Residential Review and Redesign

Fact Sheet - Delivering an Array of Accessible Residential Services

Introduction

Participants in the 43 community and stakeholder consultation sessions held throughout BC, consistently reinforced the importance of having a diverse and comprehensive array of residential placement and treatment options and support services in place. This would enable matching children and youth with appropriate resources, and sustain out-of-home placements, while working to achieve permanency. 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.

The residential services system can be broadly categorized into four types: kinship care, foster care, contracted/staffed residential care and tertiary care. Participants moved away from the more traditional notion of a continuum' of residential care whereby a child or youth is moved along from family based care in a kin or foster family through to increasingly more specialized placements if they are not coping well. Instead, participants suggested we need an array of services. Comprehensive assessment at the front end would enable workers, family members and youth to identify what type of residential care and/or treatment would be most beneficial at that time as a bridge' to better outcomes and achieving permanency. For example, for a child that presents significant behavioral challenges such as a tendency to violence, extreme risk-taking and for self-harm, it may be most effective to place the child in a more specialized treatment-focused resource (e.g. treatment foster care or staffed resource) at the outset to assess, stabilize and treat them so that their birth or extended family can resume caregiving with support.

Community and Stakeholder Consultions - What we Heard...

Participants suggested that there are a number of areas that should be considered and addressed as the plan for residential services is developed:

- **Recognize that "access to care" has many dimensions:** Access to an array of residential care options and supports was discussed 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 in order to sustain residential placements such as foster care, e.g., mental health counseling or substance withdrawal management (detox).
- **Build an array that accounts for the complexity of child and youth needs in these times:** Many participants commented that the needs of children who are requiring a residential care placement or residential therapeutic intervention/treatment now are "more complex and challenging" than in the past. This "complexity" was attributed to shifts in MCFD policies and practices such that more efforts are made to prevent a young person from coming into care or a specialized placement with the result that when children and youth are brought into the residential care system they have often experienced more disruptive life events and emotional and physical trauma.

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Many of the children and youth who are receiving residential care have multiple needs, e.g. mental health concerns and problematic substance use, attachment disruption, special needs such as fetal alcohol syndrome etc.

- **Develop coordinated responses to address complexity:** Given the complexity of needs, a coordinated or integrated and comprehensive response across various services and systems is often needed to meet the developmental needs of the children and youth who come to our attention, eg inclusive of health services, educational supports, etc.

- **Match child and youth needs to resources more effectively:** Participants also raised questions and concerns about whether the residential placements that are currently in place are being used most appropriately. Given that the supply of resources is limited, the ability to match a child or youth's needs to a placement's capacity to respond to those needs is often not easy or possible.

- **Enhance intermediate level, specialized placements and supports:** Complexity also raises questions about whether we have in place the array of residential resources needed for the children and youth who require residential care. Many consultation group participants suggested that increased availability of specialized placements was needed to ensure timely assessment, treatment or respite. In particular, many participants spoke about the challenges faced in accessing specialized residential and non-residential services for children and youth with complex or concurrent concerns, especially mental health concerns, problematic substance use (addictions), FASD, autism and other developmental challenges and special needs. These children and youth often cannot be accommodated in family care settings and, given the complexity of needs and challenges, may require specialized, short term tertiary care responses such as a dedicated Provincial Assessment Centre for youth.

- **Enhance access to residential care without having to come through the CFCS Act:** Residential services for children with severe mental health problems are almost entirely tertiary care hospital-based services, and if alternate family care or staffed residential care services are required, the child or youth must be brought into care under the CFCS Act, if eligible. This seems to work against the principle of achieving permanency particularly for those children and youth whose families want to stay engaged, but need some help.

