanency discussion until later planning stages or after the child has a CCO. Clinical supervision time was also noted as an opportunity for supervisors and practitioners to ensure permanency plans are developed.

As noted above, timely access to such programs as Family Finders and Roots might lead to early identification of other family members and caring adults that could support permanency planning. Family Group Conferencing, Family Case Planning Conferences, Family Circles and other engagement and planning approaches could engage family members to ensure that the child or youth's connections are restored or sustained, while also ensuring safety.

Assessment, planning and placement matching processes were also a focus of attention and, while assessment practices are being addressed by other Ministry initiatives, it is acknowledged that good assessments of history, context, relationships, strengths and needs support better planning and placement matching. In turn, when children and youth have good plans and are well matched, the role of residential care as a transitional bridge to permanence is better supported.

It was also recognized that workload and practice challenges have resulted in backlogs in such areas as the preparation of the medical and social history of the child's birth family, completion of adoption home studies, development or revision of case plans, file reviews to identify extended family connections, and preparation

14 An MCFD Permanency Framework was drafted in 2005 but not implemented, although Kelowna adopted many aspects of the framework and has been implementing a permanency planning model. Experience with this model will help to inform further development of a framework.

15 For more information see Georgia Department of Human Services/Division of Family and Children Services and Casey Programs (2009) Permanency Roundtable Project and Process Evaluation. Retrieved from http://www.casey.org/Resources/Publications/pdf/garountable_fr.pdf

of court documents to secure a CCO and open up other permanency options when a return to family is not an option. Some action needs to be taken to address these conditions and facilitate more permanency planning.

Sustaining a goal of permanence

A premise of the Annie E. Casey Foundation's Family to Family initiative is that every child, no matter how old, can achieve permanency and should have a case plan for permanence. This premise was frequently echoed and reinforced by contributors throughout Phases One and Two. MCFD staff shared several powerful examples of sustained attention to permanence, including one where a youth who had been in care for many years finally felt connected to a family and wanted to be adopted prior to her 19th birthday which was just a few months away. The worker and family fast-tracked the adoption process and the youth had her permanent family by the time she turned 19.

The following recommendations and supporting actions reinforce this Strategic Direction

Recommendation 1: Permanency Framework

MCFD should develop and implement a permanency framework to guide and support practice.

Rationale: In order to embed a permanency mindset in the broader child welfare system and ensure that it informs planning and decision making for children and youth within the residential care system, some strategic and concrete actions need to be taken to weave the principle and practice of permanency into legislation, policies, procedures, recording and reporting requirements, and information tracking. Staff, service providers and caregivers also need to be supported to understand the value and dynamics of permanency, what the four dimensions of permanency entail, and how it may be achieved in a child/youth-centred way. Other players in the system also need to be informed in order to support the permanency focused actions being taken within the child welfare system. Of particular importance is the court system; more timely hearings and decisions would better facilitate permanency planning.

Supporting Actions:

1. Review the *CFCSA* for any possible changes to strengthen the principle of permanency within that Act.
2. Review and revise all applicable policies, standards and procedures across all program areas and identify and develop new policies and standards as required to ensure the goal of permanency for children and youth is adequately reflected and emphasized.¹⁶

¹⁶ A redesign of the Aboriginal Operational Practice Standards and Indicators (AOPSI) is currently being undertaken with

3. Develop policies that require, at the point of entry into residential care or soon after, preparation of a permanency plan that includes identification of an alternate permanent family should reunification with parents not be successful (i.e. contingency, concurrent, dual track permanency planning).
4. Develop a Permanency Framework document based upon MCFD's draft 2005 Permanency Framework to support implementation of revisions to policies, standards and procedures and to guide practice.
5. Ensure the Integrated Case Management system currently in development embeds permanency focused actions throughout all service pathways.
6. Review and revise relevant policies to ensure that permanency planning, including adoption registration of eligible children, is required for children and youth of all ages. The criteria, approval, and decision review process to address any exceptions to this policy will be clearly described in policy and procedures.
7. Establish a policy that supports the funding of the legal costs of the post-majority adoption of a young adult who was formerly under a Continuing Custody Order.
8. Work with the Ministry of Justice to identify ways to reduce court delays and unnecessary court appearances so that permanency for children and youth can be achieved sooner.

Recommendation 2: Permanency Training and Education

MCFD should enhance knowledge and understanding about permanency pathways and options.

Rationale: The child welfare system has primarily been safety focused, and the residential care system has been oriented to finding places for children and youth to live safely. The expansion of this perspective to include permanency doesn't just happen because we declare that it is important; staff, service providers, caregivers, community partners and family members all need to be assisted to understand the many facets of permanency and how to achieve it in practice. Working session participants suggested that education and training was necessary starting right at the post-secondary training level for social work, child and youth care, and counseling psychology in particular. The proposed action for system-wide, cross-disciplinary/cross-sectoral professional development training reflects the belief that a 'whole systems' approach is required to create permanency for children and youth. All of the professionals involved with a child or youth must share the same intention to facilitate permanency for him/her and look for opportunities to support the young person's development and resilience so that they might successfully bridge into healthy long term relationships and connections.

Delegated Aboriginal Agencies. MCFD is also undertaking a policy revision process across all program areas. The recently completed Child Protection Response Policy addresses the goal of permanency.

Supporting Actions:

1. Develop a system-wide permanency-training program that includes an Aboriginal permanency lens for MCFD workers, Team Leaders and Managers across all program areas, including Child Protection/Family Service, Guardianship, Resources, Adoption, CYMH, CYSN, Youth Services & Youth Justice, as well as for caregivers and key community service providers.
2. Work with the Ministry of Advanced Education to take steps to promote greater emphasis on permanency approaches in social work and child and youth care college and university curricula.

Recommendation 3: Regional Permanency Initiatives

MCFD should support and evaluate regional initiatives that promote permanency.

Rationale: During the Residential Review consultations and planning sessions many examples of promising and effective local and regional practices, programs, and procedures were shared. Youth and caregivers also shared stories of particular individuals and teams that had made a significant positive difference in their experience. These examples and stories demonstrate that there are many strengths to build from at the local and regional level as we proceed with residential care redesign; there are people and teams that are already practicing in ways that reflect the Strategic Directions. The intention of this recommendation and the supporting actions below is to build on these strengths by: learning more about the programs and practices that appear to hold promise; sharing this knowledge and experience more broadly; expanding, 'scaling up' or replicating current practices and programs that support better residential experiences and outcomes; implementing and evaluating practices and programs that have been successful in other jurisdictions; and addressing weaknesses within the system that interfere with or delay good planning and permanency action. Underlying these supporting actions are two beliefs. First, change must take place at the local and regional level, closest to the children, youth and their families and communities. Second, there is a 'know-do' gap (i.e. we already know a great deal about what effective practice looks like, but we do not consistently act on that knowledge and understanding).

Supporting Actions:

1. Enhance permanency planning from the point of first placement and throughout the child or youth's time in residential care by:
 - a) Implementing policies and procedures that require the identification of an alternate permanent family at the point of entry into residential care, or soon after, in preparation for the possibility that reunification with parents is not successful (i.e. contingency, concurrent, dual track permanency planning.
 - b) Making greater use of collaborative planning and decision-making processes

such as Family Group Conferences, Mediation, Traditional Decision-Making, Family Case Planning Conferences, Youth Transition Conferences, Family Circles, and Care Team planning when deciding to place, move or proceed with a permanency arrangement.

- c) Increasing the availability of planning resources such as Family Finders, Roots workers, Kinship and Collaborative Practice workers.
2. Assess the progress of Kelowna's recently implemented permanency model and support knowledge exchange about the outcomes for children and youth and the practice learning with other regions.
3. Identify where backlogs in adoption home studies may be occurring and implement a plan to clear up existing backlogs and maintain timely flow-through of home studies on an ongoing basis.
4. Review the permanency plans for all children and youth under Continuing Custody Orders, longer term Temporary Custody Orders and Special Needs Agreements, and those in care for extended periods under the *Family Relations Act* S.29(3) and the *Adoption Act*, to identify what additional steps could be taken to place the child or youth in a permanent family arrangement using processes such as family finding, Roots, Traditional Family Circles, intensive file reviews, permanency roundtables, Youth Transition Conferences and targeted youth adoption initiatives.
5. Explore with service partners in at least one Region, the feasibility of implementing a foster-to-permanence model similar to the model developed by the Elgin/St Thomas Children's Aid Society in Ontario.
6. Develop locally relevant strategies for achieving legal permanency for Aboriginal children and youth through reunification, permanent transfer of custody, custom adoption and adoption.
7. Work with service partners to identify all family reunification programs/services including traditional reunification programs that are currently operating in BC to determine program characteristics, the evidence-base, success factors and transferable best practice models, thereafter undertaking more formal evaluations of a selection of different program approaches.

Strategic Direction #2 - Enhancing Kinship Care

Give priority consideration to placement with relatives and other significant adults who have an established relationship with a child or have a cultural or traditional responsibility toward a child.

Intention: This Strategic Direction recognizes that placements with relatives or adults who have an established relationship with a child or youth serve to maintain family connectedness, stability of relationships, cultural identity and achieve better outcomes for children and youth. More specifically, the ministry must continue to take steps to remove structural and procedural barriers to the use of kinship out-of-care placements and establish incentives and better supports to promote the use of these placement options.

MCFD's interest in kinship care is strongly connected to the goals of stability, continuity and permanency. When a child is unable to live with his/her parents, placement with a relative, or a person known to the child (e.g. neighbour, godparent, teacher, coach) or someone who has a cultural or traditional connection and responsibility to the child helps to sustain the child's connections to family, community and other meaningful activities, routines and relationships.

In particular, MCFD intends to promote increased use of kinship placements where the child or youth is not in the ministry's care (out-of-care options) by strengthening policy and procedures, enhancing training for staff, addressing how kinship care providers are identified, assessed and supported, and improving care provider access to mentoring, support groups and educational opportunities.

The use of kinship care is growing in many countries across the world. Although the primary model of kinship care described in the literature involves children who are in government or agency care being placed with relatives (i.e. restricted foster care), the identified benefits and challenges are also relevant for out-of-care kinship arrangements.

A Campbell Collaboration review of over 62 kinship care studies conducted over 15 years compared outcomes such as safety, permanency, and well-being between kinship care and traditional foster care (Winokur, et al, 2009). Although the profiles and needs of the children were similar, results indicated that outcomes for children in kinship care were generally superior to children placed in traditional foster care. Children in kinship care tended to experience more stability: children in non-kin foster care were three times more likely to experience a placement change than children in kinship care. Children in kinship care tended to have fewer behavioural and mental health challenges and experienced more normative behavioural development and higher mental health functioning. Children in kinship care were

also more likely to be placed with their siblings and have a positive perception of their placement.

It is important to note that these positive results were achieved in the context of kinship care providers generally receiving less support and service than traditional foster care. The implication of several studies is that children would realize even greater benefits from well supported kinship care programs.

Interestingly, children in traditional foster care were much more likely to be adopted (achieving legal permanency) while children in kinship care had almost four times the odds of residing with their care providers until the age of majority (achieving relational and physical permanency but not legal permanency). Kinship care providers may be reluctant to adopt the child or children in their care for financial reasons, concerns about the child losing access to specialized care and treatment if they are no longer in care, or due to concerns about severing parental ties and escalating family tensions. Several jurisdictions have implemented subsidized guardianship initiatives to address this issue. In response to an MCFD review of kinship care in 2009, a Kinship Care Provincial Advisory Table comprised of representatives from MCFD Provincial Office and Regions, Delegated Aboriginal Agencies and Aboriginal Affairs and Northern Development Canada was established in October 2010 to address this Strategic Direction. The following recommendations and supporting actions reflect the Advisory Table's work plan.

Recommendation 1: Kinship Out-of Care Options

MCFD should develop and implement strategies that promote increased use of kinship out-of-care options for Aboriginal and non-Aboriginal children and youth.

Rationale: When kinship placements of adequate quality are used, outcomes for children appear to be at least as good as (and often better than) they are for children placed in non-kin foster care across a range of indicators. For many Aboriginal families and communities, kinship care placements are significantly more desirable than placement in non-kin homes as they reflect more traditional approaches to raising children as a shared family and community responsibility and they may help to sustain extended family connections and the child or youth's cultural ties and connections.

