CHILDREN IN CARE

IN NEWFOUNDLAND AND LABRADOR

A REVIEW OF ISSUES & TRENDS WITH RECOMMENDATIONS FOR PROGRAMS AND SERVICES

KEN FOWLER PHD

DEPARTMENT OF PSYCHOLOGY
MEMORIAL UNIVERSITY OF NEWFOUNDLAND

SEPTEMBER 2008

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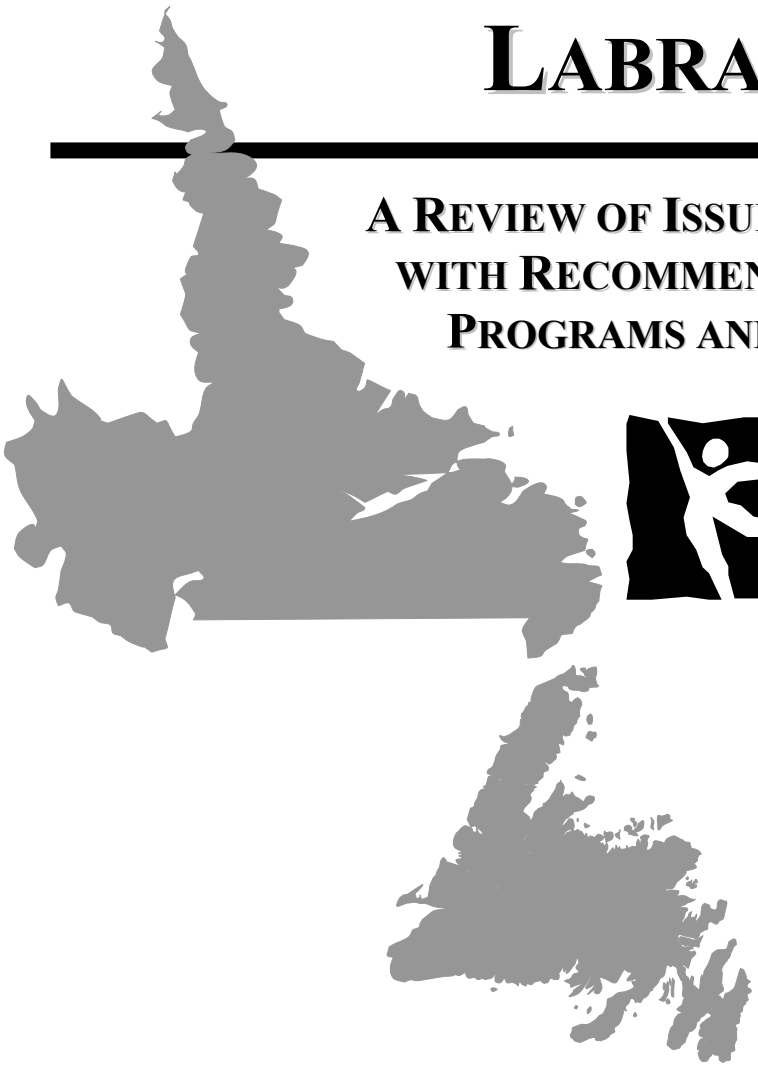

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EXECUTIVE SUMMARY

This study involved an in-depth exploration of provincial and regional programs and services associated with children in the care/custody of a director of Child, Youth & Family Services. The primary objectives of this study were to establish an accurate profile of all children currently in the care and custody of a director of CYFS, determine the extent to which existing placements were suitable, to identify the gaps in the current placement continuum, and offer recommendations about how to strengthen the placement resources currently available, as well as identify ways to address identified gaps in the existing continuum.

In addition to a best practice literature review, subsequent stages involved the construction, testing, development, and utilization of a questionnaire designed to profile children in care/custody, as well as a comprehensive interview process designed to assemble prevailing beliefs and experiences via focus groups and interviews with key stakeholders.

An instrument called the Children in Care Profile Questionnaire was developed, disseminated and completed by front line professionals in order to establish a profile of children currently in the care of a Director of Child Youth and Family Services. The questionnaire was designed to explore a variety of issues such as general demographic and placement information, ratings of emotion/psychological and physical wellness, aspects of social integration, school performance, child's family history, presenting issues, and services provided to the child.

A total of 579 questionnaires were completed and returned (primarily by social workers), translating into a response rate of 93 percent. Overall, 256 (or 44 percent) were from Eastern Health, 165 (or 29 percent) were from Labrador-Grenfell Health, 106 (or 18 percent) were from Western Health, and 51 (or 9 percent) were from Central Health. In terms of the ethno-racial characteristics, while the Eastern, Central and Western children were predominantly Caucasian, the vast majority of children placed in Labrador-Grenfell were Aboriginal. Innu aimun was the first language for approximately 15 percent, and 16.5 percent of children in care were not placed within a caregiver home of the same culture.

Slightly more than half of the children in care were identified as being in continuous custody, 35 percent were in temporary custody, almost 10 percent of children were in interim care, and a negligible proportion were in a Voluntary Care Agreement. On a provincial basis, approximately 82 percent of children were placed within a caregiver home either characterized as "non-relative" or "relatives or significant others." The remaining placements involved group homes, Independent Living Arrangements (ILAs) and Alternate Living Arrangements (ALAs).

It was reported that most NL children in care did keep in regular contact with their birth parent(s), but this also varied among the authorities. Further, approximately three-quarters of all children (with siblings) in care maintained regular contact, and just over half maintained regular contact with relatives, and 64 percent maintain regular contact with significant others.

There was notable variation among the regional authorities health in terms of the number of children rated as having "Excellent" or "Very Good" physical health status, particularly between children in Western Health (with high health rating) and Labrador-Grenfell Health (with low health rating). The same was true for mental/ psychological health. Variability was also noted among the authorities in terms of school performance.

The average number of placements children in care had was almost 3 per child. Further, almost 29 percent of children spent between 2 and 5 years in care, while 18 percent have spent between 1 to 6 months, and another 18 percent spent between 5 and 10 years in care.

The three primary family history challenges for children in care were neglect, emotional abuse, and substance abuse in family. Neglect includes acts of omission or commission on the part of the parent/caregiver such as failure to provide for the child's basic needs and appropriate level of care with respect to food, clothing, shelter, health hygiene and safety.

There was an average of 4.7 family history challenges per child, and children in care from Labrador-Grenfell Health had on average, one more family history challenge than the other authorities.

Provincially, children had an average of 2.8 presenting issues with the primary types being FASD (suspected or diagnosed), developmental delay, and attachment issues. There was also significant variability among the health authorities. More in depth analysis indicated a relationship between custody status, placement type and elements of child wellbeing.

During January 2008, interviews began with a number of individuals and groups associated with the CYFS in care program throughout NL (90 individuals in all). These included CYFS directors, managers and frontline staff, as well as foster families, provincial officials and representatives of the courts. Among a variety of themes and issues revealed, some of the more salient involved 1) limited in care placement options, 2) resources and service shortcomings for children in care, 3) trying to match programs and services with need, 4) aspects of the foster care system including contemporary realities of fostering, rates currently provided to caregivers, and foster home availability, 5) implications of court processes, 6) the impact of significant system and legislative restructuring on the in care program, and 7) human resource issues including social worker caseloads and turnover.

Based on the integration of best practices literature, findings from the Children in Care Profile Survey, and focus groups and interviews, nine recommendations were offered.

SUMMARY OF RECOMMENDATIONS

Recommendation 1 – That a new rate structure for the caregiver program be implemented immediately.

Recommendation 2 – That a strategy be developed and implemented across the province for the provision of ongoing education and training initiatives for foster parents.

Recommendation 3 – That the Department of Health & Community Services focus on establishing standards (and practice guidelines to support them) for the development of emergency placement options, especially for children under 12.

Recommendation 4 - That there is a clear need for the development and implementation of a provincial therapeutic/treatment foster home program as an important component of the placement continuum. This should be developed and implemented based on the unique needs of children in each region.

Recommendation 5 - That the Department of Health & Community Services develop standards for a Group Home program for the province. This should be developed and implemented based on the unique needs of children in each region.

Recommendation 6 – That the province would benefit from the introduction of a short term residential treatment program as an important component of the continuum of care, and it is recommended that the findings and recommendations of the 2003 Residential Treatment report be used to guide the development of such a program.

Recommendation 7 - That the Department of Health & Community Services develop a standardized process to help determine the most appropriate placement type for children being placed in the care of a CYFS Director. Further, that this assessment process must be culturally sensitive.

Recommendation 8 - That the Department of Health & Community Services develop a plan to implement the Canadian Looking after Children (CanLAC) Model.

Recommendation 9 - Policy and program development related to placement resources and service needs of children in care must be culturally sensitive and responsive to the unique needs of Aboriginal children and their families (i.e., the provision of mental health services).

ACKNOWLEDGEMENTS

This review was made possible by the efforts and contributions of a number of individuals. My sincerest appreciation is extended to officials from the Department of Health and Community Services, as well as regional CYFS Directors, Managers, and all social workers and other staff who took part. I would also like to acknowledge the contributions of representatives from the Janeway, Foster Parents and the Newfoundland & Labrador Foster Families Association, the Child and Youth Advocate, and representatives of the Courts for earnestly taking part in the review process. Without exception, and in a constructive and professional way, participants openly shared their experiences, highlighted challenges, offered remedies, and described successes and innovations in a sincere effort to enhance the lives of so many children and families throughout this province.

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NOTE TO THE READER

It is important to note that the language used within the child welfare literature, federal and provincial government policies and procedures, and within the public domain may vary somewhat. For instance, the reader might notice that the term "foster parent" is often used interchangeably with the term "caregiver." For a complete listing of various terms and definitions, please see "Glossary of Terms" Section in Appendix B.

INTRODUCTION

Introduction

While exact statistics tend to vary over time, the most current Canadian figures place the number of children in care at approximately 76,000 (Canadian Welfare League of Canada, 2003), with roughly 624 of those occurring in Newfoundland and Labrador (NL) (Department of Health and Community Services, 2008). Research suggests that approximately 40 percent of Canadian children in care are Aboriginal. Further, it is estimated that 6 percent of all Aboriginal children are in care (Indian and Northern Affairs Canada, 2003). It is important to note that while each province and territory has its own policies and legislation associated with children and youth in the care of the province, they may or may not have particular clauses about Aboriginal children (Canadian Welfare League of Canada, 2003).

Recent trends suggest an overall increase in the number of children removed from their homes and placed in care throughout North America (Child Welfare League of Canada, 2003). This greater demand for in care placements has translated into a shortage of options, resulting in many vulnerable children being inappropriately placed (Child Welfare League of Canada, 2003). Consequently children with long term needs may be put in a short term placement arrangement which can lead to an increased likelihood of placement breakdown and change. Reoccurring placement disruptions can delay the provision of treatment and make it more difficult for children to form secure attachments. (Aitken, 2002). Some contend that a “one size fits all” approach now seems to be the norm when trying to meet the needs of children in care, an approach which conflicts with most policy frameworks that endorse more individualized support and services (Allen & Bissell, 2004; p. 63).

Not only has there been an acknowledged increase in the demand for in care placements, some suggest that the *philosophy* and, hence, primary role of in care systems are currently ill-defined as practitioners and policy makers try to come to terms with whether the nature of child welfare is truly "child" or "family" focused (Barbell & Freundlich, 2001). As a result, some propose that social work practice has been compromised by confusion concerning which outcomes and practices are actually in the children's best interests. According to Barbell and Freundlich (2001) for example, “In this (perplexed) context, the child welfare system continues to struggle to define and achieve appropriate outcomes for children” (p. vi).

Foster care in particular seems to be feeling the influence of such a compromised context as it has unfairly felt a growing pressure to be *the service* that must respond to societal crises impacting children and their families, especially when family needs deepen and escalate, and other service systems are unavailable (Barbell & Freundlich, 2001). Indeed, some of the broadest service gaps recognized throughout the United States and Canada involve substance abuse and mental health; they exist due to funding challenges for specialized services and poor coordination among service systems (Allen & Bissell, 2004). Prevention and early intervention services that might be appropriate for domestic violence problems are even much more difficult to obtain, and treatment resources often are not available except in crisis situations (Barbell & Freundlich, 2001).

How does an in care system generally work?

Children may enter the in care system in a variety of ways. For instance, custody may be assumed by a state or province shortly after a child's birth when it seems quite obvious that the parent(s) will not be able to provide adequate care and support (Canadian Welfare League of Canada, 2003). In other circumstances, children with special needs from remote communities may be placed in care to facilitate access to services not available in their own areas (Ponti, 2008). However, it often seems that the removal of a child occurs when it is clear that their needs are neglected or they are at considerable risk within their homes. Indeed, a variety of salient risk factors may include parental addiction, extreme poverty, homelessness, violence, prenatal drug and/or alcohol exposure, family history of mental health disorders, complex medical problems, and cognitive or functional impairment of parents (Gough, 2007; Ponti, 2008).