- **Enhance the non-residential supports to sustain placements or out of care arrangements:** In addition to having access to a range of residential placements, participants identified a number of other services and supports that children and youth in residential care may require, ranging from general to specialized supports such as:

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

Many of these may be recommended in assessments or plans of care yet access is limited due to geography and lack of services in the area, waitlists, restrictive eligibility criteria, etc. Although these services are not within the scope of the residential services review, the need for them to stabilize and support residential care is important to note.

Defining the Array in BC as....

There was extensive discussion in all consultation sessions about what residential options are currently available and what options should be included within an array of residential services. This range included:

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

Recognizing that youth custody services are mandated by federal criminal law, the principal concerns raised in relation to services to youth justice clients were the needs for improved access to substance use treatment resources and supportive housing for older adolescents who are transitioning to adulthood and unable to return to their family home. Regardless of the type of residential placement arranged, many participants reinforced that the orientation or aim of the system needs to focus on "ensuring permanence" for the child/youth, be that with birth parent, extended family members, an adoptive family, or some other arrangement that ensures a lifelong connection for the young person with caring and competent adults.

Contracted Residential Resources, Tertiary and Specialized Treatment - Current BC Statistics

On any given day in British Columbia, over 10,000 children/youth access some form of Residential Service. **Figure 1** depicts the percentage of the care type as of December 2010. **Figure 2** depicts the percentage of Residential Services placements by program responsibility.

Contracted Resources

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" (e.g., 4 to 6 beds) with 24/7 rotational staff.
- Smaller, more individualized staffed placements, e.g., 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, e.g., one-to-one family support and one-to-one youth support workers, emergency call-out support and sometimes complementary specialized day treatment/intervention services. These types of family based care programs have elements of (but are not the same as) Multi-Dimensional Treatment Foster Care (MTFC) and are more common in the community youth justice and addictions treatment sectors.
- Hybrid models of family-based caregivers bringing on substantial additional relief and support staffing to assist with the care and management of high needs children.

Generally speaking, contracted/staffed residential resources are intervention/treatment focused and as such have fixed program lengths, i.e., they are interventions not placements per se.

There has been a marked reduction in reliance on the traditional staffed group home model of service, with increasing reliance on contracted/ staffed family care models as well as on specialized level 3 foster care placements. This systemic trend, in combination with a relatively low and reducing reliance on tertiary care services noted, raises questions about whether staff-supported/contracted family-based models of service and specialized level 3 foster homes have sufficient supports in place to meet the needs of challenging children and youth who might have been in tertiary or group home care in the past.

Figure 1 - Types of Residential Services

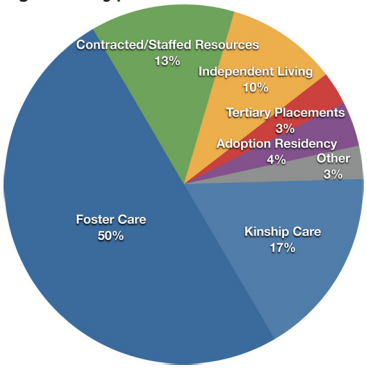
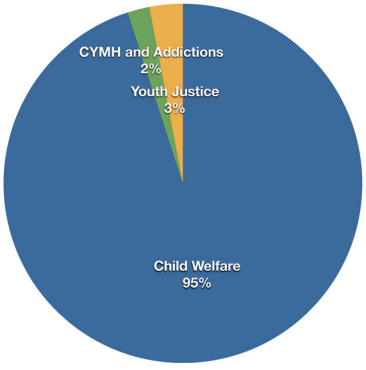


Figure 2 - Residential Services by Program Responsibility



Tertiary and Specialized Residential Treatment Services

For the purposes of this project, **Tertiary and Specialized Residential Treatment Facilities (TSRT)** are:

- owned and operated directly by MCFD, Health Authorities, or Crown Agencies*
- available to all children and youth, not just children and youth in-care of MCFD
- delivering voluntary or involuntary services through a variety of legislation.**
-

They include:

- designated health facilities and designated mental health facilities
- custody or secure care of youth with complex developmental disabilities and behaviours
- facilities for youth with substance addictions
- custody of youth in conflict with the law.