Criticisms of (and risks associated with) kinship care identified in the literature include the claims that kinship placements have been used indiscriminately to reduce care costs rather than meet the child or youth's needs, that kinship caregivers are not adequately screened and assessed to ensure that they are suitable caregivers, and that matching of the child or youth to the kinship family's characteristics and capacity is set aside. The supporting actions below speak specifically to the need for policies, procedures and practices to address the emergence of kinship out-of-care arrangements. Key actions include staff training and skill development in

making informed choices about the best placement option for a child or youth and in identifying, assessing, and supporting kinship families. To address the phenomenon noted above where certain children and youth are less likely to be adopted, a legislative amendment to the CFCSA was passed in 2011 (although it has not yet been proclaimed) that would enable kinship families to apply for permanent transfer of custody rather than pursue adoption. This would result in legal permanency for the child, acknowledge parental ties, and provide financial support to the care provider if required.

Supporting Actions:

1. Establish policy and procedures that require consideration of extended family or other significant adults in a child's life as the preferred placement option at every point in the placement planning and decision-making process for a child or youth.
2. Finalize and implement the Extended Family Program (EFP) policy and procedures.
3. Remove barriers to using kinship out-of-care options that result from financial and service differences between out of care kinship options and kinship (restricted) foster care.
4. Clarify when kinship (restricted) foster care should be considered instead of an out-of-care option and change existing family care home descriptor from restricted foster care to kinship foster care.
5. Develop policies and procedures for the new *CFCSA* Section 54.01 permanent transfer of custody orders in preparation for future implementation.
6. Develop an MCFD staff training program that supports the greater use of Kinship out-of-care options including the new *CFCSA* amendments for permanent transfer of custody orders.
7. Develop and implement plans to enhance how kinship out of care providers are identified, assessed, contracted and supported by increasing the availability of resources such as Family Finders, Kinship/Roots/Collaborative Practice workers, resource workers and administrative staff to assist with these tasks.
8. Ensure that budget allocations to local community offices are adequate to achieve targeted increases in the use of out of care options.
9. Work with Delegated Aboriginal Agencies and Aboriginal Affairs and Northern Development to identify ways to increase the use of kinship out-of-care options for Aboriginal children and youth.

Recommendation 2: Care Provider Education and Support


MCFD should develop and implement kinship care provider education and support services.

Rationale: Children and youth placed with kinship care providers face the same challenges and risks as children placed in traditional foster care arrangements. They are likely to have experienced trauma and developmental disruption due to parental neglect or abuse, familial mental health or substance use issues, inconsistent parenting, chaotic living situations, income insecurity within their family, learning challenges and schooling disruptions, etc. They may have developmental delays, mental health or substance use issues themselves. As such, they may come into the kinship care family with special care and treatment needs.

Kinship care families (like traditional foster care families) require education and ongoing support to meet the needs of the children and youth in their care. In some cases, existing training and supports may be suitable for the kinship care providers; however, the circumstances surrounding kinship care are different than for foster caregivers and a more specific approach to education and support may be more appropriate. For example, whereas foster caregivers need to be trained to understand and meet the developmental needs for a wide range of children that may be placed in their care, kinship care providers will focus their caring on one child or several children within a sibling group and these children will be known to them. They will need to learn about the specific needs and developmental pathways for this child or children only. They will need to know how to respond to their unique behaviours and how to find services and resources that fit best for these children. In addition, kinship care providers will have pre-existing and often complex relationships with the child's parents which need to be understood and addressed. As such, their learning and support needs will be different than for foster caregivers. The supporting actions below address this difference and assume that kinship care arrangements will continue to grow.

Supporting Actions:

1. Develop educational curricula and materials for kinship out-of-care providers.
Note: This action is included in the Caregiver Education Framework project underway – see the second recommendation under **Strategic Direction #3 - Strengthening Foster Care**.
2. Develop and implement kinship out-of-care provider support services. Such services could be linked with existing or new foster caregiver support services or specific services for kinship care providers.
3. Contract for the development and implementation of a provincial Information and Referral Line for extended family members caring for related children.

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4. Prepare and distribute public communications and resource materials about kinship out-of-care options.
 5. Make the above noted actions and services available to current Child In Home of a Relative (CIHR), Child Out of Parental Home (COPH) recipients and Grandparents Raising Grandchildren as well as Extended Family Program and other Kinship out-of-care options care providers.

Strategic Direction #3 - Strengthening Foster Care

Realign and strengthen foster care services and supports to better achieve permanency and stability

Intention: This Strategic Direction proposes to realign and strengthen foster care services and supports to better achieve permanency and stability. Fifty percent of the children in residential care are placed in foster homes. Foster care is an essential part of the residential care array of services and yet it is vulnerable and under stress. The ministry must take steps to re-focus and strengthen foster caregiving with a particular emphasis on retaining foster caregivers by: realigning caregiver training, education and cultural awareness; better supporting foster caregivers and children; enhancing and targeting caregiver recruitment; and reviewing and aligning caregiver compensation. The review and realignment of compensation would need to recognize the new or expanded caregiver roles and responsibilities arising from greater care expectations, specialization, birth or kin family engagement and an increased focus on achieving permanency.

Skilled, committed, and engaged foster caregivers enhance the capacity of the system to meet the needs of vulnerable children and youth. Recruitment and selection, education and training, consultation, support, recognition and compensation were identified key factors in the development and retention of a strong and diverse range of foster caregivers.

It is 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 participants and in the literature. Direct supports ranged from 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 consultation, 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

counseling or treatment for problematic substance use, the foster caregiver is more likely to feel supported as well.

Recommendation 1: Caregiver Recruitment

MCFD and service providers, with advice from Delegated Aboriginal Agencies (DAAs), should recruit a greater diversity and scope of caregivers who can work in partnership with birth and extended families and Aboriginal communities to support reunification and alternate permanency outcomes.

Rationale: Throughout the Phase One consultation sessions and the Phase Two working sessions the topic of caregiver recruitment received a lot of attention. Participants described what other jurisdictions and researchers have noted:

- The pool of foster caregivers is aging and many will leave fostering over the next decade
- New and younger caregivers are difficult to recruit for a variety of reasons
- If the pool of foster caregivers is diminished, it will be more difficult to match children and caregivers to enhance the likelihood of a successful placement
- Despite the significant number of Aboriginal children in care and the desire to place children within Aboriginal homes, there are few Aboriginal foster caregivers available to meet the need
- As there is limited apparent diversity amongst foster caregivers, it is more difficult to match children with distinct cultural, ethnic or life circumstances with families that share a similar background or orientation
- The children and youth coming into care have complex needs and often require knowledgeable, skilled and experienced caregivers which are in limited supply

All of these factors point to the need to make recruitment of foster caregivers a top priority in order to enhance diversity, availability and sustainability of the foster care system.

The development of effective foster caregiver recruitment strategies requires more data than is currently available within the system. There is currently no way to collect and aggregate demographic information about foster caregivers, such as their age, qualifications and experience, years of fostering, and cultural background. While resource workers often have knowledge about caregivers and their characteristics, preferences and strengths as a result of their relationship with them, there is no consistent way to capture this information as a basis for both determining what types of homes are needed (e.g. not enough youth-friendly homes but more homes than are needed for infants) and supporting the matching of children and youth to suitable placements.

Working session participants discussed the importance of having both a provincial recruitment strategy and local/regional strategies. Each service delivery area and region will likely have distinct recruitment priorities based on the characteristics and needs of the children and youth in their area and the characteristics and supply of current foster caregivers; however, all would benefit from a sustained provincial recruitment strategy and ready access to data, resources, examples of promising practices, and a network of other people engaged in recruitment processes.

Supporting Actions:

1. Examine ways to routinely collect demographic information about foster caregivers that can be used to identify trends and gaps relevant for recruitment and retention planning.
2. Gather information from the regions, DAAs and other jurisdictions on effective caregiver recruitment and marketing strategies and share this information provincially through a variety of ongoing knowledge exchange activities (e.g. provincial SharePoint site, website, future training materials).
3. Develop and implement a sustained approach to foster care recruitment including:
 - More widespread use of effective strategies currently underway such as child-specific in- neighborhood or 'community of interest' strategies (e.g. cultural and immigrant communities, the gay and lesbian community, church and service organizations).
 - Targeted recruitment of Aboriginal foster caregivers, relief foster caregivers, and specialized foster caregivers for safe babies care, child and youth mental health and special needs populations.

Recommendation 2:

Caregiver Assessment/Approval/Training/Education

MCFD and service partners, with advice from Delegated Aboriginal Agencies (DAAs), should develop and implement a new caregiver education program that includes preparatory, foundational and specialized components and promotes Indigenous world views and teachings within each component.

Rationale: The greater focus on permanence, and the reframing of residential care as a bridge to permanence rather than as a longer-term arrangement for the child or youth, will result in different and new expectations for many foster caregivers. This will need to be considered in the development of recruitment strategies, screening and assessment processes, training and support. For example, some foster caregivers indicated that they are uncomfortable working with a child or youth's parents, extended family or culture-kin, and yet this will be a key expectation within

the context of achieving permanency. The expectation of cultural attunement and the need to support and facilitate cultural connections, particularly for Aboriginal children and youth, will also require training and support.

Foster caregiver orientation and training was discussed at length throughout Phases One and Two of the review, with the general consensus that while the current curriculum (pre-service and post-approval) has strengths, it also has a number of weaknesses in terms of content/curricula, delivery approaches and timing. Work on the training was started several years ago but then was put on hold pending completion of other work within MCFD. Those involved in this process believed that a good foundation had been laid and urged MCFD to resume the work, and this was achieved. The Caregiver Education Framework Project described in the first supporting section below is now underway under the guidance of a Provincial Advisory Table that is comprised of MCFD staff from all regions, regional foster parent support agencies, the B.C. Federation of Foster Parent Associations (BCFFPA), the Federation of Aboriginal Foster Parents (FAFP) and the Federation of BC Youth in Care Networks (FBCYICN).

The framework that is proposed below reflects a more developmental, respectful, caregiver-centred approach to learning. It recognizes that caregivers often come into the fostering role with experience and education, and this should be assessed and recognized as appropriate so that a more personalized learning plan can be developed in consultation with the caregiver. It also recognizes that a caregiver's learning receptivity is greater when they see the need for the knowledge and skill, such as when a child with mental health concerns is placed with them and they need to develop specific knowledge and skills to care for that child. Such learning needs can be incorporated into a learning plan and met through specialized training, resource sharing, coaching or mentoring by experienced foster caregivers or service providers, and clinical support or consultation.

Information gathered during the review highlighted the regional and community disparities in the delivery of the required pre-service (preparatory) training offered to prospective foster caregiver applicants and the disconnect between the pre-service training and the caregiver assessment and approval process. The information also indicates that many caregivers do not complete the current mandatory training within the required two years following approval. Once children are placed in the caregiver's home, there is both less incentive and less available time to complete the training. Many participants suggested that MCFD should be very clear and consistent about their expectations of caregivers to:

- Complete an integrated pre-service training and assessment process and any mandatory post-approval training.
- Participate in learning and training events to maintain and refresh their knowledge and caregiver competencies.

As one foster caregiver suggested: "If we want to be treated as professionals in the system, we have to act like professionals and get the training we need to do the job." It was also suggested that this should be supported through more innovative, engaging and accessible delivery approaches (including online learning), provision of child care during learning/training sessions, assistance with travel and out-of-pocket costs, and other strategies to remove the barriers to participation.

Another topic that received a great deal of consideration was the assessment process for caregivers.¹⁷ Project research illustrated the value of integrating the caregiver assessment and approval process with pre-service or preparatory training. A number of other jurisdictions using such an integrated approach have seen benefits in terms of:

- Allowing prospective caregivers to make a more informed decision about becoming a foster caregiver.
- Promoting a better understanding of the needs of future children they may care for as well as caregiver expectations and key competencies.

Challenges around the capacity to respond to expressions of interest and timeliness in commencing and completing home study assessments were also raised. Current caregivers shared stories about having encouraged friends and family members to apply to become foster caregivers, only to discover that their recruits would not be contacted or receive information for many months due to backlogs in the assessment and home study process, resulting from lack of staff available to complete the processes. Efforts should be made to clear the backlog while also considering how best to assess caregivers in light of new or shifting expectations to work with birth and extended families, support cultural connections, and support permanency for children and youth.

