



Who Cares?

**B.C. Children with Complex Medical,
Psychological and Developmental Needs
and their Families Deserve Better**

December 2014



**REPRESENTATIVE FOR
CHILDREN AND YOUTH**

December 10, 2014

The Honourable Linda Reid
Speaker of the Legislative Assembly
Suite 207, Parliament Buildings
Victoria, B.C. V8V 1X4

Dear Ms. Speaker,

I have the honour of submitting the report *Who Cares? B.C. Children with Complex Medical, Psychological and Developmental Needs and their Families Deserve Better* to the Legislative Assembly of British Columbia. This report is prepared in accordance with Section 6 (1)(c) of the *Representative for Children and Youth Act*.

Sincerely,

A handwritten signature in black ink, reading "mesturpellafond". The signature is written in a cursive, lowercase style.

Mary Ellen Turpel-Lafond
Representative for Children and Youth

pc: Mr. Craig James
Clerk of the Legislative Assembly

Ms. Jane Thornthwaite, MLA
Chair, Select Standing Committee on Children and Youth

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Executive Summary

In April 2011, news of an 11-year-old boy being tasered by police captured headlines and the attention of people across B.C. and nationwide. The Representative's investigation into that incident, reported in *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children*, found failure after failure in the Ministry of Children and Family Development's (MCFD) care of the child – most grievously in failing to provide him with a suitable home and the necessary supports to help him heal from early childhood trauma and meet his full potential.

While extreme outcomes such as this incident can help bring a system's deficiencies to light, they can also be sometimes written off as unusual, isolated and unforeseeable. To do so, however, is to ignore the potential risks to the health and well-being of the nearly 9,000 children and youth in B.C. who are cared for in the same system which so egregiously failed that one young boy. Their experiences deserve consideration as well; their stories are equally worthy of our attention.

Giving proper recognition to each of these unique individuals is beyond the scope of any one project. However, this review aims to give voice to a particularly at-risk group of these young people – those with complex care needs, requiring the highest level of services and supports. From early childhood trauma, including severe abuse and neglect, to physical and developmental disabilities, to assault and self-harm – these are children who have survived horrific circumstances and need a carefully planned continuum of services and a placement that is properly equipped with thoroughly trained caregivers so that they can heal and grow. At the very least, they need a safe place to live so that they can be shielded from further harm. And yet, as the findings of this report show, even this very basic need often has gone unmet for these young people.

The failure to provide proper care often begins with the assessment and planning processes. As detailed extensively in the Representative's 2013 report *Much More Than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care*, high-quality, evolving life-plans must be treated as a necessity and not a luxury. For youth with complex needs, it is particularly important that this planning be built on detailed assessments of strengths, abilities and areas needing support. Failure to do so has an economic, social and moral cost, seen all too clearly in the outcomes for these young people.

And still, even in cases where assessments are done and planning is completed, there are no guarantees. A lack of human and financial resources means that children may not get the services they need to thrive, or even a suitable place to live. For Aboriginal children, this absence of resources is even more glaring. Not only was there an absence of proper cultural planning, but there were, at best, limited efforts to provide culturally-competent training to caregivers of Aboriginal children who were part of this review. This should be the exception, rather than the rule, and points to the nearly complete abandonment of culturally appropriate services for Aboriginal children in care.

This evidence of poor planning or meaningful work also raises questions about the implementation of related services, such as Individual Education Plans and school supports. It is difficult to have confidence that they are being used effectively, which would mean that these children's opportunities to develop their skills and abilities are severely compromised in B.C.

The result is not only poor outcomes, but a staggering loss of potential. Children and adolescents are remarkably resilient, and growing evidence from fields such as neurobiology about brain plasticity demonstrates that positive outcomes are possible. With strong emotional, cultural and behavioural supports and a fully funded and staffed system of services, these youths' lives could have told very different stories. Instead, we are seeing the results of siloed and separate services that are difficult to access. And the government's 2008 attempt at interconnectedness, the much-touted Child and Youth with Special Needs framework signed by the ministries of Education, Health and Children and Family Development, has had seemingly little impact. Children, particularly the most vulnerable, and their caregivers continue to struggle with navigating a chaotic system.

The ministry itself has recognized the shortcomings of its residential care system. A 2012 review conducted jointly with the Federation of Community Social Services (FCSS) essentially called for a comprehensive overhaul of the residential care system. Yet any momentum from the joint report seems to have dissipated. The piecemeal approach of adding a few services here and there appears to be continuing, with MCFD starting and stopping various activities and initiatives aimed at changing the system.

This approach cannot, and will not, achieve the outcomes that young people in care deserve. The B.C. government, federal government (for on-reserve residential care) and MCFD must fully commit to providing the necessary resources to improve the residential care system with a strong focus on the best interests of children and youth. As stated in previous reports by the Representative, the ministry must develop a continuum of residential services for children and youth with complex care needs, address the need for trauma-informed service for children in care, and focus on the practice and application of assessment and planning to ensure that the developmental needs of children in care are met.

Most of all, the attitude of complacency, of "making do", must be changed. It is simply unacceptable when speaking about the lives and well-being of children. There should be no tolerance for poor quality of service, lack of supports and unsuitable placements.

Every child in B.C. has the right to be safe, to be supported, to be heard and to stay connected to their family. This should be no different for children and youth in government's care. And yet, for too many, being brought into government care can be a case of "out of the frying pan, into the fire." This review shows that, while in residential care of MCFD, these young people were often re-traumatized rather than helped, re-victimized rather than protected, and disconnected from their families and communities with little to no thought about how they might transition out of care into adult life. Underserved and unsupported, some of B.C.'s most vulnerable children are drifting through the cracks of this province's fractured residential care system, and will continue to do so unless government takes decisive action.

Introduction

In February 2013, the Representative released *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children*, detailing the devastating consequences that resulted from failing to provide an appropriate residential placement for a boy with complex care needs.

As noted in that report, many of these deficiencies were the result of MCFD's failure to follow both its own standards and its obligations as a prudent parent. Based on those findings, previous reviews and investigations, and reported incidents, the Representative sought to understand the experiences of other children with complex care needs and whether they had a safe, nurturing and secure home in B.C.'s residential care system.

The current review focused on whether the ministry is meeting its requirements to:

- adequately assess and plan for the needs of youth;
- study and approve placements;
- ensure that youths' placements are meeting their needs; and
- monitor placements to ensure quality of service.

The information in this report was gathered in three main ways: a) reviewing the case files of a number of children in care; b) conducting interviews with ministry and delegated Aboriginal Agency (DAA) staff, contracted service providers and foster parents; and c) holding consultations with youth about their experiences in residential placements.

No child should experience the institutional neglect and poor practice described in *Who Protected Him?* Unfortunately, as the results of this aggregate review show, other children and youth in care continue to be harmed by not having residential placements that meet their needs.

Who Protected Him?

Who Protected Him? focussed on an 11-year-old Aboriginal boy who was tasered by police outside his staffed residential home. His complex needs included many emotional, behavioural, medical and developmental issues.

The boy was abused and neglected both in his family's home and while in ministry care. He was moved 15 times while in care and had been subjected to isolation and confinement since the age of eight in multiple group homes contracted by the ministry.

This investigation showed a residential care system that was not only substandard, but also violated the civil and human rights of the child.

The Representative found that the ministry did not fulfill its role as a "prudent parent" and did not provide proper oversight and action in planning for the child's needs.

The report's key recommendation was that MCFD should develop a plan to address the deficiency in matching children in care who have complex needs to appropriate residential placements that meet their needs.

Aggregate Reviews

The Hon. Ted Hughes stated in his BC Children and Youth Review¹ that the Representative for Children and Youth should have the discretion to determine the kind of review that is appropriate in the circumstances and that cases could be examined in aggregate form.

Hughes wrote: *"The primary method of reviewing child injury and deaths will be to examine aggregated information, and identify and analyze trends that will inform improvements to the child welfare system as well as broader public policy initiatives."*

Often aggregate reviews are based on data from files and other administrative records. The information from these files and records is then reviewed and analyzed as a group in relation to legislation, policies and practices to determine if there were any recurring circumstances or trends.

The Representative has completed two previous aggregate reviews. The first was an in-depth look at the lives and deaths of 21 infants within a two-year period (*Fragile Lives, Fragmented Systems: Strengthening Supports for Vulnerable Infants, Jan. 2011*). The second was a snapshot of 15 youth who died by suicide and 74 who self-injured over a three-year period (*Trauma, Turmoil and Tragedy: Understanding the Needs of Children and Youth at Risk of Suicide and Self-Harm, Nov. 2012*).

The case reviews tell the stories of youth who were physically, sexually or emotionally harmed, experienced substance overdoses or harmed themselves. Many of them experienced traumatic events in their families of origin as well as in their MCFD/DAA-approved placements. Examples are used throughout this report to illustrate the circumstances and experiences of these children and youth, with identifying information removed to protect their privacy. Pseudonyms are used for case review examples to protect the identity of the youth and their families.

The Representative acknowledges the resilience of youth in care and the important and often challenging work that caregivers and service providers in this province take on.

Scope

The Representative examined whether B.C.'s youth in care with complex needs had their needs and best interests met and their rights respected within the existing residential care system (e.g. foster and group care). For the purposes of this review, youth with "complex needs" were defined as persons up to age 19, who have serious emotional, mental health, developmental or behavioural needs that persist, cause functional impairment in the home, school, and/or community, involve multiple sectors/child-serving systems; and require specialized treatment or service planning that is integrated.²

¹ Hughes (April, 2006). *BC Children and Youth Review: an independent review of B.C.'s child protection system*. Retrieved from http://www.mcf.gov.bc.ca/about_us/pdf/BC_Children_and_Youth_Review_Report_FINAL_April_4.pdf

² Nickel, Dawn (2013). *Supporting Children and Youth with Complex Needs: Best Practice Approaches* [PowerPoint Slides]

The Best Interests of the Child

The United Nations Convention on the Rights of the Child (an international agreement ratified by 194 countries, including Canada in 1991) Article 3 states: *"The best interests of children must be the primary concern in making decisions that may affect them. All adults should do what is best for children. When adults make decisions, they should think about how their decisions will affect children."* This particularly applies to the ministry and DAAs with guardianship responsibilities for children in care, as per Article 20 of the Convention: *"Children who cannot be looked after by their own family have a right to special care and must be looked after properly, by people who respect their ethnic group, religion, culture and language."*

B.C.'s *Child, Family and Community Service Act (CFCS Act)*, which mandates the work of MCFD, states that a number of relevant factors must be considered when determining what is in a child's best interest, including *"the child's physical and emotional needs and level of development."* It also states: *"if the child is an Aboriginal child, the importance of preserving the child's cultural identity must be considered in determining the best interest."* This principle is further reflected in s. 71 of the Act, which prioritizes a safe placement with the child's extended family or Aboriginal cultural community for Aboriginal children and youth in care.

Two types of residential placements (Level Three foster homes and contracted residential placements) were selected as these tend to be where youth with complex needs are placed. These can generally be distinguished by whether the caregivers are trained, approved and monitored by MCFD/DAA (foster homes), or where the ministry contracts with an agency to provide services.

Once these criteria were established, the Representative set out to answer the following questions:

- What were the characteristics and needs of the youth placed in these residential placements?
- How were the needs of youth assessed?
- How did the system of residential care support, plan for and respond to these youth?
- How were the needs of youth matched to the placement?
- How did MCFD/DAA monitor and support to provide the best quality of care possible?

Methodology

To answer these questions, the Representative used information from three main sources:

1. Thirty-one case reviews, drawn from the incidents of critical injuries and deaths of children and youth reported to the Representative between December 2010 and December 2011;
2. Interviews with 95 individuals including frontline workers, DAA staff, residential care providers and youth mental health professionals, conducted between November 2012 and November 2013; and
3. Three consultations with youth who have lived in MCFD/DAA-funded residential placements, held in the summer of 2013.

These diverse sources allowed the Representative to not only collect evidence from many different perspectives, but also to provide snapshots of the residential care system over nearly three years. This helped to illustrate whether issues were isolated incidents or pervasive and systemic.

Case Reviews

The cases reviewed for this report were drawn from the 49 critical injuries and deaths involving young people with complex needs reported to the Representative between December 2010 and December 2011 (a time frame selected to overlap with the date of the critical injury investigated in *Who Protected Him?*, which was April 2011). A sample of 31 youth was chosen based on the type of injury, their city or region, Aboriginal status and gender, and the type of residential placement (see Table 1). This sample includes both of the youth who died and 29 youth who experienced critical injuries (see Table 2).

Eight illustrative case examples from that sample and one from a previous review are included in this report to help communicate the challenges and missed opportunities these young people faced. While all 31 youth were in MCFD's care at the time of the reported incidents, only 12 of the incidents occurred in the placements themselves. The other 19 incidents occurred in places such as school, a youth detention centre, or a family member's or friend's home. This includes the two youth who died, one of whom was killed in a motor vehicle accident and the other at a friend's home.

The case documentation included information about the child and his or her family, as well as medical, police and placement information. This information was used to outline a timeline of major events in their lives and analyze the key factors related to these incidents. Data collection and analysis focused on the youths' characteristics and needs, the services delivered to them, and the quality of care they received. A cross-case comparative method was then used to identify recurring themes. In cases where concerns arose regarding the follow-up to a critical injury, subsequent records were examined to determine the youth's current safety and well-being.

