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Reconstructing Residential Care

The Alberta Association of Services for Children and Families

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Contents

Editorial

I am pleased to offer a few comments and perspectives on the recent (May 22, 2014) Research Day sponsored by the AASCF. While it was a pleasure and honour for me to present some recent international perspectives on residential and alternative care research, it was a very pleasant surprise to hear about some of the many research and evaluation initiatives that are taking place in Alberta agencies. As I noted in my opening words at the gathering in Red Deer, we have moved into to the era of the "Mission-driven, Results-oriented, Improvement-directed, Relationship-based, Child-centered, Family-focussed, Culturally-respectful, Ecologically-appropriate, Trauma-informed, Value-for-money, Participatory, Virtue ethics- and Evidence-based Child Welfare System." In other words, government and accreditation expectations are now very high and diverse, requiring administrators and practitioners alike to grapple with increasing complexity and rapid change. Organizational development expert Harrison Owen created the term "raplexity" to bring these two notions together into one concept.

On this Research Day, it was evident that in response to these challenges, many agencies in Alberta are embracing the notion of developing evidence grounded in their own agency experiences, and I was impressed by the willingness of presenters – and especially line workers without a great deal of research training – to take a risk and share not only their evident successes, but also their frustrations and struggles. Research in real life is messy, and we don't often hear about this side of things in what end up as polished and problem-free accounts in published articles. This took personal courage and a strong commitment to the task of improving services and to creating a more open and collaborative child care system on the part of the presenters. I applaud the efforts of the AASCF for making the time and space for these important and ground-breaking discussions, and to all of the participants who attended, whether as presenters or not. I witnessed engaged dialogue in all of the sessions I attended, and the questions and comments throughput the day were thoughtful, critical and supportive of each other's efforts.

I came away truly inspired by the spirit of open inquiry I had experienced, and reflecting on how far our child and youth care field has come over the past decade. Professional child and youth care journals have for many years urged practitioners and local agencies to embrace the task of knowledge development and the publishing of results so that this learning can be built upon as we engage with allied professions in the enterprise of service transformation. I hope that this issue of the AASCF can be distributed widely and shared across the child welfare sector, as it should inspire others to pick up the challenge of documenting practice-based evidence in support of more grounded and relevant evidence-based practice.

Onward and upward AASCF!

James P. Anglin

Professor, School of Child and Youth Care

University of Victoria, British Columbia

Reconstructing Group/Residential Care in Alberta

A Discussion Paper

Rhonda Barraclough

Introduction

As part of an effort to examine and evaluate the group/ residential care[1] outcomes for youth in Alberta service providers[2] from around the province have participated in a discussion session at the request of the Alberta Association of Services for Children and Families (AASCF). Two similar sessions have been held, one in January 2013, and a larger consultation group in June 2013. The purpose of both discussions was to:

- Discuss current strategies that are working well with youth in group/residential care;
- Begin a process to work with the Ministry on reconstructing group/residential care to improve outcomes for youth in care; and
- Imagine a better system of care

This paper is a recording of those discussions and is intended to be a starter for further discussion with the Ministry of Human Services. Our assumptions are that:

- Right now youth are not always getting the best care possible;
- There are some very innovative and well research programs being used in the province;
- That financial resources (operating and staffing) have lagged and that is part of the challenge but certainly not the whole problem; and
- There is a will and a way to discuss and redesign this type of care in collaboration with the Ministry.

The purpose of that further discussion will be to inform policy makers and financial managers about best practice and how to better serve the most complex children and youth in the care

[1] Group Homes usually means a staffed and supervised home that serves 4 – 8 children; Residential treatment usually means established or designated for the care and treatment of more than 8 children
[2] The names of all those consulted with is attached at the end of this document

system in Alberta. By group/residential care we refer to institutional and group home settings in which children in the care live, this does not include shelter care, detention or hospitalization.

Our discussion is rooted in a continuum of care perspective where residential care is viewed in the context of an array of other service options. We hope to inform critical policy, practice dialogues and alter the utilization of residential treatment and group care.

What does an ideal care model look like?

The participants were asked to think back over the last decade to when they felt they have provided the best programs and had the greatest success. In doing so they were able to imagine the following service model for now and into the future:

- Intake needs to be managed. Children cannot be placed because this is the only place or last resort place. Services are provide to children at the right time when they need them;
    - Including high fidelity wrap around services[3] at intake.
    - Placement based on need
    - Funding supports need
- Aboriginal services must be provided in all resources. A comprehensive strategy needs to be developed to meet the needs of indigenous children and their families.
- The resource can and does provide therapeutic and clinically well trained people to work with the young people. Relationships are built with the youth and their families;
    - Emphasis on outcomes;
    - Trauma informed;

[3] High Fidelity Wraparound is a process that helps complex needs youth/families put together a team of people who will help them meet goals that they choose. This team is made up of people that the youth/family chooses and may include family, friends, relatives, neighbors, and professionals (i.e. teachers, social worker, and probation). This team is intended to support them beyond the involvement of High Fidelity Wraparound.

  - Well trained staff; and
  - High clinical oversight and consultation
- As much has possible provide onsite, or specialized schools that aim for successful school experiences and integration into regular system when appropriate;
- Staffing models need to include a balance of professional and caring staff. Many homes in the past have had house parents; or house moms; or cooks and these staff often provide a support and consistency to youth along side of the professional CYCC or therapists;
  - Retention strategies are needed to keep the workforce strong;
- Child focused, family based care is the preferred option for children;
  - There needs to be an inclusion of the family and community in the process;
- All programs have after care support including in home family support;
- Clinical care and intensity of the program changes as the child changes – The program changes for the child- not the other way around;

- Have a group of services so that the young person can move through as needed. Foster care and respite should be part of the continuum of group and residential care- step up and step down care as needed. Group/ residential care is only part of a continuum of care for a child. This needs to be seen as a temporary stay and not the permanent option for a youth. Step up and step down care needs to be part of the practice;
- Single Case Plan with a discharge plan at the beginning;
- Work with young people as they transition to adulthood – most families don't stop at the magic age of 18. We need to work with young adults as long as they require;
  - Suggest having SIL type services/support for youth aging out. The after care experience needs to be flexible;
- Cross system collaboration must be part of the solution;
- Stability, attachment and permanency are paramount;
  - Permanency needs to be the focus – including looking at the relationships the youth has.
- Youth whenever possible should have a connection to their family;

- Youth mental health is prevalent and is often not well cared for by any system.
    - There is inadequate screening and assessment and services for this population;

What are the strengths of this type of model?

- All models will have a clinical focus, be evidence based and child centered- family focused;
- Well maintained space/homes - facilities (physical infrastructure) that has been developed is a real strength as it would cost millions to build these in today's dollars.
- Can work with very complex youth and provide for their individual needs;
    - Cheaper and better for youth than hospitalization and psychiatric beds;
- Flexibility in the model allows staff to have flexibility and to draw from many skill sets;
    - Stable staff teams should be a result of a well funded and supported system of care;
- Increase in child care and clinical skills over time as staffing stabilize and this equals increased benefits to youth and families;
- Staffing should stabilize and then supervisors can provide supervision based on clinical models;
- Resource can be multi-dimensional – school; medical; mental health; addictions can all be addressed;
    - Provide relational opportunities. Especially when the young person is not able to handle family intimacy. They can succeed in a group care setting;
    - Can provide creative opportunities for youth (wilderness adventure; community integration, etc.);
- A continuum of services is provided and given when needed by the young person and their family;
- Beds are mid points not end points. Hopefully beds are a temporary point in the treatment of a young person.
- A relational, support model will walk with the family as they travel through the necessary support for their child. This needs to include after care services;

- Fits well in an Outcome Based Service Delivery (OBSD) model - Can follow a 'lead agency' environment, and provide improved outcomes based within the model;
    - Good outcomes will be achieved with less time and intensity.