* *Group homes or other types of congregate care are included in the Residential Service Review Project under the heading of Contracted/Staffed Residential Care.*

** *Involuntary care or treatment provided under the Youth Criminal Justice Act and the BC Mental Health Act*

These tertiary residential facilities provide intensive and specialized services - custody, medical or psychiatric assessment and stabilization, medical treatment, or psychiatric treatment, singly or in various combinations. There are eight unique facilities in BC providing tertiary services. Most provide services to a specific geographic region; however, a few provide services to the entire province. Six of eight facilities are owned and operated by a Health Authority, one is operated by Community Living BC, and one is operated by MCFD.

1. Prince George Hospital (H)	5. BC's Children's Hospital (H)
2. Kelowna General Hospital (H)	6. Sunnyhill Hospital (H)
3. Queen Alexandre Centre for Children Health Hospital (H)	7. Provincial Assessment Centre (CLBC)
4. Surrey Memorial Hospital (H)	8. The Maples (MCFD)

The largest component of tertiary care is **youth custody** yet there is only an average of 130 youth in custody in BC - one-third of the 400 in 1996/97. BC has the lowest per capita rate of incarceration of young offenders in the country. There are three youth custody centres in the province:

1. Prince George Youth Custody
2. Burnaby Youth Custody
3. Victoria Youth Custody

Mental Health - These 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.

Substance Use - The Ministry of Health Services, through the 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 inpatient psychiatric units and tertiary services; MCFD shares responsibility with the Health Authorities for components of the community-based child and youth mental health services particularly for youth with concurrent disorders.

Ministry of Health Services - Facility Types

	IHA	FHA	VCHA	VIHA	NHA	BC Total
Substance Use - Youth Residential Treatment	0	15	40	0	7	62
Substance Use - Youth Support Recovery	0	1	4	7	0	12
Substance Use - Youth Detox (withdrawal management) - Community Based	0	6	10	7	1	24
Substance Use - Youth Detox (withdrawal management) - Family Care Homes	5	0	3	3	0	11
Substance Use - Supported Housing - Youth	0	0	0	4	0	4
Youth Substance Use Beds Total	5	22	57	21	8	113

MCFD is undertaking a review of Tertiary Care Services as a complementary piece to the fuller Residential Services Review. Key Informants said :

Information from Key Informants about Tertiary Care Service Gaps

- Frequent changes in MCFD staff and/or numerous staff involved in each case slows decision-making and action.
- Youth with complex combinations of mental health, developmental disabilities or neuro-developmental disorders as well as challenging behaviours arriving through Emergency due to a crisis in the home/ community placement. In general, these youth require long-term care rather than treatment. Typically these youth stabilize fairly quickly in the hospital but discharge can be delayed while a placement is prepared.
- Youth with mental health conditions who are returned to the hospital frequently for stabilization when less intensive services provided earlier would forestall the need for hospitalization and reduce trauma for the patient and family/caregivers.
- Youth with aggressive and antisocial traits such as Oppositional Defiant Disorder or Conduct Disorder who do not generally benefit from hospital-based treatment or other forms of congregate care.
- Youth with a primary diagnosis of Substance Use Disorder.
- Youth transitioning to adult Mental Health or Community Living BC services.

Youth Transitions

"We have to reduce the number of youth who are 'aging out' as CCO's [Continuing Custody Orders] with no permanent connections and family involvement. By the time a youth reaches age of majority they should have positive long term connections."

Throughout the community consultations a significant number of participants discussed transitions for older youth in care. Youth who were in care or on a Youth Agreement often lack the knowledge, experience, education, and life skills necessary to carry them forward into being healthy, self-sufficient and contributing members to society. Many of these youth leave care without proper transitional planning. This can lead to homelessness, incomplete education, unemployment, unresolved issues and personal challenges.