Table 1: Youth Demographics

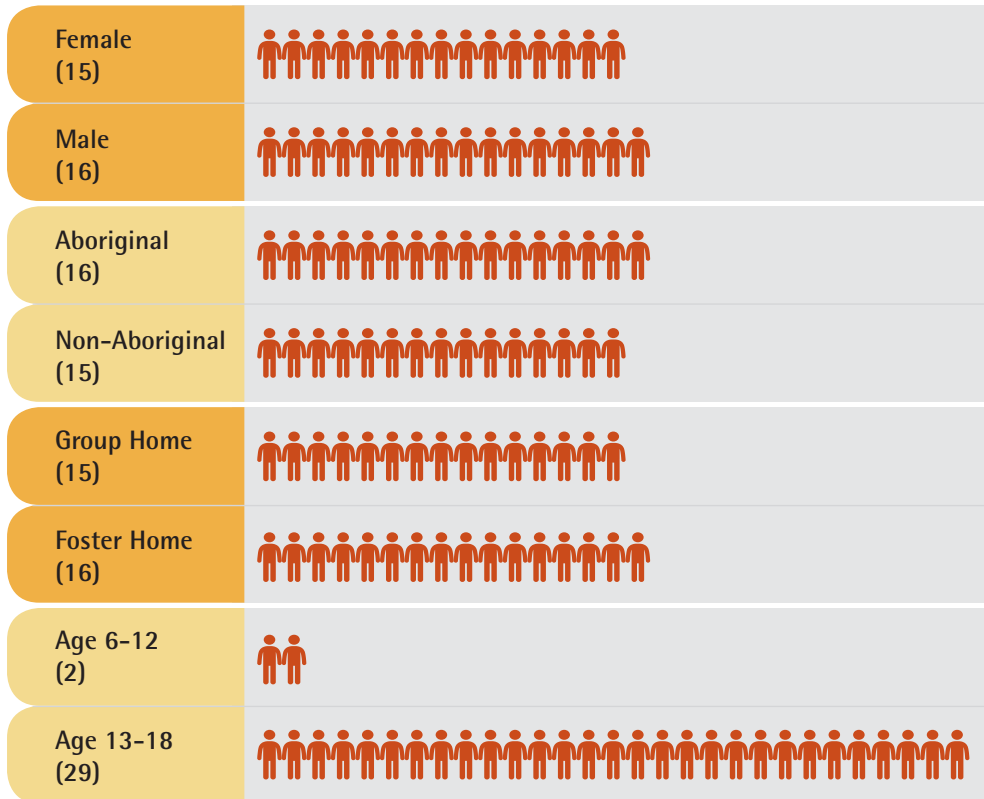
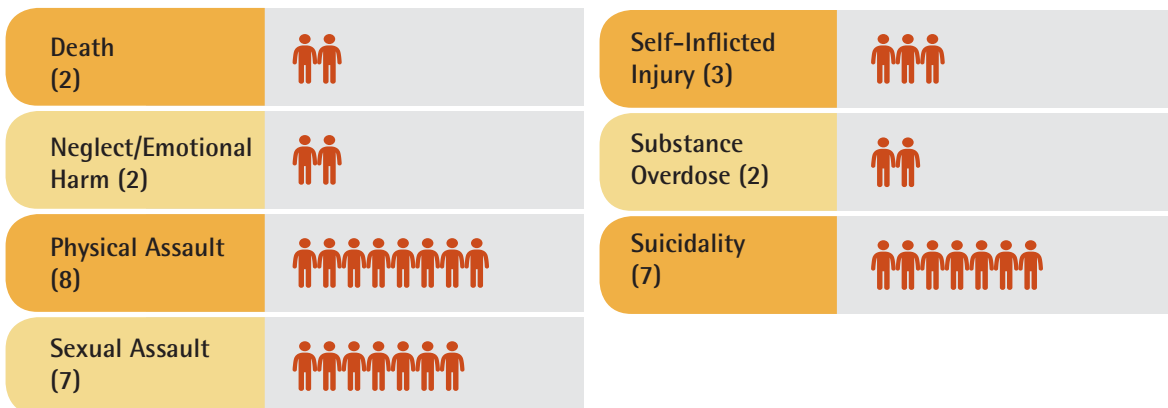


Table 2: Nature of the 31 Critical Incidents



Case Examples

The experiences of eight different young people are shared (using pseudonyms) to illustrate their experiences and missed opportunities.

Peter was failed by a system that allowed him to drift essentially unsupported for more than 17 years. An early Fetal Alcohol Spectrum Disorder (FASD) assessment was misplaced by service providers and not used to inform planning. As a teenager, he suffered from depression and used alcohol problematically. Three assessments at the age of 14 identified learning and emotional problems. However, services appear to have been intermittent and inadequate with no continuity and sustained effort. (p. 24)

Caroline's experience illustrates how unpredictable tragedies can compound a young person's pre-existing complex needs. When her former adoptive mother developed cancer, this young girl – already struggling with a number of physical and mental conditions – was unable to cope. She spent her next years in care in a combination of hotels, hospitals, group homes and in custody, all with an uncertain future ahead of her. (p. 29)

Dean, a boy with multiple complex care needs, lived separately from his foster parent, with the ministry's knowledge that hired staff were providing care overnight and some weekends. However, a failure to properly study and monitor this home meant that the foster parent's unacceptable hiring practices, resulting in improperly screened and untrained caregivers, went unnoticed until Dean disclosed that one of them was sexually abusing him. (p.33)

Stefan's experience provides a stark and heartbreaking illustration of the enduring impact of adverse early experiences, MCFD's failure to intervene protectively and in a timely manner, and the system's inability to adequately address his complex needs. (p. 37)

Tyler's experience demonstrates the lack of early interventions and the continued need for support services when he turns 19. As an infant, Tyler was exposed to traumatic abuse and neglect. His grandparents, who cared for him for most of his childhood, were not provided with effective supports by the system and he was taken into care from the only home he had ever known at age 12. While in care, he had little physical or emotional stability, he was victimized by a sexual predator, he moved frequently, and was involved in street violence. (p. 40)

Sam's experience shows the extreme drift that children in care can experience. Between stints being cared for by his mother, he drifted through 19 foster homes and group homes, had his rights violated in a foster home and never received appropriate mental health supports. Not only was the residential care system unable to meet his complex care needs, it also failed to protect even his basic human rights. (p. 43)

Jill's experience with child protection and the foster care system is a clear example of "too little, too late." By age 14, she had been exposed over an extended period to extreme emotional harm as a result of abuse, neglect, parental mental illness and problematic substance use and domestic violence. She had sought sanctuary at 14 with her boyfriend and his family, where she was exposed to illicit drugs and actively recruited into the sex trade. When Jill was finally taken into care, she was moved numerous times and eventually placed in a contracted placement with staff who did not have the skills necessary to provide her with adequate care to address her unassessed mental health needs. (p. 46)

Jessica's experience shows that a youth's experiences in care depend greatly on the individual caregivers – even within the same agency. Her foster parent was subcontracted by an agency and had the appropriate skills to care for her, while staff at other homes run by the same agency were downloading pornography and engaging in sexual activities on-site. (p. 48)

Interviews

The Representative conducted interviews with frontline workers and managers from MCFD, DAAs, residential care providers and mental health professionals. A total of 95 service providers were interviewed between November 2012 and November 2013.

These interviews were conducted to gain an understanding of the youth-serving systems within which service providers work, and the challenges and successes they encounter in their efforts to meet the needs of youth. (Note that these service providers were not necessarily involved with the 31 youth included in this review.)

In addition, youth in care were consulted to get their perspectives on what does and does not work in foster homes and staffed homes. The consultations consisted of open-ended questions designed to obtain the youths' care experiences and perspectives. Three consultations were held between June and July 2013. The first was conducted at a BC Federation of Youth in Care Network steering committee meeting, with 16 youth participating. The second was conducted with five youth in the Cranbrook area, and the third was with the Vancouver Aboriginal Child and Family Services youth advisory committee, with nine youth participating. In total, 30 youth were consulted, and their responses were also captured in graphic form during the process (see Appendix A).

The combination of case reviews, interviews and consultations provide recent accounts from youth and service providers living in both urban and rural locations. The information from these various sources identified areas that can be improved, questions that should be answered, and steps that can be taken to ensure that the provincial government is meeting the needs of the young British Columbians entrusted to its care.

Background

In many cases, children often come into government care when they have been or are likely to be physically, sexually or emotionally harmed or neglected. In other cases, children are placed in voluntary care agreements because their families are overwhelmed, struggling to cope with their child's behaviours or being put at risk because of them.

When children are taken into care by the ministry, they may be placed in a variety of different types of MCFD-funded homes, such as with relatives approved as restricted caregivers, foster parents or contracted agency caregivers.

In any given month, there are more than 9,000 B.C. children and youth living in placements under the *CFCS Act*, with approximately 8,000 children or youth in the legal custody and care of the ministry and the rest in independent living arrangements.³ According to the joint MCFD/FCSS Residential Review, 95 per cent of all children and youth in residential services are from the child welfare stream, three per cent are from the youth justice stream and two per cent are from Child and Youth Mental Health and addiction streams. Regardless of their differing needs, all children and youth in care in B.C. have the same legal rights (see sidebar on s. 70 of the *CFCS Act*) – each one to be valued and respected equally.

Section 70(1) of the *CFCS Act* states that Children in care have the right to be:

- Fed, clothed, nurtured and given the same quality of care as other children in the placement
- Informed about plans of care
- Consulted and express views about significant decisions affecting them
- Reasonable privacy and possession of their personal belongings
- Free from corporal punishment
- Informed of the standard of behaviour expected by their caregivers and of the consequences of not meeting caregivers' expectations
- Receive medical and dental care when required
- Participate in social and recreational activities if available and appropriate and according to their abilities and interests
- Receive religious instructions and participate in religious activities of their choice
- Receive guidance and encouragement to maintain their cultural heritage
- Provided with an interpreter if language or disability is a barrier to discussing decisions affecting their custody or care
- Privacy during discussions with members of their families
- Privacy during discussions with a lawyer, representative, Ombudsperson or a member of the Parliament
- Informed about and assisted to contact the Representative or Ombudsperson
- Informed of their rights, and the procedures available for enforcing their rights.

³ *MCFD/FCSS Residential Review Final Report*, June 2012. Retrieved from http://www.mcf.gov.bc.ca/pdf/resrevproject_final_report.pdf

History of Residential Care in B.C.

With few publications to document its history, it is not easy to accurately summarize how ministry-funded care has evolved over the years.

What is clear, however, is that the types of placements available in B.C. have continually shifted. In the 1980s, there was a greater reliance on tertiary care beds such as treatment centres. Then, in the early 1990s, the number of beds at these tertiary facilities (such as the Maples and Ledger House) decreased by at least one-third.⁴ Children whose complex needs would previously have been met in treatment facilities with professional care began to be placed with foster parents and community agencies that lacked the long-standing expertise and training of the facilities.

A number of changes occurred with this shift. To match caregivers' expertise to the needs of children, a four-level foster care system was implemented in the mid-90s. Children who continued to require care were placed with contracted agencies, leading to the rapid growth of "satellite homes" with caregivers subcontracted by these agencies (at one point, several community agencies had 30 to 40 subcontracted homes). With limited monitoring by the contractors themselves, and the ministry unable to properly monitor and supervise each sub-contracted home, problems quickly arose, such as children from other jurisdictions being placed in these homes. Eventually, a ban was placed on satellite homes in the late 1990s to address the situation, although some contracted agencies continue to operate satellite homes.

In the early 2000s, foster parent training was standardized and all foster parents were required to undergo 53 hours of training in subjects such as child and youth development, recognizing abuse and neglect, Aboriginal children in care, substance misuse and suicide awareness. This standardized training was intended to provide foster parents with specialized skills to help them deal with physical, emotional or behavioural needs of children in care. Around this same time, a core services review resulted in budget cuts, and many community agencies lost their contracts, leaving fewer homes for children in care.

Throughout the 2000s significant changes were made. New legislation was introduced and child welfare service delivery became regionalized. Government created five service delivery regions (subsequently reduced to four) and just recently, the ministry sub-regionalized by creating 13 Service Delivery Areas within those.

Despite various shifts in models, resource allocation and knowledge, B.C. does not appear to have a better system today than three or four decades ago; it may even be worse. The Province has a system that does not always meet the needs of vulnerable children in care. Children continue to live in homes in which the foster parent doesn't actually reside. There are still contracted agencies that run multiple homes. There are also Level 3 foster parents who operate more like a contractor and foster parents can hire their own staff to care for children. Worst of all, children are not receiving the quality of care that they deserve and some are being harmed by the very system that is supposed to keep them safe.

⁴ "The Maples had 60 youth in residence in the late 1980's compared to only 22 today, while Ledger House has reduced its facility capacity from 16 beds to 8 beds." Retrieved from p.17 of *MCFD/FCSS Residential Review Report* (June 2012) http://www.mcf.gov.bc.ca/pdf/resrevproject_final_report.pdf. According to MCFD numbers, there are currently 13 beds at Ledger House.

Today, there are fewer tertiary resources for children in care with complex needs, and community resources are limited as well. As such, children are being shuffled through the residential care system from placement to placement until they age out of care.

Trauma-informed Practice and Integrated Approaches

The term “trauma-informed practice” describes an approach to working with individuals that recognizes the impact of adverse experiences on future behaviour and coping ability. The effect of early childhood experiences on adolescents has been studied extensively and is recognized as a primary contributor to adolescent maladjustment, negative health outcomes and difficulties with social relationships. These adverse experiences include, but are not limited to, physical and sexual abuse, extreme neglect, exposure to violence and traumatic separations.

“Trauma-informed approaches ready a system or service for any individual or group with trauma experience by increasing awareness of trauma, encouraging recognition of trauma signs among clients and staff, and responding by integrating this knowledge into policies, practices and procedures.”⁵

Given what is known about the cumulative effect of variables such as emotional, physical, sexual abuse and neglect on child and youth functioning and the emerging evidence of their influence on brain development, the challenge will be determining the most effective way to address the trauma.⁶

Recent research has shown that the brain is plastic and receptive to environmental input. This has clinical, practice and policy implications, and provides an opportunity for improved outcomes for children and youth. A number of therapeutic approaches have been developed which draw on this research. These approaches have a number of similarities, focusing on strengthening attachment, teaching self-regulation, and reducing anxiety and impulsivity. One particular approach, the Neurosequential Model of Therapeutics (NMT) developed by Dr. Bruce Perry,⁷ is used as the basis for work with youth with complex needs in Alberta and other jurisdictions.

The trauma-informed approach includes a child-focused program within a therapeutic milieu, with common principles such as:

- adoption of a common and clearly articulated philosophy of care
- culturally relevant care that includes participation of the youth in developing the plan and engagement with the child or youth’s family and community
- transition plans developed after-care to support the work done in treatment, and
- ensuring that interventions do not re-traumatize children.

⁵ Poole, N. (2014). *Trauma informed practice in child and youth services* [PowerPoint slides].p.7.

⁶ Burnside, L. (2012, March). *Special Report for the Office of the Children’s Advocate: Youth in Care with Complex Needs*.

⁷ Perry, Bruce & Hambrick, Erin (2008) *The Neurosequential Model of Therapeutics*. Reclaiming Children and Youth. Vol. 17, No. 3.

Background

However, B.C. has been slow to adopt a system-wide approach that is integrated and trauma-informed. Rather, we have discrete initiatives being piloted in different areas of the province which may or may not include the common principles of a trauma-informed approach. MCFD has launched its complex care initiatives such as the six complex care beds at the Maples Adolescent Treatment Centre and the 20 beds in various communities across the province. The ministry appears to be lagging behind other provinces in providing a range of residential options for children and youth with complex care needs.

For example, Hull Services, a non-profit agency in Calgary, offers a broad spectrum of services to meet the individual needs of children, youth, young adults, families, and communities.⁸ These range from community-based prevention and early intervention, to home-based family counselling and remedial education, to intensive and secure residential treatment. With 80 residential beds, and the associated educational and community programs, Hull serves 3,500 children and families at any given time. It is also in the process of becoming a flagship centre for NMT.

Woods Homes, also based in Calgary, serves a similar population and number of clients through a network of crisis counselling, in-home support and foster care, street services, residential treatment, specialized learning centres and youth-in-transition programs. Woods is also launching a research chair in children's mental health in conjunction with the Faculty of Social Work at the University of Calgary.

Both of these organizations have active research services and strong cultural components to their programming. For example, youth and families at Hull Services and Woods Homes receive individually tailored, culturally appropriate and responsive treatment derived from an Aboriginal perspective. Aboriginal youth are connected to Elders and activities are designed to provide teaching, spiritual opportunities and cultural context to young people in their care. A connection to culture and cultural identity has been noted in the literature as one of the factors that contributes to better outcomes for Aboriginal children and youth.⁹

It is clear that B.C. comes nowhere close to having the quality, range and depth of residential and related services that are available in just one city in Alberta and no over-arching approach to addressing the unique needs of this group of children and youth. Despite having a larger population and a comparably high level of needs, B.C. has significantly fewer specialized treatment beds than Calgary and is lacking an integrated service delivery system. This is an example of how professionals working with children and youth in this province are stymied by the absence of resources and a comprehensive service approach.