When referrals are made to child protective services, and claims of maltreatment are substantiated, the courts and health ministries/authorities must carefully assess whether the child can remain in their home with proper supports and services, or whether the child should be removed and placed in the care of a province or state. For children for whom it is clear that they cannot remain with their birth parent(s), they may be placed with caregiver families who are relatives (or have a significant relationship with the child), non-relative caregiver families,

some form of therapeutic family arrangement or a collective care environment such as a group home (Canadian Welfare League of Canada, 2003).

While there may be several in care options, it is widely contended that the preferred placement option is within a family environment as it has been observed that most children in these arrangements tend to have better mental, psychological and academic outcomes compared to children placed in group or residential care situations (e.g., Kluger, Alexander & Curtis, 2000). Indeed, research continues to demonstrate that healthy early experiences in terms of supportive family relationships lead to sound identity formation, while negative familial experiences such as parental substance abuse and neglect may lead to significant mental health challenges (Hertzman & Keating, 2000).

Coinciding with the removal of a child is the process of developing a permanency plan based on the particular child's needs and challenges, and their family circumstances. It is also generally the case when children are placed into care that it will be a *temporary* measure as reunification with parents is often the ultimate (and desired) goal. In fact, it seems a primary objective of the courts that birth parents be provided with the necessary services and supports they might need to regain custody (Bass, Shields & Behrman, 2004). However, there are still a significant number of cases whereby reunification will not be possible and adoption may be the primary focus of the permanency plan.

Children in care: A vulnerable population with complex needs

Despite the fact that children have to be removed from their family to ensure their safety and well being, it is still a very intrusive action. Being placed in care can initially mean distress, uncertainty and instability for children and their families (Bass et al., 2004). In extreme cases, children experience even more trauma or hardship as a result of being placed into care if they are being moved from placement to placement awaiting a more permanent and secure family environment; it defies the entire rationale of provincial intervention (Badeau, 2004; Bass et al., 2004). Hence, it has been proposed that the first order of business for child welfare is, at the bare minimum, to do no harm, and at best, enhance the lives of children and their families (Badeau, 2004).

It is quite common that children are taken into care after experiencing serious and prolonged negative life events (e.g., various forms of maltreatment), and such situations can significantly hinder normal emotional, physical or cognitive development (Jones-Harden, 2004). It is also generally accepted that children in care tend to have higher than average medical, emotional, developmental and educational needs. And, according to Ponti (2008), "These special needs are often chronic, under-recognized and neglected. There are many barriers to health care including lack of or inadequate medical records, lack of consistent care or follow-up due to temporary placements, and difficulty accessing services. There are no practice guidelines specifically designed to meet the health care needs of children and youth in foster care" (p. 129).

It has also been widely noted that the Canadian children currently placed in care have more demanding and complex emotional and behavioural issues than ever before (Bass et al., 2004; Ponti, 2008; Stein, Evans, Mazumdar, Rae-Grant, 1996). According to the most recent incidence study of reported child abuse and neglect in Canada, at least one physical, emotional or cognitive health problem was observed in 34 percent of confirmed maltreatment investigations (Trocmé, Fallon, MacLaurin, Daciuk, Felstiner, Black et al., 2003). It was further revealed that approximately 15 percent of children living in families under investigation had a learning disability, 10 percent had developmental delays, 3 percent had a substance abuse-related birth defect, and 2 percent had a physical disability (Trocmé et al. 2003). In terms of behavioural issues, approximately 40 percent of investigated children had at least one behavioural functioning issue, with 13 percent of cases having attention-deficit hyperactivity disorder (ADHD), negative peer involvement, or poor school attendance (Trocmé et al., 2003).

Components of the in care system

It is true that while provinces or states are ultimately responsible for the children in care, they require the involvement and support of many organizations such as the courts, private service providers, and other public and government agencies (e.g., mental health counselling, addictions treatment, etc.). However, there are often no broad, encapsulating policies or regulations that govern or manage the involvement of these agencies as there can be both formal and/or informal agreements. As a consequence, some characterize in care systems as a

conglomeration of several overlapping and interacting agencies tasked with providing services, support, or other assistance to children and their families (Bass et al., 2004).

However, the potential disconnect among agencies can mean that caregivers and caseworkers may be left trying to manage and negotiate the requirements and regulations of multiple systems. Further, a lack of coordination among specific agencies, chronic under funding, and inaccessible services and support can lead to a "system" that may discourage and negatively impact children, families and caregivers who desperately require support and intervention (Bass et al., 2004). Two critical parts of the in care system that may have major implication for the outcomes of children are the court system and the frontline workers.

The courts

The courts play a pivotal role when cases of maltreatment or neglect are being investigated; first as the authority in decisions to remove children from their homes, and then to rule on permanency plans put forth by the caseworkers which ultimately lead to reunification or the termination of parental rights (Allen & Bissell, 2004). It is widely recognized that the quality of the child's/family's experience with the court process can have major implications. For instance, the court's degree of sensitivity toward children who have been removed from their homes, as well as the capacity to gain a keen understanding of a child's individual situation, challenges, needs, social circumstances, etc., can lead to better decisions about plans of care and in care options (Bass et al., 2004). Further, given that the interaction among legal representation required for the process (i.e., parent attorney, Health Authority attorney) can be quite acrimonious, the more respectful and responsive individuals are to the child can lead to less distress and negative reactions (Bass et al., 2004).

Perhaps one of the most contentious issues regarding the courts is the time it takes to reach decisions around the futures of children placed in care. In the literature, several refer to children in such situations as "legal orphans" where it can take years for a ruling to be reached as to whether a child will be reunited with birth parents or placed for adoption (e.g., Allen & Bissell, 2004; p. 65).

The frontline

As another major component of in care systems, the literature strongly suggests that the child welfare frontlines throughout North America may be aptly described as very discouraging places to work by many professionals, resulting in high turnover rates among leaders and caseworkers (e.g., Allen & Bissell, 2004; Bass et al., 2004). In particular, caseloads have been regarded as overwhelming, job duties and timelines unmanageable, and child/family demands numerous and complex (Allen & Bissell, 2004).

Such findings have certainly been observed within a Canadian context. In a national survey conducted by the Canadian Association of Social Workers (CASW), a number of very salient themes emerged which spoke to poor morale of practitioners, a shortage of qualified social workers, and high attrition rates (Canadian Association of Social Workers, 2003). However, among the observations, caseload size was deemed the most significant challenge to effective child welfare practice, suggesting that it is the prime reason for the inability to form meaningful relationships with children and their families (Canadian Association of Social Workers, 2003).

Recruiting and retaining foster/caregiver families

Contemporary child welfare research strongly suggests that the recruitment and retention of foster parents have become significant problems throughout the Unites States and Canada. For instance, studies note that pervasive social and financial changes, such as larger numbers of women working out of the home, and an increase in single parent families, as well as economic challenges, may drastically compromise recruitment (Barbell & Freundlich, 2001). However, in terms of retention, while many might leave fostering as a function of advancing age, a significant number of others terminate their involvement primarily because they are frustrated with their experiences (Barbell & Freundlich, 2001). In fact, according to the National Commission on Family Foster Care (1991), as many as 60 percent of foster parents withdraw from the program within the first 12 months (National Commission on Family Foster Care, 1991). Similar foster parent attrition rates have also been noted in more current literature (e.g., Waldock, 2001)

Some research suggests that the financial burden assumed by foster parents can play a part in program attrition. For example, foster parents are expected to cover out of pocket expenses prior to being reimbursed, only to be compensated at very low rates. This scenario can be quite challenging and distressing, particularly in situations where there are foster parents who are single, older, and/or whose incomes fall within a low-to-middle earnings bracket (Barbell & Freundlich, 2001). Nonetheless, other studies suggest that "non-economic factors" tend to be the primary reasons for high attrition such as insufficient respite, inadequate consultation and support from social workers, poor agency response to crisis situations, disrespect for foster parents as partners and team members, inadequate training, and few opportunities to provide input into training or services for foster parents (National Commission on Family Foster Care, 1991; Waldock, 2001).

The literature also suggests that the dissatisfaction felt by foster parents can seriously influence recruitment of new foster parents. Indeed, research does strongly indicate that currently active foster parents are *the* most proficient recruiters of new foster parents (Barbell & Sheikh, 2000). Hence, foster parents' poor experiences and attitudes about the agency with which they are affiliated can negatively impact both their own participation as well as their willingness to assist agencies in bringing new foster parents to the program (Barbell & Sheikh, 2000).

What does the current research recommend to improve in care programming?

In light of the challenges and issues associated with child welfare in care systems presented above, a variety of potential remedies and recommendations have been offered in response.

A quick response is vital

The issue of timely decision making surfaced repeatedly, particularly with respect to the courts. For example, according to Allen and Bissell (2004), in order to significantly improve in care systems, there should be more expedient decisions about reunification or other permanent placements. Similarly, it was recommended that establishing and addressing the needs of children must begin during the primary stages of the placement with initial health screening, and continue at regular intervals while the child is in care. During this time, case

plans must also be established to ensure that individual needs are being met, and that the most effective developmentally or age appropriate services and support are offered while being sensitive to the child's culture (Bass et al., 2004).

Keeping children at home with family services

Another general recommendation offered in the literature concerned the need to expand services and resources to keep children safely at home. Accordingly, by addressing the needs of families and involving them as partners (where possible) in helping to keep the children safe, the trauma and distress associated with a removal can be eliminated (Allen & Bissell, 2004).

The essential attributes of foster care

Many authors contend that it must be clearly acknowledged and communicated that foster care is a *temporary* circumstance for the care of children and this should provide the premise on which foster care will evolve and be defined (Barbell & Freundlich, 2001). Further, as a function of its temporary nature, foster care programs must ensure that children are placed with families within their own cultural groups and communities whenever possible (Dougherty, 2001; Barbell & Freundlich, 2001). In fact, cultural sensitivity must always be endorsed so that the cultural strengths and values of all families are respected, endorsed and accommodated (Dougherty, 2001).

Regardless of the permanency plan developed for the child, it is important to recognize and accept the fact that birth families will always play a significant role in children's lives (Dougherty, 2001; Fahlberg, 1991). While this makes sense for those who will be reunited with their parents or placed with members of their extended families, it is also true for children who cannot return home as they still have psychological connections with their birth families. Such associations are vital to children's sense of self, ability to cope with and resolve loss, and ability to form new and more lasting attachments (Fahlberg, 1991). When children must enter foster care, a community-based approach should be adopted that allows the involvement of the many individuals who know and care about the child: e.g., members of the child's extended family, neighbours, friends, teachers, and others already involved in the family's life (Dougherty, 2001; Barbell & Freundlich, 2001).

In care systems must also address the needs and concerns of foster parents. There should be greater consultation and support from social workers, better agency response to crisis situations, the inclusion of foster parents as partners and team members, and more effective and available preparation and training (National Commission on Family Foster Care, 1991; Waldock, 2001).

Addressing the medical, psychological and developmental needs of children

Since it has been widely recognized that children in care have a higher incidence of special needs including chronic medical conditions, mental health issues, and developmental and academic delays, the medical community should be cognizant of, and be prepared to respond to this fact (Ponti, 2008). It is recommended that physicians partner with child welfare professionals and, coinciding with the placement of a child, there should be initial medical screening including a physical examination to test for, and treat acute or chronic health conditions (Ponti, 2008). Further, given the potentially frequent transitioning of children through the in care system, it is vital to establish and maintain thorough medical records, and these health care records follow the child or youth throughout, and beyond the in care placement (Ponti, 2008).

The Child Welfare System in Newfoundland and Labrador

The Child, Youth and Family Services Act (referred to hereafter as "the Act") provides the legislative framework within which services to children, youth and families are delivered in Newfoundland and Labrador (NL). The Act includes legislative provisions for four program areas including Protective Intervention, In Care, Youth Services and Family Services. The Department of Health and Community Services through the Children and Youth Services Division is responsible for the administration of the Child, Youth and Family Services Act as well as to track the quality and provision of child welfare services throughout the province. Legislatively, the Provincial Director of Child, Youth and Family Services (CYFS) has the task of establishing and overseeing provincial policies, programs, and standards (Gough, 2007).

The Health Authorities

The actual delivery of programs and services under this Act are the responsibility of four regional Health Authorities (Eastern, Central, Western and Labrador-Grenfell). Under Section 4 of the CYFS Act, the board of each regional Health Authority has to appoint a Director in the region to oversee the delivery of child, youth and family services within that region. Labrador-Grenfell Health Authority has an additional Director who is responsible for the Innu Zone. Children who need to be removed from their families for protective intervention are placed in the legal guardianship (called the "care and custody") of the Director of each regional Authority. The Directors of each region delegate their responsibilities for child, youth and family services to registered social workers employed by the regional Health Authorities.