Current challenges

- Requires a shift in values and a new perspective of group and residential care;
    - Ideologically many people see this services as the last resort – "nothing else works" "precursor to jail";
    - Care is thought about as linear and based on time rather than on developmental stages and needs of young person;
    - The residential services are seen as separate from other services;
    - Aligning funding with the flexibility required;
- Inappropriate placements of young people – need to consider the resources abilities; the complexity of the situations; level of matching;
- Youth who are coming into these services are more complex than in the past;
- Group care/residential placements are seen as last resort. It needs to be integrated into the continuum of services;
- Staff groups are tired, when people are tired they are not always the most innovative;
    - Staff are not trained due to shortages/funding or alternatively are fatigued by training that is prescribed by accreditation and others, and may not be the best practice training needed;
- Exclusion of community resources
- Currently residential services provide 'beds' and generally speaking the youth goes there and live there, often for extended periods of time, without a discharge plan; and often there are recommendations made at discharge and these are not followed through with in whatever the aftercare program is, and often that leads to readmissions and young people being even more traumatized.

What is needed?

- Review of funding formula
    - Address the real costs
    - Ensure operating costs remain realistic with cost of living
    - Ensure funding/ contracts provides flexibility beyond bed occupancy
    - Injection of funds immediately (to stabilize workforce and reestablish services)
- Stabilization of the current work force.
    - Wages need to be increased
    - A strategic and flexible model will help to have staff be part of exciting work and should help to have them stay as flexibility and creativity will be part of the solution
- Address Occupational Health and Safety(OHS) issues
    - A focus on staff safety
    - Currently there is very high incidence of serious injury in group homes. This needs to be addressed as a sector
    - WCB costs are increasing significantly
- Refocus the use of residential and group care from the Ministry/CFSA and agency perspectives.
    - Intake needs to be intentional
    - Discharge needs to be planned and supported
    - A variety of placement options need to be used and supported based on the needs of the child
    - Provide congruence in services for the children
- Provide a consistent, collaborative and coordinated approach to ensuring care for complex children.
    - Requires best practice principles and a service delivery model based on evidence and supported outcomes. Anglin (2008) discussed the need to focus on and provide support for pain and pain-based behavior[4]

[4] Pain based behavior has been used to remind us that acting out behavior and internalizing processed such as depression are frequently the result of a triggering of internalized pain. It is important that staff is able to respond to the behavior and anxiety (Anglin, 2008).

- Agencies can and will provide step up/step down services to young person and their families as is necessary based on their needs. The services need (family support, foster care, respite, etc.) in this model will be part of the service offered by the group/residential provider
- Eliminate unplanned discharges. Discharge should be planned for from the beginning and remains a goal throughout the treatment process. Support is offered as after care services.

Turning Strengths into Opportunities

- Youth will get the support they need in the right resource at the right time based on their individual circumstances.
- Multi ministry collaboration
- Innovative evidence based work. Models that are used are well research and supported.
  - I.E. CARE model or Trauma informed practice as examples
- Fits well with Outcome Based Service Delivery
- Care will be the most efficient use of resources. Agencies and CFSA will be able to collaborate without constraints of systems thinking.

Recommendations

- Identify and eliminate barriers in the system;
  - Coordinate responses and intake assessments to ensure the best placements;
- Develop a funding model that allows for flexibility and less on days in the bed;
  - Look at the needs of the child and what the case plan is;
- Address the real costs of caring for youth. Operating costs and reasonable wages must be addressed;
- Rebrand or value the system of care. Cannot continue to be seen as the last resort;
- All approaches are strength based, child centered and family focused
- Make sure we are using common language. Clear understanding of permanency/intake/transitioning;
- Embed this work with outcomes – might note be in a lead agency;

  - Define, expect and deliver good outcomes for this population of youth;
- Take the time to research other models;

Next Steps

- Understand issues for the Ministry/CFSA perspective;
- Meet with ADM Mark Hattori and designated CEO group, to discuss further the issues and proposed changes to group/residential care;
- Broad consultation;
- Develop a clearinghouse or library of research on group care/residential care;
- Hold a research symposium where people can learn from each other about the work they are doing and what research it is founded in;
- Do a literature review on best practices;
- Address workplace Occupational Health and Safety (OHS). AASCF to begin a committee to work with government to address concerns;
- Audit via chapters good or promising practice;
- Hold focus groups with youth;
- Write an article for Journal;
- Work with Ministry to develop a better funding model
- Joint training with Ministry and Agency staff to ensure collective understanding of needs

Conclusion

The group of service providers who participated in this discussion aim to:

- Develop a better system of care for complex young people who require group/residential care (treatment and not just beds);
- Focus on best practice;
- Provide efficient and effective services based on the child and their families needs; and
- Improve outcomes for young people in their care.

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A Renewed Perspective of Group Care and Residential Treatment: An Orientation toward Therapeutic Group/Residential Care

Part One - Setting the Context: Establishing Value in the Service System and Initiating the Construct of Therapeutic Group/Residential Care.

Anton Smith, M.S.W., Allen Balser, M.A.L., Bjorn Johansson, M.S.W.

Abstract

This piece is the first of three articles that describe the resource and advocate for the role of group care within a therapeutic spectrum of care. In this article the writers offer a historical perspective that identifies themes of connectedness and describes the social responsibility child and youth care pioneers undertook despite the state's desire to move "underprivileged" and marginalized children out of the public eye. Additionally, five waves of group care development are described. Lastly, the authors offer some definitions of group care and residential care that are currently gaining traction within the research and practice communities in the western world. These definitions are built both on factors that differentiate programs as well as defining the separation of general group care from therapeutic group care. Therapeutic residential care or therapeutic group care are terms with an agreed upon meaning in the literature and in essence, are emerging constructs. Throughout this article the terms group care, residential care, and residential treatment are used in a broad and somewhat inclusive manner to include various group care and residential programs consistent with the literature. The second article will provide insight to what may be some of the critical components or "active ingredients" (Whittaker, 2011) that are present in an effective therapeutic group care program. The third and final article, will explore a future vision for group/residential care in Alberta.

Introduction

There appears to be a renewed level of optimism within the research and practice communities with respect to group and residential care services offered to young people and families. Group care and residential care are often accessed in the practice environment as a last resort (Anglin, 2002; Lee, Bright, Svoboda, Fakunmoju & Barth, 2011; Whittaker 2011). For practitioners, the

debate over “last resort” versus “treatment of choice” (Whittaker, 2011) is a limited one, as many would agree that “treatment of choice” is clearly a better option. This renewed optimism is gaining momentum as service providers invest in models of care that shorten the gap between “what we know and what we do” (Holden, 2009). An emphasis on “Best Practice” has resulted in group care service providers implementing program models that are utilizing “evidence informed practice” and “evidence based practice” within the care environment. This momentum, along with an improved understanding of child trauma (Bloom, 1997; Perry & Szalavitz, 2006), has resulted in a desire to understand and improve upon the critical components of therapeutic group care.

Criticisms about group care and residential service have been typically focused towards the areas of high service costs, outcome limitations, and an overall concern for staff and client safety (Lee et al., 2011; Whittaker, 2012; Whittaker & Pfeiffer, 1994). Although these criticisms may have some validity, many of the empirical studies were one group design. Several of these critical studies have over-generalized group care and residential care and do not detail the important characteristics of the group care condition (Lee et al., 2011). A recent example of an over-generalization is found within the article by the Anne E. Casey Foundation entitled (“Right Sizing Congregate Care”, 2010) (Whittaker, 2011). In this article the writers make little attempt to discriminate between the levels and types of group care and utilize confusing descriptors such as, “congregate care and institutional care”, terms that have not been commonly used in group care since the 19th century (Whittaker, 2011). These criticisms have sparked a wave of interest in the use of other resources, such as earlier intervention services, kinship care, and family based services. Few would argue that young people are served better through early intervention services and family based services.

However, there is a population of young people and families where group care and residential services should be the “treatment of choice” and in some situations the “first choice” (Whittaker, 2011). Often children and families experience a series of failures in non-residential alternatives prior to being referred to group care and residential services (Durrant, 1993; Whittaker, 2011). These failures compound an already entrenched pessimism, while adding to the complexity of the initial referring problems (Durrant, 1993). A shift in thinking about residential service as a “last resort” to a “service of choice” is needed to effectively serve many of the young people and

families with complex challenges. It is the authors' unwavering belief that group and residential care has an important, if not vital, role in the future of all care services. It is their hope that this article will provide a coherent and leveraged perspective into the discussion.