⁸ *Hull Services (2011/2012) Annual Report*

⁹ Public Health Agency of Canada. *Aboriginal children: the healing power of cultural identity*. Retrieved from <http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/ahsunc-papacun/aboriginal-autochtones-eng.php>

In the U.S., integrated service delivery systems have been implemented through Wraparound¹⁰ programs. These programs are built on the premise that collaboration between families, community-based agencies and governmental bodies improves outcomes for children, youth and families with complex care needs. Wraparound is a *“family-oriented, democratic practice that demonstrates a faith that individuals with complex needs can be served in the best possible practice when they have their own voice and choice and partners are willing to collaboratively wrap around them.”*¹¹ Programs involve developing individualized care plans for youth who require services from multiple sectors such as education, health, mental health, youth justice and child welfare. Promising research evidence during the past 20 years has resulted in the Wraparound model being referred to by Ontario’s Provincial Centre of Excellence for Child and Youth Mental Health as the most promising model for cross-agency service integration.

While B.C. has taken some steps towards filling some of the gaps in the current system, there is much more work to be done. There is an opportunity to provide stronger supports for children and youth with complex care needs and to achieve much better outcomes. This is especially true for Aboriginal children and youth. The limited number of Aboriginal caregivers and the absence of a strong cultural component to care is of deep concern to the Representative, as is the complete disconnection with families and communities when children enter these services.

B.C.'s Ministry-funded Residential Care System

At any given time, half of the children and youth in ministry-funded residential care are in foster placements. The others are in contracted (staffed) placements (13 per cent), kinship care placements (17 per cent), independent living arrangements (10 per cent), tertiary care (three per cent), adoption residency (four per cent) and other (three per cent).¹²

For this review, the Representative focussed on Level Three foster homes and agency-contracted placements that are funded by MCFD. Within these two types of placements, the residential settings ranged from individual placements in foster or staffed homes to seven-bed contracted placements.

¹⁰ Wraparound is a definable planning process for children and youth with emotional and behavioural needs that results in a unique set of community services and natural supports that are individualized for a child, youth and family to achieve a positive set of outcomes.

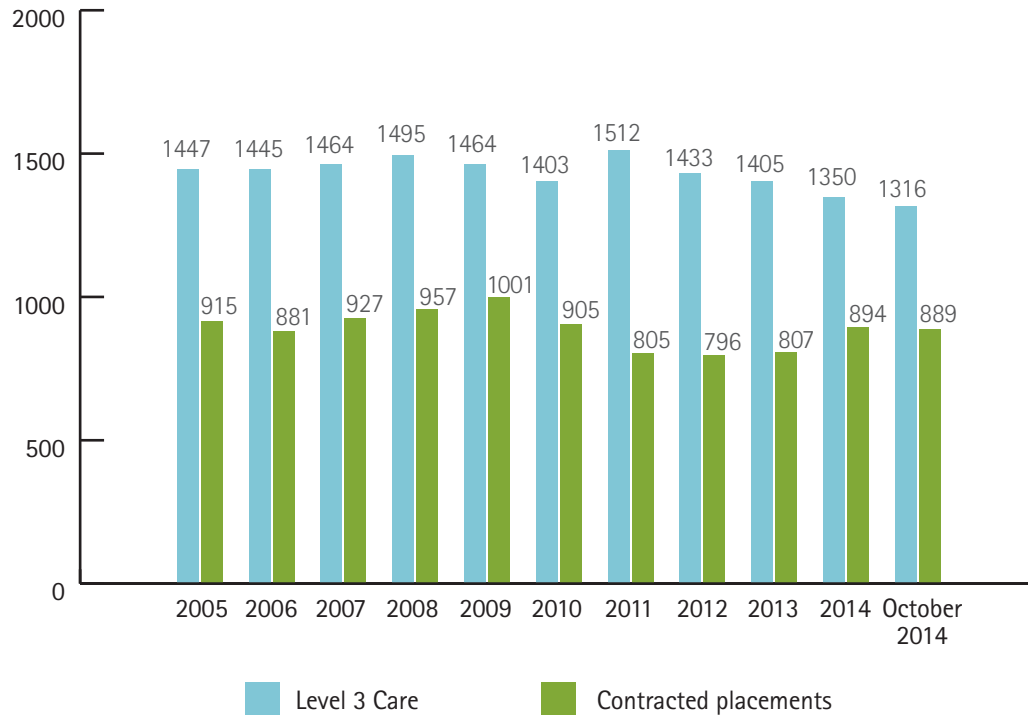
¹¹ Government of Alberta & Community-University Partnership for the Study of Children, Youth and Families (June 2010). *Integrated supports for children, youth and families: A literature review of the wraparound process*. p. 8. Retrieved from <http://education.alberta.ca/media/1920533/executive%20summary%20lit%20review.pdf>

¹² MCFD/FCSS Residential Review Final Report, June 2012. Retrieved from http://www.mcf.gov.bc.ca/pdf/resrevproject_final_report.pdf

Background

The following section provides an overview of the differences (and commonalities) between homes in B.C.'s foster care system and agency-contracted homes.

Number of Children in Level 3 Foster Care and Contracted Placements

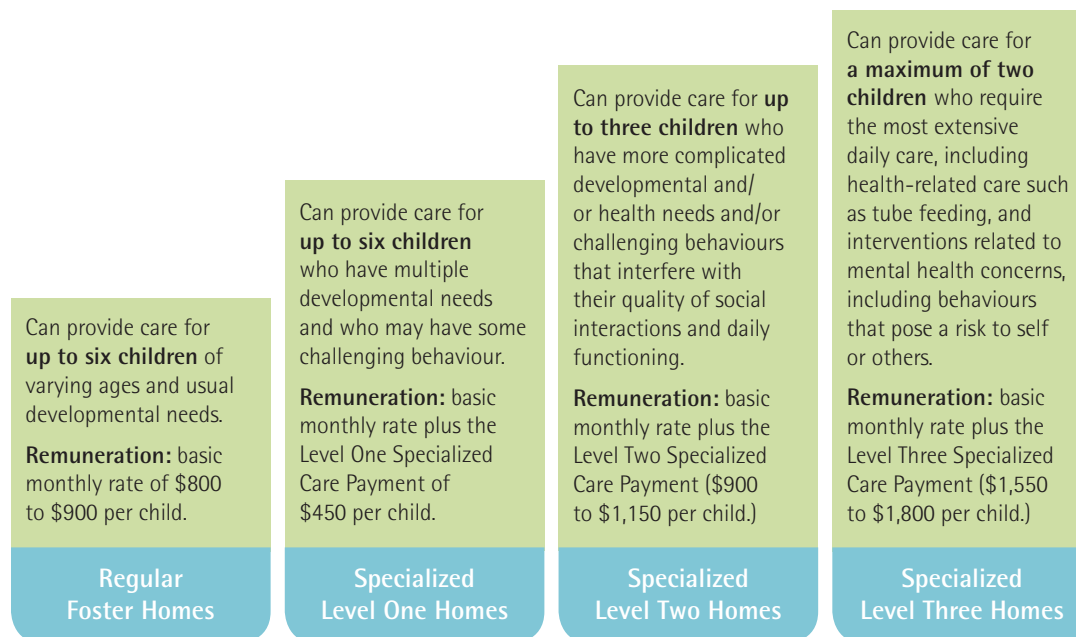


Source: Ministry of Children and Family Development Corporate Data Warehouse

Notes: 1. Figures are March 31

Level Three foster homes

In an MCFD/DAA foster home, the foster parents are recruited, trained, supported and monitored by the ministry. They also typically live in the home where they are fostering the children and youth. Foster parents can also be assigned one of three levels of specialized care, based on their skills and experience, and ability to care for youth with different developmental needs.



Levels of care based on MCFD information, available at www.mcf.gov.bc.ca/foster/levels.htm.

Amounts have been rounded to the nearest \$25.

Contracted Residential Placements

The foster care system cannot meet the needs of all children and youth requiring care. For children who require more specialized services, the ministry/DAA can contract with caregivers to provide care that focuses on the particular needs of a single child or youth, or a group of children or youth. These contracts may be awarded to individuals with specialized training, skills and experience, or to agencies that then hire and train the caregivers for a staffed residential placement (a group home, family care home or a staffed one- or two-bed home). Some agencies also use a “satellite model,” in which they subcontract with foster families. In these circumstances, it is the agency, and not the ministry, that recruits, approves, monitors and supports the subcontracted foster home.

Contractors can be non-profit organizations, for-profit organizations or a combination of the two. They provide a variety of supports to the home, from basic residential care to a full spectrum of services such as youth care workers, therapists, life skills assistants and tutors. Some operate as large organizations with multiple programs in different communities serving children, youth and adults with special needs, mental health issues and/or high-risk lifestyles. For example, a large organization may be responsible for a dozen homes with placements for 20 children in total. Programs can range from short-term emergency accommodations to long-term residential options.

Background

In some circumstances, the agency's staff complement includes youth workers, on-staff or contracted psychologists and other support workers.

Under B.C.'s *Community Care and Assisted Living Act*, a contracted residential placement which has three or more beds must be licensed, regulated and monitored by a regional health authority. All incidents involving youth in a licensed facility must be reported to both the ministry and the licensing officer within the regional health authority for follow up. (Two of the youth in this review resided in such placements.)

Contractors operating staffed residential facilities are required to go through an accreditation process if the contracted agency receives \$500,000 or more in MCFD and/or Community Living BC (CLBC) contract funding.¹³ The accreditation process includes an internal review, onsite survey, and quality improvement plan. Agencies are usually accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA), MCFD's two not-for-profit, approved accrediting organizations.

This review included an examination of the youths' case documentation to determine whether practice was in keeping with the applicable MCFD and DAA standards for both foster homes and contracted placements. However, as illustrated in Table 3, clear monitoring guidelines, including the nature of quality of care concerns or the process for a protocol investigation (see text box), do not exist for contracted placements.

Following the ministry's review of a large contracted agency in May 2014, MCFD has stated its intent to undertake a review of the current residential standards to ensure clarity and consistency.

Quality of Care Concerns and Protocol Investigations

A **quality of care concern** is a situation when, while the child's safety is not at issue, concerns exist about a foster home's adherence to standards, such as a family's access to a child in care or methods used for discipline. The standards do not set one specific procedure for when and how to complete quality of care concern reviews, leaving it to the social workers' discretion.

A **protocol investigation** occurs when instances of abuse and/or neglect in a foster home are reported. Social workers with MCFD or DAAs have specific procedures to follow when such reports relate to a foster home. The procedures include notifying the foster parent that an investigation will take place, completing a thorough investigation and developing a communication plan with the foster parent. Investigation findings are reported to foster parents and involved MCFD/DAA staff no more than 30 days from the commencement of the investigation. Possible outcomes include leaving the children in the foster home, placing restrictions on the number and age of children in the foster home, removing children from the foster home, requiring the alleged offender to leave the foster home or closing the foster home.

¹³ Retrieved from http://www.mcf.gov.bc.ca/accreditation/faq_contractor.htm

Table 3: Comparison of Placement Types

	Foster Placements	Contracted Placements
Caregivers typically live in the home?	Yes	No
Caregivers recruited and trained by:	MCFD/DAA	Contractor
Remuneration determined by:	Rates set by MCFD	Set by contract manager on a case-by-case basis
Caregiver standards:	Standards for Foster Homes ¹⁴	Standards for Staffed Children's Residential Resources (SSCRS) ¹⁵
Social work standards for MCFD staff:	Caregiver Support Service Standards (CSSS) ¹⁶	Caregiver Support Service Standards (CSSS)
Social work standards for DAA staff:	Aboriginal Operational Practice Standards and Indicators (AOPSI) ¹⁷	Aboriginal Operational Practice Standards and Indicators (AOPSI)
Guidelines for monitoring caregivers/placements:	CSSS (MCFD social worker) AOPSI (DAA social worker)	CSSS; however, there are no guidelines for addressing quality of care concerns or protocol investigations

Ministry/Federation Joint Residential Review

In 2010, MCFD and the Federation of Community Social Services of BC (FCSS) entered into a joint initiative aimed to improve the care and outcomes for children and youth in residential resources operating under MCFD contracts. The residential review project had three phases:



Phase 1 was completed in June 2011 and Phase 2 was completed in June 2012, with the release of a report identifying seven strategic directions (see sidebar) and 32 recommendations and supporting actions reflecting what stakeholders, key informants and advisors said would be critical to changing residential care and improving the experiences and outcomes for children and youth.

¹⁴ Standards for foster homes (1998) http://icw.mcf.gov.bc.ca/manuals/docs/cfdev/rr/standards_foster_homes.pdf

¹⁵ Standards for Staffed Children's Residential Services (1998) http://www.mcf.gov.bc.ca/child_protection/pdf/standards_residential_services.pdf

¹⁶ Caregiver support service standards (2006) http://www.mcf.gov.bc.ca/foster/pdf/sp_caregiver_support.pdf

¹⁷ Aboriginal Operational Practice Standards and Indicators (2009) http://www.surroundedbycedar.com/files/brochures_and_documentation/AOPSI_2009.pdf

Seven Strategic Directions

- 1) **Achieving permanency:** Embed permanency¹⁸ as a key priority throughout the residential care delivery system.
- 2) **Enhancing kinship care:** Give priority consideration to placement with relatives and other significant adults who have an established relationship with a child or have a cultural or traditional responsibility toward a child.
- 3) **Strengthening foster care:**
 - Realign and strengthen foster care services and supports to better achieve permanency and stability.
 - All components of the array must share a common framework or common principles guiding practice to ensure children, youth and families benefit from a coherent and integrated system of care and treatment.
- 4) **Planning and developing an accessible array of residential care and treatment services:**
 - Building a planned system of residential care and treatment services based on research and best practices.
 - Building a planned system of intermediate residential care and treatment services based on research and best practices.
 - Addressing the key gaps in tertiary care and treatment services.
- 5) **Addressing youth interests in permanency and transitions:** Pursue permanency options for youth aged 16 to 18 and improve preparations for transitions to adulthood including strengthening post-majority supports and services for 19- to 24-year-olds.
- 6) **Working together effectively:** Enhance the working relationships within the residential care system as an essential foundation for implementing the recommendations and supporting actions across all of the strategic directions.
- 7) **Enhancing accountability in residential care:** Build accountability and continuous learning into the process of implementing the recommendations and supporting actions across all of the strategic directions for residential services.

Phase 3 is still in progress. Following the joint residential review, MCFD developed a document entitled *Blueprint for Action* to “set out a multi-faceted response” – both to the review and to the initial consultations with Aboriginal partners that were part of that review.

The *Blueprint for Action* was intended to provide a plan for redesigning the residential care system, to be implemented in five phases. The first phase was to establish a “hub and spoke” structure to allow for integrated teams at the local service area or community level. These teams were to be comprised of ministry or DAA staff, community social service agencies and foster parents as part of a “community of caring” services system. The next four phases included linking in youth and adult support services, extended family support services, family services and the early years and community Child and Youth Mental Health services.

¹⁸ Permanency is defined as safe, stable and enduring family relationships for children and youth through reunification, adoption, transfer of guardianship or other meaningful lifelong connections (*MCFD/FCSS Residential Review*, June 2012).