CYFS social workers in the Health Authorities act in the best interests of children by adhering to several defining standards outlined by the Department of Health and Community Services. In addition to a commitment to investigate allegations or evidence that children may be in need of protective intervention, social workers are also committed to providing 1) a range of services to assist families and communities in caring for their children, 2) care for children for whom it is not safe to live at home, 3) comprehensive planning for children in temporary or continuous custody, and 4) family supports and services to promote child health and integrity, being mindful of the importance of preserving the cultural heritage of children and their families (Gough, 2007).

In terms of the number of children in the care and custody of a regional director, provincial statistics reveal that there has been a notable increase since early 2000. According to the Division of CYFS (the Department of Health and Community Services), for instance, the number in care went from 625 in 2002/03 to 775 in 2005/06.

The main principles of the Act

As the primary piece of provincial legislation serving to protect and promote the health and well being of NL children, the CYFS Act is defined by a number of guiding principles, many of which include:

- the best interests of the child are paramount in any decision,
- every child is entitled to safety, health, and well-being, and maltreatment prevention activities are integral to promoting these basic rights,
- the family is the basic unit of society and is responsible for its children,
- the community has a responsibility to support the safety, health, and well-being of children, and may require assistance in fulfilling this responsibility,
- kinship ties are integral to a child's growth and development, and if the child's safety, health, and well-being cannot be assured within the immediate family, the extended family should be encouraged to care for the child as long as this does not put the child at risk of harm,
- the cultural heritage of a child should be respected and connections with a child's cultural heritage should be preserved, and
- in the absence of evidence to the contrary, a child aged 12 or over is presumed to be capable of forming and expressing an opinion regarding his or her care and custody.

Further, factors believed to be pivotal in addressing the best interests of the child include:

- the child's safety and developmental needs, cultural heritage, views, and wishes,
- the importance of stability and continuity in care, including the continuity of relationships with family and others with whom the child has a significant relationship,
- the child's geographic and social environment,
- the child's supports outside the family, and
- the effect upon the child of a delay in the decisions that affect the child.

Conditions under which protective intervention is necessary

Section 14 of the CYFS Act provides the grounds for determining when a child is in need of protective intervention. This section involves where the child:

- is, or is at risk of being, physically harmed by the action or lack of appropriate action by the child's parent.
- is, or is at risk of being, sexually abused or exploited by the child's parent;
- is emotionally harmed by the parent's conduct;
- is, or is at risk of being, physically abused or exploited by a person and the child's

parent does not protect the child;

- is, or is at risk of being, sexually abused or exploited by a person and the child's parent does not protect the child;
- is being emotionally harmed by a person and the child's parent does not protect the child;
- is in the custody of a parent who refuses or fails to obtain or permit essential medical, psychiatric, surgical or remedial care or treatment to be given to the child when recommended by a qualified health practitioner;
- is abandoned;
- has no living parent or a parent is unavailable to care for the child and has not made adequate provision for the child's care;
- is living in a situation where there is violence; or
- is actually or apparently under 12 years of age and has been left without adequate supervision,
- allegedly killed or seriously injured another person or has caused serious damage to another person' property, or
- on more than one occasion caused injury to another person or other living thing or threatened, either with or without weapons, to cause injury to another person or other living thing, either with the parent's encouragement or because the parent does not respond adequately to the situation.

Reports of child maltreatment are received at regional CYFS offices. Upon receiving information that a child may be in need of protective intervention, a social worker shall assess the information to determine what action is required. In cases where protective intervention is required, social workers assess the child's safety using a risk management process (Gough, 2007). In situations where a child's health, safety, and well being cannot be assured, the social worker must consider other options. An initial approach is to assess the possibility of the child being placed with an extended family member or other person who has a significant relationship with the child (and who is assessed as able) to provide safe and temporary care. If this is not an available or suitable option, the social worker can make application to the court to remove the child and request the child be placed in the custody of a Director of CYFS.

NL consideration of Aboriginal Children

NL's CYFS Act strongly supports the notion that the cultural heritage of children be respected and preserved. It also identifies the responsibility of the community and the extended family to support the safety, health, and well-being of children. These clauses have particular relevance for social workers who work to establish case plans for Aboriginal children.

There are no dedicated First Nations child and family service agencies in NL such that child welfare services are provided to Aboriginal families by the regional Health Authorities (most notably by Labrador-Grenfell Health) (Gough, 2007). In order to enhance child and family service delivery in Aboriginal communities, Community Services Workers (or community members employed by the Health Authorities) assist social workers in providing culturally appropriate supports to Aboriginal families. Further, the CYFS Act allows for the appointment for an additional Director of CYFS for Labrador. A second Director has been appointed and is responsible for service delivery to the Innu Communities.

THE CURRENT REVIEW

The current review

Within the context of the literature briefly discussed above, and in an effort to move towards effectively addressing the needs of children who have been (or will be) placed in the care/custody of a Director of CYFS, the following review of NL's in care program was conducted. Accordingly, the discussion and analyses contained in this report represent an in-depth exploration of the provincial and regional services and programs as they currently exist, as well as proposed measures required for the system to become more integrated, responsive, proficient and complete.

Purpose of review and general methodological approach

During November, 2007 on behalf of the Department of Health and Community Services and the four regional Health Authorities, a review of the in care program for children less than 16 years of age commenced. At that time, three primary objectives were identified which included;

1) The establishment of an accurate profile of ALL children in the care and custody of a Director of CYFS that would be sufficient to provide an understanding of their particular needs. Of particular interest were issues such as:

- The extent to which there are presenting issues,
- The types of presenting issues such as FASD, ADD, etc.,
- The types of supports/services they require, and
- The types of placements in which they currently reside,

2) The determination of the extent to which existing placements were suitable, and if it was observed that existing placements were not appropriate, to identify the gaps in the current placement continuum, and

3) Recommendations about how to strengthen the placement resources currently available as well as the identification of ways to address identified gaps in the existing continuum.

The review of the in care program involved the collection of various forms of information which allowed for a detailed exploration of program processes, resources, and intended and/or

actual outcomes. In addition to best practices document reviews and preliminary meetings with program representatives to define the specifics of the methodology, subsequent stages involved the construction, testing, development, and utilization of the Children in Care Profile questionnaire, as well as an interview process designed to assemble prevailing beliefs and experiences via focus groups and interviews with key stakeholders.

Children in Care Profile Survey

Based on the recommendations of a Steering Committee tasked with guiding this particular study (i.e., Department representatives and the Regional Directors), a questionnaire was developed, disseminated, and completed by front line social workers in order to establish a profile of children currently in care. Through multiple meetings with the Regional Directors and Department Officials, a draft instrument was constructed and refined. By the beginning of February 2008, a version of the instrument was sent to a small group of professionals throughout the province for the purposes of pilot testing. By mid-February, feedback was received from the field, alterations were made, and the instrument was finally approved for distribution.

In terms of content, the final version of the questionnaire was designed to explore a variety of such issues, including:

- general demographic and placement information,
- ratings of emotion/psychological and physical wellness,
- aspects of social integration,
- school performance,
- child's family history,
- presenting problems/issues, and
- services availed of (See Appendix A for final instrument).

Who completed the questionnaires?

The Children in Care Profile Survey captured information associated with 579 children throughout Newfoundland and Labrador (NL). Based on the most recent statistics from the Department of Health and Community Services, as of March 2008, it was estimated that there were 624 children in care, placing the response rate at an extraordinary 93 percent. As a note, while salient findings have been presented and discussed in this document, the Children in Care Profile Survey data file may continue to supply policy makers and regional

representatives with vital information about the in care program well beyond the scope of this report.

Eighty-one percent of the respondents were the child's social worker who worked with the children for an average of 1.3 years. However, 57 percent of the Labrador-Grenfell Children in Care questionnaires were completed by individuals who were not social workers; these tended to be Clinical Program Mangers, foster parents or Regional Director. The time social workers reported working with the children also varied with region. The shortest duration was reported in Central (i.e., .82 years), while the longest duration was Labrador-Grenfell (i.e., 1.7 years). Approximately 33 percent of respondents consulted other people when completing the questionnaires; mostly with foster parents.

Limitations of the Children in Care Survey

Aside from the remarkable response rate, perhaps a primary limitation of the Children in Care Survey is its reliance on the self report of CYFS professionals whose knowledge and awareness of child issues may vary considerably. This is particularly true for questions about perceived the health and wellness, social interaction, and school performance which are much more subjective and hence difficult to answer. There are also missing data with some questions because the child might have been too young, or the social worker might not have had enough knowledge to provide a response given the child's relatively brief association with the CYFS system. Finally, the issue of comparison group is also important to be wary of as the perceived wellness (or academic performance) of a child could be interpreted in comparison to other children the same age from the general population, or other children experiencing the same life circumstance (e.g., a developmental delay). Therefore, the mental/psychological wellness of a child with ADHD, for instance, may be rated as "excellent" compared to other children with a similar diagnoses, or "fair" or "poor" when compared to children not dealing with such an issue.

Key Informant Interviews with Provincial Officials, CYFS Directors, Managers Social Workers, Professionals, and Foster Families

There were actually two types of qualitative data utilized in this review: 1) information resulting from several meetings/sessions, and pieces of correspondence, and 2) themes and issues identified from key informant interviews and focus groups.

Participation in meetings/sessions and important correspondence

Throughout the course of the review, several meetings and sessions focusing on the in care program were attended. There was also some correspondence received from particular interest groups offering specific issues and perspectives. All these important sources of information were considered during report development and were vital for: a) considering the logistics of the research process: b) establishing the sampling frame of potential respondents, c) informing the Children in Care instrument development, d) identifying lines of questioning for the key informant interviews, and e) suggesting appropriate documentation and literature sources which describe and endorse best practice approaches.

During each meeting/session, various issues were raised and deliberated, and data collection involved extensive note taking where appropriate. Accordingly, the following is a listing of the meetings that were participated in between November 2007 and April 2008.

Recurring meetings with Department of Health and Community Services officials: Arranged in order to define the scope of the review, establish a logistically feasible methodological approach, discuss the types of salient issues that one might expect during the review, and create a sample frame representing those most suitable for the interviews.

Recurring meetings of the Regional CYFS Directors/Department Officials: Regional CYFS Directors and Department officials actually made up a Steering Committee which served to guide this study. These meetings were absolutely crucial for identifying suitable regional informants and scheduling regional visits, reviewing drafts of the Children in Care Profile questionnaire, arranging pilot testing of the instrument, and discussing major regional issues associated with the in care program. These individuals also closely reviewed drafts of this report.

Foster Care Rates and Services Committee meeting: During November, 2007, one meeting was attended with a special committee established to explore and recommend issues associated with the Foster Care Program. This committee and the resulting work were very useful for helping to frame recommendations around foster family support.

Meeting/teleconference with Newfoundland and Labrador Foster Parents Association: This session involved a number of respondents from several Foster Parent Associations around NL, many of whom contributed via teleconference. This meeting was vital for informing foster families of the purpose and approach of the research, as well as recruiting foster parents for key informant interviews. Note: the provincial Foster Families Association was also important for raising awareness of the review via its newsletter.

One day Consultation on Emergency Placements for Young Children – Eastern Health: This event took place during late January (2008) and involved the contributions of 23 public and private sector stakeholders and representatives including CYFS staff, Eastern Health professionals from other programs (e.g., The Janeway Family Centre), community representatives (e.g., Caregivers, St. Francis, Shalom, etc.), and Department of Health and Community Services officials. Among a wide variety of issues and topics discussed, of particular concern was emergency placements for young children. This session actually yielded a report of important findings and recommendations, many of which provided a very important context for this review.

Correspondence from Southwest Foster Families Association: Since it was difficult to meet many important informants in person, some decided to forward correspondence outlining very important issues associated with foster care within their particular region. Accordingly, a letter was received from Southwest Foster Family Association outlining various issues and concerns.

Key informant interviews

Starting during January 2008, interviews were conducted with a number of individuals and groups associated with the CYFS in care program throughout NL. Given the provincial scope of the review, one visit was made to each Health Authority.

Most interviews/focus groups ranged between 45 and 120 minutes, and took place at provincial government buildings or regional Health Authority offices. While the primary intension was to meet participants face-to-face, given the geographical expanse of some areas, and the relatively short duration of the review, teleconference technology was also arranged and employed from the Labrador-Grenfell site. On three occasions, telephone interviews were also conducted to ensure the inclusion of key informants that were not available during the visits.