Supporting Actions:

1. Develop and implement an evidence-based Caregiver Education Framework that is developmental, attachment-based and trauma-informed. The intention is to prepare culturally competent foster caregivers that are able to support the permanency goals for children and youth including being able work effectively with birth, kinship, adoptive families and the child's community.. The framework will position caregiver education as a positive learning opportunity that supports ongoing development of caregiver skills and capacity.

Features of the Caregiver Education Framework will include:

- Preparatory caregiver education as a mandatory home approval pre-placement requirement

¹⁷ MCFD has established a Caregiver Assessment Review Table to examine caregiver assessment policies and practices and recommend enhancements.

- Preparatory training will be compatible with and supportive to the foster caregiver home-study assessment and approval process
 - A prior learning-assessment process and recognition of traditional knowledge and competencies, relevant courses or workshops taken via colleges, health authorities, school districts and MCFD
 - Caregiver's demonstration of competencies and equivalencies that will be incorporated into their individual learning plans
 - Caregiver education linked to ongoing support, mentoring, coaching and clinical supervision
 - Caregiver individual learning plans and the completion of ongoing education and training credits tied to caregiver compensation and incentives using a clear and transparent process
2. Identify where backlogs in foster caregiver applications and home studies may be occurring and implement a plan to clear up existing backlogs as well as maintain timely flow-through of applicant follow up, screening, pre-service training and assessment home studies on an ongoing basis.
 3. Develop and implement plans for ensuring consistent utilization of a provincial caregiver home-study and approval process that is compatible with the new Caregiver Education Framework.

Recommendation 3: Caregiver Support

MCFD and service partners should establish a menu of accessible basic and enhanced evidence based supports available to all foster caregivers based on the needs of the children and youth being cared for.

Rationale: The need to recruit, assess and train foster caregivers is tempered by the ability of the system to retain experienced and skilled caregivers through the provision of relevant training and timely support, appropriate matching of children to the caregivers' skills and circumstances, and valuing of the caregiver as a key member of the care team demonstrated, for example, by inclusion in planning processes and respect for their input. The need for caregiver support and recognition was raised throughout both phases of the project and is also a key issue being considered in other jurisdictions.

In BC, there are a number of foster parent training and support agencies and programs. Some are stand-alone agencies and others are programs embedded within larger multi-service agencies. The project team noted that there are considerable differences between these programs and services in terms of what is offered, how it is offered and what the contract provisions are. Foster caregivers who have worked with different support programs suggested that some supports are more helpful

than others and there should be more consistency in what is made available. While some variance makes sense due to regional and local differences, the first supporting action below reflects the need to better understand these differences, determine what is most needed and effective based on evidence and experience, and work towards a comprehensive and sustainable array of supports for foster caregivers, offered through MCFD and foster parent support programs and agencies. It is also anticipated that the role may shift or expand with the introduction of hub and wraparound models such as are described below under the third supporting action below and in more detail in the following recommendation.

Other key supports for foster caregivers include access to relief, clinical supports and consultation (where appropriate). All foster caregivers will need to have some relief from the day-to-day challenges of parenting. Research and experience suggests that having timely access to regular relief helps to stabilize placements, prevent placement breakdown and retain caregivers. Access to relief should be proactive (i.e. not wait until there is a crisis) and requests for support and relief should not reflect poorly on the caregiver. Access to support and clinical consultation, particularly during times of transition or when a child's needs are more profound, will help the caregiver determine what assistance would be helpful for themselves and the children in their care. Relief comes in various forms. It could be a relief or child care worker coming into the home to care for the children on a regular basis or over a number of days to enable the caregiver to have a break, or it could be the children going to the home of the relief caregiver as part of a planned relief schedule (ideally the same relief caregiver to support continuity of relationships).

Support also comes in various other forms including: arranging for child care workers, therapists or counselors to work with the child and caregiver to moderate challenging behaviour, enhance the child's development and coping skills, mentor the caregiver using new therapeutic skills, de-escalate stress in the home (resulting from the child's needs or behaviours), and address grief, loss or personal issues that may be impacting the caregiver. The second supporting action below speaks to the need to be more intentional about the provision of relief, supports and clinical consultation services for the child and foster caregivers.

There has been significant growth in ad hoc exceptional payments to foster caregivers as a funding mechanism to enhance services and supports in specific cases. This highly individualized approach may be necessary in some circumstances but widespread use has contributed to the reality and/or perception of inequities and inconsistencies in how caregivers are compensated. A more stable and accessible system of specialized service supports in local areas and regions needs to be developed. Opportunities to increase available funding for caregiver supports may be identified by examining these ad hoc exceptional payments and redirecting resources to achieve a more equitable array of supports. The third supporting action below addresses this issue.

Many foster caregivers cited concerns with the way in which the provincial protocol framework was (or was not) being used. Inconsistent application across offices and regions, and use of the protocol in ways that were not intended (e.g. in a punitive and non-collaborative way) has diminished the usefulness of the protocol. While recognized as being an important tool, it was suggested that it needs to be reviewed and updated and that MCFD staff and foster caregivers need to be provided with good information and training about how and when it should be used to ensure accountability while also strengthening practice and relationships. The final three supporting actions below address this concern.

Supporting Actions:

1. Review the roles of foster parent support agencies and resource workers to identify options for improving utilization of existing staff resources.
2. Develop and implement plans to provide relief and clinical support services that can offer timely and required relief, assessment, consultation, and behavioural and treatment intervention supports as needed for the child and caregiver (e.g. mobile wraparound teams).

These services are to be made available to high needs placements and during significant transitions for the child, his/her family and caregivers.

3. Review and reduce the use of ad hoc exceptional payments and redirect some of this funding to the provision of a planned and ongoing array of supports and services for the child and their caregivers, including the emerging 'hub' or 'network' models noted in the following recommendation.
4. Develop information, training materials and supervision tools to promote awareness and implementation of the *Foster Parent Rights* document.
5. Review and update the provincial protocol framework and regional protocol agreements to ensure:
 - Consistency and administrative fairness;
 - Alignment with *Foster Parent Rights* and quality assurance policies and standards currently under revision.
6. Once the provincial protocol framework and regional protocol agreements are updated, provide training to staff to promote respectful, fair and timely protocol practices.

Recommendation 4: Service Redesign

MCFD and service partners should develop and evaluate alternate service delivery approaches for enhanced foster care recruitment, assessment, training, support and relief.

Rationale: The reviews of literature and practices in other jurisdictions undertaken in Phase One of the project identified a number of interesting and promising service delivery approaches that aim for a more integrated or 'full service' approach to foster care development. One set of approaches attend to foster caregiver development and support and combine the functions of recruitment, assessment, training, support (including wraparound supports for the child as well as the caregiver) and relief within one team or agency. This would be a significant departure from current practice in which these functions are spread out between MCFD teams and community agencies.

Another set of approaches redesign the foster care service delivery system itself and intentionally connect foster homes and community service agencies in a network or 'hub' that enhances resiliency within the system. For example, the Mockingbird Family Model, developed in Seattle, Washington is designed to help improve safety and stability and to mitigate the effects of trauma by organizing networks of 6-8 foster homes around a hub lead home that provides relief, peer mentoring, training and support.¹⁸ The hub home is in turn connected to an agency that provides clinical and support services.

Participants in the working sessions and key informants suggested that these approaches could address many of the concerns raised about the design of, and current practices within, the foster care system, and that they should be implemented in several areas of the province, evaluated, adapted and then replicated if they are effective. The first two supporting actions below propose these new approaches. They would reconfigure the existing functions and resources to achieve the following: more consistent, experienced and evidence-informed action on caregiver recruitment, resulting in a larger and more diverse pool of caregivers in each region; timely and effective caregiver screening and assessment that is understandable to the prospective caregiver and assists them in learning more about their role and identifying learning needs; accessible and effective training; timely access to information and support, delivered by people who are familiar with foster caregiving and the homes (including peer mentoring); access to skilled relief caregivers; and timely access to child and caregiver support and interventions to address concerns before they escalate and threaten the well-being and stability of the child and placement.

Supporting Actions:

1. Through a contract with an agency experienced in providing foster caregiver supports and services, develop and evaluate a 'full-service foster care agency delivery model' that includes caregiver recruitment, assessment, training, relief, and wraparound supports for the child and caregiver.

¹⁸ For further information see <http://www.mockingbirdsociety.org>

2. At least one office in each Service Delivery Area to develop, implement and evaluate a 'hub' or networked model of foster care, along the lines of the Mockingbird Family Model, wherein a network of 6-8 foster homes are organized around a 'hub' lead home that provides relief, peer mentoring, training and support. The 'hub' lead home is in turn connected to either an agency that delivers clinical and support services or to an MCFD clinical and support team.
3. Review and revise the Foster Home Standards to ensure they support the newly emerging service redesign and consequent changes in caregiver role expectations.

Recommendation 5: Foster Caregiver Classification, & Compensation

MCFD should commit to a fair, understandable, and transparent caregiver classification and compensation process that is implemented consistently across all regions.

Rationale: Throughout the Phase One consultations the project team received feedback about the inadequacy and inconsistencies of the current foster caregiver classification and compensation process and rates. 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 the current foster care level system requires revision or re-design and that compensation should be reviewed and enhanced. However, no clear alternatives were proposed by participants during Phase One. The project team looked for successful examples in other jurisdictions and while many have wrestled with how best to structure foster care services and compensation, weaknesses have been identified for all systems in use. During the Phase Two working sessions this issue was brought back for further discussion and consensus emerged in a few areas:

- Whatever is developed should be consistently applied throughout the province with some accounting 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).
- The vast majority of children coming into foster care have complex care needs (there are no regular foster children anymore – they all have significant needs) and the current level system doesn't reflect this reality. A new system should reflect the reality of caregiving and children's needs.
- Foster caregivers should be provided with sufficient maintenance funds to provide the child with normative, developmentally-supportive experiences such as recreation, lessons, birthday parties, activities with friends, etc.

- The classification and compensation system should be designed with the child/ youth's best interest at the centre (e.g. children should not be moved out of a foster home just because they become stable and start doing well because the home is 'an expensive level 3 home and should only be used for children and youth who are in crisis').
- The new expectations of foster caregivers working with birth families and facilitating transitions to permanence should be clearly described and considered in the classification and compensation review (e.g. while all caregivers will be expected to support permanency objectives, some caregivers may develop specific expertise in working with birth, kin or adoptive families to facilitate transition for the child or youth into a permanent family situation and this would be valued expertise, much as caregivers with expertise in caring for medically fragile infants, or teens with mental illness are valued).
- The new hub or network models require the central home caregivers to perform different tasks, such as mentoring, supporting and training other caregivers who belong to their network. Although they may provide regular relief care to the children living in the network of homes, the central home would not have children placed in their home on an ongoing basis. Such homes will require a different type of classification, compensation and contracting.
- The issue of classification and compensation requires thoughtful review and must be done collaboratively with MCFD, BCFFPA, FAFP, and FCSS and with advice from DAAs, regional foster caregiver support agencies and the FBCYICN.

Questions and points for discussion are laid out in the *Phase One Findings Report*, (pp. 74-76). Three key issues are: whether caregiver compensation should be based on the needs of the child, the skills of the caregiver or both; whether and for how long caregivers should continue to receive compensation for vacant beds when a child that has been in their care is either placed in a residential treatment resource or in youth custody resource for a period of time, but where the intention is for the child to resume living in foster care following treatment or incarceration; and how the desire for a surplus of foster homes (to support matching of child and caregiver) and the result of some foster homes being vacant for periods of time, will be balanced with the needs of many foster caregivers to have a regular income from fostering.

Supporting Actions:

1. In partnership with the BCFFPA, FAFP and FCSS and with advice from DAAs, regional foster caregiver support agencies and the FBCYICN, undertake a collaborative review of caregiver classification and compensation, including mechanisms to provide better assurances of consistency and transparency in the application of the classification and compensation system as well as consideration of expanding roles in relation to permanency objectives and service redesign, and

alignment with changes to caregiver training and education.

2. Work with service partners and DAAs to review and update the family care home agreement and other caregiver contracts, such as Client Service Agreements so that they align with the emerging foster care service design and include some flexibility for specialized contracts for foster caregivers to actively assist and participate in reunification, act as mentors and teachers of family members, new foster caregivers, adoptive parents, etc.