Since then, MCFD seems to have shifted its focus from the system-wide change described in the *Blueprint for Action*, to two primary activities: a complex care initiative, consisting of the Maples Adolescent Treatment Centre and 20 other beds in five different communities; and caregiver support networks, made up of four to eight foster homes within a community.

However, these two residential redesign activities address only some of the issues identified in the residential review. While they provide desperately needed resources for children with the most complex needs, they do nothing for the vast majority of the in-care population.

As Charles and Garfat state, one of the key problems with the current residential care system is that “*rather than being one system with one common set of values and beliefs, we have a series of overlapping and sometimes contradictory programs within which any number of historical foundations may be present.*”¹⁹

This appears to be true for B.C.’s residential care system, where discrete initiatives over a number of years have formed the ministry’s residential care model, without the sense of a unifying framework. As the ministry’s model has evolved, there has been significant research and innovative thinking with respect to caring for children and youth. While some of the planning and development has been evidence-informed, there does not appear to be an over-arching framework guiding development.

The joint report uses the term “*cohesion*” to describe a unified system of care and notes “*...vastly different beliefs, values and approaches could be confusing or destabilizing and possibly diminish any healing and development that the child or youth achieve.*”²⁰ It recommends that “*MCFD and service providers, with advice from Delegated Agencies, should establish a philosophical foundation of principles and values to guide the delivery of residential care and treatment services that reinforce safety, well-being and permanency, and support system design and practice.*”²¹ While MCFD’s *Children and Youth with Complex Needs Concept Paper* identified this need, the current approach appears to be less comprehensive.

The Representative also notes the perception that MCFD has not been proactive in involving its partners, such as contracted agency staff, foster parents, and DAAs in implementing an action plan for redesigning the residential care system. These partners each have a mandate to serve children and youth in care and have experience and expertise in residential care. MCFD has also not been active in involving families of children with unique medical needs who have placed their children in foster care in implementing the redesign action plan.

¹⁹ Charles, G. & Garfat, T. (2010). *Beyond Residential and Community Based Services: A Conceptual Model for an Integrated Youth and Family Service Delivery System in Canada*. RCYCP Vol. 23, No. 4, p.46.

²⁰ BC Ministry of Children and Family Development & The Federation of Community Social Services of BC (June 2012). *MCFD/FCSS Residential Review Project Final Report*, p.61.

²¹ *Ibid.*

Background

To date, the ministry has involved the DAAs minimally in the conceptualization and planning of the 26 new beds and the caregiver support networks. Therefore, the ministry has missed an opportunity to ensure that the residential redesign will result in positive outcomes for Aboriginal children and youth – an unacceptable fact, given that more than 50 per cent of children in care are Aboriginal, and that nearly half of them are served by DAAs. Without a clear focus on their cultural needs, Aboriginal children and youth will continue to face poor outcomes. As Chandler and Lalonde state, *“the predictable consequence of such personal and cultural losses is often disillusionment, lassitude, substance abuse, self injury ...”*²²

The ministry has not identified possible barriers to implementing these redesign initiatives, such as the isolated rural areas without access to secondary resources and the lack of new funding to support the residential redesign. Further, there is no mention of specific quality assurance activities such as the collection and analysis of data on client outcomes or an audit program to monitor whether the redesign initiatives will result in better services and outcomes for children and youth in care.

²² Chandler, M. & Lalonde, C. (2008). *Cultural Continuity as a Protective Factor against Suicide in First Nations Youth. Horizons A Special Issue on Aboriginal Youth, Hope or Heartbreak: Aboriginal youth and Canada's Future.* 10(1), 68-72.

Analysis and Findings

In order for youth with complex care needs to have positive outcomes in residential placements, the ministry must assess both the youth and the potential placements, match them appropriately and monitor the situation to ensure that the necessary services are being provided. The complexity of many of these cases also means that this must be an ongoing process. The Representative reviewed the selected case files, interview information and youth feedback to understand the extent to which these steps were being successfully completed.

The Representative's analysis finds that the ministry/DAA's are not meeting their requirements to adequately:

- a) assess and plan for the needs of youth;
- b) study and approve caregivers for placements;
- c) match youth with complex needs to suitable placements; and
- d) monitor placements to ensure quality of services.







Overall Finding

B.C.'s residential care system lacks the capacity to provide appropriate, supportive and culturally competent care to meet the needs of children and youth with complex needs.

Each of the youth included in this aggregate review had experienced trauma, and either died or was injured while in the residential care system. Despite the efforts of committed and hard-working staff, these youth frequently did not receive timely assessments of their physical, psychological, cultural, educational, social and emotional needs; the assessments were not made an integral part of planning; and workers had difficulties matching youth to placements that could meet their needs. Consequently, many had placement disruptions and drifted within the residential care system, with negative outcomes (see Table 4). Few experienced a sense of permanency or belonging.

The complex needs of the youth and the services available to them were often mismatched, particularly for Aboriginal youth because of a lack of both cultural planning and culturally competent services. This means that foster parents were often ill-equipped to care for the youth placed with them, and were under-supported by the ministry. Contracted agency staff often worked in isolation or had an arms-length relationship with the ministry. The combination of a fragmented residential care system and caregivers who lacked a good understanding of the youths' complex needs left many vulnerable youth in unsuitable homes and failed to prepare them for independent living after their time in care.

Table 4: Known Outcomes

Sexually exploited or abused (12)	
Involved in the youth justice system (9)	
Mental Health Problems (21)	
Developmentally delayed (10)	
Problematic Substance Use (17)	
Suicidal behaviours (17)	

Peter

Peter was born in the Lower Mainland, to a family from a northern First Nation. From ages 1½ to four, he and his older brother were removed from their parental home and returned several times because of his mother’s substance use. Peter had witnessed domestic violence and was reportedly sexually abused by a family member. He did not attend preschool, did not know his father, and lived in eight different homes during this time.

At the age of four, Peter was placed with his aunt. A neurodevelopmental assessment confirmed that he suffered from Fetal Alcohol Spectrum Disorder caused by prenatal alcohol exposure, and he began to receive child care and speech therapy. After almost six years, the placement broke down due to conflict between the aunt and his mother. He was moved to a group home for a year, where he had regular contact with his mother but little contact with his brother or his aunt. Group home staff noted that Peter was generally withdrawn, had anger management problems and did not want to attend school. He was later moved to a Level Three foster home, where there appears to have been ongoing communication difficulties between the social workers, other professionals and the foster parents.

When Peter was 14, his brother died and Peter started to show symptoms of depression, confirmed through two psychiatric assessments. His social worker also arranged for an FASD assessment. Shortly after this FASD assessment was complete, the previous assessment from 10 years earlier was found on file. As his doctor noted: *“This important information had been lost somewhere along the line as his social worker and foster family did not know that he had been diagnosed with partial FASD.”* A psycho-educational assessment was also completed and he was placed in a modified program with additional school supports. By this time, however, he was no longer interested in attending school.

At age 16, Peter ran away from his foster home. His friends found him outdoors, wet, partially dressed, and distraught. He had recently lost a good friend and was contemplating suicide. One of his friends called his own foster mother to help when Peter’s foster mother did not respond to his call. The friend’s foster mother took Peter home, contacted emergency services and provided the immediate care he needed.

Peter (continued)

Following this incident, the Ministry conducted a Quality of Care Review and the home remained open with the recommendation that the foster mother report the youth's absences to her placement worker. A Comprehensive Plan of Care (CPOC) was not on file. However, documentation suggests that Peter had begun using alcohol problematically, was frequently absent from school and was involved in some minor criminal activity involving the police.

Subsequent to this incident, Peter was hospitalized after having a seizure while heavily intoxicated. The incident was not reported to the Representative. For the next year, it appears that his circumstances worsened and he became more involved with alcohol. It does not appear that any transition planning took place. The last documented placement on file for Peter, at age 19, was his mother's home.

With the exception of his time in his aunt's home, Peter's placements were not First Nations homes and did not appear to have a strong cultural component. While he had ongoing contact with his extended family, a Roots²³ assessment and a homecoming event, he was not consistently involved with his Aboriginal community and MCFD was not proactive in preserving and promoting his Aboriginal identity. Without the commitment to an ongoing cultural plan, the supports connecting Peter to his cultural heritage were superficial and insufficient to help him develop a strong cultural identity.

Assessments and Planning

Finding: Inadequate assessment, inconsistent planning and the absence of a cultural focus jeopardize the well-being of children and youth in residential care settings in B.C.

CIC Standard 11 (Assessments and Planning for a Child in Care) requires that an initial assessment of a child's needs be completed within 30 days of the child coming into care, and that a full assessment and written plan of care be completed within six months of a child coming into care. The plan of care must reflect and be responsive to ongoing assessments of the child's needs and must ensure that services in place for the child support the overall goal and are focused on the best outcomes for the child. MCFD established a practice directive in June 2013 regarding children and youth in care that, among other things, calls for a formal review of the Care Plan after each new plan is completed, a new Care Plan to be completed on an annual basis and that when a significant event occurs in the life of a child or youth, that the Care Plan is reviewed and updated accordingly.

Cook et al (2007) stressed that the first step in effective service provision is a comprehensive, culturally sensitive and language-appropriate assessment including information from a number of sources: the child's own disclosure; collateral reports; therapist observations; and standardized measures.²⁴ A thorough and comprehensive assessment of the child's needs must be completed as early as possible in order to determine what placement would best meet a child's needs and therefore be in the child's best interests. Such assessments must include input from families.

²³ The Roots program assessment identifies children for whom a return to family and community may be appropriate, assists with the development and implementation of appropriate reunification plans and identifies and implements strategies to strengthen the child's connection to their community and culture and the community's involvement in planning for the child.

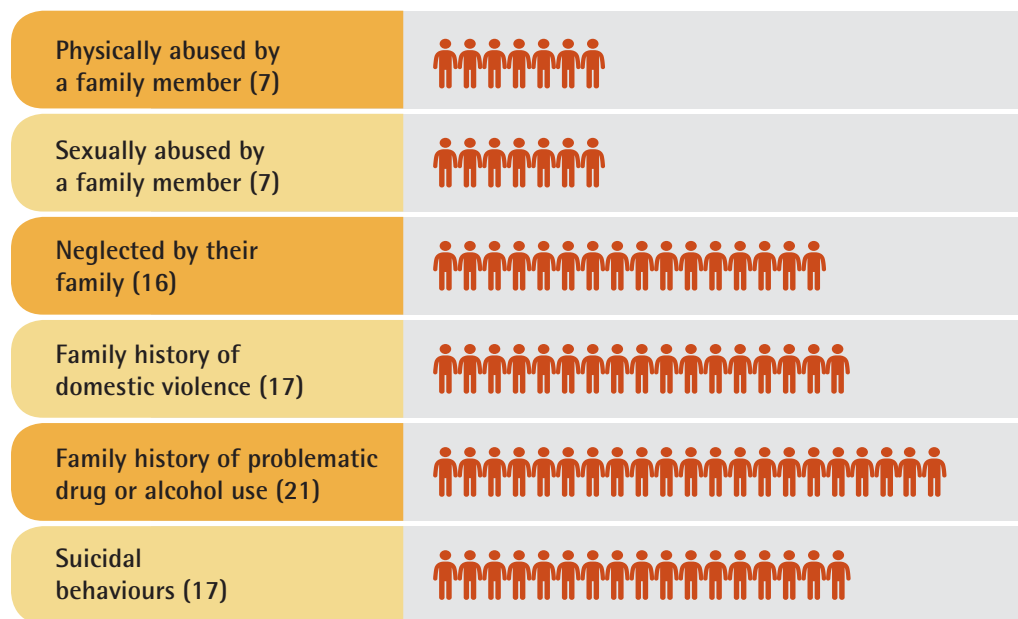
²⁴ Cook, A.; Spinazzola, J., Ford, J.; Lanktree, C.; Blaustein, M.; Sprague, C.; Cloitre, M.; DeRosa, R.; Hubbard, R.; Kagan, R.; Liautaud, J.; Mallah, K.; Olafson, E.; van der Kolk, B. *Complex Trauma in Children and Adolescents, Winter 2007 Focal Point, Vol. 21, No. 1.*

Assessments

While the majority of the youth in the sample (24 out of 31) had received an assessment at some point in their lives, few had such assessments completed when they first entered into care or had ongoing assessments. Even when conducted, assessments were not necessarily used to inform planning or service provision. In short, standards of practice were not met.

This is particularly concerning when the complex needs of the youth in the sample are considered. The case reviews showed that all 31 youth were involved with two or more services including Child and Youth Mental Health, child welfare, substance use, child and youth with special needs, youth forensic psychiatry, youth custody services and community probation services. Furthermore, they were known to have experienced at least one form of trauma in their family of origin (see Table 5). These traumatic events in childhood – often termed adverse childhood experiences – are associated with social, emotional and cognitive impairments that can lead to increased risk of unhealthy behaviours, violence or re-victimization, disease, disability, and premature mortality.²⁵

Table 5: Known Early Traumatic Experiences



As well, comprehensive assessments not only identify a child or youth’s deficits but can also identify strengths. Cook et al (2007) identified areas of competence and creativity as mitigating factors in the impacts of complex trauma.²⁶ The identification and fostering of unique abilities and strengths were few and far between in the 31 files reviewed by the Representative.

²⁵ Anda, Robert (2011). *The Health and Social Impact of Growing Up With Adverse Childhood Experiences: The Human and Economic Costs of the Status Quo.*

²⁶ The term “complex trauma” describes both children’s exposure to multiple traumatic events, often of an invasive, interpersonal nature, and the wide-ranging, long-term impact of this exposure. These events are severe and pervasive such as abuse or profound neglect. Retrieved from <http://www.nctsn.org/trauma-types/complex-trauma>

MCFD's 2013 concept paper, *Children and Youth with Complex Care Needs*, identified a common comprehensive assessment as the core of the approach to care and treatment. However, interviews with staff revealed that the practice and application of assessment in planning is being hampered by chronic staff shortages, staff workload, turnover and stress, as well as a lack of access to medical and mental health professionals in various communities.

Planning

In her March 2013 report, *Much More than Paperwork: Proper Planning Essential to Better Lives for B.C.'s Children in Care*, the Representative recommended that "MCFD and DAAs focus on the practice and application of assessment and planning to ensure the developmental needs of children in care are met, including the desired outcomes and expected outcomes from services."²⁷ At the core of this is a Comprehensive Plan Of Care (CPOC), which is required by ministry standards for each child or youth in care.

That report found inadequate documentation and use of CPOCs, and the results of the case reviews and interviews were no different. Few of the caregivers interviewed reported being provided with a CPOC. Further, 18 of the 31 youth files (58 per cent) had CPOCs that were outdated, lacked components such as a cultural plan, were not comprehensive or failed to list caregiver responsibilities. Given the complex needs of the youth in these placements, caregivers must not only be fully aware of the youths' needs, but involved in the development of the plan to serve them.

"We have not received any CPOCs. We do our own assessment and service planning for each child. We have our own psychologist on staff."

– contracted service provider

"We are on our own and accept it when we get the referral ... we can ask for care team meetings but we sometimes don't get a response from MCFD/DAA."