Valuing the Wisdom of Our Child and Youth Care Pioneers

In 1601, the first Elizabethan Law was established to assign public responsibility for needy children by placing them in Alms-houses (Holden, 2009). In Ireland unwanted children were cared for in monasteries and later in workhouses (Holden, 2009). Later during this time period, similar care was provided through orphanages, reform schools, Alms-houses and apprenticeships in North America (Holden, 2009). Much of the effort during this time focused on public safety whereby the needs of children were secondary to the public need. Children were often displaced by being shipped away to emerging colonies in other continents. In North America they were given train tickets to the developing west or housed out of the public eye in strict disciplinarian facilities (Holden, 2009). It was only in the later part of the 19th and early 20th century where an interest in these children arose from some of the pioneers of child and youth care. Johann Pestalozzi was one of the first pioneers to actually live within the child's life space when he cohabitated with children from very deprived backgrounds (Brendtro, Mitchell and McCall, 2009). He created a stir in Europe as he educated young people and reclaimed them to be solid citizens. His educational techniques were grounded in relationships of love, trust and gratitude (Brendtro et al., 2009).

One of the greatest pioneers of the 20th century was a Polish child and youth care worker, pediatrician and writer by the name of Janus Korczack. (Brendtro, 1999). Korczack published his first book entitled, "Children of the Streets" in 1901 and established a "House of Children" which provided care for over two hundred Jewish street children (Brendtro, 1999). He was so dedicated to his work that the Catholic Church appointed him to the position of associate worker to the Catholic orphanages (Brendtro, 1999). When Hitler invaded Poland, the Nazi's didn't know what to do with this famous Child and Youth Care worker and presented him with a chance to get away. His reply to their offer was, "who would leave children at a time like this?" (Brendtro, 1999). They were moved to the ghetto in Warsaw and later put on a train and transported to Treblinka where Korczack perished along with his beloved children. During this

time in the ghetto, he kept a diary which was entitled, “Ghetto Diary” (1978) (Brendtro, 1999). His last entry in this diary stated simply but powerfully, “I exist, not to be served or loved, but to love and act” (Brendtro, 1999).

> “If you go to Treblinka you will see that there are no more buildings; only green grass and pine and birch trees, and a memorial consisting of a ring of rocks. On each rock is the name of a city or a country from which some
>
> Jews came, one million of them, to their end in that place. Only one person has his individual name on one of those rocks. In the centre, on
>
> the largest rock, is the name of someone in our profession: 'Janusz Korczak and children'. (Brendtro, 1999)

Like Korczack and Pestalozzi, pioneers such as Mary Carpenter, Jane Addams, Anna Freud, Thomas Stephanson, Thomas Barnardo and August Aichorn all echoed themes of humane treatment, enlightened practice, sustaining relationship, and the nurturing of competence and confidence in children (Brendtro et al., 2009; Holden, 2009). These researchers and writers were the roots of modern day Child and Youth Care and they spawned a second wave of 20th century educators. According to Anglin (2002), some of the more notable works authored during this time period included “Bettleheim (1950, 1955, 1967, 1974), Redl and Wineman (1951, 1952), Polsky (1962), Polsky and Claster, (1968), Treischman, Whittaker and Brendtro (1969), Whittaker and Treischman (1972), Whittaker (1979), Hobbs (1972), Brendtro and Ness (1983)…” Other significant authors include Maier (1987), Fewster and Becker (1990) and Durrant (1993).

These writers and pioneers have provided a context for the discipline of Child and Youth Care. What is most salient in the evolution of the discipline and subsequent practice is a coherent, cohesive thread of connection. This thread binds what the pioneers discovered and what we now more richly understand from research. These connections are impressive. Fritz Redl, who introduced the concept of the life space interview, was a student of Anna Freud who in turn, was the daughter of Sigmund Freud (Brendtro, 1999). Larry Brendtro, a renowned child and youth care professional and writer was a student of Fritz Redl (Brendtro, 1999). Today, most

practitioners in the field are students of Larry Brendtro and today's practitioner is both student and teacher as they continue to strengthen these connections - connections that evolve, as we collectively challenge, advocate, support, research and develop services and resources that impact the lives of the children and youth who have experienced exceptional levels of hardship, trauma, neglect and abuse.

The Evolution of Group Care in Canada

Charles & Gabor (2009) suggested that the roots of North American group living environments for children followed five distinct waves. The first wave of residential care, referred to as the "Moralistic-Saviour Era," started in the late 18th century and continued well into the middle of the 19th century. The resource began in response to a moralistic motivation that believed society had a moral obligation to provide basic care to children who had been abandoned or orphaned. Further dispensation was offered to children who were seen to have significant mental or physical disabilities. Provision of these services was often provided within an adult population and blended without consideration of special need or circumstances. Often the motivation for these paternalistic programs was to "save the souls" of young people and this mission was served by religious organizations. By similar process, it was during this time that mission schools were beginning to be established on First Nation reserves. During the middle part of the 1800's and lasting until the first part of the 20th century, the second generation of residential services evolved from a "Reformation-Rescue" perspective. Within this paradigm, the moralistic motivations were still involved in the care of children. However, the difference was the desire to protect and rescue children. During this time, formal institutions such as the early Children's Aid Societies as well as preliminary, rudimentary child welfare legislation developed with a focus on protecting, reforming and training children. It is important to note these programs were designed to replace family involvement and essentially began institutionalizing care.

A third wave of reform brought a philosophy referred to as the "Protection-Segregation Era," starting in the late 1800's and lasting until the 1940's. In this time period the inklings of service specialization were being applied to residential services. One legacy of categorization leading to segregation was the emergence of the Residential School System and its subsequent impact upon the children of many First Nation communities. Some other characteristics of

specialization included the categorizing of care into distinct areas such as adult, child, insane, delinquent, orphans and poor/homeless. The philosophy focused on the impact of one's environment setting the stage for a treatment focused perspective. There was also a growing awareness that interventions needed to be adapted to meet the emerging needs of the child.

The "Treatment-Intervention Era" arose in the 1940's and lasted throughout the 1950s and was influenced by the earlier era's specialization of client needs and a specialist approach to treatment. The greatest change during this time was the formalizing of treatment professions with greater attention to child development. A further development in the specialization movement was terminology shifting to describe children requiring treatment as being "disturbed". It was during the latter part of this era that foster care systems evolved and many orphanages were changed into treatment facilities. Treatment institutions continued to evolve with the development of smaller cottage settings and community-based group homes. The most important shift during this era was in the active use of the milieu as a vigorous force in the child's treatment.

The "Specialization-Intervention Era", evolved from the 1950's treatment interventional approaches and reached a peak during the 1970s. During this time the focus was to determine what aspects of the milieu were having a positive impact upon the child's life and how a negative milieu could be avoided. This thinking began to generate a shift towards individualized treatment programs that valued the client's personal needs.

A "Consumer-Community Partnership Era" began to materialize in the 1970s and continues to evolve today. Much of the early impetus for the consumer/community partnership finds its roots in the development of outpatient and aftercare services that emerged from residential treatment facilities. These early attempts at wrapping around post-care services came from the realization that there needed to be smoother and more effective transitions from the residential setting into community. Another significant development in this time was the recognition of the role the client, family and community played in treatment success. Empowered practices, such as client and family ownership of the treatment, along with a client advocacy movement, ensured the voice of the young person and family were valued in the treatment process.

Towards a Definition of Group/Residential Care

Residential care is a broad term that encompasses many different forms of residentially based placement and treatment services provided to children and youth with a wide range of needs. It is a placement option or service at the intersection of three major child serving systems: child welfare, mental health and justice. This “broad stroke” definition has led to the aggregation of diverse programs under one umbrella term, as if group care were a monolithic construct. Yet, group care differs significantly along a range of dimensions including function, target population, length of stay, level of restrictiveness, and treatment approach (Leichtman, 2008). Clear operational distinctions between different group care settings do not exist in the research literature and the need for clarity has been established throughout the literature (Leichtman, 2006). Group care is often intended as a placement of “last resort”, and as a response to antisocial characteristics or psychosocial problems that cannot be addressed in less restrictive family-based settings. Since the emergence of a growing number of alternative family and home-based treatment options, group care has increasingly been challenged to justify its place in the treatment spectrum.

Although residential treatment is now a well-established therapeutic modality, problems in defining the concept, with which pioneers in the field struggled fifty years ago, are no less present today. We act as if there is a consensus on what the term residential treatment means, but the concept remains elusive. It has been applied to modest group homes, leading psychiatric hospitals and to institutions with fewer than twenty five beds. Furthermore, the concept of residential treatment ranges from institutions with several hundred beds to smaller group homes for dependent and neglected children. The range of what constitutes residential treatment also includes those offering comprehensive treatment for the most profound psychiatric disorders, to those treatment programs with widely differing philosophies and practices.