Strategic Direction #4 - Planning and Developing an Accessible Array of Residential Care and Treatment Services

A key finding in Phase One was that, while BC has many different residential care programs and services, work is required to create a more integrated, accessible and evidence-informed 'system' of residential care. This is particularly important given the often complex and multi-faceted needs that the children and youth coming into residential care present. The Strategic Direction that emerged through Phase One was to plan and develop an accessible array of residential care and treatment. Key ideas underlying this statement include:

- There is an *array* of services - The term array was intentionally selected as the evidence points to the importance of matching a child's needs within a residential care context to an appropriate residential care setting. Therefore we need a variety of residential care options within a system of care to facilitate the matching. Array also suggests something different than a continuum; the latter implies that one starts accessing services at one end of the continuum and then moves along to more intensive services at the other end of the continuum until such time as one's needs are adequately met. In the case of many children coming into residential care, this has meant that they start in a regular or level one foster home and then if this doesn't work they are moved into higher level homes, then staffed placement and then possibly a tertiary care or correctional facility. This approach may result in multiple moves, disruption and lack of attention to the child's needs. The notion of array suggests that a child could, for example, go directly into a residential treatment setting for intensive assessment and treatment, given their presenting needs and the plans for the child. This reflects having 'the right services at the right time' in order to create a bridge back to family or an alternative permanent family arrangement wherever possible.
- Services include both *care and treatment* - Building on the ideas noted above, it became clear through the consultations and working sessions that while all children in residential care require care, many also require treatment. The complex histories and needs of many children in residential care call for a treatment-based response. (e.g. addressing trauma, loss of, or lack of, attachment, mental health issues, developmental delays associated with FASD, brain injury or autism, and/or issues related to the parents' or the child/youth's problematic substance use).
- The array is *planned* - Practice-based evidence suggests that many of the residential care elements currently available have not been strategically 'planned' for - they have emerged in a more ad hoc manner (e.g. when existing

services are not able to meet the needs of a particular child and a contract for a specialized one or two bed resource is arranged on an interim basis and then not modified over time).

- The array is *accessible* – Many participants suggested that even when we know what type of placement a child or youth needs, we are unable to arrange it for them, therefore a system of residential care needs to ensure accessibility. It was recognized that not all services will be or should be available in every area of the province, however, a planned and integrated system will enhance accessibility by having a better sense of what is available where, and how referrals may be made across the 4 MCFD Regions or 13 Service Delivery Areas (SDAs).

As Phase Two and the working sessions progressed, this Strategic Direction was expanded and three sub-topics were identified. The most significant addition made explicit the fact that the system's design would be based on research and best practices. The sub-topics covered three dimensions of the system: the overall system and how it is planned and designed; intermediate residential care and treatment (offering more intensive and specialized, evidence informed and shorter term care and treatment within higher level family or group care settings); and tertiary residential care and treatment. The latter was informed by MCFD's internal review of tertiary care.

Each of these three sub-topics, their recommendations, and supporting actions are described below but it is important to note that together they speak to the overall intention of a well-planned and accessible system of quality residential care.

Sub-topic a) *Building a Planned System of Residential Care and Treatment Services Based on Research and Best Practices*

Intention: MCFD is committed to matching residential care and residential treatment placements to the assessed individual needs of the child, minimizing placement moves, promoting placement stability and achieving permanency – safe, stable and enduring family relationships for children and youth through reunification, adoption, guardianship or other meaningful lifelong connections. To meet its commitment, MCFD needs to plan for, implement and fund foster care and staffed residential placements (and different types of these residential placements) so that there is ongoing, available capacity that promotes greater likelihood of a 'good fit' for an individual child at the time it is required. The principle of having ongoing and available capacity needs to be applied at the regional, service delivery area and, to the extent possible, community level, as it is not always feasible to have highly specialized types of placements available in every local community.

All components of the array must share a common framework or common principles guiding practice to ensure children, youth and families benefit from a coherent and integrated system of care and treatment.

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.

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 counseling 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, 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. All of this was considered in the development of the recommendations and supporting actions.

Recommendation 1: Planned Service Design

MCFD should develop a planned system of evidence-based residential care services that meets the care and treatment needs of children and youth.

Rationale: As Phase Two evolved, there was a growing recognition that having access to an array of services and supports was not sufficient – the array needed to be evidence-informed, planned, integrated and cohesive. The need for some province-wide consistency and continuity in what was available within the array was felt to be important, while also ensuring that there was some flexibility built into the system to address community, SDA and regional differences. Working session participants believed that this could be supported by establishing a shared foundation for the array of services (e.g. what needed to be included, guiding values and principles, clarification of roles and responsibilities within the system, etc) and by providing the Regions/SDAs with consistent data sets, planning tools and frameworks, to guide each area in developing an appropriate Residential Care and Treatment Resource

Plan. This is addressed in the supporting actions below.

Throughout the project, we have learned about promising practices underway both in BC and in other jurisdictions and have tapped into research and evaluation literature suggesting what practices and programs seem to make a positive difference (or don't) in the lives of children and youth. There is sufficient available evidence to expect that requests for proposal (RFPs) for residential care and treatment programs and services will demonstrate that the proposed service is:

- Informed by and reflects contemporary research (which includes practice-based evidence arising from community and practitioner knowledge and evaluation, as well as academic and research evidence);
- Culturally attuned and reflects the cultural needs of the children, youth and families that will use the service;
- Effectively providing clinical supervision and support;
- Aligned with the strategic priorities set out in this report.

As an evidence-informed, planned, integrated and cohesive system is designed and implemented, existing policies and standards will need to be revised, as laid out in the latter three supporting actions below.

Supporting Actions:

1. Develop a resource planning process and supporting tools to be used in preparing Community, Service Delivery Area, Regional and Provincial Residential Care and Treatment Resource Plans.
2. Develop Community, Service Delivery Area, and Regional Residential Care and Treatment Resource Plans that address the full spectrum of foster family care including treatment foster care and specialized staffed resources. The Resource Plans are to:
 - Be guided by a common set of principles and values that provide a foundation for all residential and linked support services;
 - Provide for clinical supervision and clinical support services that vary in intensity and sophistication as required;
 - Address the need for specialized residential services within each region to the extent feasible, recognizing that cross-regional development and access to highly specialized community residential treatment resources, and to tertiary care resources, will be required;
 - Clearly distinguish between residential care and residential treatment, the latter referring to time-limited, evidence-based clinical treatment interventions

such as treatment foster care approaches, clinically focused staffed residential treatment interventions, and tertiary treatment resources such as the Maples Adolescent Treatment Centre;

- Recognize that while as a general rule intermediate residential resources are intended to be time-limited and treatment-focused, residential resource plans need to account for the reality that there are some special needs children whose complex needs are so profound and lasting that they may require an intermediate level of staffed residential or intensively supported family based -care over the long term;
 - Support 'good fit' matching for the child's assessed needs by using prevalence data and other similar research-informed data, profiles of child needs, caregiver characteristics and residential program descriptions to plan for the ongoing and available capacity of placement spaces.
 - Provide clarity regarding the roles and responsibilities of MCFD and the community social service sector. Recognize that the community social service agency sector is the deliverer of intermediate residential treatment services such as staffed residential treatment and treatment foster care approaches, including the full service delivery of clinical support services and the recruitment, training, and support of family caregivers for these treatment resources.
3. When issuing RFPs for contracted intermediate care and treatment resources, ensure that the proposals and evaluation criteria are based in research, informed by cultural competencies and a theoretical model that includes appropriate clinical supervision and support services, and are aligned with stability, treatment and permanency outcomes.
 4. Review and revise the Standards for Staffed Children's Residential Services to ensure they support the newly emerging principles and values (philosophical foundation), service redesign and consequent changes in care, and treatment expectations.
 5. Review and revise the Caregiver Support Service Standards to ensure they support the newly emerging principles and values (philosophical foundation), service redesign and consequent changes in caregiver role.
 6. Review and revise relevant program area policies and standards (CYMH, CYSN and Youth Justice) to ensure they support the newly emerging principles and values (philosophical foundation), service redesign and consequent changes in caregiver roles and care and treatment expectations.

Recommendation 2: Philosophical Foundation

MCFD and service providers, with advice from Delegated Aboriginal Agencies, should establish a philosophical foundation of principles and values to guide the delivery of residential care and treatment services that reinforce safety, well-being and permanency, and support system design and practice.

Rationale: We envision an evidence-informed, planned, integrated and cohesive system of residential care. Cohesion is important in ensuring that children and youth who received care from different parts of the residential care system do not experience alarming differences when they go from one service to another. Differences in programs are expected, but vastly different beliefs, values and approaches could be confusing or destabilizing and possibly diminish any healing and development that the child or youth achieve in a previous placement. For example, if the child experienced relationship-focused, strengths-based care and treatment in one setting and then was placed in a setting that relied on a rewards and consequences behavioural approach, it could be very confusing for the child or youth. It was felt that greater cohesion could be achieved if we established a philosophical foundation to guide the delivery of residential care and treatment.

Of particular interest to the project team and many of the working session participants is the Child and Residential Experiences (CARE) model developed by the Residential Child Care Project Team at Cornell University's Bronfenbrenner Center for Translational Research. This model has been informed by research undertaken with BC agencies, by University of Victoria's Dr. Jim Anglin, as well as child development, trauma-based, resiliency and related care research. The model has been implemented in jurisdictions throughout the US, Australia and Europe and is particularly interesting because of its 'whole systems' approach. The six principles must be reflected in the practices of all parts of an organizational and community system, meaning that they inform not only how a child is cared for and treated, but also how supervision is given to staff, how staffing decisions are made, how boards allocate their budgets, how relationships within the community are formed and sustained, etc. Given the evidence base underlying the CARE model, the second supporting action below proposes that the model be implemented and evaluated here in BC.

Supporting Actions

1. Develop the principles and values that will form the philosophical foundation for residential care and treatment services in BC.
2. Assess the potential of the Children and Residential Experiences (CARE) model as a philosophical foundation for residential services, particularly intermediate treatment resources by contracting for and evaluating a residential program that uses the CARE model in at least one agency in one or more Regions.

Recommendation 3:

Access to the Right Placement at the Right Time

MCFD should enhance the residential care system's capacity to provide effective and timely responses to the assessed needs of children and youth.

Rationale: In both phases of the project, two of the most consistently cited opportunities to improve the experience and outcomes of children and youth in residential care were improving placement planning and matching and tracking the number of placement changes a child experiences to assess the intentions behind the move, whether they are planned/unplanned and whether action needs to be taken to stabilize the child in an appropriate placement. Many participants felt that there needed to be a higher level of accountability for the development and management of plans of care both within MCFD (e.g. Comprehensive Plan of Care - CPOC), between MCFD youth, families, service providers and caregivers (e.g. care plan developed in a collaborative planning process) and within the residential care settings (e.g. specific care/treatment plans). This was supported by research on child outcomes. The first supporting action below proposes the development of planning tools to facilitate matching children and caregivers.

It was also suggested that the new integrated case management information management system (ICM) should have an 'alert' function that would inform the staff and service providers that are connected to a child or youth once a child has been moved three times within a year. This would trigger a collaborative review process to assess the situation for the child and determine whether an intervention is necessary to provide more stable care or treatment.

Supporting Actions:

1. Develop placement planning tools to support matching the child's assessed needs with the capacity and skills of the caregiver or treatment provider.
2. Ensure clear policy is in place regarding the importance of promoting and sustaining placement stability.
3. Develop an information system (ICM) 'flag' in circumstances where a child or youth has moved three or more times within a year.
4. Develop and implement a '3+ moves' collaborative review processes to identify ways to sustain the current placement or ensure the next placement is a good fit and adequate supports are in place to maintain placement stability.

Recommendation 4: Inter-Ministry Coordination

MCFD should strengthen connections and coordination between the MCFD tertiary care, intermediate residential care and foster/kinship care systems and hospital

and other treatment and residential services offered through Health Authorities and CLBC.

Rationale: Some of the services and supports that children and youth within MCFD's residential care system need are provided by other ministries and authorities and stronger connections and coordination between the systems will benefit children and youth and improve outcomes. A significant number of youth served by MCFD experience problematic substance use. While residential care providers, including foster caregivers as well as staffed resources, attempt to meet the care and treatment needs of these young people, more specialized intervention and treatment is often needed from the health authorities that deliver this service. Youth and caregivers in the consultation and working sessions noted that lack of access to timely treatment for substance use problems can contribute to placement breakdown. This risk was particularly heightened for children experiencing concurrent or complex conditions where substance use, mental health concerns and/or developmental delays were affecting the young person.