– contracted service provider

This includes recognizing and prioritizing planning around developing and preserving cultural connections and identity, which are protective factors that mitigate risk for Aboriginal children and youth. It is imperative that cultural planning be part of their process when brought into care, particularly for Aboriginal children and youth with complex needs. And yet, only half of the 16 Aboriginal children and youth in the sample had evidence of cultural planning on file, and none had a comprehensive separate cultural plan as required by the MCFD and DAA standards (see textbox on p. 28).

²⁷ Pg. 90

Standards of Culturally Competent Care

AOPSI Voluntary Standard 11 – Preserving the Identity of the Child in Care and Providing Culturally Appropriate Services:

The social worker will preserve and promote the cultural identity of the child in care and provide services sensitive to the child's view, cultural heritage and spiritual beliefs

CIC Standard 1 – Preserving the Identity of an Aboriginal Child in Care:

In partnership with the Aboriginal community and identified delegated agency, take ongoing action to establish or preserve the identity of Aboriginal children in care by

- Exploring a child's cultural connection, heritage, community or tribal history and descent.
- Developing a cultural plan to promote the child's Aboriginal identity
- Making applications to pursue membership or entitlements
- Honouring and following placement priorities for Aboriginal children in care

Transition Planning

All of the youth in the Representative's sample experienced some degree of childhood maltreatment. It can therefore be anticipated that many will require supports as adults. Planning for this transition to adulthood must begin early, and consider the impact of trauma and their ability to function independently. The documentation in the files reviewed by the Representative showed little effective or comprehensive planning by either the ministry or DAAs with respect to the youths' needs when transitioning out of care.

The Representative's *Much More Than Paperwork* report identified transition planning as a significant weakness in the ministry's service delivery to youth, and recommended that "*MCFD immediately develop policies and guidelines to support youth who are transitioning out of care and consider how best to support them beyond the age of 19 given that planning has not been adequate to date to support smooth transitions.*"²⁸ While MCFD implemented a new Care Plan in June 2013, it is too early to assess whether this has resulted in improvements in transition planning.

Interviews indicated that many service providers and caregivers recognize the need for more comprehensive transition planning and the need for services for youth in care after the age of 19. They expressed frustration with the challenges experienced in properly transitioning youth out of care and making sure that their needs are met after they turn 19. They felt that there was also a significant gap between the child- and youth-serving system and the adult-serving system, resulting in youth not receiving the level of services necessary to meet their needs as they grow older. This means that many youth experience the negative repercussions of having to leave their placements, and also have difficulty accessing needed adult services.

²⁸ The Representative for Children and Youth (March, 2013) *Much More Than Paperwork: Proper Planning Essential to better Lives for B.C.'s Children in Care*. p. 93

Caroline

Caroline, a non-Aboriginal girl, was removed from the family home as a baby when her mother was incarcerated. Caroline's father had a mental illness characterized by frequent psychotic episodes, and he was unable to care for his daughter. She was placed in a foster home and was diagnosed with FASD. Caroline was subsequently adopted by the foster family at age five, and lived with them until age nine, when she threatened her adoptive sister with a knife. The adoptive mother reported to MCFD that she could no longer care for Caroline in her home.

Caroline came back into care under a Special Needs Agreement and was placed in a foster home. This placement appeared to be stable, until her former adoptive mother developed cancer, and died two years later. Sadly, Caroline believed that she had caused the cancer by being a source of significant stress for her adoptive mother, and reacted with increased aggressive behaviours. This caused her foster placement of three years to break down and, when her social worker could not find a suitable placement, Caroline was placed in a hotel with three child and youth care workers for three weeks.

She then spent three more weeks at BC Children's Hospital, where she was assessed by a psychiatrist and diagnosed with a number of physical and mental health conditions including diabetes, Fetal Alcohol Spectrum Disorder, Attention Deficit Hyperactivity Disorder), and a moderate learning disability. She was prescribed medication and discharged from the hospital without a formalized discharge plan or community placement plan. Again, the social worker was unable to find a placement for her, and Caroline spent two more weeks with child and youth care workers in a hotel. A foster home was then found for her, but this placement broke down in short order as her behaviour became more challenging than the placement could handle.

The ministry placed Caroline in a contracted group home when she was 13. There were numerous incidents in which she was aggressive toward staff, and the group home made some staff changes to accommodate her specific behaviours. They also hired a behavioural consultant to assist with developing behavioural interventions to be used in the home. She was connected to child and youth mental health services, but her appointments with the mental health clinician were frequently cancelled for various reasons such as her unexpected court proceedings. She was assessed by a forensic psychiatrist, whose assessment differed from her previous diagnoses. This resulted in a change of medication. Her behaviours continued to deteriorate to the point where she was frequently assaulting staff and co-residents.

When she was 15, Caroline attempted suicide by electrocution. She refused to go to hospital and was transported there by police. She was assessed at the hospital as not being suicidal and was discharged back to the care of group home staff. When she returned to the home, her aggressive behaviour escalated even further. She attacked a staff member by striking him in the face, injuring him. Police were called and she was arrested and charged with assault.

While in custody, she was assessed by Youth Forensics as not eligible for CLBC services. However, she is a youth with complex needs and will require significant support services after age 19. She is currently living in a secure adult psychiatric facility because there are no other placement options for her.

Service providers were particularly concerned about barriers to transition planning such as waitlists for adult mental health services and challenges in engaging youth in voluntary substance use and mental health services. Service provision is often divided between child and adult mental health service delivery systems. This poses a considerable challenge to caregivers and service providers when coordinating adequate services for youth aging out of care.

Analysis and Findings

Youth in care consulted as part of this review emphasized the need for more supports in the areas of education and employment training such as the need for tutors, help with budgeting, pre-employment training and work experience opportunities. Interestingly, service providers did not comment on the need for these types of supports.

"Adult services don't start considering our youth until a maximum of three months prior to aging out of care ... health services won't do assessments until three months before their 19th birthday."

– MCFD staff member

Innovative Practice: Youth Transition Conferencing (YTC)²⁹

One program aimed at planning for youth leaving care in a more comprehensive and timely way is the Youth Transition Conferencing (YTCs) program. The goal of this program is to *"help youth garner the supportive resources necessary to prepare for life after foster care through the development of permanent connections."*³⁰ YTCs are planned and prepared to assist a youth in creating or fine-tuning a plan for their future as they prepare to leave ministry care. The youth has a choice to engage or not, whom to invite, what their goals will be, a say over the agenda, choice of meal, etc. The process is strengths-based and solution-focused. The broad purpose is to increase the number of youth who successfully transition from care or from youth agreements to life in the community.

The YTCs program was designed by a social worker and has been operating with one permanent social worker since 2006. Currently, youth transition conferences are offered to transitioning youth in the Surrey area, but the program staff member has trained MCFD staff in several other areas of the province. The University of Victoria recently completed a preliminary evaluation of the program. The sample of 33 former youth in care who participated in YTCs reported positive associations with YTCs. They also reported high evaluations of their current well-being and felt that their support group provided them with emotional and practical help. Former youth in care who participated in YTCs reported that they would recommend it to others.³¹

Planning for youth in the sample with developmental delays who were assessed as being eligible for CLBC services appeared to begin somewhat earlier, and involved both ministry and CLBC staff. Of the 31 youth whose files were included in this aggregate review, 10 met the eligibility criteria for CLBC. Challenges in this area included youth not wanting to be labelled as being served by CLBC, as well as limited services being available despite planning beginning prior to the youths' 19th birthday and failure to engage families and communities.

²⁹ Vanon, Tony (Fall 2011). "Youth Transition Conferencing: A Collaborative Strengths based Method to Engage/Support Youth in Their Transition from Teen to Young Adult." *Ontario Association of Children's Aid Societies Journal*, Vol. 56, (4).

³⁰ Howard, 2013

³¹ Rivers, K. & Magnuson D. (June 2014). *Youth Transition Conferencing: A report from 33 participants*. University of Victoria School of Child and Youth Care. Retrieved from <https://www.evernote.com/shard/s185/sh/0cc465b4-f82f-4656-9779-f4cdeec21104/a49a0e6fa410058355edd8be37cdadde>

In 2010, CLBC expanded services to provide a new program known as Personalized Supports Initiatives (PSI) to adults who are assessed as having significant limitations in adaptive functioning and either a diagnosis of FASD or an Autism Spectrum Disorder (ASD). Of the 31 youth whose files were reviewed, four additional youth would likely be eligible for this service through CLBC,³² and one was pending an FASD assessment.

Of the 16 youth who were not assessed as being eligible for CLBC services as adults, 11 had been diagnosed with a serious mental health problem associated with complex trauma. These include oppositional defiance disorder, anxiety disorders, depression, obsessive compulsive disorders and dissociative disorders. Unlike CLBC services for adults with developmental delays or limitations in adaptive functioning, there appears to be no equivalent adult mental health transition services for youth aging out of care with a diagnosed mental illness.

Young people in care face bleaker long-term outcomes when they are not properly supported with transitioning to adulthood. The Representative's report, *On Their Own: Examining the Needs of B.C. Youth as They Leave Government Care* provided a comprehensive overview of the challenges facing youth aging out of care. To add to that report's findings, the current review finds that the ministry needs to adequately address the impacts of early trauma while a youth is in care in order to make the transition to adulthood less challenging. Further, the ministry needs to provide youth with life skills and practical supports for transitioning to independence. The youth themselves suggested that they needed in-home support and help with such skills as budgeting and resume writing.

Placement Study and Approval

Finding: Varying practices for the selection and training of caregivers result in inconsistent levels, quality and cultural competency of care.

This review found a range of different criteria and practices used by MCFD/DAAAs and contracted agencies for recruiting, screening and training caregivers for the qualifications necessary to provide care to youth with complex needs. Furthermore, it became apparent that MCFD/DAA-funded residential care services vary greatly in design and quality across regions – so greatly that it is difficult to accurately identify a home as a group home, Level Three foster home, staffed/contracted home or satellite home.

According to the standards, ministry Level Three foster families are required to have the skills and experience necessary to provide care to youth who have extensive daily needs and who require the most support, including cultural and therapeutic supports to address mental health and substance use issues, trauma, and behavioural challenges.

The 16 foster homes in the sample had foster parents with anywhere between one and 18 years experience fostering. The average number of years experience was seven. Many of the Level Three foster families appeared to be well-intentioned, but the documentation indicated that they lacked the ability and knowledge necessary to care for children and youth with challenging behaviours. Their

³² Source: <http://www.communitylivingbc.ca/individuals-families/support-for-adults/fasd-autism/>

caregiver qualifications ranged from no fostering experience to considerable skills and experience working with children with complex needs. Of the foster home files reviewed, nine were shown to be ill-equipped to provide care to the youth placed with them, such as having limited experience with youth showing suicidal behaviours or children with special needs. These nine homes were often over-assessed and under-supported by MCFD/DAAAs – for example, some foster parents lacked conflict resolution skills and were not provided with training or additional support staff to help manage in times of crisis.

As well, only three of the placements in the sample had caregivers with documented cultural competency training. It also appears as though placements were not held accountable to the standards, policies and legislation on supporting cultural continuity for Aboriginal children and youth. For example, AOPSI standards place equal weight on safety and identity, and the CSSS is clear on the actions required to preserve cultural identity and connection (see sidebar). Mandatory cultural competency training for foster parents and contracted resources staff would be an initial step towards ensuring the cultural needs of Aboriginal children and youth are met.

Continuity of care was particularly lacking for Aboriginal children and youth living on-reserve. For example, interviews found that since the federal government only provides funding when a child is occupying a bed in the home, some of the group homes on-reserve are not fully staffed. As well, a child can lose his or her bed if absent for a period of time. The provincial government should be providing funding to fill the gap in service but has not. This is a violation of Jordan's Principle, which directs that Aboriginal children should all receive necessary services regardless of who pays.

Interviews with Level Three foster parents also indicated that some foster parents were operating more like contractors, in that they did not live in the home or provide direct care to the youth, but instead hired their own staff to care for youth placed in two- or three-bed specialized foster homes. Previous reviews by the Representative have also found this to be the case (see Dean's experience on p. 32 for an example).

Cultural Competency Training for Caregivers

AOPSI Voluntary Services Standard 31:
"upon completion of the application and homestudy process, the approved applicants will participate in training to ensure the safety of the child and to preserve the child's identity."

CSS Standard 7 states that, based on a caregiver's identified learning needs, the director develops and follows up on a plan with the caregiver to ensure that he or she receives information and/or education on topics including sensitive and responsive practices to use with a child's family to maintain the family's involvement with the child, consistent with the child's plan and cultural plan and knowledge of a child's unique culture in order to preserve the child's identity and connection to his or her community.

Dean

Dean, a non-Aboriginal boy, was born into an environment of domestic violence and instability. When he was four-years-old, his mother requested MCFD services because she could not manage his behaviours (including inattentiveness and anger), and struggled with her own mental illness. She reported that because of his challenging behaviours she thought it *"might be better to kill her son."*

MCFD provided Dean's family with child care services and his mother with parenting programs and counselling services. At age seven, Dean was enrolled in a program for children who witness abuse and Child and Youth Mental Health services. At nine, he was assessed by a psychiatrist after he reported hearing voices and displayed aggressive and sexualized behaviours. He also received a number of assessments through the school district and worked with a behavioural interventionist. At age 11, he received multiple diagnoses of developmental and behaviour disorders. He was later hospitalized several times for self-harming behaviours.

Dean eventually came into MCFD care when he was 14. At age 15, he was placed in a Level Three foster home where the foster parent did not reside. Rather, his foster parent maintained a separate residence for himself and his family. He supported Dean during the day and hired night staff to care for him in the evenings and two weekends per month. MCFD was aware of this arrangement.

When Dean was 16, he disclosed to his foster parent that a night staff member had sexually assaulted him on two occasions. The staff member had recently been terminated by the foster parent because of a drug relapse and physical altercations with the boy. MCFD planned to complete a Quality of Care Review on the foster home but never did. Six months after his disclosure to his foster parent, Dean told police that the abuse had been taking place for six months. MCFD then conducted a protocol investigation, which found that the foster parent had not completed regular criminal record checks for the night staff, and his hiring practices involved hiring individuals with no specific training in working with youth who he met through Narcotics Anonymous and gatherings at the local Starbucks. MCFD subsequently closed the foster home.

Dean was sexually abused while in MCFD's care because MCFD did not fulfill its responsibility to adequately study and monitor the foster home. The foster parent did not live in the foster home, proper criminal record checks on night staff were not completed and proper attention was not paid to hiring qualified staff to meet the needs of this vulnerable boy.

"We practise different things in different parts of the province and this has been frustrating for foster parents who have moved from other areas. We have different rules (e.g. levelling and capacity) and I don't blame them because we don't even know why. Why aren't there specific rules for the whole province?"

– Ministry staff member

The 15 different contracted residential resources included in this review were operated by 10 different agencies, eight of which were accredited. Six of these resources were managed by one or two staff persons who did not have a background in working with children in care. In other circumstances, agencies sub-contracted with a family to provide care. The supports to these various models vary greatly, with some agencies relying completely on community-based services and others providing in-house supports such as counsellors or youth care workers. Any one contractor may have a variety of residential care models such as family care and group care arrangements, while smaller agencies may have

only one model. This review did not find any placement design guidelines from MCFD or DAAs for operators, other than a general requirement that placements meet relevant standards.