The term residential treatment began to be used in the late 1940s. As New Deal reforms such as Social Security and Aid to Dependent Children took effect, the need to institutionalize children for economic reasons diminished. At the same time, psychiatry and social work became increasingly influential disciplines (Preyde, Frensch, Cameron, Hazineh, & Burnham, 2010). As a result of these reforms institutions that formerly provided homes for neglected children,

schools for the retarded, or containment for delinquents were redefined as mental health facilities.

> "Group care programs for youth served by public systems share common features, but also encompass significant variation. The purpose of residential programs can vary from care and protection to treatment, educational emphasis or detention services. Despite this enormous program variability, the terms "group care", "residential programs" and "treatment facilities" are often used interchangeably to describe settings that provide 24 hour care for youth in peer groups (CWLA, 2004)." (Lee et al., 2011)

While these terms and standards provide definition to the dynamics of modern group and residential care, what is meant by residential treatment is, in many ways, less clear now than it was fifty years ago. At that time, the term described an approach to treatment and to some degree it still does. It is, however, difficult to specify precisely what constitutes that treatment approach - largely due to residential programs being oriented around a host of disparate treatment philosophies, with little attention being given to articulating the unifying concepts that underlie them. Residential treatment has also been used to denote a type of facility, yet they differ markedly in program size, organizational structure, clientele served, and practices utilized. At times it seems residential treatment is little more than a label applied to diverse programs united only by the distinction that they all provide inpatient treatment and are not licensed as hospitals. The vast program variations for group care programs present significant challenges and implications for both the practice and research communities. Many empirical studies are one-group designed, which is helpful for describing a population and assessing whether they have improved over time. However, they are unable to determine if the youth would have done just as well or better in an alternative setting (Lee et al., 2011). From a practice perspective, group care programs are at times used as a "last resort" often in instances when a family setting is deemed inappropriate or not available (Lee et al., 2011). Butler and McPherson (2007) argue for the importance of definition for residential treatment and identify components that include: therapeutic milieu, a multidisciplinary team, deliberate client supervision, intense staff supervision and training, and consistent clinical and administrative oversight. These components require further definition as they incorporate a broad range of group care programs. Lee et al. (2011) propose reporting standards that further identify program differences in

residential and group care programs. These reporting components include: outcomes (program goal), size of facility and residences, populations served, setting and location, program model, practice elements, staffing, system influences and restrictiveness of setting. In light of what Lee et al. (2011) proposed, these identified reporting standards provide an opportunity for a coherent look into the Alberta service system, by attaching common language and labels that provide a context of understanding.

In addition to Lee et al. (2011), Martha Holden (personal communication, 2013) suggested examining recent literature that differentiates therapeutic group care and group care. Whittaker, Del Valle & Holmes (in progress) offer a "nominal definition of "therapeutic residential care":

> 'Therapeutic residential care' involves the planful use of a purposefully constructed, multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support and protection to children and youth with identified mental health or behavioral needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources. (Whittaker et al., in-progress)

Whittaker (2011, 2012) views group care and residential care as suffering from what he terms "benign neglect" in the understanding of how successful residential services operate. This neglect fails to fully understand the critical components or "active ingredients" of residential/group care, such as principles, program models, funding, performance measurement and research. In response to this condition of "benign neglect" Whittaker et al. (in-progress) have a manuscript ready for publication in September 2014 by Jessica Kingsley Publisher, London and Philadelphia, Therapeutic Residential Care with Children and Youth Developing Evidence Based International Practice. This book views therapeutic residential care as a specialized segment of group care and residential services with the aim of understanding child needs while examining model programs and practices. Additional analysis is focused upon the training, evaluation and support structures that constitute therapeutic residential care. Their final investigation examines how programs partner with families, prepare children for transition from residential services and accurately forecast and monitor service costs. What seems to be

emerging from this rigorous examination is that the term “therapeutic residential care” has gained traction in the international community (Versa Consulting, 2011; Whittaker, 2011).

From a practice perspective, a report generated by an Australian organization, Versa Consulting, Pty LTD (2011) makes some clear conclusions that identify key provisions and features of successful therapeutic group care. One of these conclusions claims therapeutic residential care (TRC) leads to better outcomes than general group care when there is a program model applying particular program elements that underpin practice. This report also concluded that a therapeutic specialist providing direct clinical oversight is essential to program success. Clinical oversight is provided to front-line staff by a psychologist, clinical social worker or other registered clinical staff. Some other key features identified in their conclusions included enhanced staff training, a practice theory, and an augmented staffing model that reduces staff/client ratios. Their final conclusion stated that therapeutic residential care has a clear and definitive economic and cost benefit.

A foundational Child and Youth Care belief proposes that children have an innate capacity to grow and develop (Bernard, 2004; Holden, 2009). It is from this developmental perspective Henry Maier (1987) defines first order and second order of change, within group care environments. First order of change provides conditions for children to progress on a normal path of development (Holden, 2009; Maier, 1987) while second order of change is much more intense and complex. In a second order of change process, children are not only provided with environments that create conditions for normal development, but also to behave, think, feel and learn differently (Holden, 2009; Maier, 1987). Programs with a second order of change focus must have greater competence and be more adaptive to carry out meaningful interventions that go beyond supporting normative child development (Holden, 2009). Therapeutic Group Care must, by definition, be focused on the second order of change. Maier (1987) emphatically states that it is essential for group care programs to be clear about what order of change they are focused upon. Given the need for congruence across systems of care (Anglin, 2002) it is crucial that macro systems be focused on this need for specialized developmental care as well.

Three Broad Definitions for Constructing Practice and Practice Language

As previously stated, the definitions for what comprises a group/residential care spectrum of services is dynamic, variant and may even be somewhat arbitrary. This lack of overall clarity in definition provided challenges to the writers of this article and lead to definitions being shaped by both research and practice experience. There may be other resources that do not fit neatly into the definitions that have been crafted, and they are certainly valid in their own right. For the purposes of discussion these definitions are where the authors "landed" in their practice grounded analysis. These definitions are offered in a broad context and as a start to organize our thinking and language as the profession delves further into specific differences.

Campus-Based Therapeutic Care

Generally, the goal of campus-based therapeutic care is to return the young person to a community based setting (family, independent living or community group living). In a campus-based facility the group size varies. Usually their population is 20 to 100 children or youth housed in a number of residences with each residence having 4 to 12 occupants. The client characteristics are typically young people who have a chronic history of abuse and neglect and multiple diagnoses (both psychiatric and psychological). Many have challenges forming attachments and engaging the intimacy of a family with their overall function ranging from mental retardation to average intelligence. Young people placed in this setting require programming that is targeted at what Henry Maier refers to a second order of change (Maier, 1987). Typically, the youth in this type of program have struggled in community settings and require a setting that promotes efficacy and regulation through the program's ecology. The program ecology is the strength of a campus based resource as it has its own internal ecology or community that is modified for children to be successful and offers a significant greater amount of attachment opportunities. These programs may be specialized in their treatment approach or have a developmental orientation, with the setting being either rural or urban. Rural programs may include an agricultural, wilderness or ranch component to their service.

By nature of definition, campus based facilities are usually quite comprehensive with an onsite school, recreational facilities, intensive activity program using recreation and adventure based experiential learning. Common practice elements may include family therapy and clinical

oversight (e.g. a minimum ratio of 1 Masters level clinical staff to 14 young people), access to a consulting Psychiatrist, and they operate within a specific program model that is practice informed and supported by evidence. Another important element of campus-based treatment includes appropriately educated and trained caregivers who have had a minimum of forty hours of in-service training that relates to the program model and the child and youth care perspective. Staff ratios will typically range from 1 staff- 1 client to 1 staff - 4 clients. Facilities are generally highly structured and may be open or closed facilities.