Although there are mechanisms in place at the provincial level to discuss issues of this nature, participants urged MCFD to work with colleagues in the Ministry of Health (MoH) and Health Authorities to improve access to the services and supports (e.g. assessment, planning and treatment) required by young people facing complex issues, and to improve access to consultation for foster caregivers and other service providers responsible for the day-to-day care of these young people.

Enhancement of inter-ministry/authority (MCFD, MoH, Health Authority, Ministry of Social Development, Community Living BC) collaboration was also proposed for transitional planning for youth who will be leaving the child and youth system and accessing the adult system either for income and employment assistance, substance use treatment, mental health or adult community living services. This is also addressed under **Strategic Direction #5 – Addressing Youth Interests in Permanency and Transitions**.

For a variety of reasons, ministries and authorities are relying more and more on family caregiver based residential care. For example, CLBC is developing more 'homeshare' arrangements for adults with developmental disabilities as an alternative to staffed models such as group homes. The MoH is encouraging the development of family care arrangements for seniors as an alternative to institutional care. Health Authorities have developed family-based substance use withdrawal management, treatment and recovery support homes for youth. MCFD has developed a strong family-based care home model within the youth justice system and over the past decade has significantly reduced the use of staffed group care for children and youth in favour of family care arrangements such as foster and extended family/kinship care. Throughout this time there has also been growth in the number of international students attending BC schools, and people are recruited as 'home stay' families. This increased demand for family care arrangements is occurring at a time

when housing costs are increasing, both parents in two-parent families typically must work, there is a growing number of single parent households and the willingness and capacity of families to take on the responsibility of caring for a child, youth, senior, adult with complex needs, a disability or international student is limited. Competition between these various programs is increasing and may result in unintended consequences on system capacity and costs. The second supporting action below calls for the ministries and authorities to review this situation and consider ways to coordinate efforts and develop a plan, including rationalization and alignment of compensation.

Supporting Actions:

1. In partnership with the Ministry of Health and Health Authorities, examine ways to coordinate access to substance use treatment consultation and treatment support services to MCFD funded or operated residential resources, including foster family care. **Note:** Existing Provincial Child and Youth Mental Health and Substance Use Committees or Networks can support this work.
2. Given the increasing reliance on family caregiver- based residential services across service streams, working with CLBC, the Ministry of Health and the Federation of Community Social Services of BC, consider undertaking a cross-ministry and cross-sectoral review of family caregiver services with a view to examining opportunities for collaboration in recruitment, education and training and support services as well as the feasibility of rationalization and alignment of compensation.

Recommendation 5: Change the Mechanisms for Access to Services

MCFD should identify ways to make residential care and treatment accessible without requiring parents to place children in care under the CFCSA.

Rationale: Residential services for children with severe mental health problems are almost entirely tertiary care hospital-based services which may not be the most appropriate placement for some children and youth. However, if alternate family care or staffed residential care services are required for mental health assessment, care or treatment, the child or youth must be brought into care under the CFCSA. This creates a dilemma for parents and family members who wish to remain actively engaged with the child or youth and intend for them to return home (where there are no safety concerns) as they must transfer care to the ministry in order to access the specialized treatment that their child needs. This is contrary to the goal of achieving permanency and should not have to be a pre-requisite for residential care and treatment. This dilemma is addressed by the first supporting action below.

For some children and youth with special needs, long-term residential care may be

appropriate due to the complexity or severity of their needs and the inability of their families to meet their needs (e.g. medical fragility, dual diagnosis of developmental disability and mental health concerns, extreme behavioural challenges). However, where parents and family members wish to remain actively involved in their child's life, an alternative to the child being brought into care under CFCSA could better support family connections and sustain the parent's guardianship role. This is addressed by the second supporting action below.

Supporting Actions:

1. Examine the issues and options that would enable children and youth with serious mental health problems requiring residential assessment and/or treatment to access such services in a way that does not require parents to place their children in care.
2. Similarly, examine issues and options for children and youth with special needs to access residential services without requiring parents to place their children in care.

Sub-topic b) *Building a Planned System of Intermediate Residential Care and Treatment Services Based on Research and Best Practices*

Intention: The current system of intermediate residential care and treatment (staffed or specialized resources that are between family/foster care and tertiary care) needs to be systemically planned, re-focused and re-invested, with particular attention to the development of a system of specialized types of intermediate residential treatment services that are based on research evidence and the best practice literature.

Throughout the consultation and working sessions, participants suggested that the current array of residential care and treatment programs and services had strengths but also had some weaknesses. Most notable were the following:

- Access – Lack of timely access to programs and services in general, and lack of locally available and accessible specialized services so children and youth do not have to seek care long distances away from their home communities.
- Availability of intermediate care resources – Evidence and experience documents that the range and number of intermediate care resources available in all regions has been significantly reduced over the past decade. While some of this reduction can be attributed to an evidence-informed shift in practice towards more family-based care, there remains a need for intermediate care resources to

address the needs of some children and youth. These are staffed or specialized resources that are typically short-term, intensive and treatment-focused and that help 'bridge' a child or youth back to birth family, an alternate permanent family care arrangement or a foster care home.

- Specialized evidence informed resources - Research and practice evidence suggests that the array of intermediate care resources needs to be expanded to include 'step up/step down' resources. These resources are often appropriate for children and youth with mental health concerns when the nature of their illness may require more or less intensive treatment at times. The step up refers to when a young person experiences moderate to severe symptoms of mental illness and requires support but is assessed as not requiring hospitalization. The step down offers a residential care and treatment option for young people with a mental illness to transition between hospital and returning home or to another less intensive family care arrangement.
- Capacity to meet the needs of children and youth with dual diagnosis, complex or concurrent conditions.

The recommendations below aim to address these challenges.

Recommendation 1: Review and Realign Existing Contracted Resources

MCFD should review and as necessary, realign existing contracted residential resources to ensure that they are evidence-based, treatment-focused, and aligned with Regional and Service Delivery Area Residential Care and Treatment Resource Plans.

Rationale: During Phase One, a number of questions were raised about existing contracted residential care services. Do we have the right array and sufficient number of staffed and specialized residential care and treatment services to meet the needs of children and youth? Are these services evidence informed? Are the residential resources that are currently in place being used most appropriately? Are these resources treatment-focused? Are they creating a bridge for children to move back to family or family-based care? The answer to many of these questions was that improvements are needed. As previously noted, there are many elements of a residential care system in place, however work needs to be done to create an evidence informed, planned, integrated, and cohesive system of residential care and treatment. Much of this effort needs to be focused within the area of intermediate care.

As a starting place, the participants in working sessions suggested that we need to establish clear criteria for admission to intermediate care resources. Due to the lack of placement options within the broader system, some children and youth are being placed based on the availability of a bed rather than the fit between the child's needs

and the resource's expertise. As such, some children are placed in intermediate care resources that do not need such a level (or type) of care whereas others that do need such intensive care and treatment are unable to access what they need.

It was also noted that the lack of placement options has resulted in a proliferation of what the project team and advisory group came to call 'ad hoc' or 'one-off' resources. These resources are often developed at a time of crisis for the child, to keep them safe for a period of time while more suitable longer-term arrangements are made. Over time however, these one and two bed resources have become common in the system and while they may be addressing the children's need for care, it is not clear whether they are providing treatment that is evidence informed, specialized (with well qualified and supported practitioners), culturally attuned, intensive, and short term.

The supporting actions below call for a review of contracts, realignment of resources as needed and a scaling back of 'ad hoc' resources in order to enhance the development of evidence informed intermediate care. These actions are controversial. However, they are also necessary in order to create a planned system of residential care and treatment that uses the available resources to the greatest effect possible. Community based agencies that are contracted to provide intermediate residential care would continue to have the key role in service delivery. These actions will open up the opportunity for agencies to work with MCFD to create a better system of care for the children and youth that they are most concerned about.

Supporting Actions:

1. Establish clear criteria and screening mechanisms for admission to intermediate residential treatment services, including prior clinical assessment, clear timelines for duration of placement (clear beginning, middle, end), as well as expectations and planning for transition / after care support.
2. Review existing contracted residential resources and make required changes to ensure that each residential program is time-limited, treatment- focused, culturally informed, evidence-based and appropriately clinically supported.
3. Identify the funding resources dedicated to client-specific, ad hoc staffed residential care purposes and develop plans to progressively scale back or eliminate such practices, redeploying funding to establish evidence-based intermediate residential treatment programs on an ongoing basis.

Recommendation 2: Evidence-Based Residential Treatment Programs

Utilizing re-aligned and re-deployed resources arising from the above recommendation, MCFD should implement and evaluate new evidence-based intermediate residential treatment resources to address complex needs and

support transition home or to an alternate permanent placement.

Rationale: Throughout the project, information was gathered from the academic literature and other jurisdictions highlighting effective evidence-informed intermediate residential treatment practices and programs. Participants in the working sessions were particularly interested in approaches that were comprehensive and 'wrapped around' the child/youth with an array of supports to address the complex issues that young people needing intermediate care and treatment present (including mental health concerns, lack of attachment, history of trauma, disrupted or chaotic family life and development). The first supporting action below encourages MCFD, service providers, and caregivers to implement and evaluate these evidence based approaches.

Of particular interest were Treatment Foster Care, Multi-Dimensional Treatment Foster Care, and wraparound, network-based residential treatment approaches. 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 and 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 are important factors 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.

Multi-dimensional Treatment Foster Care (MTFC) is an evidence-based 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, behaviour 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 use of rewards and consequences and 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 in over 60 sites spreading across the world.¹⁹

¹⁹ For further information see <http://www.mtfc.com/currentsites.html>

Other promising residential treatment approaches utilize a network model in which a staffed residential treatment resource (e.g. 4 beds) is at the centre of an array of TFC/ MTFC or other skilled foster homes. The role of the staffed residential care resource is to assess, stabilize and facilitate appropriate matching/placement, and then provide specialized support, training and relief for the children, youth and caregivers within the network in order to facilitate treatment, address emerging issues that threaten to destabilize the home and support transitions. This approach enables specialized care and treatment for children and youth with complex needs, while also offering family care and relationship continuity.

Supporting Actions:

1. Develop and evaluate intermediate residential treatment programs such as Treatment Foster Care, Multi-Dimensional Treatment Foster Care and Staffed Residential Therapeutic Programs that are delivered by community agencies and which are designed to address specific needs of children and youth such as attachment, trauma, mental health and neuro-developmental needs within a cultural context. The necessary wraparound specialized supports and clinical interventions are included in the intermediate treatment model.

Recommendation 3: Invest in Intermediate Residential Treatment

MCFD should enhance the residential care system's capacity to provide effective and timely treatment responses to the assessed clinical needs of children and youth through new investments of funding.

Rationale: This recommendation acknowledges that the fiscal situation for MCFD is challenging and that there are few or no new resources available to allocate to the array of residential care and treatment services and supports at this time. Prior recommendations propose that existing services and supports be reviewed to assess effectiveness, and that some resources could be realigned and redeployed in order to address some of the identified gaps in the service array. This final intermediate care and treatment recommendation suggests that the reallocation of resources will likely not fully address the gaps and needs that were identified through the project. As such, the project team has concluded that additional resources are required and that they should be allocated on a priority basis to intermediate residential care and treatment for children and youth that present particularly challenging needs and concerns, as are described in the supporting action below. Regional and provincial resource plans will inform the specific investments that will be required.

Supporting Actions:

1. Once existing contracted residential resources are reviewed, redeployed and new evidence-based models have been implemented and evaluated, as per the

recommendations above, request funding for investment in additional 'step up/step down' intermediate residential care and treatment resources as indicated through the development of regional and provincial residential resource plans. Priority for proposed new investments to be given to enhanced intermediate residential care and treatment services for youth with serious mental disorders, concurrent (mental health/substance use) disorders, dual diagnosis (mental health/developmental disabilities), sexual exploitation, eating disorders, and complex developmental and neuro-developmental disorders in combination with challenging behaviours.

Sub-topic c) *Addressing the Key Gaps in Tertiary Care and Treatment Services*

Intention: The increased use of community-based placements and reduced reliance on tertiary facility care over the past two decades is widely regarded as a positive direction and should be maintained. Enhancements to tertiary care should be limited to those services that are fundamentally necessary to fill service gaps that cannot otherwise be addressed by community-based alternatives (including intermediate care). Notably, the Residential Review identified that there are some young people who would benefit from intensive, short-term tertiary assessment and treatment due to their significant developmental and mental health needs.