Participants were asked to provide insights and commentary based on experiences with and perceptions of various aspects of the in care program in general, and the particular challenges and barriers typical of the variety of associated services (See Interview Guide). For each interview session, participants were audio taped to ensure accurate and effective data collection. Upon completion of the interviews, data were transcribed (by the researcher) and reviewed for recurring themes and issues. In all interviews, participants were actively encouraged to discuss any other issues they felt were important. Qualitative researchers have widely endorsed this approach as it enhances the validity of the data since participants themselves pattern the timing, content and context of the topics discussed. However, probing questions were used to elicit further information or to clarify information provided. Salient aspects of participant accounts were also paraphrased. These sorts of probes are vital for the interpretation of participant stories and they help ensure the validity of the presented interpretation.

Interview guide

During the interviews, participants were presented with several broad areas of inquiry which included themes such as the following;

- typical presenting issues of children in care;
- the types of supports and services typically required by, and actually being provided to children;
- required services or resources that are not available;
- type of placements children are typically placed in;
- the suitability of the placement, and the type of placement that might be more appropriate;

- potential ways respondents believe gaps in the placement continuum should be addressed;
- changes in services and supports; and
- recommendations/remedies where the program might be improved.

However, several additional issues and themes were identified and added to subsequent interviews, which included;

- child issues; challenges in maintaining contact with biological parents, frequent changes in social workers/foster families, addressing wellness issues in a timely fashion (e.g., counselling), managing complex needs and challenges,
- social worker issues; e.g., workload, lack of professional support, high turnover, difficulties recruiting/filling vacancies, fear and worry re: child outcomes and professional judgment.
- the value of a variety of in care options along a continuum of care; e.g., therapeutic foster homes, a provincial residential treatment centre
- foster families; e.g., recruitment/retention, burnout, the need for changing roles, responsibilities, financial support, training, social worker support (or lack thereof), and
- potential issues and barriers created by the court system.

The participants

A variety of groups involved with the in care program throughout the province were identified as having specific investment in the results of this review and, as such, were provided an opportunity to share their experiences, perceptions and recommendations. More specifically, the qualitative component of this review involved interviews with respondents falling within a variety of categories, including CYFS Directors, Managers and social workers (and other frontline staff), as well as foster families, provincial officials, and representatives of the courts.

Systematic, non-probabilistic sampling was used in the current research where the primary purpose was not to establish a random or representative sample drawn from a population, but rather to identify specific groups of people who either possess characteristics or live in circumstances relevant to the phenomenon being studied (in this case, the provincial in care program). As Table 1 shows (see below), a total of 90 individuals throughout NL were

involved as key informants.

Table 1 – Number of respondents by category and program/service

Participant Category		Number of Respondents
Eastern Health Authority (Including Janeway)	CYFS Director	1
	CYFS Manager	2
	Social Worker	14
	Pediatrician	1
Central Health Authority	CYFS Director	1
	CYFS Manager	1
	Social Worker	3
Western Health Authority	CYFS Director	1
	CYFS Manager	3
	Social Worker	5
Labrador-Grenfell Health Authority	CYFS Director	2
	CYFS Manager	8
	Social Worker	7
	Community Service Worker	1
NL Foster Families Association	Executive Director	1
Foster Parents		30
Office of the Child and Youth Advocate	Child and Youth Advocate	1
Department of Health and Community Services	Director of Children & Youth Services	1
	In care Program Consultant	1
Department of Justice	Provincial Court Judge	1
	Solicitor	1
Former Child in Care		1
Community Organizations	St. Francis	1
	Shalom	1
Private organizations	Caregivers	1
Total		**90**

Establishing confidence in the data

An investigative technique known as "triangulation" was employed as a means of facilitating a more comprehensive analysis of all information sources assembled for this review. Where convergence (agreement) was observed across stakeholder groups and data sources, the overall level of confidence in the findings was enhanced. More simply defined, where

consensus was achieved among the responses of key respondents such as provincial officials, program managers, frontline staff, foster families, court representatives, and these responses were supported by the information captured via the Children in Care Profile Survey, it was deemed highly likely that the circumstances observed were indeed factual.

CHILDREN IN CARE PROFILE SURVEY

Children in Care Profile Survey

The Children in Care Profile Questionnaire was completed by professionals throughout the province (primarily social workers) in order to profile children in the care of a Director of CYFS. Presented below is in-depth information associated with 579 children; a response rate of 93 percent.

Demographic and general placement information

Of all children represented in the Children in Care Survey, Figure 1 shows that 44.2 percent (or 256) were from Eastern Health, 28.5 percent (or 165) were from Labrador-Grenfell Health, 18.3 percent (or 106) from Western Health and 8.8 percent (or 51) from Central Health.

Figure 2 shows that, for each Health Authority, there were generally more boys placed in care. It would appear that Western had the greatest proportion differential (i.e., 60.4 vs. 39.6 percent), while Central had the least proportion differential (i.e., 51.0 vs. 49.0 percent).

Children in care in NL had an average age of 8.8 years. While there was slight variability among health authorities, the children placed in Eastern were on average one year younger

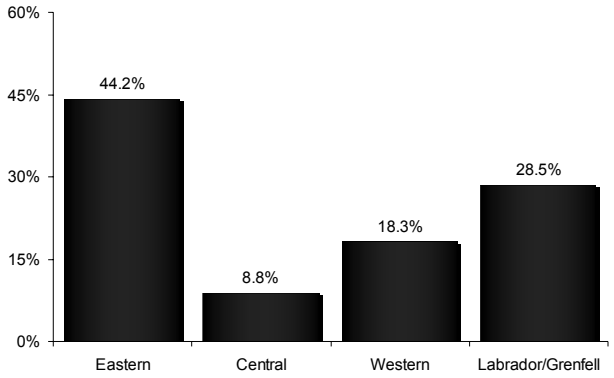

Figure 1 – Proportion of children in care by Health Authority, 2008

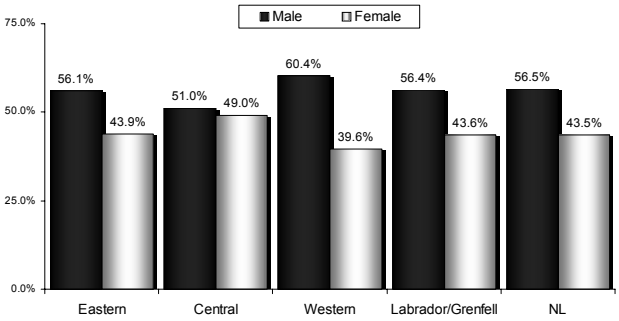

Figure 2 – Proportion of children in care by gender, Health Authority and NL, 2008

Text Box 1 - Some notes on regional variations in child age categories

- Eastern Health had the highest proportion of children less than 2 years of age (i.e., 13 percent). The other regions ranged between 4 and 5 percent.
- Central Health had the highest proportion of children between 2 and 4 years of age (i.e., 24 percent). The other regions ranged between 13 and 18 percent.
- Eastern Health had the lowest proportion of children between the ages of 5 and 9 years (i.e., 22 percent). The other regions had between 25 and 29 percent.
- Western Health and Labrador-Grenfell Health had the highest proportions of children 10 years of age and greater (i.e., 54 and 51 percent respectively). Central Health and Eastern Health had 44 and 48 percent respectively.

than those placed in Western (i.e., 8.5 vs. 9.4 years) (See Text Box 1 about regional variations in child age categories).

In terms of the ethno-racial characteristics of children in care, Figure 3 shows that for Eastern, Central and Western, the proportion was predominantly Caucasian with the proportion of Aboriginal children ranging between 3.1 and 6.1 percent. However, 93.9 percent of children placed in Labrador-Grenfell were Aboriginal. It is also noteworthy that 29.3 percent of all children place NL in care were Aboriginal children (See Text Box 2 for additional notes).

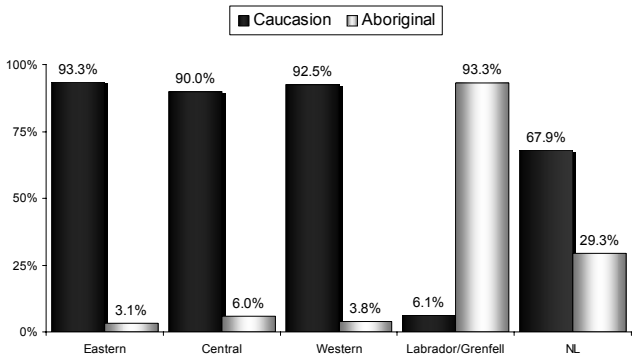

Figure 3 – Proportion of children in care by ethno-racial group, Health Authority and NL, 2008

Text Box 2 - Some notes on child's first language and whether child is placed in own culture

- From a provincial perspective, English was the first language of 85 percent of children placed in care, while Innu Aimun was the first language for approximately 15 percent.
- In terms of the first language of children in care in the Labrador-Grenfell Health Authority, half were Innu Aimun.
- In NL, 16.5 percent of children in care are not placed within a caregiver home of the same culture
- In the Labrador-Grenfell Health Authority, 43 percent of children in care are aboriginal placed in non-aboriginal homes

The custody status of children in care throughout NL is presented in Figure 4. According to the figure, 52.7 percent of children were identified as being in continuous custody (i.e., permanently in the care of CYFS Director), 34.8 percent were identified as being in temporary custody (i.e., temporarily in the care of a CYFS Director for a specified period of time), and 3.1 percent fell into the "Voluntary Care Agreement" (or VCA) category (whereby a parent voluntarily transfers care and supervision to a Director of CYSF). It is notable from the figure that 9.4 percent of children were identified as being in "Interim Care" having yet to receive a ruling from the courts regarding their custody status.

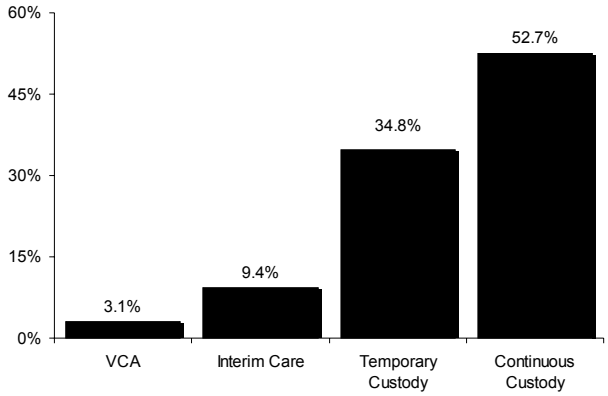

Figure 4 – Custody status of children in care, NL, 2008

Note: VCA = Voluntary Care Agreement

Custody arrangement by region is presented in Figure 5. Among the authorities, Western had the greatest proportion of children in continuous custody while Central had the lowest (i.e., 64.8 vs. 35.3 percent). It is also evident from the figure that Eastern and Central had the highest percentages of children in interim care (i.e., 13.3 and 13.6 percent respectively).

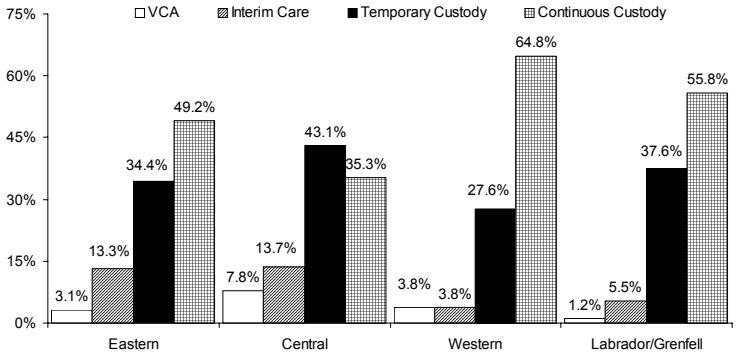

Figure 5 – Proportion of children in care by custody status, Health Authority and NL, 2008

In terms of whether the children were placed within NL, the data revealed that 37 of the 579 were sent out of province for care (accounting for 6.5 percent of all placements – See Figure 6). From the figure, it is clear that the vast majority of outside placement came from the Labrador-Grenfell Authority (i.e., 15.9 percent)

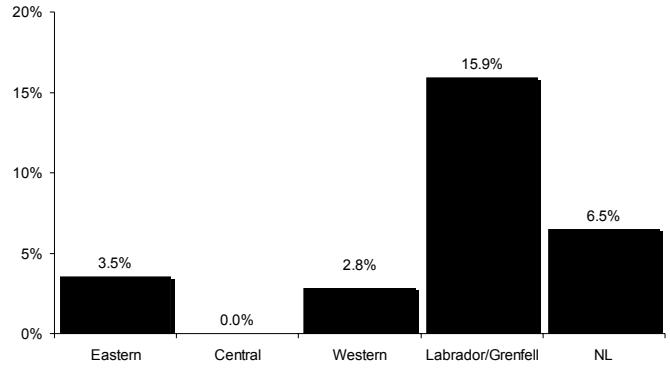

Figure 6 – Proportion of children in care placed outside the province by Health Authority and NL, 2008

With regard to type of in care placement, the majority of children (i.e., 56.5 percent) were placed within a caregiver home characterized as "non-relative", 25.5 percent were placed in a caregiver home with relatives or significant others, and 3.3 percent were placed in group homes (See Figure 7).