While flexibility in residential placements is necessary in order to meet youths' diverse needs, this range and diversity of models, without guidelines, is of concern, as it appears to have resulted in confusion regarding who is responsible for monitoring and reviewing the homes. The significant variation in services prevents the accurate comparison of service delivery among regions and interviewees commented that this results in major funding inconsistencies across the province.

Another area of concern identified through the interview process was inconsistency in screening and training of care providers for contracted homes. For example, some agencies require staff to possess a diploma in child and youth care or social services, while others do not require any specific educational background, degree or diploma. In May 2014, MCFD conducted a review of one of its larger contracted agencies and determined that there was inconsistent application of ministry standards. For example, caregivers did not meet ministry standards, policies and procedures for screening, assessment and approval prior to children being placed with them. Both foster parents and contracted staff in group homes did not always have the specialized skills or knowledge to understand complex needs of youth such as special needs, substance use challenges, sexual exploitation, mental health needs and behaviours stemming from childhood trauma.

Interviewees commented that it was easier to recruit more qualified staff in urban areas that have universities offering relevant programs. Some contracted agencies, particularly those in highly-populated areas, reported that they were able to hire staff with exemplary skills and experience. Interviews indicated that some agencies experience very little staff turnover and are able to hire registered nurses, psychologists and counsellors, and/or provide their staff with training on matters such as problematic substance use, FASD and non-violent crisis intervention. Some had funding for behavioural consultants, an on-call psychologist, speech and language therapists and autism services. These agencies reported that they were better able to address the individual needs of the youth in their care than those without these services.

Other agencies, however, struggled to find qualified staff and had inadequate screening, assessment and training of caregivers – in some cases, staff members lacked any experience or education related to working with children or youth. Much of this was related to geographic location. Smaller urban and rural areas generally, but not exclusively, had more difficulty finding appropriate staff. Furthermore, some of the youth with the most complex needs were being cared for by staff hired by contracted agencies at just above minimum wage. Staff turnover is often associated with low wages, contributing to a climate of instability and lack of continuity of care for the young people placed in these homes, as the Representative found in *Who Protected Him?* Agencies also reported that they didn't have funding for any specialized or support services for the children in their care. In these circumstances, care providers rely on community-based services to support youth.

"MCFD wanted us to have staff with degrees, but it was difficult to recruit. We have difficulty recruiting and retaining staff."

– contracted service provider

"Some of the staff don't like kids; I swear to God they have to be desperate for people."

– youth in care

Youth Perspectives

"They need to hire staff who understand us."

"Foster parents should care and not be doing it just for the money."

"You need to keep a better eye on staff."

"Staff need more training."

"My foster parent is 75 – there should be mandatory retirement."

The issue of competition between various contracted agencies and the ministry for qualified caregivers was also raised. For example, MCFD was reported to have recruited qualified staff from a contracted agency to become ministry foster parents.

While the Representative has observed through this review that many service providers lacked the knowledge necessary to care for youth with complex needs, some service providers demonstrated a wealth of knowledge and experience working with children and youth. It is critical that the ministry acknowledges and uses this knowledge and experience in renewing its residential care system.

Matching Youth to Appropriate Placements

Finding: The ministry did not provide appropriate placements for children and youth with complex needs, particularly in rural and remote areas of the province.

While many children and youth enter the care system with complex care needs, there are limited options to meet these needs in MCFD's current service delivery system. Interviews with service providers showed that there is a strong commitment to providing quality service and flexibility in developing services to best address need.

Innovative Practice: Cicada Place

Since 1999, Cicada Place's independent living program has provided supported housing units for youth ages 16 to 22 in Nelson. Funded by BC Housing, MCFD (which provides a full-time staff person) and community fund-raising, the program supports youth in their transition to independence, as well as in learning self-care and life skills. The residence has a total of 11 apartments, three of which are two-bedroom and prioritized for single parents, and a resident caretaker. Referrals are made from the community, MCFD or are self-referrals. Cicada Place is a drug-, tobacco- and alcohol-free environment.

The program works collaboratively with other youth programs in the community and has served youth with a variety of needs including substance use problems, mental health issues and developmental delays. There is currently a considerable wait list. Additional program supports and an outreach service are areas for future development when and if funding becomes available.³³

³³ <http://ncsc.kics.bc.ca/index.php/cicada-place>

Analysis and Findings

The youth reviewed by the Representative's Office appeared, for the most part, to have their basic needs such as food and shelter met. However, complex mental health, developmental, cultural, educational and other needs often went unmet, and few of the youth appeared to have achieved any sense of belonging in their families, foster families or culture. The concept of permanency, so prevalent in the youths' perspectives and in the ministry's planning documents, may well be thought of as a sense of belonging.

The failure to place youth in resources that best meet their needs is a contributing factor to placement breakdown, which amounts to a re-traumatization of the youth. The youth in the Representative's sample moved between one and 19 times, with an average of seven moves. Interviewees also noted that some youth have been in care for 10 or more years and have not had regular contact with their families or communities. One individual spoke of the disconnect (see text box) experienced by children being removed from her community at an early age, saying that when she saw them again, *"they were strangers to me."*

"MCFD has paid severely for this as youth are not connected to home communities and have attachment difficulties due to moving around while in care."

– MCFD social worker

"Lots of children are moved with no supports and every staffed home does things differently."

– Level Three foster parent

"One of my kids lost his placement every time he was held in custody."

– Level Three foster parent

*"We would be notified one week before a move and there was no discussion about it. It was, pack your sh*t up and let's go!"*

– youth in care

Impacts of Cultural Disconnection

The impact of cultural disconnection on Aboriginal youth has been studied in terms of outcomes such as physical health and mental health, and behaviours including self-harm and substance use. Research has shown that *"knowledge of and participation in cultural activities [...] may reduce developmental risks and increase positive pathways for First Nations adolescents."*³⁴ And yet, studies have shown that among ethnic minorities, Aboriginal youth score the lowest in cultural identity, making the need for cultural connection that much greater for Aboriginal youth and children in care.

³⁴ Gfellner, B.M., & Armstrong, H.D. (2013). "Racial-Ethnic Identity and Adjustment in Canadian Indigenous Adolescents" in the May issues of the *Journal of Early Adolescence*, DOI: 10.1177/10272431612458036

Stefan

Stefan, a First Nations youth, was born to a mother who suffered from mental illness and substance use problems. His parents separated shortly after his birth. As an infant, he lived with relatives in another province. When he returned to his mother, she was involved in a violent relationship. Over the next two years, MCFD received numerous child protection reports related to domestic violence and parental drug and alcohol use.

By age five, Stefan had experienced continual instability and neglect in his home environment. His mother had often left him unattended or with dangerous caregivers and he had not received any dental care, resulting in his five front teeth being pulled due to infection. He was removed from his mother's care.

Once in care, he remained in his first foster home for six years until he was 11-years-old. This foster home broke down due to the foster parent no longer being able to manage his behaviours. He subsequently moved 14 times. The multiple moves disrupted his ability to form and maintain positive attachments.

MCFD referred Stefan to various experts to assess his cognitive abilities. While Stefan's early trauma and deprivation were noted in assessments, it does not appear that a comprehensive therapeutic plan was implemented to address these issues. The neuropsychological (age seven) and psycho-educational (age 13) assessments provided a picture of his learning limitations, but also identified his areas of competence such as artistic talent, athleticism and mechanical ability. However, no specific actions were taken to encourage these areas of competence in a sustained way, nor were these findings shared with him.

He had numerous changes in primary social workers and there was no CPOC on file for the most recent two years. He received limited cultural planning and no separate cultural plan was available on file to suggest that social workers facilitated a connection to his heritage. He had no contact with his mother during his time in care until she contacted him when he was 15. He had occasional contact with his father and siblings, but lacked a permanent adult in his life.

While there were a number of services provided to him, they were ad hoc, short-term and ineffective. He had a close relationship with his first therapist (an Aboriginal CYMH clinician) but the therapist terminated the relationship after only three months with little notice or closure. Stefan struggled to connect with any one helper after that point.

As an adolescent, his circumstances deteriorated as he became more street-involved and used drugs and alcohol. He made several suicide attempts and only attended school sporadically. Stefan's most recent foster home environment appears to have been chaotic and potentially abusive. He struggled with mental illness, but was provided with limited supports to plan for his transition out of care.

None of Stefan's placements appear to have been in First Nations homes. He maintained some connection to his culture through contact with his mother and attended First Nations events with her. The DAA attempted to arrange a visit to his band in Ontario; however, Stefan was unable to go. Overall, the supports to develop and preserve cultural identity were minimal.

Stefan has since aged out of care without the skills or emotional stability to manage living independently.

Availability of Placements and Services

Interviewees commented that placements reflected the availability of resources rather than the needs of the youth. Social workers across the province discussed the challenges with placement matching and planning. Often, youth need emergency and/or specialized placements and there are not enough residential options available. This has resulted in some youth living in hotels for periods of time (up to five weeks for one youth included in this review.) Documentation indicates that four of the 31 youth had been placed by MCFD in a hotel or a motel (a costly and non-therapeutic placement) for a period of time because there were no foster homes or group homes available.

In their interviews, both ministry and DAA front-line workers remarked on the lack of individuals and families coming forward with the requisite skills and experience to care for youth with complex needs, particularly in rural and remote areas. Communities with a limited range of residential options often exhausted all capable extended family members and used hotels as a last resort before sending a child out of their community.

Foster parent recruitment and retention has been identified as one of several priorities for MCFD's strategic initiatives department. This is particularly important for Aboriginal youth, who represent approximately half of B.C.'s children and youth in care. Of the 16 Aboriginal youth in this sample, only two resided in Aboriginal homes at the time of the incidents under review, and few received culturally appropriate or culturally sensitive supports. Few foster parents had documentation in their files to suggest that they received specialized training in cultural competency and none of the Aboriginal children in this review had separate cultural plans on file.

In their interviews, contractors from one region described how placements are found for youth with complex care needs. They described a residential table meeting that occurs by teleconference with contractors and MCFD/DAA resource staff every two months and how they felt uncomfortable with the process for finding placements for youth. The residential table meeting was described as a meeting where contractors essentially bid on youth in a process similar to an auction. One contractor was particularly uncomfortable with the process because it was a private process rather than a public process such as BC Bid, a forum for receiving requests for proposals from the public.

Contractors said that they are aware of other jurisdictions, such as Ontario, where youth in care are given two to three placements from which to choose (a practice that does not occur in B.C.)

"Matching youth to resources is a dream ... the North gets forgotten; there is no real continuum of resources."

– MCFD staff member in northern B.C.

"There is a huge lack of resources for youth in care who are low-functioning. There are no supports for these kids and they end up being placed in regular homes or in group homes with the general population. The caregivers do not have proper training to understand their special needs."

– MCFD staff member in northern B.C.

"It's difficult matching a placement to a kid because the reality is we need to place them somewhere. The only other option is a hotel or a motel or a shelter."

– DAA resource worker

Innovative Practice: Raven's Lodge

Raven's Lodge is a licensed live-in program for up to five female Aboriginal youth in the care of Vancouver Aboriginal Child and Family Services Society. The program is operated by the Urban Native Youth Association (UNYA) and uses a "culture as therapy" approach. UNYA operates more than 20 different programs with the purpose of empowering youth to make positive lifestyle choices and create positive changes in their lives. Youth are consulted in the development of programs and services, and have access to a variety of services, including alcohol and drug counselling, wellness counselling, and mentorship.

Activities include connecting youth with their culture, working on life skills, learning about health, and keeping family ties strong (when appropriate). Youth are invited to explore their Aboriginal identities with program staff knowledgeable in traditional ways of living. Staff use the holistic Circle of Courage model to meet the overall needs of youth. The lodge includes 24-hour staffing, one-to-one support, youth transition support, cultural activities and ceremonies, and recreational activities in a safe and judgement-free environment. The program also supports youth and potential foster homes to assist with a smooth transition.³⁵

As well, nearly all the caregivers who were interviewed said they received limited information about a youth's history and needs prior to placement in their care, especially for emergency placements. As well, the majority said they never received CPOCs. As such, caregivers were not always aware of the child or youth's needs for additional support services for mental illness, behavioural issues, tutoring or life skills. Both foster parents and social workers commented on the difficulties accessing necessary community-based support services for foster parents and youth in their care.

"Some children/youth come with a lot of services already in place and sometimes we have to work harder to get services for kids."

– contracted service provider

"We used to have youth outreach counsellors who worked with the most critical youth. The funding was cut and this service was never replaced."

– Level Three foster parents

"We don't have the funding or capacity to hire a psychiatric nurse. These kids are more and more difficult. It's difficult to work without an on-call therapeutic person."

– contracted service provider

In order to better support foster parents, MCFD is currently implementing a caregiver support network whereby specialized foster parents provide support to other foster parents who are all connected to each other as part of a network. While this project is promising, it is a small step toward adequately supporting foster parents and youth in their care and achieving a cohesive, responsive and trauma-informed foster home system.

Contracted service providers, several foster parents and social workers all commented that they believed MCFD's decisions are financially motivated. For example, workers said that they felt pressured by MCFD management to choose placements based on cost and availability and that this impacted placement decisions, sometimes to the extent that children were

placed with caregivers who were unable to provide the appropriate level of care required. There was also a perception that placement quality was not always linked to the cost of the placement.

³⁵ <http://www.unya.bc.ca/programs/live-in-programs/ravens-lodge>

Tyler

For the first 20 months of his life, Tyler, a First Nations boy, was in an environment where he was exposed to domestic violence and was neglected. His mother struggled with problematic drug use and suffered from a serious mental illness. His father had been raised in foster care and had criminal involvement, for which he later served time in prison. When Tyler was taken into care by MCFD, he was living in squalor and his safety had been severely compromised. His mother was nowhere to be found and he was being cared for by a relative who was inebriated and unconscious.

He and his sister were temporarily placed in a foster home, and then with their grandparents, with whom they lived for 10 years. Tyler was assessed by a child psychiatrist and diagnosed with post-traumatic stress disorder and reactive attachment disorder, as a result of witnessing physical violence and possibly being sexually abused. He was also assessed as having speech, language and fine motor delays. The psychiatrist recommended a number of therapies, as well as specialized child care and further assessment. He received speech and language therapy and was enrolled in a therapeutic playschool, where he received play therapy. When he was assessed again at age three, professionals noted symptoms of psychosocial deprivation, and prenatal exposure to alcohol and cocaine was suspected. He continued in school with modified programs.

It does not appear that other services were provided during these years, until he was referred for a mental health assessment at age 11, after making suicidal statements. He was diagnosed with a pervasive developmental delay and mild autism. Based on the assessment, he received services from an FASD support therapist.

Escalating incidents of violent behaviours in the home and at school were documented, and Tyler was referred for autism funding. The grandmother noted that he had been playing with matches and she was afraid he might start a fire. He also had occasionally expressed suicidal ideation. There were, however, many positive observations about Tyler. He was noted to be curious, usually gentle and kind, as well as creative and athletic. Individual attention and a structured environment were recommended for him to thrive.