Therapeutic Community Group Care

The typical goal of therapeutic community group care is to return the young person to a family, kinship family, foster family or to prepare them for independent living. Program sizes will vary and are usually between 3 and 6 young people who live in a residential setting. One of the features of smaller, community situated programs is they are located within closer proximity of the client's family and community. Additionally, the program may target the needs of particular populations and provide a therapeutic program that is tailored to these needs. Due to the smaller population of clients the programs can be fluid in service parameters such as age, gender and developmental capacity and be able to adapt to emerging system needs. One of the key capacities of this program milieu is the smaller number of clients and staff the young person will encounter when compared to the larger residential campus-based treatment program. The smaller group living environment can strengthen their relational capabilities while providing opportunities for intensive connections. Another feature of this service environment is the overall access to the community including neighbours, local school, stores and other situations that can be used to assess their functioning capacity, while building their competence within a community.

Similar to campus-based treatment, client characteristics may include a history of trauma, abuse and neglect, multiple diagnoses (both psychiatric and psychological). They may also have challenges forming attachments and struggle to handle the intimacy of a family. As with the clients in campus-based treatment, the young people being served in a therapeutic community group care setting require what Maier calls second ordered change (Maier, 1987). Additionally,

there are qualifications similar to those required in campus-based treatment, with staff ratios ranging from 1 staff-2 clients to 1 staff-4 clients.

Community Group Care

The overarching goal of community group care is to prepare children and youth to live in either a home or independent living situation. These programs provide a supportive, nurturing environment, while maintaining a structured milieu. While similar in overall program structure to a therapeutic community group care program, the difference lies largely within the orientation. A community group care program focuses on the overall nurturing, safety and security of a child without an overt emphasis on therapeutic intervention. The focus of this program model highlights role modelling and teaching using the day to day routines, experiences and structures as the catalyst for learning. In many ways the program functions as a surrogate home providing opportunity for parental involvement. The young people placed within this setting require programming that is at the first order of change (Maier, 1987).

Concluding Statements/Insights

Great strength and resolve has flowed from the pioneers of group care. They sparked a quest for excellence two centuries ago and this search continues today as the field embraces a continuous quality improvement commitment, driven by a desire to produce the right outcomes for children served. Group care programs have had a significant, if not auspicious history, along with a rich role caring for children over the past two centuries. From the beginning of formalized group care the role has undergone several significant iterations. Change continues to be an important theme for group care as the current climate of political will has placed group care programs squarely in the sights of change. Fortunately, the historical experience of group care has demonstrated that this resource can and will change. Those who have been involved with group care over the past twenty five years have witnessed significant change already. For those of us who have practiced at the front line level, this change is welcome.

The relevance of the group care resource is not where this debate lies. There are deeper and perhaps more important considerations to be explored, such as what constitutes the critical components of group care and how these important ingredients of care can be enhanced. What are the overall system benefits of a healthy spectrum of group care resources and finally, what

optimum care, care that includes group and residential care, would look like. These are the questions the writers will explore in the next two articles.

What has and continues to validate group care as a vital resource is the capacity of these programs to provide stability. In a Californian study 8933? young people indicated higher-level residential programs achieved greater placement stability, with stability deteriorating as the level of care decreased (Sunseri, 2005).

Finally, although there is a reluctance to place children into high-level programs and children are generally first required to fail at lower level programs (Fail to proceed), the result of this study indicated that when properly assessed and placed into the appropriate level of care at the outset, the majority of children exit the residential care system altogether and return home or to a home like settings sooner and at a lower cost (Sunseri, 2005, p. 55).

Stability and safety are potent and vital assets for care plans and a significant determinant of success. It is from this place of stability that children and youth can begin to examine their deeper pain and trauma (Bloom & Farragher, 2010). Stability provides the foundation for the risk taking that is essential in developing resiliencies, capacities, strategies and insights that will allow them to re-enter their homes and communities from a successful orientation.

The level of optimism mentioned in the introduction is strengthening as Group Care and Residential Care programs advance their sophistication in the delivery of services through aligning with evidence informed and evidence based practice. The research is also providing evidence that higher-level group care and therapeutic residential care are producing some promising results for children and families. Defining higher-level care in the context of therapeutic group care or therapeutic residential care through describing critical components or active ingredients of the service promises to provide the practice community a framework to explore their own services. The challenges will be to establish congruence across the service system in shifting the services to be utilized as “treatment of choice” or “treatment of first choice” and not as a “last resort”.

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Group Care Symposium #1 – May 2014

The overall goals of the Group Care Research Symposium were to:

- Identify examples of group and residential care practice informed by research and evaluation in Alberta; and
- Discuss ways to improve outcomes for young people in their care.

The day included a keynote address by James Anglin and presentations from a variety of group care providers in Alberta.

Following are short descriptions of the presentations that were given:

Hull Services – NMT Trauma Informed Care in Practice

Presenters: Patrick Foran and Jan Ference

The Preadolescent Treatment Program (PTP) at Hull Services in Calgary is an intensive residential treatment program for kids with significant behavioral and mental health issues. PTP has recently modified its treatment lens to reflect the growing recognition of the effects of trauma on the developing brain of a child.

We have all been hearing a lot about trauma informed care but what is it really? This session will examine what makes a program trauma informed. We will detail the implementation of Dr. Bruce Perry's NMT (Neurosequential Model of Therapeutics) at PTP as an example of how to integrate trauma informed care into your program model. We will explore the process of how to go from a model to implementation and how to utilize High Fidelity Wraparound and family finding to establish permanance. We will illustrate the importance of a relationally rich environment, the significance of relational permanence and a milieu that uses somatosensory, patterned repetitive, and music and movement "dosing" activities to help regulate children. We will also use a case study of a specific child utilizing an NMT metric and show how this data informs treatment in a developmentally sensitive manner.

Our stated outcomes are a reduction of the average time in care and a reduction in the frequency and intensity of critical incidents and a return to a less intrusive environment. We will provide data from our CAFAS (child and adolescent functional assessment scale) rating scales, an empirically-based assessment designed to objectively determine a youth's functioning across important life domains. We will also demonstrate the changes in child functioning using the NMT brain metric and data on critical incidents and time in care to illustrate our success and how this approach has informed and improved our practice.

Oak Hill School – Student Participation and Academic Improvements in a school setting while attending a campus-based therapeutic care facility

Presenters: Allan Traub and Anton Smith

Outside the home setting, school is where young people spend the most of their time. Many of the young people associated with Children's Services have a history of challenges specific to attendance and academic performance in school. School culture and curriculum require a specific design for many of the young people to be successful in school. Changing the culture of a school takes purposeful planning and considerable effort. Through the joint adoption and implementation of common philosophies and practices within the home setting and school program, Oak Hill School has been able to affect positive change in attendance and academic performance within the school at Oak Hill Boys Ranch.

Since 2010, Oak Hill Boys Ranch and Oak Hill School have strengthened their collaboration in their thinking, acting and supports. This has been driven by the implementation of a common service philosophy and crisis management programs. This collaboration has required a great deal of support and joint services delivery efforts. Cornell University's Children and Residential Experiences (CARE) and Therapeutic Crisis Intervention (TCI) programs have been the core focus for school programming, along with the inclusion of attachment principles by Dr. Gordon Neufeld, and in part, the collaborative problem solving approach by Dr. Ross Greene.

The presenters will share the data that signifies the significant shift Oak Hill School has experienced from a model of traditional behavioural supports to a model of supports that address individual student needs. The positive change Oak Hill School has experienced is demonstrated through significant improvement in school attendance, positive expressions by students towards school, significantly high rates of literacy improvement, along with grade nine students meeting or excelling above provincial averages on Alberta's Provincial Achievement Tests (PATs). The data includes attendance records, CARE surveys (Cornell University), standardized academic test instruments (Fountas & Pinnell, Star Reading), and surveys of student expression.

The presenters will provide an overview of the Oak Hill School program with a purpose of increasing understand of the value of a campus-based setting from an educational perspective. Participants of the presentation will understand the significance of educational environments on student outcomes specifically in student attendance and academic performance. They will understand some of the environmental conditions] s and the specialized educational curriculum in a campus based environment for children in care that provide exceptional results.

Wood's Homes – The Phoenix Program: a Canadian Perspective on the Residential Treatment of Adolescents with Sexually Abusive Behaviors

Presenters: Gareth Fields, Joyce McDonald and Cloe Westelmajer

Sexual abuse of others by adolescents is a critical issue and one that has received considerable media attention in recent years as the general public has become more aware of the connection between adolescent antisocial behaviour and adult criminal behaviour. Specialized treatment for adolescents who offend sexually has been shown to lead to significant reductions in both sexual and nonsexual reoffending (Worling, Littlejohn & Bookalam, 2010). Such treatment also necessitates reliable and valid risk assessment tools for adolescent sexual offense recidivism in order to determine the program's effectiveness (Worling, 2010).