As described earlier in the Statistical Overview of the Residential Services System, it is striking how small the tertiary care component of the residential services system is, comprising only 3% of the total residential services system. Moreover, the reliance on tertiary care services has markedly decreased over the past two decades.

The largest component of tertiary care is youth custody yet BC has the lowest per capita rate of youth incarceration in Canada (tied with Quebec), and the number of youth in custody has declined precipitously (75%) in the past 15 years.

With the closure of Woodlands and other facilities for the developmentally disabled, including youth, there is no longer any tertiary/institutional capacity for that special needs population.

Although there has been some enhancement of 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. For example, 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.²⁰

Generally speaking, these are very positive developments and a considerable strength of the existing system, but some weaknesses are evident. Maples programs and other mental health assessment and treatment facilities have waitlists and also 'bed blockers,' (children or youth who are ready for discharge from hospital but who cannot be discharged because there is not a 'step down' intermediate level residential treatment resource available in the community). Similarly, it is acknowledged that children and youth are sometimes placed in hospital when a 'step up' residential treatment resource would be a more suitable alternative but is not available.

Despite knowing that there are waitlists for some mental health hospital programs and hearing throughout the consultations about the pressing need for mental health residential treatment resources, the project team is not recommending the development of additional, very expensive tertiary care mental health treatment resources, with two exceptions discussed below. In this regard, we earlier recommended establishing a dedicated array of intermediate residential treatment services for youth with serious mental health disorders, dual diagnosis and concurrent disorders as per **Sub-topic b) Build a System of Intermediate Residential Care and Treatment Services**. Enhancements like this should contribute to the more efficient use (i.e. intake and flow through) of existing hospital-based resources by creating a system of 'step up/step down' community residential treatment alternatives and thereby relieve pressures on mental health hospital based services. This issue that should be re-visited once such system enhancements are in place.

Two exceptions relate to specialized services for dual diagnosis youth and Safe Care/ Secure Care services and are discussed below.

Recommendation 1: Dual Diagnosis

MCFD should develop specialized services for youth with dual diagnosis.

Rationale: A small number of highly vulnerable youth with a dual diagnosis (concurrently developmentally disabled and mentally ill with complex needs) require specialized psychiatric and behavioural interventions, supports and residential services. Such specialized resources are in scarce supply, especially for youth who are experiencing an acute episode that requires stabilization, assessment and treatment before transition, with supports, back to the placement of origin or to an intermediate 'step down' placement. The only specialized and dedicated hospital based resource for this highly complex population is CLBC's Provincial Assessment Centre (PAC), which occasionally admits youth to a small 11-bed resource that serves adults with a dual diagnosis. Otherwise, youth with a dual diagnosis find themselves in (and

²⁰ 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.

frequently cycle through) youth custody and youth forensic, Maples and other mental health facilities – none of which have the expertise to adequately address the needs of this population. Hence a dedicated program (in effect, a dedicated PAC for youth) is needed. Otherwise, the need for enhanced residential service resources for children and youth with a dual diagnosis will need to be addressed through the development of a system of 'step up/step down' intermediate care and treatment resources referred to in **Sub-topic b) Building a System of Intermediate Residential Care and Treatment**.

Supporting Actions:

1. Establish a tertiary residential unit at the Maples Adolescent Treatment Centre for youth with complex mental, developmental and neuro-developmental disorders and challenging behaviours, similar in purpose to CLBC's Provincial Assessment Centre. Time-limited services would include stabilization and short term treatment, assessment and planning, medication reviews and trials, community-readiness and planned respite. Such a service would form part of the Provincial Residential Resources Plan that will complement the Regional and Service Delivery Area Residential Care and Treatment Resource Plans.

Recommendation 2: Safe Care

MCFD should consider the implementation of Safe Care services at the appropriate time.

Rationale: 'Safe Care' or 'Secure Care' refers to the involuntary care of a young person when they have been determined to be at severe risk of harm to themselves or others based on their behaviours and condition (e.g. youth who have been sexually exploited or have severe substance use issues). The need for, and appropriateness of, safe or secure care has been discussed and debated for over a decade in BC. Some suggest that it is a necessary resource within the array of residential care and treatment options. Others suggest that it can be used inappropriately, has not demonstrated significant benefits for the detained young person, and may further alienate the young person from key positive relationships.

Safe Care for British Columbia's Children: A Discussion Paper, released in May 2004, outlined a proposal for replacing the 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.

During Phase One consultations, the need for safe or secure care was raised by only a few participants and did not appear to be a priority. During Phase Two consultations and working sessions, including those with youth, there was general acknowledgement that safe or secure care legislation and resources may be a necessary component of a comprehensive array of residential care and treatment services. However, any available resources should first be allocated to enhancing the array of voluntary intermediate and tertiary care and treatment options.

Supporting Actions:

1. The implementation of legislatively mandated involuntary Safe Care services for youth who are sexually exploited and/or have severe substance use issues and are at high risk of harm to themselves should be given serious consideration but only at such time as a full array of voluntary residential care and treatment services are in place (especially the intermediate residential treatment resources referred to in earlier recommendations). Otherwise, the immediate development of this involuntary option could prove to be a very expensive default option that is unnecessarily accessed due to the lack of available and suitable alternative resources.

Strategic Direction #5 - Addressing Youth Interests in Permanency and Transitions

Pursue permanency options for youth aged 16-18 and improve preparation for transitions to adulthood including strengthening post-majority supports and services for 19-24 year olds.

Intention: Engaging youth in permanency planning is essential whether the goal is legal permanence with a family or maintaining relationships and connections that are important to young people as they transition to adulthood.

Recommendation 1: Permanency Options & Supports for Youth

MCFD should develop permanency plans with young people that include options for legal permanence as well as continuity of relational, cultural and physical connections that are meaningful to them.

Rationale: Achieving Permanence is an overarching theme throughout this report. MCFD staff currently pay considerable attention to permanency planning for children under the age of 12. However, participants in the project consultations and working sessions, including youth, suggested that older youth fall off the permanency radar. As a consequence, approximately 500 young people per year leave government care at the age of 19 – most of them without any planned permanent family connections or options.²¹

As was noted in the Phase One findings report, the life experiences and outcomes for young people who have been raised in care are significantly poorer than for other youth. This is due to a wide array of factors, some of which the care system has no control over (e.g. the circumstances that result in the child or youth coming into care). However, participants in the working sessions affirmed that, once in care, all children and youth, regardless of age, should benefit from a permanency mindset within the care system so that opportunities for legal, physical, relational and cultural permanency are enhanced. Participants, supported by research evidence, urged that greater attention be paid to permanency planning with older youth, and that the care system “never give up on the possibility of a permanent family or lifelong connections” for older youth.

Avery (2010) illustrates the possibility of sustained attention to permanence in his description of a Social Capital Building model for youth transitioning from care. The

²¹ In addition, about 400 Youth Agreements ended in 2011/12 at or within three months of the youth's 19th birthday.

Permanent Parents for Teens project sought to find permanent adoptive parents or committed permanent parents who 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. Fifty percent of the 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.

Frietag (2009) describes Los Angeles County's achievement of improved outcomes for children including the contribution made by the Permanency Partners Program to reducing lengths of stay in foster care and consequent cost savings.

In addition to planning for permanence and lifelong connections, the residential care system has a responsibility to prepare young people for transitions into adulthood just as any responsible parent would do. Many young people that participated in the consultation and planning sessions spoke about the lack of preparation and opportunity to learn basic life skills. Lack of care planning and goal setting for adulthood, repeated placement disruptions that interrupted learning opportunities, dealing with other more pressing and sometimes untreated conditions (such as FASD, mental health or substance use concerns) that interfered with their capacity to learn, and lack of opportunity for the young person to participate in planning for their future, were all factors that interfered with transitional planning and action. As one youth said, "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."

The supporting actions below are repeated from earlier sections, and are included here to reinforce that the permanency mindset and thoughtful planning for transitions to adulthood should extend across all ages.

Supporting Actions:

1. Review the permanency plans for all youth under Continuing Custody Orders, longer term Temporary Custody Orders and Special Needs Agreements, and those in care for extended periods under the *Family Relations Act* S. 29(3) and the *Adoption Act* to identify what additional steps could be taken to place the child or youth in a permanent family arrangement using processes such as family finding, Roots, traditional Family Circles, intensive file reviews, permanency roundtables, Youth Transition Conferences and targeted youth adoption initiatives.

Note: This action is also included in **Strategic Direction #1 - Achieving Permanency** and is noted again here to emphasize the importance of youth

involvement and consideration of specific processes that may support youth to achieve permanency such as Youth Transition Conferences, involvement of neighbours, teachers, coaches and targeted youth adoption initiatives.

2. Review and revise all applicable program area policies and standards that promote ongoing permanency planning with youth, including provision for a dual track planning approach, i.e. continuing to seek permanency and concurrently planning/preparing for adulthood inclusive of normative skill development experience in the event that the young person will not have family resources to draw upon.

Note: This action is also included in **Strategic Direction #1 -Achieving Permanency** and is noted again here to emphasize a broad dual track planning approach that is highly inclusive of youth.

Recommendation 2: Planning and Preparation for Youth Transitions

MCFD should enhance the range of living options and supports for youth approaching the age of majority.

Rationale: Amongst the general youth population there are young people who are at varying stages of readiness for independence. Some are adept at acquiring core life skills, have been assisted by parents and others to do so, and are ready to live independently by 17-18 years of age. Others remain more dependent into their early and mid 20s for a variety of reasons. This is a typical developmental process for all young people. Increasingly within our society youth remain connected to, if not living within, their parental or extended family homes for much longer. Given that the youth population in general is so diverse, and that societal trends are resulting in youth remaining more connected and dependent to a later age, we should expect to see a similar range within the youth in care population. However, there are limited options available to youth and their care team members (guardianship worker, foster caregiver, resource worker, service providers, trusted adults, etc) to facilitate the development of independent living skills and achieve a safe and developmentally appropriate transition to adulthood. This is addressed in the first supporting action below, with particular emphasis on engaging the youth in their own care planning.

Many of the youth participating in the consultations suggested that more diverse housing options should be developed so that a better 'fit' can be achieved between the developmental needs of the youth and the characteristics of the residential placement. In particular, residential and housing options that help prepare youth for more successful transitions to adulthood are needed. Examples of both informal arrangements made between a youth and their foster caregiver and other funded transitional housing programs were identified by the youth participants in a number of communities. Many of these programs are available to young people beyond the

age of majority, allowing for extension of support into the early 20s. For some this makes a huge difference. As one young man said, “many of us just aren’t ready to deal with our issues until 18 or 19 and then ‘boom’ we are out [of care] and have no support.” In his case, he became connected to a transitional housing program that assisted him to receive income assistance and medical care, live in a more supportive community and learn necessary skills. He was developmentally ready to be more engaged, and by the age of 21 he was prepared to move on and more successfully transition to adulthood. The second supporting action below calls for the enhancement of these options, in collaboration with the Ministry of Social Development.

The third supporting action addresses a frequently raised concern by youth and others about the use of Youth Agreements (YA) and Independent Living (IL) arrangements. Many youth shared ideas about when, how and for whom these options should be used. They suggested that many youth are put on YA or IL when they are simply not ready to handle that level of independence, whereas other youth are ready and need this option and yet don’t meet the criteria, or there are insufficient resources. The attachment of community-based support workers to youth on YA and in IL was proposed by working session participants and reflects evidence of what is beneficial for young people who are transitioning into adulthood and greater independence.

Supporting Actions:

1. Collaborate with youth to ensure the development of transition service plans are based on their individual capacities:
 - Young people who are able to be on their own require skill development and transitional supports, including connection to family and Aboriginal or other cultural communities and possible assistance in youth friendly rentals (e.g. John Howard Society, North Island)
 - Young people who are mostly able to be on their own but need supportive adults require supportive living arrangement and adult touchstones (e.g. foster care family transitions to a room and board situation)
 - Young people who are not able to live on their own require supported transition to adult supported living situations
2. Review existing youth transitional housing models (e.g. Nanaimo, Campbell River, Nelson, Prince Rupert) and take steps in collaboration with Ministry of Social Development and BC Housing to expand the availability of transitional housing.
3. Ensure that youth who are on Youth Agreements and in Independent Living are provided with guidance and support from agency-based youth workers, Aboriginal communities and other appropriate adults to a degree that is sufficient to address their assessed needs.