Multiple professionals noted that he required stability and continuity. However, when he was 12, his grandparents could no longer manage him and he was moved to an emergency group home. During this time, he met a sexual offender who allegedly assaulted Tyler during the next three years. Subsequently he was frequently moved – a total of 21 times to 14 different locations over his next seven years in care. At 15, he had a short admission to BC Children's Hospital after making threats to kill himself and others. Shortly after this, he disclosed the abuse at the first group home.

At 16, Tyler became involved with the youth justice system and spent time in youth custody and group care. He stopped attending school, but participated in an employment training program for a period of time. His files noted concerns about his substance use and there are reports of him being involved with "street" life and a violent subculture. Multiple episodes of extreme frustration and anger, and his unwillingness to participate in support services, are documented in his file. Tyler is now ill-prepared to enter the adult world because the system failed to protect him in his early years.

During the interview phase of this review, several ministry staff members said that they used contracted residential resources as a placement of last resort for youth who have not experienced success in other residential settings. In these placements, their basic needs may have been met, but they may not have been receiving the therapeutic services necessary to address the trauma they have experienced or the behaviours associated with having a developmental delay, substance use or mental health problems.

Others interviewed commented that contracted agencies are called upon to provide care to the youth with the highest needs in the province. As previously noted, these are often youth who have experienced numerous placement disruptions and have multiple care needs, and the case reviews revealed a wide range of service delivery models, availability of qualified staff, staff training and outcomes across the province.

The file reviews and youth consultations showed that experiences in care vary greatly, even within the same contracted agency. The consequences of a lack of overarching principles emphasize the continuing need for staff to be trained in trauma-informed approaches to ensure consistency in care for vulnerable youth. The reviews also demonstrated the impacts when agencies are unable to recruit staff with the requisite skills to build positive relationships with youth in their care who have complex needs.

Mental Health Needs

The mental health needs of children in care are not being met in the current residential system of care. This was clearly shown in the case examples where foster parents and group home staff struggled to care for youth with complex mental health needs. Interviews with staff also showed that care providers do not have access to necessary mental health professionals such as psychologists, psychiatrists or mental health clinicians.

"[The ministry and DAAs] have pressure to place a youth because there is nowhere else for them to live, and we have to push back and say it's not a good fit ... sometimes [the ministry] will then threaten to cut our contracts."

– contracted service provider

"MCFD will sever relationships with caregivers ... once a child is stabilized, MCFD moves them to a cheaper resource ... It's all about the money."

– contracted service provider

"There are contract deliverables, but once successes are made, kids are pulled from our homes."

– contracted service provider

Youth Perspectives

To the youth surveyed, a staffed home means:

- "home with rotating staff"
- "lots of rules"
- "bad living conditions"
- "pretty great"
- "awesome experience"
- "worst time of my life"

"Youth in those placements are more about housing than treatment ... Most are there because of attachment and trauma ..."

– mental health professional

Consistent with what was previously reported in the Representative's April 2013 report, *Still Waiting: First Hand Experiences with Youth Mental Health Services in B.C.*, there are inadequate mental health supports for youth in the province. Eight of the youth included in this aggregate review were unable to get timely psychiatric assessments, while others only received them as they were involved with the youth justice system, in which case such services would be court-ordered conditions. The Representative notes that these detailed and expensive forensic reports are not disclosed back to support planning or needs of residential services for children. This lack of support was also identified in the final report of the MCFD/FCSS Residential Review:

“There are currently no intermediate, community residential mental health programs, and if such residential services are required, the child must be brought into care in order to be placed in a foster home or contracted/staffed resource.”³⁶

Service providers and foster parents felt that the absence of intermediate community residential mental health programs has consequences for youth with complex needs living in unsuitable homes with caregivers who are ill-equipped and under-supported to care for them. In addition, the absence of intermediate residential homes makes it difficult to transition children and youth from a hospital stay back into their communities. This decreases the likelihood that any positive change that occurred in the hospital can be sustained. It can also increase the pressure on foster parents, whose skill levels cannot equal those available in a hospital setting.

Some staff who were interviewed were aware of the impact of childhood trauma and trauma-informed approaches to working with children and youth in care, but did not feel that the residential care system was trauma-informed. For example, a number of interviewees were aware of MCFD's Interior Complex Care initiative (which aims to develop sub-acute care for youth transitioning from tertiary care back to the community). While recognition of these needs is a first step, some mental health staff were concerned that residential placements, particularly those in rural communities, were often unequipped to address the needs of the youth they are serving.

There are many different reasons why a youth may not access mental health services. Interviewees said that many youth do not want the “label” that can come with a psychiatric diagnosis, are concerned about the stigma associated with mental illness or find it difficult to get help under the current child and youth mental health model. Currently, child and youth mental health services are primarily office-based and in urban communities. Youth and service providers expressed a need for more outreach-based mental health services with flexible hours and locations. The lack of early intervention for children with mental health issues also continues to be a huge concern for all parties. Many interviewees discussed youth justice being the default system to get youth connected to appropriate and adequate mental health and addiction services. Collectively, these concerns show that many believe that the current system does not meet the mental health needs of young people in care.

³⁶ MCFD/FCSS Residential Review Project Final Report, June 2012, p. 15.

Sam

Sam is a First Nations boy who was born prematurely. His parents had a history of domestic violence and mental illness, including alcohol addiction and untreated schizophrenia. Sam and his three siblings were in and out of care throughout childhood, often living with relatives.

At age seven, he was assessed by a psychologist at the Sunny Hill Health Centre for Children,³⁷ who indicated that prenatal drug and alcohol exposure, lack of appropriate prenatal care, environmental risk factors, multiple caregivers, and exposure to domestic violence were likely contributors to his poor impulse control, disorganization and lapses in memory, and that Sam should be highly supported. The psychologist noted that Sam's history places him at a "very high risk" for emotional and behavioural problems and that caregivers would need to protect him from emotional trauma.

Sam was placed with his uncle under the Extended Family Program (EFP), where he resided for more than a year. Sam was referred by a school counsellor to Child and Youth Mental Health services due to concerns regarding PTSD, depression and the parent-child relationship; however, his uncle refused the services offered as he preferred that Sam be served by an Aboriginal organization. These services were not provided.

When Sam was nine, his uncle became intoxicated and threatened suicide, saying he could no longer manage the boy's aggressive and defiant behaviours. As a result, the DAA placed Sam back into the care of his mother under a voluntary care agreement. He was subsequently removed from his mother's care less than a year later because of concerns about Sam's safety.

At age 12, an agreement was signed between Sam, his mother and the DAA related to his safety and care. Between the ages of 12 and 13, Sam was again in his mother's care, but frequently lived with his brother and the uncle he had previously lived with under EFP. His uncle had substance use problems, which raised concerns regarding Sam's safety. The DAA applied for a protective intervention order prohibiting Sam from living with this uncle.

At 14, Sam came back into care and was placed in a foster home through a voluntary care agreement due to concerns around his own substance use, criminal activities, lack of housing and his mother's substance use issues. He was connected with an Aboriginal mental health counsellor who identified conduct disorder, suspected FASD and learning problems. However, Sam was not interested in engaging in counselling. He was referred to an Assertive Outreach³⁸ counsellor after missing appointments and disclosing that his substance use started at age nine.

³⁷ This centre is for children from birth to 19 years with complex medical, physical and developmental needs. Some of the children have conditions affecting physical, motor or sensory development or have acquired brain injury, prenatal exposure to alcohol or other drugs, cerebral palsy, or autism. The centre provides outpatient assessment and services. Retrieved from <http://www.bcchildrens.ca/Services/SunnyHillHealthCtr/default.htm>

³⁸ An assertive outreach counsellor helps youth who are not engaging in mental health or addiction services to connect with local community services.

Sam (continued)

At the same time, his rights were being violated at his foster home. At times, he was not provided dinner and food was locked away; he was also ignored when he asked for help with household duties. He was quickly moved to a different Level Three foster home but the foster parent, while well-intentioned, lacked conflict resolution skills and would rely on police to de-escalate situations. Both of these foster homes were unable to provide him with the therapeutic care that he required. The social worker only visited the youth sporadically and did not complete a CPOC due to Sam being constantly missing.

Because of his frequent moves, little planning was done for Sam. As an adolescent, he never received comprehensive mental health assessments or treatment. Four referrals were made to mental health services, but he missed most of the appointments. He is now well-known to police and is involved with Youth Justice Services as a result of theft and assaulting a relative. He has been detained in cells and custody centres multiple times. While in custody, he suffered from a broken shoulder after being restrained by staff. Sam is now in continuing care.

Monitoring and Quality Assurance

Finding: There is no comprehensive monitoring and oversight of residential care in B.C. to help ensure child and youth safety.

The case reviews and multiple interviews conducted for this review showed inadequate levels of monitoring and follow-up to critical incidents for both Level Three foster homes and agency-contracted placements, raising the likelihood that youth with complex needs were placed in settings that compromised their health and well-being.

A lack of clear and effective standards was also observed, particularly with respect to contracted residential placements. While the CSSS provide direction in monitoring and liaison with staffed residential placements, there is no ministry or AOPSI standard for reviewing quality of care concerns and conducting investigations when there are concerns with contracted placements. As a result, some ministry/DAA resource social workers said their roles were unclear when it came to monitoring a contracted agency that manages multiple individual care homes.

The case reviews showed that annual reviews of foster homes were not completed regularly and that quality of care concerns in foster homes and contracted homes were not always addressed in a timely manner (e.g. foster parents drinking, lack of supervision, poor decision-making by caregivers, lack of food in staffed homes) resulting in multiple concerns being reported before a social worker looked more closely at the concerns in a home.

The lack of monitoring and oversight by MCFD was particularly clear when it came to youth who were chronically missing from their placements. As mentioned previously, 19 of the 31 incidents did not occur in the placement itself, and some of these youth were injured while they were missing from their foster and group homes. MCFD's tolerant approach and lack of focus on this issue is extremely concerning. Several interviewees discussed the challenges with youth running away from placements and the difficulties with keeping them safe due to their high-risk activities.

"Seems like they will just hire anyone."

– youth in care

"Staffed homes are required to abide by Staffed Residential Resource Standards and for the most part they are left to monitor themselves."

– MCFD/DAA staff

"There is no standard incident report. I complete information about the child's status and follow up."

– Level Three foster parents

Overall, the Representative's case reviews and interviews with staff suggest that the ministry and DAAs need to screen and monitor both their foster homes and contracted homes more effectively.

Foster Homes

Of the 16 foster homes reviewed, 10 did not have documentation of regular annual reviews, meaning that the placement social worker likely did not monitor and review the home according to ministry standards.

Twelve of the homes also underwent a protocol investigation and/or Quality of Care Review, and six were closed as a result of protocol investigations.

The ministry conducts home-studies on foster parents and requires them to undergo 53 hours of training after 21 hours of what the ministry describes as "pre-training." However, the foster parent may not be the one providing direct care to the children in the home. In some cases, Level Three foster parents hired staff to provide direct care, but the hired staff were not assessed or monitored by MCFD or DAAs beyond a criminal record check. This lack of oversight can have devastating consequences for vulnerable children and exposes a serious flaw in the training and monitoring of foster homes. It also defeats the purpose of a foster home where connection with the parents is considered to be a critical component of the intervention.

Interviews with foster parents and contractors showed situations in which foster homes were being operated to house three or more youth, yet were still avoiding the requirement for licensing by the health authority – for example, placing two youth in an upstairs suite and two more in a downstairs suite, or having separate housing units on the same property. There appears to be no monitoring or enforcement regarding the licensing of such arrangements.

Contracted Residential Placements

At best, the overall approach of the ministry and DAAs to addressing quality of care concerns in staffed residential placements can be described as arm's-length. Staffed residential service standards do not outline clear procedures for MCFD responses to quality of care concerns in contracted placements, which has resulted in inconsistent responses to, and monitoring of, quality of care concerns and critical incidents. Five of the 15 contracted residential placements included in this review had a protocol investigation and/or a Quality of Care Review.

Social workers and service providers who were interviewed said that often the contractor followed up on quality of care issues with their care provider rather than the MCFD social worker addressing these concerns – a clear conflict of interest. With respect to child protection concerns, it appears that at times the contractor conducted a preliminary review before MCFD's investigation. There do not appear to be any written guidelines, responsibilities and procedures for communication and

Analysis and Findings

collaboration in these circumstances. Ministry and DAA staff across the regions appeared to have different understandings of their roles with respect to contracted agencies. For example, some social workers said that they would initiate a protocol investigation if there have been multiple quality of care concerns with a particular contracted home, while others felt it was the contractor's responsibility to investigate and address quality of care issues.

When concerns were raised, ministry and DAA staff often discussed them with the contractor, rather than the caregivers, making it difficult to know if these discussions resulted in concerns being addressed and the care improved for the children or youth in question.

The ministry and DAAs also have difficulty tracking quality of care concerns for larger agencies that manage multiple homes in different communities and service-delivery areas. Similar concerns may arise at each of the homes, but without central tracking this information is unavailable to the designated placement worker and cannot be addressed in a comprehensive way, leaving children and youth at risk. Several interviewees commented that a key ministry liaison for contracted agencies is necessary. As a result, the ministry or DAA may not realize that there is an issue with the quality of care in the home until multiple reports are received.

"Sometimes agencies don't go directly to MCFD with issues or concerns in the home. They try to provide a positive impression of their work."

"We rely on the contracted agency's honour that they are submitting critical incident reports and following accreditation standards."

– MCFD and DAA staff members

Jill

Jill is Métis and has been involved with the ministry since the age of one. Her parents separated, and she bounced back and forth between her mother's and father's homes at an early age. Jill witnessed domestic violence between her mother and another partner. There were 30 intake calls received by MCFD with respect to the care her mother provided. Jill's mother used substances and suffered from mental illness. Jill and her sibling eventually lived full-time with their father. Unfortunately, there were child protection concerns with the father's care as well, with 14 intake calls on the father's ministry file. Jill's father was violent and also had a mental illness. Over 14 years, the ministry referred the family to support services rather than intervening in a way that ensured that Jill and her sibling grew up in a safe and nurturing environment. At the time of Jill's removal from her father's care at age 14, she was living on the streets and couch-surfing because her father was homeless and had been physically aggressive with her.

She resorted to living in an unsafe situation with her boyfriend, where she was being actively recruited into the sex trade by her boyfriend's mother. Within a year of coming into ministry care, Jill was placed in six different foster homes before being placed in a contracted placement with another female youth around the same age.

Jill (continued)

Jill was frequently absent from her placement, often ending up in situations with people who took advantage of her. She was sexually assaulted by two men and six months later was sexually assaulted by a man twice her age, who choked her and recorded the assault. She experienced mental illness symptoms such as anxiety, but never received a mental health assessment or mental health services. She also developed a dependence on drugs and alcohol. Jill became involved in criminal activity and was involved with Youth Justice Services.

The contracted agency continued to struggle with staffing for its homes. When interviewed by the social worker, Jill stated that the workers in her group home worked really hard, but needed more staff and support. She also stated that there was no consistency around house rules (for example, smoking). The contracted agency did not have a clear philosophy and documentation in the file suggested that the home was under-staffed, impacting the level of supervision and monitoring of the youth.

Overall, the child welfare system failed to keep Jill safe in her home environment and she continues to drift through a residential care system that is unable to provide her with the care that she requires.