Youth in particular had a great deal to say about how they were prepared (or not) for independence and adulthood, with the general consensus being

that a great deal more should be done, starting at an earlier age (e.g., 13-14 years of age). This implies that youth are going to spend their adolescent years in care, which was an assumption that a number of people challenged, especially if there is going to be more of a focus on achieving permanency. As expressed by one participant, when youth in care are approaching the age of majority:

Work with the youth wherever possible - even if we have to push ourselves into their lives - to plan for his or her transition out of care and ensure that the young person has life skills and at least one permanent and healthy connection with a supportive adult."

However, given that many young people are in residential placements during their adolescent years, more intentional preparation for independence was called for. This preparation may include:

- Life skills education ranging from how to cook, clean, and budget, to how to open a bank account, negotiate a rental agreement, arrange utilities, access health care, get along with roommates and develop healthy personal relationships.
- Education and training advice, work skills preparation, and job readiness.
- Assistance or guidance for the youth to set goals, apply for and participate in school or the workforce, look after their personal health and well-being, locate and sustain a safe and affordable place to live, etc.
- Establishing connections with adult systems to facilitate transitions (e.g., mental health, substance use treatment services, community living, housing).
- Arranging for post-majority supports such as educational bursaries like the Youth Education Assistance Fund (YEAF), the FBCYICN Dream Fund and the FCSS Youth in Care bursary, an Agreement with Young Adults (AYA), or facilitating transitions from a Youth Agreement (YAG) or Independent Living Agreement (ILA) to an AYA.
- Ensuring that the youth have some positive adults in their life who are willing to be available for the long-term.
- Supportive housing for older adolescents and youth transitioning to adulthood. As it is very difficult for many young people to find safe and affordable housing, a number of youth suggested that transitional and supported housing would make a significant and positive difference for them. Several interesting examples of successful transitional and supported housing arrangements in some locales have been developed, such as the targeted supported housing for homeless youth, for example, MCFD shares responsibility with the Health Authorities for components of the community based child and youth mental services for youth with concurrent disorders.

About 550 discharges from care a year are due to Youth turning 19.

Transition Services for Youth; MCFD Services & Supports

The Ministry of Children and Family Development currently has a number of programs and services that are intended to support a young person as they make the transition to adulthood. These include financial and support service agreements that are developed with the young person to meet their individual goals. While the financial supports are a necessary component, it is often the relational and personalized supports that make the most difference in successful transitions and it is vital not to underestimate the level and range of support a young person needs even when they appear confident and competent. More recently the focus has shifted from preparation for the 'transition to independence' to a 'transition to adulthood and inter-dependence'

with appropriate and healthy interdependencies in place similar to other young people transitioning from their birth families who still maintain strong connections to family and friendship networks as they make the transition to adulthood. The MCFD programs include:

- Independent Living Agreements - Youth in care as young as 16 up to age 19, may access the "independent living program" that provides financial support for housing and daily living costs and support for completing education, training and life skill development. This program, sometimes known as "supported independent living" is intended to provide youth with the opportunity to prepare for the transition to adulthood and practice their independent living skills with supports in place. This plan is supported by a guardianship worker or youth support worker.
- Youth Agreements—provides one or more services, such as "residential, educational or other support services," and/or "financial assistance" to establish a foundation for youth to implement changes in their lives. Youth Agreements support 16 to 18 year old youth in need of assistance through a comprehensive "Plan for Independence" to live independently while transitioning to adulthood without being in MCFD care. This plan is supported by a Youth Support Worker.
- Agreements with Young Adults - provides up to 24 months of financial assistance and support to youth 19 – 24 years of age who were formerly "in continuing care" or on a "Youth Agreement" while engaged in education, training, or a rehabilitative program.
- Youth Supported Independent Living (CYMH) - available in the Fraser and Vancouver Coastal Regions through a contract with the Vancouver Coastal & Fraser Health Authorities for young people aged 17 up to 19 years who have significant and persistent mental health problems. Services include supported housing, life skill development and individualized supports. Where appropriate the young person can transition to the adult supported independent living services provided through Adult Mental Health Services in the Health Authorities.
- Youth Education Assistance Fund (YEAF) – provides grants for young people aged 19 to 23 years who were in care under a Continuing Custody Order and are attending post-secondary education or accredited training. Grants can be provided for up to four years, with the grant amount varying from year to year. The current grant is $5,500.