Since 1987, Wood's Homes has served youth with sexually abusive behaviours by operating the Phoenix Program, an 8 bed intensive residential treatment program. Phoenix is one of more than 30 residential, community, clinical and educational programs offered by Wood's Homes, a large non-profit multi-service agency located in Calgary, Alberta, Canada. Over the past two decades the Phoenix Program has been involved in an iterative process of program development. This process has involved ongoing review of the Phoenix practice and outcomes research, refinement of evidence-informed policy positions and reciprocating back to revised best practice.

This presentation will review and highlight qualitative and quantitative date gained from several outcome measures being used by the program to measure sexual offense-specific treatment. This includes a focus on sexual risk, client functioning, sexual health, and family capacity building as measured by Juvenile Sexual Offender Assessment Protocol (J-SOAP-2), the Abel Assessment for Sexual Interest (AASI-2), and the Child and Adolescent Functional Assessment Scale (CAFAS). The presentation team will also focus on evidence informed practice for children and youth who are displaying sexually abusive behaviours.

Bosco Homes – The Importance of Family and Community in Group Care

Presenters: Patrick Langlois and Gena Decker

For youth and families to be successful they need to be involved in the decisions and the goal planning. Goals need to be relevant to the family and be centered on what the family wishes to achieve. Historically youth have been removed from families and the youth has been labeled the problem, or the family has been labeled the problem. Goals were then identified by professionals and worked on in isolation. This model fails to see the family as a unit and to see that the family system needs to be engaged in the process to promote success. A Family Centered and Solution Focused/Strength Based Approach in group Care engages the family and enables the family to define the priorities. The essence of this approach is to engage families in achieving goals they set and reuniting families as quick as possible. It is important to identify goals with the family that will allow for reunification and to not add or change goals as

that creates an environment of discouragement and failure. The presentation will explore; (1) how group care can connect with and involve the family, (2) how group care can help the youth and family make community connections to help support forward momentum, and (3) to focus on a family's strengths and competencies, and to use these to help strengthen the family and help them carry out their responsibilities. When looking at Family and community the goal is to ensure the youth has positive connections as family is deemed to be any important people in the life of the youth.

Bosco Homes use the ETO (Efforts To Outcomes) Database to collect outcomes for each youth in our care. Each youth has a goal encompassing family and community. The efforts to this goal are monitored with daily reports staff enter in the database. Quarterly the staff, the youth, the caseworkers and the families complete a survey on the services received. The Database information and the survey information is compiled to produce quarterly reports. These reports provide the information to allow for forward momentum and the opportunity to see were adjustments need to be made.

See full article below.

Wood's Homes – The evolution of family centered care in short term residential treatment: using outcomes to inform practice

Presenter: Bjorn Johansson, Cindy Jing Fang, and Brittany Corolis

Structure of Program: The Exceptional Needs Program is a short term intensive residential treatment program for youth with complex mental health needs located in Calgary, Alberta through Wood's Homes. The program supports adolescents and their families in developing the skills to manage mental health within the family system. In taking a family centered care approach, the youth is not thought of as the problem; rather, a problem exists within the family which is addressed by all family members. Treatment is focused on learning strategies, developing family relationships, family counseling and practicing the skills which are protective factors in mental health.

Overview of Program Outcomes: The National Child Welfare Outcome Indicator Matrix (NOM) was developed in consultation with provincial and territorial ministries to provide a framework for tracking outcomes for clients and families receiving child welfare services. This framework incorporates a variety of outcome indicators subsumed under four overall domains (child safety, child well-being, permanence, and family and community support. The Wood's Homes Outcome Measurement (WHOM) is an adaptation of this framework and includes an extended range of child and family outcome indicators under the four primary domains.

Current research indicates that family involvement is a critical component to success in group care. Outcome measures for the Exceptional Needs Program attempt to strike a balance between addressing the risk factors of the referred client as well as tracking the changes in perception of family members about overall family functioning.

Data to be Presented & Program Change: Client functioning and family capacity for a three year period ending December 2013 will be shared and discussed. Specific interventions and treatment will be connected to how outcomes have informed and evolved service delivery at the Exceptional Needs Program.

Oakhill Boys Ranch- Implementation of Children and Residential Experiences (CARE): Creating Conditions for Change

Presenter: Anton Smith and Stacey Charchuk

Research indicates that in order to have positive outcomes with children in their care, organizations must have a positive culture and climate. Children and Residential Experiences (CARE) provides a practice framework orientated in the Child and Youth Care theory. This presentation will provide a brief overview of the organization; brief overview if client demographics; the six CARE principles that form the foundation for creating conditions for change in residential care. These principles have a strong research and/or theoretical relationship to positive child outcomes. The baseline data and results from 3 years of follow up data that has informed practice change along with the organizations experience with the implementation of the of the CARE program will be presented.

A real experience of one agency's change using the CARE practice model will be presented. The Agency will explain how everyone in the agency is vital in helping to create a new culture and illustrate how that transformation results in improved outcomes for the children. The presenters will present the first years data in the context of the organizations change and the Three year measurement of the same data. The data and analysis presented will include: Organizational Social Context Survey (University of Tennessee), CARE Knowledge and Beliefs, Current Practice and Youth Perception Surveys (Cornell University).

Workshop participants will have an opportunity to reflect on their own organization's change process, examine their understanding of basic principles that contribute to children's positive growth and development, and to actively engage in discussion with trainers for the CARE Curriculum.

Closer To Home Community Services – Family-Style Teaching Homes: An alternative to Traditional models of Group Care

Presenter: Erin O'Reilly and Arlene Oostenbrink

Closer to Home has provided community-based, family-style, professionally parented group care programs for the past fifteen years using the evidence-based Teaching-Family Model. Over this time, we have collected data using the Child and Adolescent Functioning Assessment Scale (CAFAS) to inform practice and ensure a high-fidelity implementation of this best practice model. This presentation will focus on outcomes over the last two fiscal years, highlighting successes and creative ways to address challenges presented by traditional group care service deliveries. It will describe an innovative adaptation we have recently implemented to enhance outcomes for youth in our programs, with a focus on ensuring that youth achieve permanency despite complex behavioral, emotional and mental health challenges.

Highlights of our outcomes include 78% of youth reducing risk factors, 100% of youth participating in structured community activities, 92% of youth improving or maintaining (if on par) school and social functioning and a 93% satisfaction rating from consumers including youth,

parents, case workers, teachers and other involved family and professionals.

One outcome that has presented more challenges is youth being discharged to less restrictive placements. In 2012-2013, 75% of youth were discharged to less restrictive placements, falling short of our 80% target. To improve outcomes for youth in this area, CTH has worked with Children's Services to turn a 15 bed contract (between three homes) into a 15 bed program consisting of two group homes and five individual "Family Teacher" Homes. These homes provide "least restrictive" options for youth who would typically be served in group care, while helping them prepare for even less restrictive placements or ideally, family reunification.

We look forward to sharing an evidence-based alternative to traditional group care models that is supported by positive outcome data, and promotes permanence and family reunification options for youths who would otherwise grow up in care.

See full article below.

Wood's Homes – The Long and Winding Road leading to Residential Treatment

Presenters: Kathleen Rhodes and Bjorn Johansson

Structure of Program: The Exceptional Needs Program is a short term intensive residential treatment program for youth with complex mental health needs located in Calgary, Alberta through Wood's Homes. The program supports adolescents and their families in developing the skills to manage mental health within the family system. In taking a family centered care approach, the youth is not thought of as the problem; rather, a problem exists within the family which is addressed by all family members. Treatment is focused on learning strategies, developing family relationships, family counseling and practicing the skills which are protective factors in mental health.

Overview of Program Outcomes: The National Child Welfare Outcome Indicator Matrix (NOM) was developed in consultation with provincial and territorial ministries to provide a framework for tracking outcomes for clients and families receiving child welfare services. This framework incorporates a variety of outcome indicators subsumed under four overall domains (child safety, child well-being, permanence, and family and community support. The Wood's Homes Outcome

Measurement (WHOM) is an adaptation of this framework and includes an extended range of child and family outcome indicators under the four primary domains.