Recommendation 3: Post-Majority Services and Supports

MCFD should make post-majority services and supports, including Agreements with Young Adults (AYA), available to a broader group of youth previously under CCOs.

Rationale: As suggested above, the developmental capacity and needs of young people who have been (or are) in care needs to be taken into account in the planning for services and supports. The Ministry's Agreements with Young Adults (AYA) initiative currently allows for MCFD staff to enter into an agreement with a young person to provide financial assistance and supports that will help them finish high school, learn a trade or develop vocational skills, complete a rehabilitative program or attend college or university. The AYA is a valuable tool that has made a significant difference in the lives of many young people who have spent years in care.

However, the practice evidence points to a few concerns. The first is the eligibility criteria. Currently, agreements may be available to youth if, on their 19th birthday, they were in the continuing custody of a director under the *CFCSA*, under the guardianship of a director of adoption, under the guardianship of a director under section 29(3) of the *Family Relations Act*, or were on a youth agreement with MCFD or a DAA. The requirement that the young person be in care at the age of 19 in order to be eligible for AYA unintentionally contradicts or compromises the emerging focus on permanency. If adoption, transfer of custody, or an alternative permanent family arrangement is attained for a young person in continuing custody prior to the age of 19 then they are no longer eligible for the AYA or other post majority supports which means that a difficult choice needs to be made between permanency and access to much needed post majority supports. The first supporting action below calls for amendments that will eliminate the contradiction and tension between these two desirable outcomes.

The second concern with existing AYAs is that participants are only eligible for support for a total of 24 months between the ages of 19 and 24. In practice, this has created hardship for young people who need more stable and ongoing support for a longer period of time in order to achieve their learning and development goals and become more self reliant and capable. For example, due to school disruptions growing up in care, a young person may need to go back to finish high school, or they may need to participate in a rehabilitation program. These first steps may take a number of months. When they are ready to participate in post-secondary training, their access to AYA support will be time limited and may not be sufficient to help them achieve a diploma or certificate and will definitely not be sufficient to help them achieve a degree. The second supporting action below proposes to extend access to AYA throughout the 19-24 year period. There are considerable cost implications associated with extending the AYA program from 24 to 60 months, however it is anticipated that the long-term outcomes for these young people will be significantly

improved. This reasonable extension of support to young adults also reflects what many families provide to their own children.

The third supporting action below addresses another unintended barrier to achieving permanency for youth with special needs who will need adult services provided by CLBC. There is an operating agreement between CLBC and MCFD/DAA designed to ensure early planning for youth in care under a CCO who could be eligible for CLBC services upon becoming an adult at the age of 19. The agreement outlines the required process and the staff roles to ensure that early and appropriate planning occurs in a timely way for the youth in care. Given the challenges that CLBC faces in providing services to a broad spectrum of young people moving into the adult care system, access to services and supports for CCO youth is extremely important. However, as achieving or sustaining permanency is also important, MCFD staff and significant adults in a special need youth's life must be able to facilitate both permanency and access to adult care. The proposed action aims to facilitate and support both permanency and access.²²

Supporting Actions:

1. Ensure that if a youth was under a CCO and achieved permanency through adoption or transfer of custody after the age of 16 years, they still can access AYA and other post majority services.
2. Enable AYA supports to be continuously available from age 19 until the young person's 24th birthday.
3. In partnership with CLBC, review the existing operating agreement and current practice issues to ensure that it provides for access to CLBC adult services for children and youth who were under CCOs and have achieved permanency through adoption or transfer of custody prior to their 19th birthday, to reduce barriers for achieving permanence.²³

²² This passage has been amended subsequent to the initial release of the final report to better reflect the nature of the current agreement between CLBC and MCFD and the commitment to review the agreement and practices to reduce barriers to permanency for special needs youth in care.

²³ This passage has been amended subsequent to the initial release of the final report to better reflect the nature of the current agreement between CLBC and MCFD and the commitment to review the agreement and practices to reduce barriers to permanency for special needs youth in care.

Strategic Direction #6 - Working Together Effectively

Enhance the working relationships within the residential care system as an essential foundation for implementing the recommendations and supporting actions across all of the Strategic Directions.

Intention: Collaborative, respectful, solution-focused and culturally informed, relationships within the residential care system are keys to improving the experiences and outcomes for children and youth. More time needs to be spent on building and sustaining relationships as well as establishing inclusive teams and partnerships for assessment, planning and action.

In Phase One of the project, the most frequently raised concerns, ideas, and suggestions pertained to how individuals and systems worked together in the interests of children and youth in residential care. 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 sources of information in Phase One 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 substance use treatment) 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.

During Phase Two, participants in the working sessions, the advisory group and project team all considered how best to create the context, processes and structures that enable people to work together more effectively. Three areas were selected as having the greatest promise: establishing collaborative and inclusive planning processes and ensuring that practitioners had the necessary skills and supports to successfully facilitate and guide collaborative work; clarifying roles and responsibilities amongst the participants in the planning and service delivery process, including cross-ministerial and sectoral roles; and improving communications and information sharing so that people involved in planning and caring for children and youth in residential care had the necessary information. Each of these are outlined in the recommendations and supporting actions below.

Recommendation 1: Collaborative Processes

MCFD should ensure collaborative assessment and culturally appropriate planning throughout the duration of a child/youth's time in residential care, with a clear focus on longer term outcomes as well as short term needs and interests.

Rationale: Given the complex backgrounds and needs of many of the children and youth served by the residential care system, it is clear that people with diverse expertise, experience, knowledge of the children and their situations, and with the capacity to support the child or youth in the short or long term need to be brought into the assessment and planning process. Both practice and research evidence suggests that collaborative approaches to assessment and planning are generally more effective at setting the stage for meeting the child's needs and achieving positive outcomes.

MCFD has introduced a number of collaborative planning processes over the past decade, such as Family Group Conferencing and the Family Development Response, and has encouraged greater inclusion of youth, family members, community representatives and other significant people in the child or youth's life in these planning processes. Many of the DAA's and service providers have also developed community based, collaborative service planning processes, such as Family Circles, that complement MCFD's processes.

Despite this progress, participants in consultations and working sessions suggested that much more needs to be done to embed a collaborative mindset into the way in which assessment and planning is done. In particular, more consistent effort needs to be made to include and welcome the child, youth, family members and significant adults, service providers, and caregivers into the planning process, to demonstrate respect for their perspectives and suggestions and to establish plans with the greatest

level of engagement as possible. When family members and significant adults are engaged, the research demonstrates that the likelihood of family reunification or of kinship care is enhanced. In the event that a child's placement is at risk of disruption, the more inclusive and collaborative approach may lead to creative solutions to stabilize the child, or at the very least, ensure that the placement decisions and transition planning is well informed and accountable. The first supporting action below addresses the need to ensure that there are clear expectations set out in policy and standards for inclusion and collaboration.

Collaborative work is not easy. It is often more time consuming (at least in the short term), challenging (given diverse perspectives and likely tensions), and facilitative skills are needed to ensure that the process is respectful, child and youth centred, and productive. The second supporting action below addresses the importance of helping practitioners learn how to include, welcome and engage people in collaborative planning and decision making processes.

Supporting Actions:

1. Review and revise policies and standards to reinforce the necessity of engaging the child, youth, parents, family members, caregivers, service providers, Aboriginal communities and other significant people who know and care about the child or youth in decisions to place, move, reunify or proceed with an alternate permanency arrangement.
2. Prepare and support practitioners to more successfully engage children, youth, family members, Aboriginal elders and significant others in planning and decision-making processes through training in collaborative practice and supervision.

Recommendation 2: Role Clarification and Cross-Ministerial Collaboration

MCFD should clarify the roles and responsibilities of key parties in planning and decision making for children and youth in residential care (e.g. youth, family members, foster caregivers, MCFD staff, community service providers and partners) and demonstrate value and respect for what each person brings to the process.

Rationale: Participants in the working sessions strongly recommended that work be done to clarify the roles and responsibilities of diverse parties with respect to planning for children and youth in residential care including MCFD staff, caregivers, community service providers, as well as staff in other ministries and health authorities and DAAs. The lack of understanding about mandates, roles, responsibilities, as well as what each party is able to contribute to the process of generating and implementing plans can lead to misunderstandings, frustration and

mistrust. It was noted that where partnership-based local and regional tables exist, the parties have often been able to achieve a greater level of trust and collaboration. The supporting actions below address these concerns.

Supporting Actions:

1. Set out roles and responsibilities in planning and action: who is involved, who is responsible for what and when, and what are the limitations of their role. Clarification is particularly important to improve collaboration between MCFD, caregivers, service providers, Delegated Aboriginal Agencies, CLBC, and Health Authorities.
2. Establish community partnership tables that include foster caregivers, service providers and other community partners to promote relationship-building, role clarification and communication.

Recommendation 3: Communications and Information Sharing

MCFD should improve communications and information sharing processes to ensure that people who are actively engaged in providing care and treatment are knowledgeable about the child/youth's needs, goals and plans, key relationships and desired outcomes.

Rationale: Throughout both phases of the project, participants described situations in which they were unable to access key information, in a timely way. Caregivers and community service providers in particular described how this compromised their ability to deliver appropriate care and treatment to the children and youth in their care and/or keep other children and youth safe. While recognizing that confidentiality and privacy of all personal and case information must be respected, it was also felt that there are some unreasonable barriers (policies, procedures, interpretations and attitudes) that get in the way of appropriate and timely information sharing to serve the best interests of the child and youth. The supporting actions below address these concerns.

Supporting Actions:

1. Review current legislation, policies and standards and confirm the current requirements for and restrictions on information sharing across program areas, disciplines, ministries/authorities and sectors.
2. Take whatever steps necessary to remove barriers to information sharing practices.

Strategic Direction #7 - Enhancing Accountability in Residential Care

Build accountability and continuous learning into the process of implementing the recommendations and supporting actions across all of the Strategic Directions for residential services.

Intention: The ministry should develop and implement a comprehensive accountability framework for residential services that aligns planned changes and enhancements to the system of care with specific, measurable outcomes and corresponding indicators. The framework should draw on measures and indicators currently in use by the Ministry (where possible) and those suggested by current research on outcomes for children and youth in residential care. The ongoing monitoring of outcomes and service quality should be directed towards continuous learning and adjustment of actions and strategies based on available evidence from practice and academic research.

The importance of addressing outcomes and accountability as part of planning to improve the system of residential care became increasingly clear as the project moved from identifying the issues and areas for potential change to crafting solutions. During the working sessions held in April of 2011, a theme of accountability emerged as participants began to grapple with the question of how to ensure that the changes being proposed would have a lasting impact. Given that similar efforts to make substantive changes to various aspects of the system of care in BC and in other jurisdictions have often fallen short of expectations, participants felt that it was critical to build in mechanisms that would help to hold all stakeholders accountable to the results of our efforts.

Several sources of information and input informed the development of this section. Participants at the working sessions, and again during meetings with the project's advisory group in the spring of 2011, provided insightful guidance on the core elements of the recommendations in this area. Interviews with key informants, including experts on outcomes measurement in Child Welfare, were conducted. The original literature review did not specifically examine outcomes and accountability as it was not one of the original emergent themes at the time it was completed, so a further search of relevant literature was conducted. The recommendations and supporting actions described below reflect a balanced and thoughtful approach to ensuring that we collectively monitor our change efforts and learn as we go.

Recommendation 1: Accountability Framework

MCFD should develop and implement an accountability framework that includes both client outcome measures and measures of service quality that emphasize the importance of youth, family, caregiver and Aboriginal community input. The framework should support examination of outcomes in relation to child profiles, placement types and costs per child.

Rationale: This first recommendation is planning based. In order to understand the results of change efforts, it is critical that we clearly outline what we mean by success and how we would know that we have achieved it. An accountability framework that outlines measures and indicators for each of the four broad themes (Achieving Permanency, Strengthening Foster Care, Developing a Comprehensive Array of Residential Services, and Working Together) will support this effort. It is suggested that such a framework must include both measures that reflect outcomes (what we hope to achieve) and the quality of service delivery (how we go about doing it).

This approach reflects the fact that changes in broad measures such as length of time in care can be achieved in multiple ways, including practice changes and changes to policy or legislation. It is our hope and intention that the changes that are achieved not only represent increases or decreases in broad indicators but also reflect meaningful changes in practice as well as how children, youth and families experience the system of care in BC.