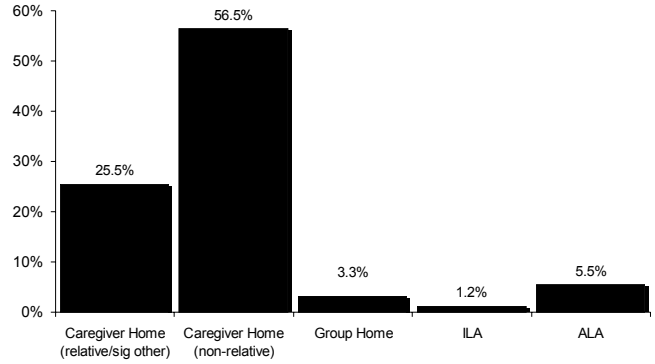

Figure 7 – Proportion of children in care by type of placement, NL, 2008

The remaining placements involved Independent Living Arrangement (ILAs) or placements designed to address the long-term, complex needs of children or youth (i.e., 1.2 percent), and

Alternate Living Arrangements (ALAs) or arrangements designed to provide emergency or short-term placements because caregiver homes and group homes were unavailable (i.e., 5.5 percent) (See Text Box 3 for Additional Notes on Types of Placements and regional differences)

Text Box 3 - Some notes on Types of In Care Placements

- Eastern had the lowest proportion of children placed in Caregiver Homes defined as "Relatives/Significant Others" (Approximately 20 percent of Placements) while Central, Western and Labrador-Grenfell each had approximately 30 percent of children placed in Caregiver Homes defined as "Relatives/ Significant Others"
- Central and Western also had a high proportion of children placed in Caregiver Homes defined as "Non-Relative" (65 and 66 percent respectively)
- Eastern and Labrador-Grenfell had lower percentages of children placed in Caregiver Homes defined as "Non-Relative" (57 and 47 percent respectively)
- Fourteen percent of Labrador-Grenfell placements were defined as "other" perhaps a function of significant "out of province" placements
- Unlike the other health authorities, 6 percent of Eastern's children involved group home placements

The caregiver home environment was assessed by determining particular aspects of family composition. Based on the analyses, it was observed that, of all caregiver homes, 76 percent were "two-parent" homes while 19 percent were "single parent" (N**ote**: some respondents did not provide this information).

The majority of caregiver homes (i.e., 64 percent) were found to have other children living in them; and of those homes, it was determined that approximately 32 percent were the biological sibling of the child in care. In the majority of such cases, there was just one other sibling.

It was further determined that 23 percent of the other children living within caregiver homes were other children in care, but not biological siblings, and approximately 35 percent of children in caregiver homes were children of the caregiver.

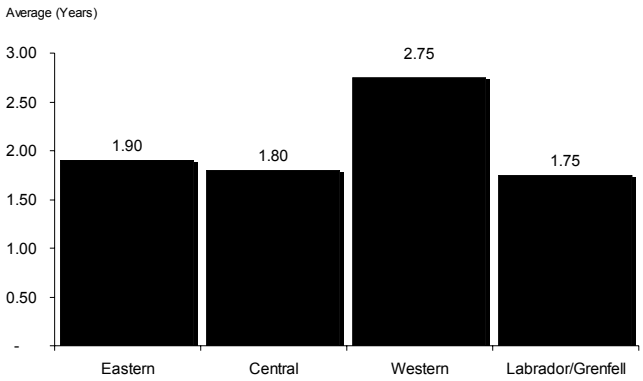

Figure 8 – Average number of years child in current placement by Health Authority, 2008

When respondents were asked how long the child had been in his/her current placement, the provincial average was roughly 2 years. This varied slightly by Health Authority, whereby current placements were longer Western (i.e., 2.75 years) compared to the other authorities (See Figure 8).

When respondents were asked to report whether the child was placed within their original community, just over 50 percent remained in their communities. As Figure 9 shows, these statistics varied with region whereby 57 percent remained in their communities in the Eastern Region compared to 36 percent in Western, 45.1 percent in Central and 51 percent in Labrador-Grenfell.

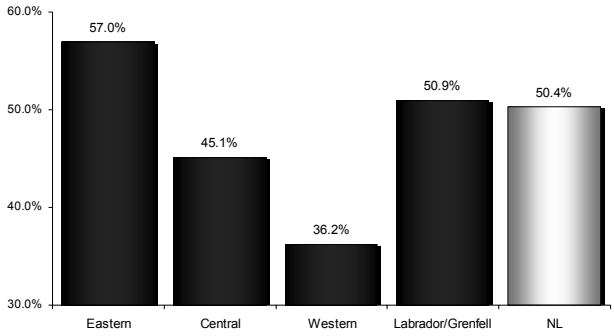

Figure 9 – Proportion of children placed in their original community by Health Authority and NL, 2008

In terms of whether children maintain contact with their birth parents, respondents reported that approximately 71 percent of all children placed throughout the province do tend to keep in regular contact (See Figure 10). Responses among the regions were again variable ranging between 90.2 percent in Central and 57.1 percent in Western.**

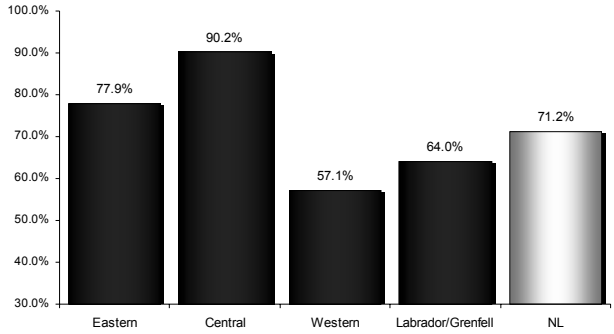

Figure 10 – Proportion of children who maintain regular contact with parents by Health Authority and NL, 2008

** **Note**: the low percentage for Western may reflect a relatively high proportion of children in continuous custody.

The average number of times per month children communicate with their birth parents is presented in Figure 11. Provincially, children were in contact with parents an average of 9.6 times. Analyses revealed that contact between children and parents were most frequent in the Eastern Authority, and there was a steady decline through Central, Western, and Labrador-Grenfell (i.e., 7.8, 5.7 and 5.3 respectively).

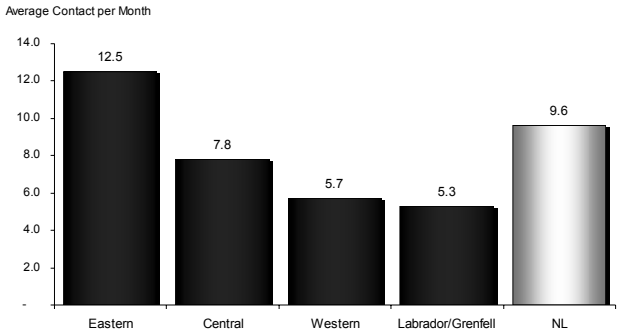

Figure 11 – Frequency of parental contact (average times per month) by Health Authority and NL, 2008

While not explicitly asked, some respondents decided to provide the primary means by which children and their parents

tend to be in contact with each other. Of the methods reported, none could be deemed most common, ranging among "unlimited access", to a variety of phone call schedules (i.e., daily, weekly, monthly, etc.), to "daily visits", "6 visits per year", "3 visits with mom, and 1 visit with dad per month", etc. (See Test Box 4 for Other notes on Child-Parent Contact)

Text Box 4 – Other notes on Child-Parent Contact

- Twenty-six percent of children do *not* have regular contact with the biological parent(s).
- "Distance" was the primary barrier impacting parental contact
- Other barriers reported included:
  - * Parent substance abuse
  - * Parent's mental health
  - * Parent in custody
- Approximately 90 percent of children in interim and temporary care have access to their parent(s) compared to 54 percent of those in continuous custody

The percentage of children who maintain regular contact with siblings (if applicable) is presented in Figure 12. As the figure shows, approximately 75 percent of all children in care (with siblings) maintained regular contact. Children in the Central Authority had the highest proportion (i.e., 85.1 percent), followed by Eastern, Western and Labrador-Grenfell (i.e., 78.9, 74.2, and 65.5 percent respectively).

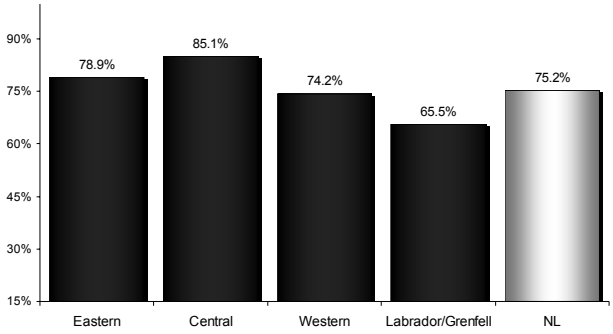

Figure 12 – Proportion of children who maintain regular contact with siblings by Health Authority and NL, 2008

Figure 13 provides the proportion of children in care who were reported to have regular contact with relatives. Overall, just over 56 percent of children across NL were thought to have regular contact, and, with the exception of Central's proportion of 74.5 percent, the regions had comparable percentages with the province (i.e., approximately 54 percent for each).

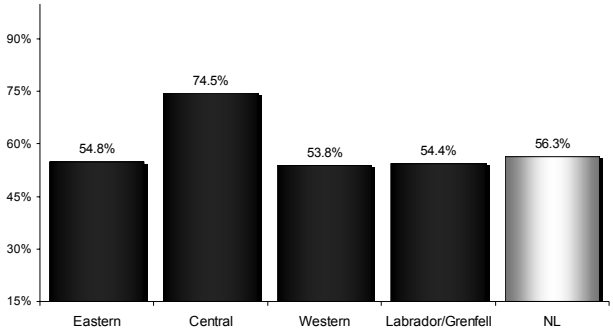

Figure 13 – Proportion of children who maintain regular contact with relatives by Health Authority and NL, 2008

In terms of regular contact with people thought to be important to the lives of children in care (i.e., "significant others"), it was observed that 64 percent maintain regular contact (See Figure 14). According to the regional trends, it would appear that the children of Labrador-Grenfell had the highest percentage of

regular contact with a significant other (i.e., 70.7 percent). The other percentages ranged between 59.3 percent for Eastern and 66.7 percent for Central.

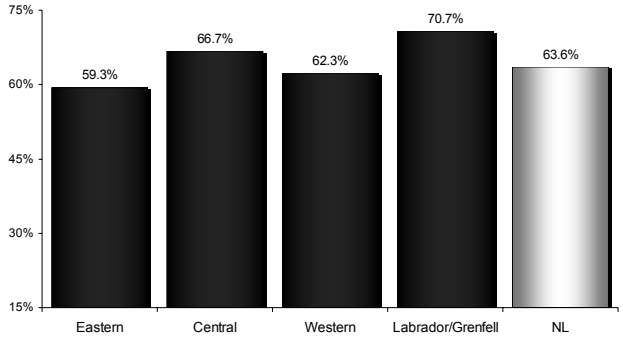

Figure 14 – Proportion of children who maintain regular contact with significant others by Health Authority and NL, 2008

Ratings of physical/emotional/social wellness

As a means of exploring various ratings of child health, wellness, social capacity, and academic performance, several questions were adapted from the National Longitudinal Survey of Children and Youth (2006-2007) (Statistics Canada, 2008). While these represent important lines of questioning, readers are cautioned when attempting to interpret the findings (See "Limitations of the Children in Care Survey" section above).

For questions assessing physical and mental/psychological health status, response categories included "Excellent", "Very Good", "Good", "Fair", and "Poor." In terms of ratings of school performance, response categories were "Very Well", "Well", "Average" "Poorly", and "Very Poorly." For questions about social integration ability where respondents were asked to rate how well children had gotten along with other children, teachers, and caregivers, potential responses included "Very well, No Problems", ""Quite Well, Hardly any Problems", "Pretty Well, Occasional Problems", "Not too Well, Frequent Problems", and "Not too Well, Constant Problems."