Current research indicates that family involvement is a critical component to success in group care. Outcome measures for the Exceptional Needs Program attempt to strike a balance between addressing the risk factors of the referred client as well as tracking the changes in perception of family members about overall family functioning.

Data to be Presented & Program Change: Client functioning and family capacity for a three year period ending December 2013 will be shared and discussed. Specific interventions and treatment will be connected to how outcomes have informed and evolved service delivery at the Exceptional Needs Program.

Renascence Homes – Parented Group Care for Long Term Specialized Children and Youth

Presenter: Errol Dohms

Renascence Homes operates two group homes in a rural area about 20 minutes NE of Edmonton. The uniqueness of this group care program is influenced strongly by: parented group care; long term care for high needs PGO youth; activity and outdoor recreation; and, spiritual and moral training. The anticipated outcomes for children and youth in our group homes include: stable, safe placement; commitment to learning; healthy lifestyle; preparation for adulthood; support through living placement transitions; positive connections with the community; and, positive relationships with family members. Measurements and indicators of success include Client Satisfaction Surveys; the Shortform Assessment for Children – SAC (University of Tennessee); caseworker feedback; and, Critical Incident Report analyses. Since Renascence Homes began using the SAC in May 2012 we have observed differences in length of involvement in the program as well as differences between individual client profiles. Client Satisfaction Surveys have been administered and analyzed annually since 2007, and the results are more likely to have an immediate effect on the program. Critical Incident Reports are compiled and analyzed, impacting treatment methods over the long term, or individual client

service plans. One example of how the outcome data has informed program change is that information from the Client Satisfaction Surveys and the SAC are brought to staff meetings and to Leadership Team meetings for discussion about program and individual service plans. This in turn has led to research in treatment methodology, and adaptation of the Circle of Courage (Brendtro, Brokenleg, Van Bockern) philosophy and practice starting in 2008. As this has been more fully implemented we have also seen a reduction in serious Critical Incidents.

Family-Style Teaching Homes: An Alternative to Traditional Models of Group Care

Erin O'Reilly

Closer to Home has provided community-based, family-style, professionally parented group care programs for the past fifteen years using the evidence-based Teaching-Family Model. The ***Teaching-Family Model*** is an organized, fully integrated approach to providing humane, effective, individualized treatment and services to individuals, families and children. Through research and scrutinized clinical practice, an integrated set of procedures emerged that has been developed and advanced resulting in a model of treatment that is cost efficient, replicable, and highly effective. The Model is a philosophy of care and treatment that prioritizes therapeutic relationships with practitioners as the primary conduit of effective treatment. Family-style relationships are seen as essential to healthy development of social and interpersonal skills.

With research evidence most currently reviewed by the California Evidence-Based Clearinghouse for Child Welfare (CEBC) in October 2013, **The Teaching-Family Model has been given a scientific rating of 3 – Promising Research Evidence** in the 'Higher Levels of Placement, Parent Training Programs and Behavioural Management Programs for Adolescents in Child Welfare' topic areas. The CEBC site states; **the Child Welfare Relevance Rating for this Model is High.**

The Teaching-Family Model is defined by standards of service and standards of ethical conduct which form the foundation of model fidelity. The Teaching-Family Association (TFA) develops and oversees the implementation of these standards in all certified Model agencies through an annual review process. Standards reflect essential elements of the Model as they apply to integrated service delivery systems.

Teaching Family programs can scale up quickly and do so in a manner that produces quality implementation quickly. This is possible because systematic implementation is integral to everything that these programs do. Thus, if a Teaching Family agency takes on a new program, the agency can count on the fact that the program will be effectively implemented well inside of a year. In short, TFA agencies can reliably deliver quality programs very quickly.

Over the last fifteen years, we have collected data using the Child and Adolescent Functioning Assessment Scale (CAFAS) to inform practice and ensure a high-fidelity implementation of this best practice model. The data from the last two years indicates that youth were typically reducing risk factors, participating in community activities, improving or maintaining (if on par) school functioning and social functioning and satisfied with the services provided. However, youth were not being discharged to less restrictive placement at the target rate, indicating that Closer to Home needed to review and adapt the programs to improve in this goal area.

The following three tables present our targets and outcome data over the last two fiscal years for our three, 5-bed Calgary Group Homes, serving fifteen youth in total.

Table 1. Closer to Home Original Stated Outcomes

Goal	Outcome	Performance Measures	Target
Children and families are Safe	Significant change in behavioral or emotional situation from intake to discharge	Percentage of youth and caregivers who maintain or demonstrate a reduction in risk behaviours in their CAFAS Scores	70% reduce/or maintain a normal level of risk (self-harmful) behaviors
Children and families are Healthy	Youth will increase or maintain positive/healthy behaviors	Improvement/maintenance of overall total CAFAS scores pre-post.	70% of youth improve and/or maintain a competent level of functioning
Improve positive connections with the community	Youth will live successfully in their community	Pre-Post CAFAS Community Subscales Community Involvement	80% of youth will score 10 or less in the community subscale. 100% of youth participate in a structured community activity.
Improve youth's functioning by increasing each youth's pro-social skills, adaptive functioning and emotional development.	Youth will return home or live in less restrictive placement and be more successful academically and socially.	Pre-Post CAFAS Pre-Post school subscale Discharge Data	70% of youth will maintain/improve in overall functioning as indicated by pre-post CAFAS scores. 70% of youth will maintain/ improve in school and social functioning. 80% of youth are discharged to a less restrictive placement
Consumers are satisfied with services provided	Consumer s will be satisfied with the overall program	Consumer Satisfaction survey	Consumer satisfaction scores will average 6 or above (out of 7).

Table 2. Outcomes – Fiscal Year Ending 2012

Goal	Target	Outcome	Above or Below Target
Children and families are Safe	70% reduce/or maintain a normal level of risk (self-harmful) behaviors	80% reduced and/or maintained level of risk behaviors	Above (10%)
Children and families are Healthy	70% of youth improve and/or maintain a competent level of functioning	67% improved and/or maintained a competent level of functioning	Below (3%)
Improve positive connections with the community	80% of youth will score 10 or less in the community subscale. 100% of youth participate in a structured community activity.	90% scored 10 or less in the community subscale 91% participated in structured community activities	Above (10%) Below (9%)
Improve youth's functioning by increasing each youth's pro-social skills, adaptive functioning and emotional development.	70% of youth will maintain/improve in overall functioning as indicated by pre-post CAFAS scores. 70% of youth will maintain/ improve in school and social functioning. 80% of youth are discharged to a less restrictive placement	67% maintained or improved overall functioning 89% maintained or improved school and social functioning 50% discharged to a less restrictive placement	Below (3%) Above (19%) Below (30%)
Consumers are satisfied with services provided	Consumer satisfaction scores will average 6 or above (out of 7).	Average satisfaction 6.4 out of 7	Above

Table 3. Outcomes – Fiscal Year Ending 2013

Goal	Target	Outcome	Above or Below Target
Children and families are Safe	70% reduce/or maintain a normal level of risk (self-harmful) behaviors	78% reduced and/or maintained level of risk behaviors	Above (8%)
Children and families are Healthy	70% of youth improve and/or maintain a competent level of functioning	69% improved and/or maintained a competent level of functioning	Below (1%)
Improve positive connections with the community	80% of youth will score 10 or less in the community subscale. 100% of youth participate in a structured community activity.	81% scored 10 or less in the community subscale 100% participated in structured community activities	Above (1%) On target
Improve youth's functioning by increasing each youth's pro-social skills, adaptive functioning and emotional development.	70% of youth will maintain/improve in overall functioning as indicated by pre-post CAFAS scores. 70% of youth will maintain/ improve in school and social functioning. 80% of youth are discharged to a less restrictive placement	69% maintained or improved overall functioning 92% maintained or improved school and social functioning 75% discharged to a less restrictive placement	Below (1%) Above (22%) Below (5%)
Consumers are satisfied with services provided	Consumer satisfaction scores will average 6 or above (out of 7).	Average satisfaction 6.5 out of 7	Above

Knowing that our Group Care programs were not achieving the target of 80% of youth being discharged to less restrictive placements, and due to the financial challenges of operating three separate group homes, in the summer of 2013, Closer to Home proposed a program re-design to Child and Family Services. This proposal included converting the existing Achievement Place 1, Achievement Place 2 and Gap contracts to a continuum of services designed to facilitate family reunification and enhance permanency services for youth in care.