Several of the indicators suggested below reflect existing literature regarding outcomes for children and youth in care, most notably the National Child Welfare Outcomes Indicator Matrix (Trocmé, et al., 2009). This matrix of measures and indicators reflects a multi-year consultation process aimed at developing a set of indicators for use across all Canadian Child Welfare jurisdictions to track child welfare outcomes. Integrating the use of these measures will not only allow for tracking the efforts related to the identified Strategic Directions but will also support comparisons with other jurisdictions in the future.

In terms of measuring performance, the importance of gathering key information on the characteristics of the children and families served was highlighted by key informants as well as in the literature on child welfare outcomes (Wulczyn, 2007). Service expectations should vary depending on the baseline characteristics of various populations of children and families served in the system of care. Identifying and collecting data on these characteristics at the outset will facilitate critical analysis of the data so that either poor outcomes or better than expected outcomes for specific populations are not missed.

An understanding of how specific populations do within the system will greatly enhance our ability to respond and improve services over time. The information on child and family characteristics currently collected as part of the Canadian Incidence

Study of Child Abuse and Neglect may provide a useful starting point for discussions on what should be included in the accountability framework.

Supporting Actions:

1. The accountability framework will identify:

- Desired outcomes linked to planned Strategic Directions in the areas of achieving permanency, strengthening foster care, array of residential care services, and working together;
- Specific systems level indicators linked to outcomes such as:
 - Of children in out of home placement, increased proportion of children placed with relatives, other significant adults
 - Decreased average length of stay for children in out of home placement
 - Increased proportion of children achieving permanence through reunification, adoption and guardianship
 - Decreased average number of placement changes – National Outcomes Matrix Measure (NOM)
 - Decreased proportion of placement changes that are unplanned
 - Increased the rate of siblings placed together
 - Increased proportion of children placed in out of home care who are in school and in the grade appropriate for their age (NOM Measure)
 - Increased high school completion rates for youth in out of home care (NOM Measure)
- Measures of service quality that are directed towards ensuring that services are responsive to emerging issues and concerns, timely, and consistently delivered. Opportunities for children and youth in residential care, their family members and caregivers to give feedback should be emphasized. Suggested measures include:
 - Increased proportion of families that indicate being included in decisions regarding their children
 - Increased proportion of children and youth that indicate being included in decisions regarding their care
 - Increased proportion of Foster Caregivers that indicate being included in decisions regarding care and placement of children
 - Increased proportion of Aboriginal communities that indicate being included

in decisions regarding their children

- Adherence to minimum standards for quality of care (e.g. frequency of contact with MCFD worker while in residential care, number of children in the home, response time for complaints, protocol investigations)
- A common set of child and family population characteristics (including severity factors and barriers) for tracking at baseline and over time to ensure that future data analysis is capable of identifying which characteristics are associated with an increased or decreased chance of success. Suggested characteristics for tracking could include:
 - Child age
 - Child gender
 - Cultural background
 - Known/diagnosed behavioral issues (NOM Measure)
 - Current/past criminal involvement
 - Family type (e.g. single parent, two parent, blended family, grand parenting, adoptive family)
 - Frequency of family moves over the past year (NOM Measure)

Recommendation 2: Alignment with Existing Accountability Structures and Contracting Expectations

MCFD should align and embed an accountability framework for the delivery of residential services within the Ministry's ongoing Integrated Quality Assurance efforts and contracted service provider requirements.

Rationale: The second recommendation acknowledges the fact that there are a number of existing accountability systems and structures in place both within the Ministry and among contracted service providers. Aligning a proposed accountability framework with the Ministry's existing accountability structures is necessary to being able to sustain measurement over time. The implementation of an accountability framework should not result in any duplication of efforts already underway, but should rather complement or expand upon existing efforts. The potential administrative impact on the Ministry should be considered in how the accountability framework is implemented, underlining the importance of streamlining efforts with existing systems and structures. The measures and indicators established in an accountability framework should also be translated into program or service level measures so that contracting for new and existing services can include consistent performance measurement expectations. Program or service level measurement

requirements should be consistent with accreditation expectations to avoid contracted service providers having to duplicate their efforts. Measurement at the program or service level should track individual client change over time (i.e. a pre, post and follow-up design) and utilize standardized tools wherever possible. As part of follow-up measurement, mechanisms for tracking the outcomes of youth that exit residential care should also be considered. Having reliable data on post-exit outcomes would provide valuable insight into the long term impact of our efforts to enhance the system of care.

In addition to aligning with existing Ministry accountability structures and contract management practices, implementation of an accountability framework for residential services should also seek to leverage current examples of success in measuring outcomes highlighted by community service providers during focus groups and working sessions. Several communities were eager to offer their stories of coming together to measure outcomes in the interests of improving services to children, youth and families. These efforts reflect a strong underlying desire on the part of both local Ministry staff and contracted service providers to improve services.

Accreditation standards related to performance measurement for contracted service providers often provide a backdrop to these efforts. Rather than dictate measurement requirements at a service delivery level with a top down only approach, there is an opportunity to leverage current efforts and common accreditation requirements to support community level outcomes measurement and improvement efforts. Local advisory and collaborative practice structures are already supported by the Federation of Community Social Services of BC and can be utilized where appropriate to support community-based efforts to identify and measure outcomes consistent with the accountability framework.

Supporting Actions:

1. Engage MCFD's Provincial Office Team responsible for quality assurance in ensuring that the residential services accountability framework is integrated within the Ministry's quality assurance framework.
2. Work with Ministry procurement staff, regional contract management staff and contracted service providers to ensure that the outcomes and measures of service quality in the accountability framework are translated into program or service level measures/indicators and imbedded within contracts for the delivery of existing and new residential services. Measures should be standardized across both Ministry and contracted services to the greatest extent possible. Measures should be consistent with current accreditation requirements, reflecting change over time for individual children and youth in care (i.e. client level pre, post and follow up measures utilizing standardized measures where possible).
3. Identify examples of success in developing and implementing outcomes

monitoring at the community level, build on that success and expand it to other communities.

Recommendation 3: Monitoring, Tracking & Continuous Learning

MCFD should develop and implement systems and structures to support monitoring of outcomes and service quality, continuous learning, and adjustment of actions and strategies based on learning as well as the use of relevant academic research findings.

Rationale: Once a framework is identified and streamlined with local, regional and provincial structures in a way that integrates with and leverages existing efforts, the next critical step is to ensure that monitoring and tracking occurs and results in continuous learning. This effort will first require getting baseline measurement of all the identified indicators and child/family characteristics outlined in the framework. Regular review structures and collaborative forums are suggested as a means to imbed monitoring and continuous learning at the local, regional and provincial level. These mechanisms should be aimed at utilizing the data that is generated to make adjustments in strategies and actions on an ongoing basis as part of cyclical quality improvement process.

Supporting Actions:

1. Develop service quality evaluation processes for monitoring practices that are guided by the Caregiver Support Service Standards. Review processes should also be developed for the Standards for Foster Homes and Standards for Staffed Children's Residential Services following their revision.
2. Establish baseline measurement for all outcome and service quality indicators and child/family characteristics identified in the accountability framework.
3. Implement regular (annual) planning and review structures within contract management processes at the local, regional and provincial levels.
4. Utilize forums or other collaborative mechanisms at the regional and provincial level for the review of performance in achieving outcomes (e.g. How are we doing so far? What's working?). Such mechanisms would allow for input from multiple stakeholders, consider relevant academic research related to the delivery of residential services, and result in specific recommendations for adjusting actions or strategies where appropriate.
5. Utilize the Federation of Community Social Services of BC's existing regional structures and relationships with regional Ministry staff to support the implementation and monitoring of the accountability framework at the community level.

Recommendation 4: Standardized Reporting Expectations

MCFD should standardize recording and reporting requirements for contracted services.

Rationale: The need for common recording and reporting requirements for contracted services has long been identified by the various stakeholders involved in the provision of residential services and was again highlighted by participants in the various focus groups and working sessions during this project. Having a common accountability framework should assist in developing these expectations. Resurrecting the Recording and Reporting Review Project findings and recommendations was specifically suggested by working session participants as a starting place for this effort. Having common reporting expectations complements the service level measures and standardization identified above.

Supporting Actions:

1. In partnership with the Federation of Community Social Services, review previous recommendations for streamlining reporting requirements and establish an agreement on what standardized contract reporting information is needed and how it will be used (based on measures outlined in an accountability framework).

Part Three – Moving Forward

The project's Strategic Directions, recommendations and supporting actions are based on extensive stakeholder consultations, as well as reviews of research, reports from other jurisdictions and previous BC initiatives. Together, they provide a blueprint for a stronger and more effective residential care system for children and youth. It is now up to MCFD and the Federation to develop plans for acting on what was learned in Phase One and generated in Phase Two of the project.

Recommendation 1: MCFD Implementation Planning

MCFD should develop detailed plans in response to the Residential Review recommendations and supporting actions, including identifying what additional resources may be required to facilitate implementation.

Rationale: In order to support implementation of the project's recommendations and supporting actions as part of MCFD's Operational and Strategic Directional Plan, structures, processes, and work plans need to be developed.

Supporting Actions:

1. Establish a Residential Services Working Group within MCFD, with advice from the Federation of Community Social Services, to develop an implementation plan consistent with the Operational and Strategic Directional Plan key actions:
 - Design and develop a system of care in 2012/13
 - Begin initial incremental implementation in early 2013
 - Continue incremental implementation and initiate action, research/evaluation in 2013/14
 - Status assessment and development of next steps in 2014/15
2. MCFD will establish processes for regularly and broadly communicating implementation progress and challenges.

Recommendation 2: Implementation Planning in the Community Social Services Sector

The Federation Board of Directors should establish a Residential Care Advisory Group to review the recommendations and supporting actions within this report, identify those that are within the scope of the community social services sector to act upon, provide advice about how the Federation may best respond, and determine what resources will be required within the sector to achieve implementation.

Rationale: While the majority of recommendations and supporting actions require action by MCFD, the Federation Board of Directors believes that the community social services sector has a responsibility to act on selected recommendations and actions wherever feasible, in order to contribute to improved experiences and outcomes for children and youth in residential care. The sector's contributions may range from simply providing advice to MCFD, through to providing leadership on selected initiatives. The Federation does not have authority to require members or other agencies and service providers within the community social services sector to accept and act upon the recommendations and actions but will endeavour to create the conditions and provide support where possible in order to move forward.

Supporting Actions:

1. The Federation will develop a plan for implementing selected recommendations and actions.
2. The Federation will establish processes for regularly and broadly communicating implementation progress and challenges.

Appendix A

Residential Review Project Team Members

Name	Organization	Role
Alan Markwart	MCFD, Senior Executive Director, Provincial Office	Co-Lead
Jennifer Charlesworth	The Federation of Community Social Services of BC (FCSSBC), Executive Director	Co-Lead
Phil Schwartz	MCFD, Provincial Office	Project Coordinator
Warren Helfrich	FCSSBC	Project Coordinator
Ken Moore	MCFD, Director of Maples (seconded to Project Team)	Project Team
Annette Harding	MCFD, Provincial Office	Project Team
Jackie Behrens	MCFD, Provincial Office	Project Team
Pamela Liversidge	MCFD, Provincial Office	Project Team

Residential Review Project Advisory Group Members

Alan Markwart	MCFD, Senior Executive Director, Provincial Office	Co-Chair
Jennifer Charlesworth	The Federation of Community Social Services of BC (FCSSBC), Executive Director	Co-Chair
Melanie Filiatrault & Heather Bayes	BC Federation of Foster Parents Associations	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 Family Services	Federation Member
Shane Picken	ARC Programs	Federation Member
Jocelyn Helland & Lorena Pilgrim	Federation of BC Youth in Care Networks	Federation Member
John Belfie	North Okanagan Youth and Family Services Society	Federation Member
Dennis Padmore	MCFD, Coast-Fraser Region	MCFD Member
Robert Watts	MCFD, North Region	MCFD Member
Mark Armitage	MCFD, Vancouver Island Region	MCFD Member
Sandi Wiens and Mona Herring	MCFD, Child, Youth and Family Policy, Provincial Office	MCFD Member
Rob Parenteau	Services to Aboriginal Children and Families, Provincial Office	MCFD Member

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Additional background material is available on Federation website.

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