In terms of child physical health ratings, Figure 15 provides the percentages for each Health Authority and the province. As the figure shows, approximately 58 percent of the children in care were judged as having "Excellent" or "Very Good" physical health status. The figure also displays notable variation among health authorities. In

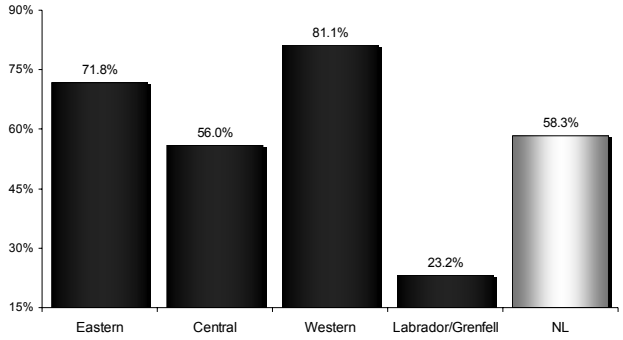

Figure 15 – Proportion of children who's physical health Status was rated "Excellent or Very Good" by Health Authority and NL, 2008

particular, proportions ranged significantly between 81.1 percent for Western and 23.3 for Labrador Grenfell.

Figure 16 provides ratings of child mental and psychological health by Health Authority and NL. As the figure shows, 54.1 percent of NL's children in care were judged as having either, "Excellent", "Very Good", or "Good" mental/psychological health, while 29.1 percent were judged as having "Fair" or "Poor" mental/ psychological health. These statistics did vary significantly among the health authorities as 78.3 percent of Western's children in care were rated as having Excellent", "Very Good", or "Good" mental/psychological health, compared to 29.7 percent of Labrador-Grenfell in care children. Conversely, 45.5 percent of Labrador-Grenfell's in care children were rated as having "Fair" or "Poor" mental/ psychological health compared to 14.2 percent of Western's in care children. Central and Eastern statistics were comparable to the provincial statistics.

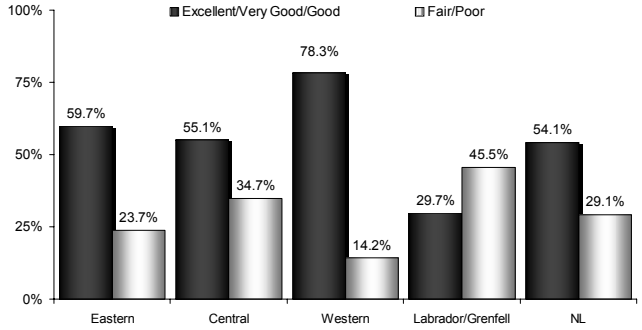

Figure 16 – Proportion of children whose mental/psychological health status was rated "Excellent/Very Good/Good" or "Fair/Poor" by Health Authority and NL, 2008

Note: Respondents were unable to judge for 16 percent of the children in Labrador-Grenfell

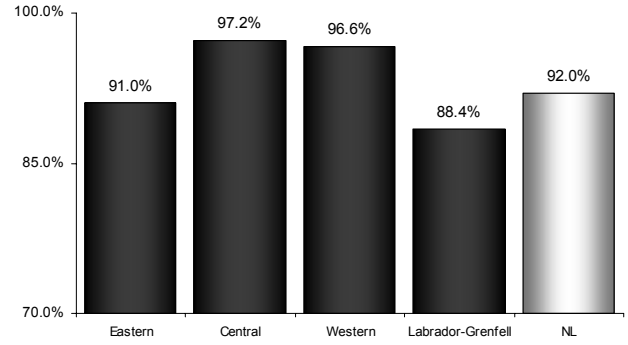

Figure 17 – Proportion of school-aged children who attend school by Health Authority and NL, 2008

Approximately 74 percent of children in care in NL were school age (i.e., 5 years of age or older), and of those, 92 percent were reported to attend school (See Figure 17). Regionally, the proportions ranged between 97.2 percent (for Central Health) and 88.4 percent (for Labrador-Grenfell Health) (See Text Box 6 for some notes on why some school-age children do not attend school).

According to Figure 18, of those NL children in care who attend school, approximately 91 percent of did so on a full time basis, while 9 percent did so on a part time basis. The statistics for each Health Authority are fairly comparable, although Central health does have a slightly different trend with more children attending school part time (i.e., approximately 14 percent).

Text Box 6 - Some notes as to why school aged children do not attend school

- It was determined that between 3 and 5 percent of in care children are school age but do not attend school. Among the most frequent reasons provide are:

  *Defiant/Refusal to attend
  *Aggression a safety concern for children/Staff
  *Physical and mental disabilities

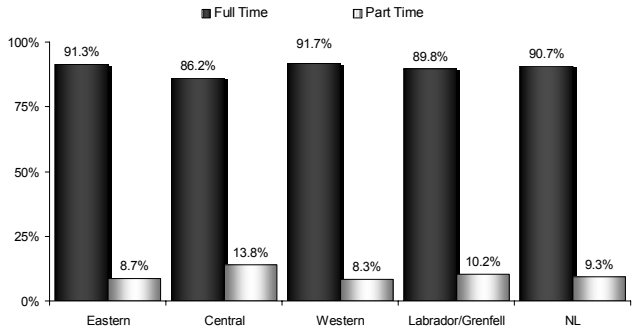

Figure 18 – Proportion of children who attend school "Full Time" and "Part Time" by Health Authority and NL, 2008

As an indication of school functioning, respondents were asked to rate (to the best of their ability) the child's school performance. For roughly 6 percent of children, responses were not provided as the child's developmental delay rendered a rating too challenging. Further, approximately 26 percent of children were not of school age at the time of the survey, and for a further 11 percent, respondents reported that it was too difficult to provide a reliable response; this was particularly true for Labrador-Grenfell where respondents were unable to provide a response for 50 children (approximately 32 percent).

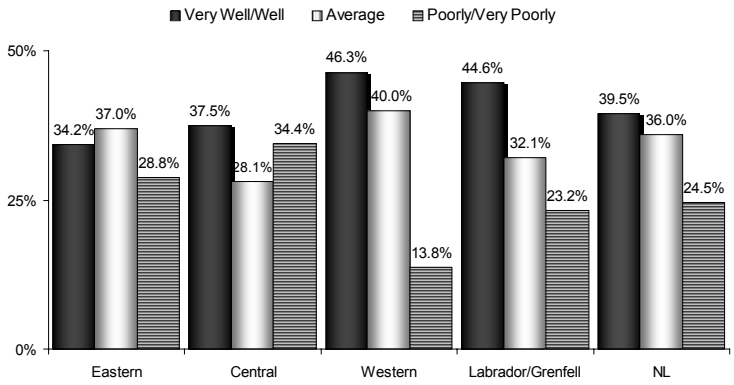

Figure 19 – Ratings of school performance: "Very Well/Well", "Average" and "Poor/ Very Poor", by Health Authority and NL, 2008

Nonetheless, Figure 19 provides rating about how respondents felt children were performing in school. On a provincial level, the figure shows that approximately 40 percent of children in care were seen as performing "very well" or "well" in school, while 36 percent were seen as performing "average." However, 24.5 percent of ratings were categorized as "poor" or "very poor." The figure also displays regional variation whereby Western's in care children had the highest

proportion rated "very well/well" in terms of school performance (i.e., 46.3 percent), while Eastern head the lowest (i.e., 34.2 percent) (See Figure 19 for other trends).

Ratings in terms of how well children got along with teachers are provided in Figure 20. According to the figure, respondents perceived that 88.4 percent of the children got along with teachers either "very well" (no problems), "quite well" (hardly any problems), or "pretty well" (occasional problems). Proportions ranged between 92.1 percent for Labrador-Grenfell and 77.1 percent for Central (in terms of getting along with teachers either "very well", "quite well", or "pretty well").

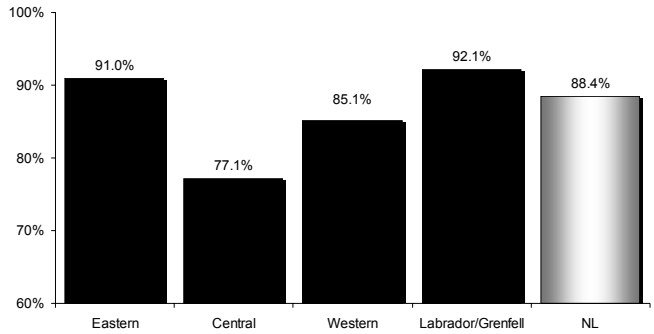

Figure 20 – Ratings of how well children have gotten along with teachers within the past 6 months: "Very well", "Quite well", or "Pretty well" by Health Authority and NL, 2008

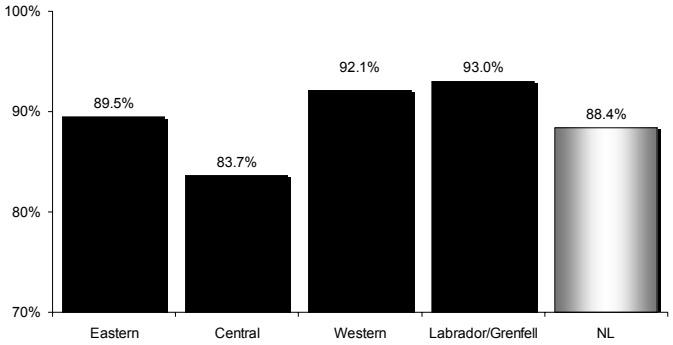

Figure 21 – Ratings of how well children have gotten along with caregivers within the past 6 months: "Very well", "Quite well", or "Pretty well" by Health Authority and NL, 2008

Figure 21 provides ratings of how well children in care were perceived as getting along with caregivers within the past 6 months (Note: for approximately 9 percent of the children, respondents were unable to say). According to the figure, over 90 percent were believed to get along with caregivers either "very well" (no problems), "quite well" (hardly any problems), or "pretty well" (occasional problems). Regionally, these statistics varied between Labrador-Grenfell (i.e., 93.0 percent) and Central (83.7 percent).

In terms of how children were rated as getting along with other friends and children in school within the past six months, again statistics are based on those children of school age (approximately 76 percent of the sample), and where respondents felt confident they could provide a perspective (this ranged between 3 percent in Western and 32 percent in Labrador-Grenfell).

Nonetheless, respondents rated approximately 86 percent of the province's in care children (or those for which there was a response) as getting along with friends and/or classmates either "very well" (no problems), "quite well" (hardly any problems), or "pretty well" (occasional problems) (See Figure 22). The figure also shows some variability among the authorities with a greater proportion of Eastern children judged as getting along with friends and/or classmates either "very well", "quite well", or "pretty well" than the other authorities (roughly 88 percent).

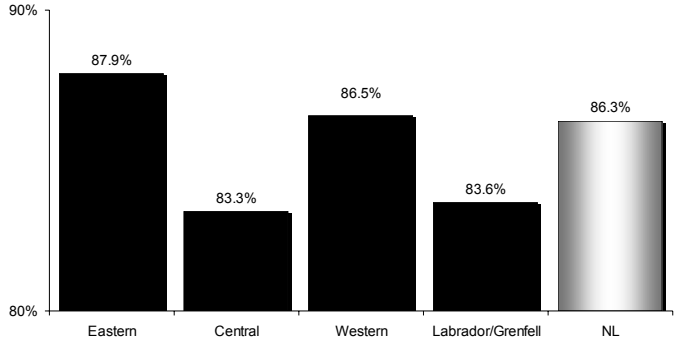

Figure 22 – Ratings of how well children have gotten along with other friends and classmates within the past 6 months: "Very well", "Quite well", or "Pretty well" by Health Authority and NL, 2008

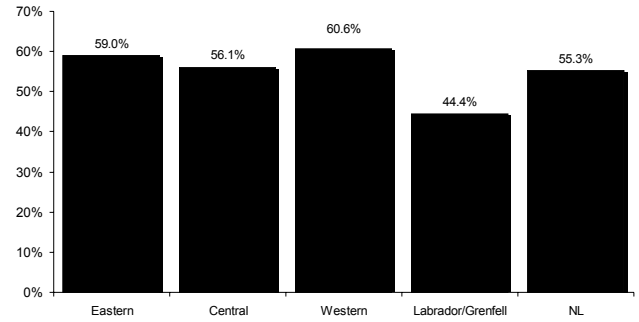

Figure 23 – Proportion of children for which there is an ISSP by Health Authority and NL, 2008

Respondents were also asked whether their children in their caseloads had an Individual Support Services Plan (or ISSP). Such a plan involves a summary and utilization of all relevant information that best represent the child's needs that help determine the most appropriate programs and services. According to Figure 23, the NL percentage of children where it was acknowledged that there was an ISSP in place was just over 55 percent. The proportion varied slightly among the health authorities between 60.6 percent for Western and 44.4 percent for Labrador-Grenfell.