The Achievement Place contract was approved and put into practice in September, 2013. It provides placements for 15 youth in two different placement types. Ten youth are placed in 2 Group Homes in the southwest community of Signal Hill, Calgary.

Five youth will be placed with up to 5 separate Family Teachers in Community-Based Teaching Homes where the caregivers are trained at the same level as group home practitioners but will operate out of their own home. In both placement types, youth will be supervised at a level that is appropriate for their level of functioning, age, skill level, needs.

In the group homes, a professional Teaching-Parent couple lives in an agency-owned home and creates a family style intensive therapeutic environment for the youth in care. The homes are staffed by two full-time professional Teaching-Parents and supported by two program support staff and one relief staff as well 1.5 overnight awake staff. In the “Family Teacher Community Homes”, one individual is required to be at home and acts as the professional parent to one youth. Where there is a couple in the home, both will be equally trained but the “at home” practitioner will be the treatment lead for the youth. All the therapeutic components of the Teaching-Family Model will be in place in the Family Teacher Community Homes.

Youth will enter at any point within this service continuum, and receive individualized treatment services with the goal of reuniting or finding families for a lifetime. Services and resources will be flexibly allocated as needed to optimize the youths’ success in less intrusive settings. For example, Closer to Home will provide services from our maintenance department, increased support in the home and increase per diems to help support the longevity of the placement.

At the same time that Closer to Home proposed this re-design, the leadership was also in the process of developing an Evaluation and Outcome Framework to line up our programs goals with the National Outcomes Matrix, as well as local and provincial initiatives such as the Early Intervention Framework and the Social Policy Framework. This work lead to an exploration of benchmarks for the Child and Adolescent Functioning Assessment Scale in which we determined that some of our targets were unrealistically high based on extensive research. Focusing on our program re-design, our Evaluation and Outcome Framework and appropriate CAFAS targets, we identified and revised our outcomes to fit with the direction of our organization. These stated outcomes are presented in Table 4 and we look forward to collecting and analyzing the data to assess the results of our new way of looking at Group Care.

Table 4. Stated Outcomes following program re-design

Child Safety	**Absence of Maltreatment** **Reduction of Risk Factors**	**0% of Staff Practices/Youth Rights reviews will indicate a concern of maltreatment 0% of Critical Incident reports will indicate injury caused by another youth 80% of youth will demonstrate a reduction in risk factors using the CAFAS**
Child Well-Being	Healthy Social and Emotional Development of Children	60% of youth demonstrate a reduction in CAFAS/PECFAS total score Youth will be absent from school for less than 10% of school days
Family and Community Connections/ Social Connections	Improved Social Connections	70% of youths will be able to identify a non-staff friend, family member or other adult person who offers and provides emotional support and assistance as measured by the *Youth Connections Scale*
Permanence	Youth has a caregiver who exercises day to day parental responsibility and provides emotional security	80% of youths will be able to identify one non-staff person who takes on the parental responsibility role and provides emotional security as measured by the *Youth Connections Scale* 80% of youth are discharged to a less restrictive placement
Consumers are satisfied with services provided	Consumer will be satisfied with the overall program	Consumer satisfaction scores will average 85% or higher.

Special Edition
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Family Centred Practice: A Group Home Perspective

Patrick Langlois, Teri Campbell, & Gena Decker

Within the core of humanity is a desire to be connected, to belong, and to have a place to call home. For youth residing in group care, this connection is a critical part of the treatment they receive. Evidence has shown that "child safety actually improves when the family is connected strongly to the community and not to the child welfare system" (State of Mississippi Division of Family and Children Services, 2005, p. 4). It is essential to include the family (or significant people) in the treatment process, as this inclusion encourages successful reunification and completion of goals. "There is a direct correlation between the frequency of visitation and the successful reunification process" (State of Mississippi Division of Family and Children Services, 2005, p. 36).

- Families are big, small, extended, nuclear, multi-generational, with one parent, two parents, and grandparents.
- We live under one roof or many. A family can be as temporary as a few weeks, as permanent as forever. We become part of a family by birth, adoption, marriage, or from a desire for mutual support.
- A family is a culture unto itself, with different values, and unique ways of realizing its dreams; together, our families become the source of our rich cultural heritage and spiritual diversity. Our families create neighbourhoods, communities, states and nations. (Parents Reaching Out, 2007, p. 1)

Families are the child and youth care worker's greatest resource. Although the family may be encountering crisis, they are also the source of previous successes for the youth in group care. The family knows which strategies work and which ideas have not generated the greatest results. The family knows where to start, and these insights can help group care staff know where to begin.

Family-centred practice is a shift from treating the youth in the context of the setting (group home) to treating the youth in the context of the family and community (National Resource for Family Centered Practice, 2009). To facilitate this process, child and youth care workers need to focus on the priorities as defined by the family. Connecting to the family is an essential aspect of family-centred practice. Mikelson, Chaisson, Bennett, Black, and Seals (2009) have identified six key components to connecting with families:

1. Asking the family what assistance or changes the family wants.
2. Listening actively to the family.
3. Working with the family's definition of the issues and goals.
4. Asking the simple questions and not making assumptions.
5. Consulting with the family on all points and not making decisions about people's lives behind their backs.
6. Always being respectful.

To work effectively with families, it is essential for care workers to establish a level of rapport and trust. This is done through engaging in conversation and listening to how the family identifies the issues. It is important to ask open-ended questions to understand fully the scope of the family's concerns and to hear the family's definition of the resolve. It is equally necessary to work with the family's definition of the issues, as this make them feel heard and validated.

When working with a family, it is imperative to include them in all decisions to develop accountability and commitment.

In our work with youths and families, the following strategies have helped us to focus on their strengths and competencies (Appelstein, 2009):

1. Shift of focus; do not view the family as the problem. Instead, view them as a partner.
2. Focus on what is going well.

3. Talk less and listen more.
4. Look for the hidden treasures and then highlight those to the family.
5. Reframe to focus on strength.
6. Acknowledge that people are more than what is seen on the surface.
7. Remember to compliment successes.

In family-centred practice, care workers engage in partnership with the family. This creates a more open system, which allows for progress. When staff or family work against each other, the bulk of time and energy is spent focusing on flaws and creating issues. Alternatively, when time is spent productively focused on the successes, strengths, and partnerships, the expended energy is purposeful. People work on solutions and feel more encouraged. In a partnership, people's trust is established, allowing for a more open and honest working relationship. This creates a safe environment where people are willing to be more vulnerable, accept the assistance, and create meaningful change. When workers focus on engaging the family, services become more focused and successful (State of Mississippi Division of Family and Children Services, 2005).

To encourage continued success, the youth and family must be connected to the community. The following strategies have helped to create those connections:

1. Engage the family and youth in their interests.
2. Find solutions to obstacles together.
3. Learn what community resources are available in their neighbourhoods.
4. Support them in creating connections they can maintain.
5. Foster independence.

It is vital to learn the family's interests: people won't engage in activities or connections which have no personal value. By finding the activities, events, clubs or associations, and resources that have meaning to the family, workers help to create connections that the family will be invested in maintaining. It is then fundamental to help the family find the required resources to maintain these connections. If the family cannot maintain these connections without the workers' assistance, then independence has not been fostered and the gains made will be

quickly lost when services to the family are removed. However, if resources are found to help the family maintain community connections on their own, then the family is more likely to continue its positive momentum independently. As noted in the *Supervisor's Guide to Implementing Family Centered Practice*, "Families connected to the community become safer homes" (State of Mississippi Division of Family and Children Services, 2005).

When engaged in family work, it is important to believe in the families and support them. It is just as important to push them a bit to work through new challenges and not rescue them. Every new hurdle a family overcomes adds to increased confidence and empowerment and makes them less dependent on others. The most important thing to keep in mind is the concept that families need to feel in control of their lives as much as possible. Care providers are working *with* the family, not *for* them. It is a team approach.

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Recommended Readings:

State of Victoria TRC Evaluation:
http://www.dhs.vic.gov.au/__data/assets/pdf_file/0005/712868/therapeutic-residential-care-report.pdf

State of Victoria, TRC - Taking Stock and Looking Forward:
http://www.aifs.gov.au/nch/pubs/issues/issues35/issues35.pdf

Northern Ireland – 5 Pilots:
http://www.scie.org.uk/publications/reports/report58/files/report58.pdf

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