Critical Incidents

The ministry's limited monitoring and quality assurance activities were particularly obvious with respect to responses to critical incidents in placements. The majority of the ministry placement workers and caregivers interviewed were confused about their roles and responsibilities with respect to reporting and responding to critical incidents in contracted residential resources. For example, in one region, ministry staff clearly stated that they have responsibility for follow-up of critical incidents, while in another region, ministry and DAA staff believed that it was an arm's-length relationship and follow up was the responsibility of the contractor.

As required by the *Community Care and Assisted Living Act*, staff at each home must notify their health licensing officer and the ministry when a critical incident occurs in a licensed home. However, the case reviews demonstrated that sometimes only one or the other – or neither – is contacted when there is a critical incident, leaving children and youth with complex needs at risk. At least six of the 31 homes included in this review had documented issues with under-reporting to MCFD.

During interviews, many caregivers commented on a lack of staff in the home in times of crisis, which often happen in the evening or overnight. As a result, they must seek direction from the ministry's After Hours social workers.³⁹ Unfortunately, these social workers are often unfamiliar with the child and may be unable to come to the foster or group home because After Hours staff may not live in the same community.

³⁹ For emergencies outside of office hours (8:30 a.m. to 4:30 p.m., Monday to Friday) After Hours social workers answer emergency calls from the public when it concerns the safety and/or well-being of children. Retrieved from http://www.mcf.gov.bc.ca/contact_us.htm

Jessica

Jessica's mother used alcohol problematically and was unable to care for this non-Aboriginal child and her sibling. Jessica's father obtained custody of both siblings under the *Family Relations Act* despite concerns about his ability to protect them and set clear boundaries with their mother. He also seemed to prioritize work over parenting. While support services were provided for a number of years, the concerns regarding inappropriate supervision continued.

At age 12, Jessica and her sibling began using alcohol and substances. Her father moved to a new community with his girlfriend but Jessica refused to go with him and was left homeless. She lived in garages, couch-surfing and even in a tent at one point before she and her sibling were placed in continuing custody of the ministry.

From ages 12 to 15, Jessica was moved 10 times. She used substances problematically and frequently ran away from her placements to be with her boyfriend. She was then placed in a subcontracted foster home run by a large contracted agency. This contracted agency was accredited by CARF and operated approximately 35 homes between 2007 and 2010. The foster parent for this home had the appropriate skills and qualifications to meet Jessica's needs and had a good connection with her.

Although there were no concerns with this particular foster home, multiple quality of care concerns were reported about other homes run by this same contracted agency. The concerns included group home staff downloading pornography and engaging in sexual activities onsite. The ministry's documentation showed that group home managers edited critical incident forms and that many of the hired staff were recovering from substance addictions. Without a key liaison, similar issues occurred in multiple homes run by this contracted agency and were addressed individually rather than collectively. Eventually, a key liaison was hired to work with the contracted agency.

There were also uncoordinated (and sometimes inappropriate) responses to critical incidents in placements involving the police and/or hospitals. Interviewees across the province commented that hospital discharge practices were inconsistent and depended on hospital staff, regardless of whether there were protocols in place – for example, suicidal youth being discharged without a safety plan, or older youth (ages 17 to 18) being discharged without notifying the guardian or the caregiver.

For the most part, police were not generally used for behaviour management purposes, and were called mainly when a youth was a risk to him or herself, or to other people in the home. However, the circumstances in which police were called varied greatly. One agency, in particular, frequently called police to help when youths exhibited challenging behaviours. In one year, this agency called police 23 times, 15 of which involved the same young person.

Finally, the ministry's inadequate monitoring and quality assurance activities, such as the lack of regular reviews, auditing and investigations of homes, have contributed to children and youth being placed in homes that either only meet their basic needs or in some cases potentially cause more harm to them.

"MCFD needs to assign a key person who knows the whole program. I would say that quality control needs to be looked at. It's not about the contract; it's about supporting the youth."

– contracted service provider

Recommendations

Introduction

In February 2013, as part of the report *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children*, the Representative recommended that MCFD urgently create a comprehensive plan to develop a continuum of residential services for children and youth in B.C. with complex needs that cannot be met in traditional foster home or group home settings and fully fund and support that plan to ensure that these vulnerable children have access to residential care to support their optimal development.

The Representative is disappointed that this recommendation has not prompted the Ministry of Children and Family Development to make the type of fundamental changes that are needed in order to properly serve and respect the needs and rights of many of the most vulnerable children in the province. There is no doubt that fundamental changes are indeed necessary to ensure that all children have their needs met in a loving, permanent family setting. Ironically, it is those children with multiple vulnerabilities and their families who are currently the least well served by this province's care system.

This recommendation must be met in order to meet the needs of these children.

The Representative has previously made recommendations relating to need for: an array of residential services for children and youth with complex needs; trauma-informed practices and services that meet the needs of children across the province; and a detailed strategy for provision of services to children and youth with special needs.

- Recommendation 1 from *Who Protected Him? How B.C.'s Child Welfare System Failed One of Its Most Vulnerable Children* (February 2013)

That MCFD urgently create a comprehensive plan to develop a continuum of residential services for children and youth in B.C. with complex needs that cannot be met in traditional foster home or group home settings, and fully fund and support that plan to ensure that these vulnerable children have access to residential care to support their optimal development.

- Recommendation 1 from *Trauma, Turmoil and Tragedy: Understanding the Needs of Children and youth at Risk of Suicide and Self-Harm* (November 2012)

That MCFD address the need for trauma-informed services for children in care in its 2012-2013 action planning on strengthening child and youth mental health services.

- Recommendation 1 from *Isolated and Invisible: When Children with Special needs are Seen but Not Seen* (June 2011)

That MCFD, working in collaboration with the Ministry of Education and the Ministry of Health as required, develop a detailed strategy for provision of services to children and youth with special needs. The strategy should be supported by the necessary resources to ensure that children and youth are receiving the services that they require.

Recommendations

Additionally, and as a result of the current report, the Representative makes the following recommendations:

Recommendation 1

That the Ministry of Children and Family Development stop placing children who have intersecting multiple vulnerabilities, including developmental, mental health, behavioural and medical needs, in inappropriate residential placements made without regard to meeting their unique needs. The Ministry, together with its delegated Aboriginal Agencies, must lead a plan for a new stream of effective and responsive treatment and care, including residential services modelled on a prudent parent approach and based on the guiding principle that all children are entitled to permanent and loving families.

Details:

- This plan should include the creation of a new class of foster and shared care that permits, when appropriate, shared guardianship (between family members and MCFD) for children who require long-term specialized support, allowing parents a continuing role in the care of their children, and keeping children in their homes and communities whenever possible
- The Provincial Director of Child Welfare should take the lead, in collaboration with the Provincial Health Services Authority and the Ministry of Education, to create alternatives to residential care whenever possible through a combination of local behavioural support, school support, proper medical care and respite for families
- In cases where a child must be provided with specialized residential support services, intensive, rehabilitative and evidence-based treatment should be provided under appropriate clinical direction to ensure that the child's time spent away from home and community is limited only to what is necessary for that treatment and support
- MCFD should report on all such cases, detailing the care plans, education, connections to family and community and developmental milestones including improvement in emotional and social functioning
- MCFD should report publicly on all instances when a child is placed in a hotel as a substitute for appropriate care or as a temporary or interim measure. Such reporting must include number of nights spent in a hotel and the reason this option was used. Any hotel stay should trigger a review and update to the child's Comprehensive Plan of Care within 30 days.

This plan should be developed by March 2015 and fully implemented across the province by September 2015.

Public reporting on hotel stays and the recommended response to these placements to begin immediately.

Recommendation 2

That the Ministry of Children and Family Development create an oversight and accountability body to advise on and guide the creation of a continuum of residential services. This body should include representation from parents, Aboriginal communities, and leadership and senior ministry officials from MCFD and the Ministries of Health and Education, and report directly to the Deputy Minister of MCFD.

Details:

The oversight and accountability body would collaborate to create strategies for both immediate and long-term actions related to residential care, including:

- Developing a consistent framework for residential care and treatment services in B.C.
- Developing the new category of foster and shared care referred to in Recommendation 1
- Incorporating best practices and evidence-based initiatives
- Including and consulting those in the community living movement
- Addressing foster caregiver recruitment and retention and a caregiver support network
- expanding use of kinship and out of care options
- developing robust and practices for contracting for residential services
- Improved practice regarding planning for youth transitions.

This oversight and accountability body should be formed by January 2015 to assist in the process referenced in Recommendation 1.

MCFD should also consider and explore the possibility of this body evolving over time into an entirely independent entity with the continuing responsibility of providing oversight and direction for residential services.

Recommendation 3

That the Provincial Director of Child Welfare regularly audit contractors providing residential care services to ensure compliance with ministry standards and maintain quality assurance for those providing care for children in B.C. Audits should ensure that operational and staffing decisions in residential facilities are made with the child's best interests and developmental needs – rather than cost-drivers – as the only consideration.

Audits to begin by April 2015.

Observation

The Representative will discuss with the Auditor General of British Columbia the possibility of undertaking a performance audit in this area and providing advice and recommendations to MCFD and health authorities on ensuring that public expenditure and services are providing optimal outcomes for children and youth.

Conclusion

Overall, the Representative's analysis of B.C.'s residential care system finds that the ministry is failing to meet the needs of some of B.C.'s most vulnerable young people. Ongoing assessments, planning, screening, matching and monitoring activities are necessary to ensure that placements are appropriate for youth with complex needs; however, inconsistencies at each step of the process mean that young people often wind up in unsuitable homes.

Furthermore, even if the process was to be followed consistently, a lack of services, particularly in rural and remote areas of the province, prevents children and youth with complex needs from receiving the necessary supports. This leaves young people at continued risk of simply drifting through the cracks of B.C.'s fractured residential care system.

The costs of this drift – towards poverty, homelessness, incarceration, untreated mental illness and victimization – are far greater than the costs of a comprehensive, fully funded and properly supported residential care system. The human cost is already unacceptably high. As the stories of the young people profiled in this report show, many children have been, and continue to be, re-traumatized by the very system that is meant to protect and nurture them.

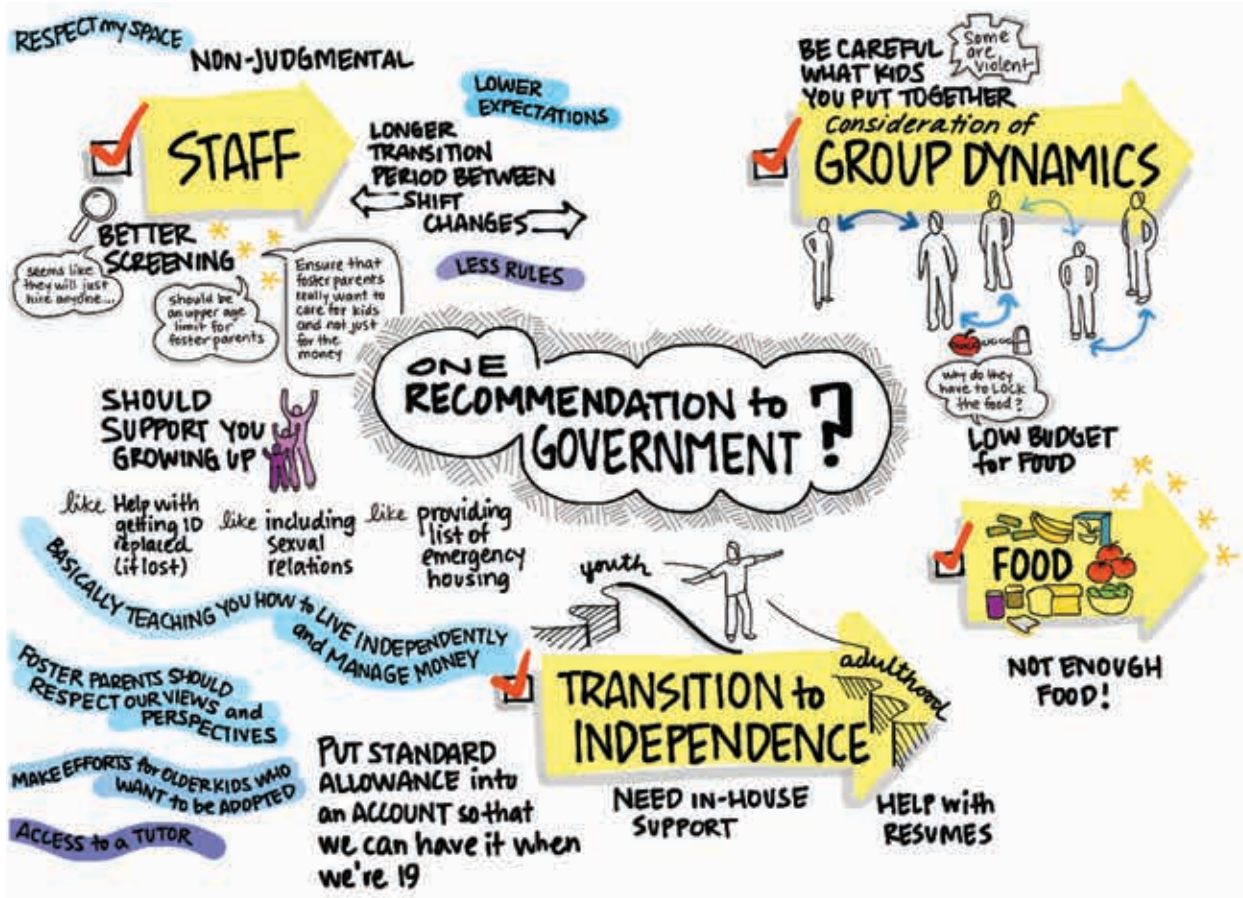
This is a particular risk for the more than 50 per cent of children and youth in care who are Aboriginal. Despite the strong and growing body of research showing the positive outcomes of developing and preserving cultural connections and identity – not to mention the legislation, policies and standards reflecting this – actual practice in B.C. is dismal. The reality seems to be one where the right to be connected to their Aboriginal culture and identity is not given the same value and respect as their other rights (to the extent that these rights are met at all). Everyone from the policy-makers to social workers and caregivers have a collective responsibility to support and ensure culturally competent care. The continued failures are legally and morally unacceptable.

Overall, B.C.'s piecemeal approach to residential care is neither cost-efficient nor effective over the long-term. Without a continuum of care across services, delivery areas and age groups, the gains made by one program or caregivers will be lost as young people move through their lives. Government must show strong leadership on this issue, engage in meaningful collaboration and make a full financial and emotional investment in the well-being of children and youth. Otherwise, these tragic stories will inevitably and needlessly repeat themselves with each new cohort of young people in government's care.

Appendix A: Youth Consultation Graphics







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Contact Information

Phone

In Victoria: 250-356-6710
Elsewhere in B.C.: 1-800-476-3933

E-mail

rcy@rcybc.ca

Fax

Victoria: 250-356-0837
Prince George: 250-561-4624
Burnaby: 604-775-3205

Website

www.rcybc.ca

Offices

400 – 1019 Wharf Street
Victoria, B.C.
V8W 2Y9

1475 10th Avenue
Prince George, B.C.
V2L 2L2

#150 4664 Lougheed Hwy.
Burnaby, B.C.
V5C 5T5



B.C.'s Representative
for Children and Youth



@rcybc and @rcybeyouth



Rep4Youth