Child's history prior to placement: Number of placements, time in care, and family history challenges

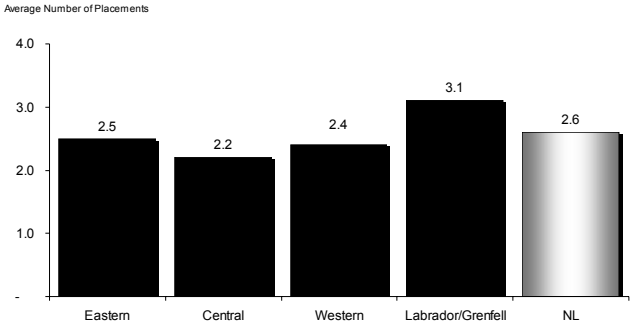

Figure 24 – Average number of placements per child in care by Health Authority and NL, 2008

In terms of the average number of placements children in care experienced, statistical analyses revealed that provincially, the average was 2.6 (See Figure 24).

Also evident in the figure is that averages tended to vary among the health authorities between 2.2 placements for Central to 3.1 in Labrador-Grenfell.

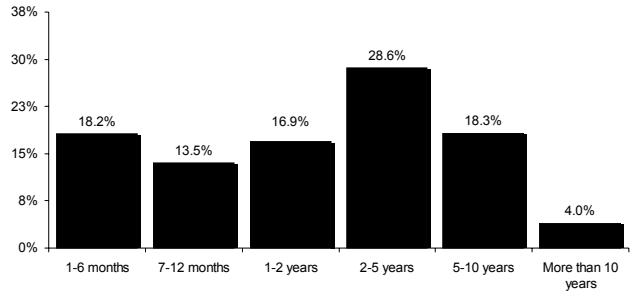

Figure 25 – Estimated time child has spent in the care/custody of a CYFS Director, NL, 2008

Figure 25 presents the average amount of time that respondents estimated the child spent in care/custody of a CYFS Director. According to the figure, almost 29 percent of children spent between 2 and 5 years in care. Further, approximately 18 percent spent between 1 to 6 months and 5 and 10 years in care. Four percent have spent more than 10 years in care (See Text Box 7 for additional notes on amount of time spent in care).

Text Box 7 – Additional Notes on Amount of Time Children Spent in Care

- Thirty-six percent of children spent 1 to 6 months in care and 22 percent spent between 1 and 2 years in care in the Central Health Authority
- Approximately 39 percent of children in care in Labrador-Grenfell were so between 2 and 5 years
- Thirty-one percent of children were in care between 5 and 10 years in the Western Health Authority
- The proportion of children in care for more than 10 years was comparable across health authorities (between 3 and 5 percent)

Respondents were asked to indicate whether various types of family history challenges existed prior to the children coming into care, ranging from physical abuse, to family violence, to neglect. As Figure 26 shows, for NL, there was an average of 4.7 family history challenges per child. With the exception of Labrador-Grenfell, the health authorities were comparable. According to statistical analyses, it was revealed that Labrador-Grenfell in care children had on average, one more family history challenge than the other authorities (i.e., 5.6).

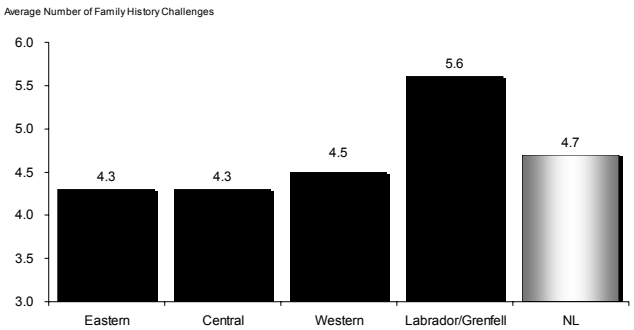

Figure 26 – Average number of family history challenges by Health Authority and NL, 2008

The types of family history challenges and their relative frequency per Health Authority are presented in Table 2.

Table 2 – The proportion of children associated with a particular family history challenges by Health Authority and NL, 2008

Family History Challenge	Eastern (%)	Central (%)	Western (%)	Labrador/Grenfell (%)	NL (%)
Sexual abuse	13.3	31.4	20.7	16.5	17.2
Physical abuse	38.8	41.2	46.2	14.0	33.3
Neglect	54.9	64.7*	75.5*	86.6*	68.6*
Emotional Abuse	61.9*	62.7*	75.5*	74.4*	68.1*
Family Break-down	38.4	45.1	34.9	59.1	44.3
Family violence	63.1*	43.1	50.0	65.2	59.5
Medical concerns	14.9	27.5	8.6	3.0	11.5
Substance abuse in family	55.3*	43.1	60.4*	87.2*	64.2*
Criminal involvement in family	26.7	25.5	26.4	35.6	29.0
Mental Health concerns in family	51.8	47.1*	49.1	59.1	53.0
Family history other	12.2	7.8	3.8	59.1	23.7

*Indicates top three family history challenges within each Health Authority and NL

On a provincial level, the three primary family history challenges were "neglect" (68.6 percent of in care children), "emotional abuse" (68.1 percent of in care children), and "substance abuse in family" (64.2 percent of in care children). Within each Health Authority, "emotional abuse" was one of the top three family history concerns for in care children from all regions (i.e., 75.5 percent in Western, 74.4 percent in Labrador- Grenfell, 62.7 percent in Central and 61.9 percent in Eastern). "Neglect" was a primary family history issue for Labrador-Grenfell, Western, and Central children (i.e., 86.6, 75.5 and 64.7 percent respectively). High proportions of in care children were also associated with "Substance abuse in family", particularly within Labrador-Grenfell, Western and Eastern (i.e., 87.2, 60.4, and 55.3 percent respectively). Family violence, was one of the top three family history issues for Eastern (and were salient issues for Eastern at 63.1 percent)

The table also shows that *among* the Health Authorities, Central Health had the highest proportion of children in care with family issues related to "sexual abuse", Western Health had the highest proportion of children in care with family issues associated with "emotional abuse." However, Labrador-Grenfell's children in care were associated with the highest proportions of seven family issues including "neglect", "family break-down", "family violence", "substance abuse in family", "criminal involvement in family", "mental health concerns in family", and "family history other (primarily "intergenerational trauma").

Child's presenting issues at the time of child's initial placement with CYFS

Figure 27 presents the average number of presenting issues estimated by respondents at the time of the child's most current placement. Provincially, children had an average of 2.8 presenting issues, and this statistic varied between Eastern Health (i.e., 2.6 presenting issues) and Central Health (i.e., 3.4 presenting issues).

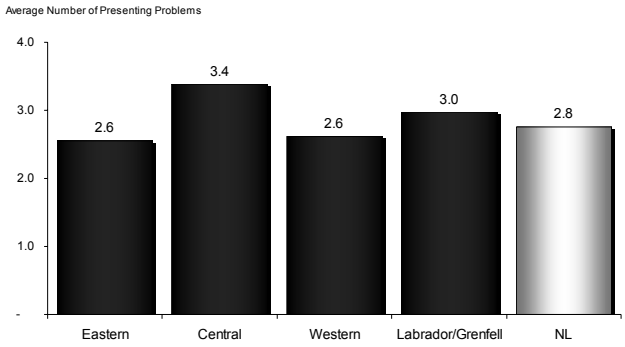

Figure 27 – Average number of presenting problems at the time of placement by Health Authority and NL, 2008

Table 3 – The proportion of children associated with a particular presenting issue at the time of placement by Health Authority and NL, 2008

Presenting Issue	Eastern (%)	Central (%)	Western (%)	Labrador/Grenfell (%)	NL (%)
Developmental delay	19.8*	29.4*	26.4*	26.4*	23.7*
Substance abuse	2.8	3.9	2.8	14.1	6.1
FASD (suspected or diagnosed)	7.5	21.6	21.0	54.6*	24.6*
ADD or ADHD	15.1	23.5*	21.7*	9.8	15.6
Depression-Anxiety	9.8	9.8	15.2	4.9	9.4
Self-harming behaviour	7.5	7.8	3.8	6.7	6.6
Suicidal	2.4	3.9	2.8	4.9	3.3
Self-mutilation	3.1	5.9	3.8	0.0	2.6
Negative peer involvement	12.3	15.7	10.4	17.2	13.6
Violence towards others	21.7*	15.7	14.3	9.9	16.5
Running away	7.1	5.9	9.7	17.8	10.5
Age-inappropriate sexual behaviour	13.4	13.7	10.5	9.8	11.9
Autism Spectrum Disorder	2.4	2.0	2.8	0.0	1.8
Psychiatric disorder	1.6	4.0	2.8	1.2	1.9
Criminal involvement	2.8	6.0[a]	2.8	3.7	3.3
Special Ed needs	20.5*	23.5*	15.2	12.9	17.6
Irregular school attendance	16.7	25.5*	11.4	25.2	18.9
Speech-language concerns	12.7	11.8	17.9	7.4	12.1
Extreme defiance-oppositional beh.	7.1	19.6	8.6	10.4	9.4
Verbally abusive	16.1	17.6	8.5	7.4	12.4
Severe Parent-Child conflict	12.2	23.5*	8.6	10.4	12.0
Severe sibling conflict	11.0	9.8	9.4	7.4	9.6
Attachment issues	19.3	21.6	21.9*	30.7*	23.2*
Child to young to detect/report	28.0	27.5	18.9	14.7	22.5

* Indicates top three presenting issue proportions within each Health Authority and NL

In terms of the types of presenting issues, Table 3 provides the proportion of children associated with a particular presenting issue at the time of placement by Health Authority and NL. According to the table, the primary presenting issues for NL in care children were "FASD (suspected or diagnosed)" (24.6 percent), "developmental delay" (23.7 percent), and "attachment issues" (23.2 percent).

Within each Health Authority, "developmental delay" was one of the top three presenting issues for all regions (i.e., 26.4 percent in Western and Labrador- Grenfell, 29.4 percent for Central, and 19.8 percent in Eastern), while "ADD" or "ADHD" was a salient presenting issue for Central and Western (i.e., 23.5 and 21.7 respectively). For Eastern Health, high percentages were observed for "violence towards others" (21.7 percent) and "severe sibling conflict" (11.0 percent). However, Western Health and Labrador-Grenfell had high percentages associated with "attachment issues" (21.9 and 30.7 percent respectively).

Among the Health Authorities, the table shows that Eastern Health had a high percentage for "severe sibling conflict", Western Health had high percentages associated with "speech-language concerns", and "autism spectrum disorder", Labrador-Grenfell had notable proportions associated with "substance abuse", "FASD (suspected or diagnosed)", "negative peer involvement", and "attachment issues", and Central Health had high percentages associated with "self-harming behaviour", and "age-inappropriate sexual behaviour" (See Table 3 for other notable percentages within each Health Authority).

In order to determine whether the child's in care placement might have influenced the existence or prevalence any potential presenting problems, respondents were asked to respond as to whether they might have changed since the placement. According to Figure 28, it was estimated that presenting problems had changed for 62.2 percent of NL's in care children, ranging between 60.7 percent for Eastern Health and 65.1 percent for Labrador-Grenfell Health.

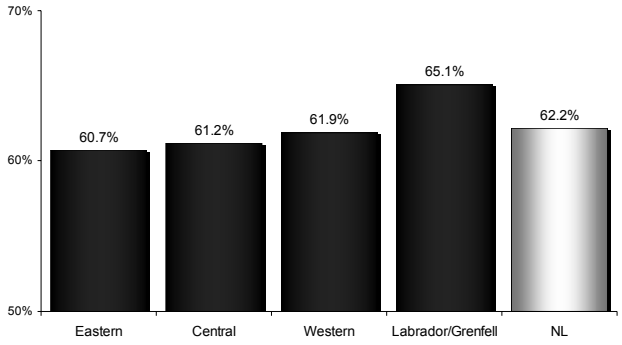

Figure 28 – The proportion of children for which presenting problems have changed since placement by Health Authority and NL, 2008

Note: Approximately 8 percent of NL respondents reported that they didn't know whether presenting problems had changed; 11 percent of NL respondents reported that the children were too young to say

However, Figure 29 shows that "change" meant different things. In particular, while it meant improvement for approximately 70 percent of NL's in care children, it also meant that presenting problems also became more evident as the child aged (i.e., in 27.5 percent of the cases). Further, the degree of improvement and problems becoming more evident varied among the health authorities.