Vancouver Island Health Authority MOU with MCFD – Working Together

In 2008, representatives from the Vancouver Island Health Authority, and MCFD signed a service planning memorandum of understanding (MOU). The MOU document is a platform for cooperation and collaboration among the sector partners. The MOU has been instrumental in guiding management of high-risk, complex cases at the regional level. Sub-regional coordinating committees are needed to carry this forward, as well as work towards enhancing existing services and resources by strengthening the capacity of the key partners to increase opportunities for collaborative practice and cross-sectoral service planning and delivery.

A set of common operating principles at both the system and service level were established and included:

System Level	Service Level
Accessibility	Responsiveness
Relevance	Mutual Commitment to Solutions
Comprehensiveness	Informed Practice
Coordinated Planning	Person-Centered Care
Quality Improvement	Accountability
Addressing Systemic Barriers	Practitioner-Supportive–clinical and administrative
Advocacy	

For further information on this initiative contact either Roxanne Still (MCFD) or Michelle Dartnall (VIHA).

Safe Care in BC Update

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

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

Other Jurisdictions - Creating Conditions for Change

Children and Residential Experiences: Creating Conditions for Change (CARE) is a multi-level program model for improving services for children in residential care. This model enables residential care agencies to organize and deliver quality care of children according to research-informed principles based on the best interest of the child. The CARE program model reflects the following six practice principles.

Developmentally focused. All children have the same basic requirements for growth and development. Activities offered to children need to be appropriate to each child's developmental level and designed to provide them with successful experiences on tasks that they perceive as challenging, whether in the realm of intellectual, motor, emotional, or social functioning. Research and theory has shown that activities that are developmentally appropriate help to build children's selfefficacy and improve their overall self-concept.

Family involved. Children need opportunities for constructive contact with family. Contact with family and community is one of the few indicators of successful treatment that has empirical validation. Parents and children, in partnership with residential care, can facilitate a transition to the home and the community. This partnership contributes to increased social and emotional adjustment by improving children's feelingof connection to family and community, their self-concept, and resiliency.

Relationship based. Children need to establish healthy attachments and trusting, personally meaningful relationships with the adults who care for them. These attachments are essential for increased social and emotional competence. Healthy child-adult relationships help children develop social competencies that can be applied to other relationships. A child's ability to form relationships and positive attachments is an essential personal strength and a manifestation of resiliency associated with healthy development and life success.

Trauma informed. A large percentage of children in residential care have a history of violence, abuse, and neglect resulting in debilitating effects on their growth and development. Adults need to respond sensitively and refrain from responding coercively when children exhibit challenging behavior rooted in trauma and pain. Trauma sensitive responses help children regulate their emotions and maintain positive adult-child relationships.

Competence centered. Competence is the combination of skills, knowledge, and attitudes

that each child needs to effectively negotiate developmental tasks and the challenges of everyday life. Residential programs must help children become competent in managing their environment as well as motivate them to cope with challenges and master new skills. Learning problem-solving, critical thinking skills, and developing flexibility and insight are all essential competencies that allow children to achieve personal goals and to increase their motivation for new learning. All interactions and activities in residential care should be purposeful and goal oriented with the aim of building these competencies and life skills.

Ecologically oriented. Children are engaged in dynamic transactions with their environment as they grow and develop. To optimize growth and development, children must live within a milieu that is engaging and supportive. Residential care staff must understand that their relationships with the children in their care are part of a larger social-ecology; their face-to-face interactions with children, the activities they promote, and the physical environment in which they work all have an impact on the developmental trajectories of children. Competent staff using skill sets informed by the CARE principles can only be effective when they are used in an ecology of residential care that will allow their expression.

Implementation of the CARE practice model began in South Carolina in 2006 and since then more than 20 agencies both inside and outside the United States have been trained. Cornell University is leading the ongoing research and evaluation on the implementation of CARE.

Holden, M.J. (2009). Children and residential experiences: Creating the conditions for change. Washington, D.C.: Child Welfare League of America.

Other Jurisdictions — Treatment Foster Care

Treatment Foster Care

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

The research and evaluative findings have demonstrated that children and youth in TFC experience more stability, have a positive perception of their placement, and that these home based interventions are more cost effective than tertiary care.

Given the complex needs of some children and youth in care, many jurisdictions have developed foster care services that are focused on more intensive therapeutic interventions within a family care home environment.

For children and youth who need this level of care and intervention, it is vital to have strong linkages between Treatment Foster Care and the child's ongoing foster family and their birth or extended family.

Treatment foster care services are also suited to providing specific time-limited interventions for children and youth with complex behavioral and mental health needs who remain in the care of their family but reside in the treatment foster home on a respite or planned stay basis while they participate

in assessment, stabilization and treatment interventions.

Treatment Foster Care, like other specialized residential services also have an important position on the bridge to permanency – supporting the stability and continuity of care needs of children and youth, while also addressing the child's unique developmental, behavioral, social, emotional and psychological needs that will help their transition back to their own home, other permanent home or their foster home. The key ingredients to Treatment Foster Care are typically:

1) Tailored to support children and youth in more restrictive non-family settings who have serious emotional or behavioural challenges and are at risk of multiple placements.

2) Clear stated philosophy with strong community links and individually designed treatment and education plans that include stated, measurable goals, a written set of procedures for achieving the goal and a process for regularly assessing the results.

3) Foster caregivers are selected and trained to provide therapeutic care to children and youth who have special needs (emotional disturbance, developmental disabilities, behavioural difficulties or special medical needs).

4) Number of children placed in a home limited to 2.

5) Care is provided within a family setting, in a home owned or under the control of the foster caregivers who are responsible for the implementation of young person's treatment plan.

6) Foster caregivers receive support, consultation and supervision from professionals who carry a small caseload and crisis intervention services available 24/7.

7) Foster caregivers are regarded as professional members of the service and treatment team.

8) Foster caregivers receive payments above those provided for regular foster care and may also receive a special stipend based on each child's needs.

9) The programme is administered by specialist agencies, or if part of a host agency, a unit specifically identified as providing treatment foster care.

Information adapted from the article Withstanding the Test of Time: What We Know about Treatment Foster Care, Robert Twigg (2006) & Information from the Family-based Treatment Association.

Multi-dimensional Treatment Foster Care

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

The Multi-Dimensional Treatment Foster Care England (MTFCE) project for 10-16 year olds, is currently piloting in 19 areas across the UK. Foster carers complete their local authority's —Skills to Foster—training, undergo a process of formal assessment and approval by the University of Oregon. The model, which has been shown to be an effective alternative to residential provision, includes teams providing intensive support to foster carers, children and birth families. Teams include program supervisors and managers, birth-family therapists, foster-care recruiters and supporters, individual therapists, skill trainers and educational staff.

MTFCE has achieved positive results in promoting placement stability.

Mockingbird Society – Emerging Therapeutic Model

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

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

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

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

The HUB home provides tangible support to both the children and adults in the MFM Constellation. Typically the Hub Home is a licensed foster family home, or in some cases a residential treatment centre, depending on the emotional and behavioral needs (acuity level) of participating children and youth.

A Satellite Home is one of the 6 to 10 families (including foster and foster to adopt, kinship, and birth families) in a Constellation providing full-time care to 1-6 children and/or youth. Therapeutic Foster Satellite Homes may be included within the MFM Constellations to provide care to children and youth with high behavioral and development needs. This model provides for planned moves within the MFM Constellation of homes that the child/ youth is familiar with through the care network activities.

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

Goal	MFM Outcome
Safety	1. Child Safety
Permanency	2. Permanency Support
Well-being	3. Placement Stability 4. Sibling Connections 5. Culturally Relevant Care 6. Community Connections
Caregiver Support	7. Caregiver Satisfaction & Retention
Systemic Change	8. Systems of Care Change

For further information see http:// www.mockingbirdsociety.org

Key Findings from the Academic Literature: The Service Array

Targeting Early Reunification with Specialized Programs - There is evidence that specialized and targeted reunification programs that work aggressively from the time of placement have positive outcomes of safe and stable returns home or to another permanent option (Pine, Spath, Werrbach, Jensen, & Kerman, 2009).

Comprehensive Support Services at the Front End of Care - Poor outcomes, high incidence of mental health issues, and an increased likelihood of placement breakdown in the first six months of care suggest the need to ensure early access to comprehensive support services for children and youth entering care, especially with regards to mental health services and services to support stability and achievement in the school environment (James, et. al., 2008; Osborn, Delfabbro, & Barber, 2008). Research suggests that early access to mental health services will reduce the likelihood of residential care placements. There is a growing body of literature on effective treatment approaches for mental health issues common amongst children and youth placed in out of home care that can be used to guide efforts (Landsverk, Burns, Stambaugh, & Reutz, 2009).

Targeted Use of Specialized Models of Care - A growing body of literature supports the use of specialized care models for higher needs children and youth, such as Multi-Dimensional Treatment Foster Care, Wrap-Around programming, Safe Babies, and Treatment Family Homes (Barth, Greeson, Zlotnik, & Chintapalli, 2009; Street, Hill, & Welham, 2009; MacDonald, & Turner, 2007; D'Angiulli, & Sullivan, 2010). These models target the specific needs of the populations they serve and have demonstrated positive outcomes.

Targeted use of Treatment-Based and Inpatient Residential Care - Although the evidence-base for the effectiveness of residential and in-patient treatment has some limitations, there appears to be general support for this intervention, both in terms of outcomes and meeting a community need (Bettmann & Jasperson, 2009). There is evidence that it is most effective when it is targeted to the very highest need children and youth and utilized as part of a more comprehensive system of care and support (Lyons, et. al., 2009). The existing research literature does not support the use of generalized small group homes as an effective care or treatment model (Barth, et. al., 2009).

Re-Thinking the Use of Supported Independent Living - There is a lack of research evidence firmly supporting the efficacy of Supported Independent Living Programs for youth emancipating from care (Barth, et. al., 2009; Montgomery, Donkoh, & Underhill, 2006). Recent research has documented poor life outcomes for youth that emancipate from foster care. There is also an acknowledgement that youth in the general population remain reliant on their parents well into young adulthood. These facts have led some researchers to call for a re-thinking of how permanency is approached for youth, emphasizing life-long relationships and the need to ensure that family-based supports are in place for youth well into their early twenties (Avery, 2010).

Increasing Contracted Service Provider Autonomy and Responsibility – Recent research has highlighted situations where contracted service providers took on greater responsibility for the comprehensive care of high needs children and youth and were given some level of authority to create collaborative networks and to make decisions about how to best use resources and organize care (Holden, et. al, 2007; Cheers & Mondy, 2009). Positive child/youth outcomes (e.g., reduced length of stay in care) and decreased costs were noted as benefits of this type of approach to contracting for services.

For further information on the Project and any questions you may have, please refer to the Federation's website: www.fcssbc.ca or contact Jennifer Charlesworth at Jennifer@fcssbc.ca

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