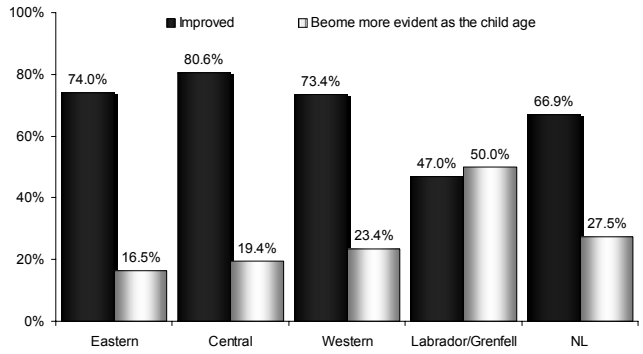

Figure 29 – Proportion of children for whom respondents felt that presenting problems had improved, or became more evident as child has aged by Health Authority and NL, 2008

Note: On a provincial level, only 5 percent of respondents felt that presenting problems actually worsened

When asked about the particular presenting problems that might have persisted since placement, Figure 30 shows that an average of 2 presenting problems persisted for NL in care children following their placement. This statistic was quite comparable among the health authorities. It is also noteworthy that these numbers are lower than the average number of presenting problems "at the time of placement" (See Figure 27) so it seems that some of these issues might have been reduced as a function of in care placement.

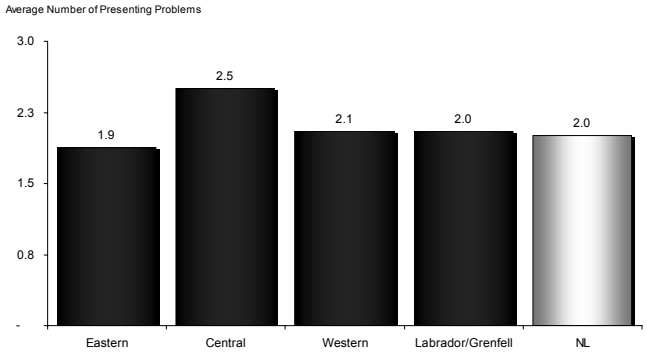

Figure 30 – Average number of presenting problems that were believed to persist since placement by Health Authority and NL, 2008

In terms of whether there was an acknowledged plan of care recognized by the respondents, Figure 31 shows that such was true for approximately 89 percent of the NL cases. However,

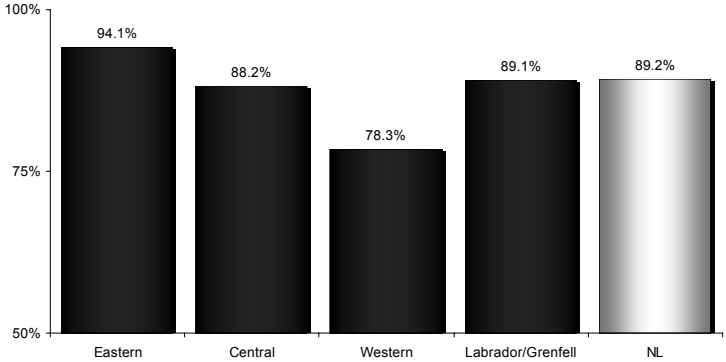

Figure 31 – Proportion of children for whom there is an acknowledged plan of care by Health Authority and NL, 2008

this statistic varied between 94.1 percent of children for Eastern Health and 78.3 percent for Western Health.

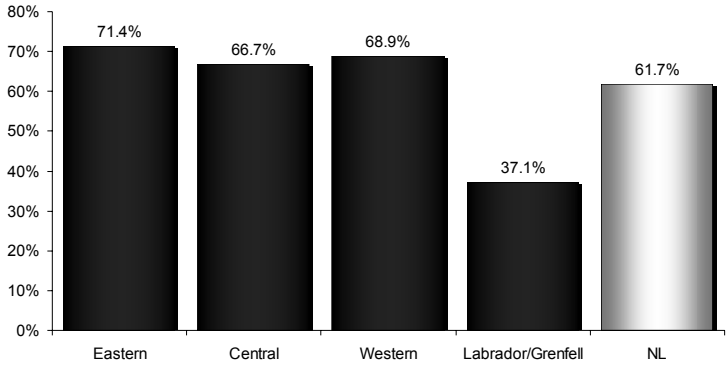

Figure 32 – Proportion of children for whom the model of coordination of services was working by Health Authority and NL, 2008

When explicitly asked whether the model of coordination of services (i.e., (a framework for the coordination and provision of services to children, youth & families) was actually working for the children, it was revealed that for 61.7 percent, it was (See Figure 32). However, these statistics varied among the health authorities where the model of coordination of services was working for 71.4 percent of children in Eastern Health, and only 37.1 percent of children in Labrador-Grenfell Health.

Services provided to children and foster families

Table 4 provides the types of services respondents acknowledged children receiving. On a provincial level, the primary service reported were "counselling services" (35.9 percent),

Table 4 – The proportion of children reported to have availed of services by service type, Health Authority and NL, 2008

Type of Service	Eastern (%)	Central (%)	Western (%)	Labrador/Grenfell (%)	NL (%)
Psychiatric services	13.8	17.6	13.2	6.3	12.0
Psychological services	9.1	5.9	9.4	15.2	10.5
Counselling services	42.9*	33.3*	33.0*	27.2	35.9*
Speech language services	11.0	19.6	9.5	12.0	11.8
Recreational services	32.7*	17.6	37.7*	37.3*	33.6*
Special Education placement	16.9	21.6*	14.2	16.5	16.7
Specialized Medical services	13.0	17.6	17.9	7.0	12.7
Respite	26.8*	43.1*	34.0*	41.8*	33.7*
Behaviour Management Specialist	24.0	21.6b	11.4	39.5*	25.7
Tutoring	19.3	9.8	27.6	22.8	21.0

* Indicates top three services availed of within each Health Authority and NL

"recreational services" (33.6 percent), and "respite" (33.7 percent). In terms of more prevalent services among the authorities, the table shows that "counselling services" were

more frequent in Eastern Health (42.9 percent), and "psychiatric services" (17.6 percent), "speech language services" (19.6 percent), "special education placement" (21.6 percent), and "respite" (43.1 percent) were most common in Central Health. "Recreational services" (37.7 percent) and "tutoring" (27.6 percent) were most common in Western Health, while "psychological services" (15.2) and "behaviour management specialist" (39.5 percent) were most frequent in Labrador-Grenfell Health (**Note**: For Labrador these services are often provided as part of the out of province placement).

The services typically utilized by caregiver/foster families are presented in Table 5. As the table shows, "babysitting" (46.3 percent), and "respite" (45.9 percent) were the most common

Table 5 – The proportion of caregiver/foster families reported to have availed of services by service type, Health Authority and NL, 2008

Type of Service	Eastern (%)	Central (%)	Western (%)	Labrador/Grenfell (%)	NL (%)
Respite	39.0*	64.7*	35.8	58.5*	45.9
Behavioural Aid	1.6	2.0	0.0	8.8	3.2
Behaviour Mangt. Specialist	18.7	9.8	8.5	36.7	20.7
Counselling	10.0	2.0	6.6	28.6	13.5
Babysitting	37.8	43.1	63.2*	49.7	46.3*

*Indicates top services availed of within each Health Authority and NL

services reported on a provincial level. Regionally, "respite" was most common for Central Health (64.7 percent), "babysitting" was most common for Western, while "behaviour aid", "behaviour management specialist" and "counselling" were most common for Labrador-Grenfell Health (i.e., 8.8, 36.7, and 28.6 percent respectively).

The relationship between care/custody status and ratings of wellness, child age, types of services, time in custody, parental/sibling/significant other contact, family history issues, and presenting problems

Introduction

The following sections provide more in-depth analyses of factors associated with care/custody status. Of particular interest are how child wellness, age, time with social worker, the number

of placements, contact with parents, siblings and significant others, types of services, family history issues, and presenting issues vary with types of care/custody status.

Despite some limitations regarding the reliability of ratings of physical and psychological/emotion wellness, statistical testing was conducted to determine whether such varied as a function of care/custody arrangement. According to statistical analyses, there were no differences in perceived physical wellness among care/custody type (See Table 6).

Table 6 – Ratings of physical well being by care/custody arrangement, 2008

Care/Custody Arrangement	N	Mean Rating
Voluntary Care Agreement	18	2.22
Interim Care	53	2.26
Temporary Custody	200	2.41
Continuous Custody	304	2.28

Note: Larger scores indicate poorer physical health status

In terms of ratings of the mental and psychological health, Table 7 shows that there was some variability in that children in VCA and temporary custody situations were rated more poorly in terms of psychological and mental wellness than those in interim care and continuous custody. However, the difference was not statistically significant.

Table 7 – Ratings of psychology/mental well being by care/custody arrangement, 2008

Care/Custody Arrangement	N	Mean Rating
Voluntary Care Agreement	18	4.06
Interim Care	53	3.47
Temporary Custody	200	3.82
Continuous Custody	302	3.48

Note: Larger scores indicate poorer mental/psychological health status

According to Table 8, children involved in a VCA and continuous custody arrangement were generally older than those in interim and temporary custody arrangement. Statistical testing revealed that the differences were significant.

Table 8 – Mean age by care/custody arrangement, 2008

Care/Custody Arrangement	N	Mean Age (Years)
Voluntary Care Agreement	18	9.9*
Interim Care	54	6.5
Temporary Custody	197	7.2
Continuous Custody	303	10.3*
Total	572	8.8

The average length of time social workers reported working with a child by care/custody status is presented in Table 9. The table indicates that children in continuous custody

Table 9 – Mean length of time the social worker reported working with child by care/custody arrangement, 2008

Care/Custody Arrangement	N	Mean No. of Weeks
Voluntary Care Agreement	16	10.8
Interim Care	50	37.0
Temporary Custody	145	51.6
Continuous Custody	251	89.4*
Total	462	69.2

have the same social worker significantly longer that other care/custody types (i.e., an average of 89.4 weeks), while the lowest amount of time was for those in VCAs (i.e., an average of 10.8 weeks). The average for interim care was 37 weeks and for temporary custody, 51.6 weeks). Statistical testing revealed that the differences were significant.

The average number of placements per child also varied significantly with type of care/ custody arrangement. Table 10 shows that those in continuous custody had the highest number (i.e., 3.1 placement) while those in VCAs had the lowest (i.e., 1.7 placements). Children in interim care and temporary custody had the same average number of placements (approximately 2 placements).

Table 10 – Mean number of placements by care/custody arrangement, 2008

Care/Custody Arrangement	N	Mean No. of Weeks
Voluntary Care Agreement	18	1.7
Interim Care	53	2.0
Temporary Custody	191	2.1
Continuous Custody	290	3.1*
Total	552	2.6

Table 11 presents the proportion of children who maintain some contact with parents, and regular contact with siblings and significant others by care/custody arrangement. The table shows that the proportions were variable with the highest representing VCAs (94 percent) and the lowest being associated with continuous custody (54 percent) (please note that the total number of VCAs was only 18). The table also shows that the proportion of children with regular contact with siblings and significant others was quite comparable among the care/ custody arrangements.

Table 11 – Proportion of children with contact with parents, and regular contact with siblings and significant others by care/custody arrangement, 2008

	VCA (%)	Interim Care (%)	Temporary Custody (%)	Continuous Custody (%)
Contact with parents	94[a]	88	90	54
Regular contact with siblings	72[a]	62	64	63
Regular contact with significant others	67	74[a]	66	60

[a] Indicates highest proportion among the custody arrangement type
VCA = Voluntary Care Agreement

In terms of type of services availed of by particular care/custody arrangement, it is clearly evident from Table 12 that children in continuous custody received the highest proportion of

Table 12 – The proportion of children receiving particular types of services, and for which there is a plan of care, and ISSP by type of care/custody arrangement, 2008

	VCA (%)	Interim Care (%)	Temporary Custody (%)	Continuous Custody (%)	Total (%)
Psychiatric services	17*	6	7	16	12
Psychological services	0	2	9	14*	10
Counselling services	56*	40	35	35	36
Speech language services	6	13*	11	12	12
Recreational services	28	21	29	40*	34
Special Education placement	6	11	11	22*	17
Specialized Medical services	11	8	8	17*	13
Respite	22	9	35	38*	34
Behaviour Management Specialist	11	17	26	28*	26
Tutoring	17	6	16	27*	21
There is a plan of care	33	85	87	94*	89
There is an ISSP	22	28	29	57*	43

* Indicates highest service proportion among the custody arrangement type
VCA = Voluntary Care Agreement

services available including psychological services (14 percent), recreational services (40 percent), special educational placements (22 percent), specialized medical services (17 percent), respite (38 percent), behaviour management specialist services (28 percent), and tutoring (27 percent). Further, the table reveals that children in continuous custody had the highest percentage for which there was an acknowledged plan of care (i.e., 94 percent), and ISSP (i.e., 57 percent).

Table 13 – The proportion of presenting family issues by type of care/custody arrangement, 2008

	VCA (%)	Interim Care (%)	Temporary Custody (%)	Continuous Custody (%)	Total (%)
Sexual abuse	11	17	15	19 *	17
Physical abuse	28	39	26	38*	33
Neglect	44	70	62	74 *	69
Substance Abuse	28	61	67*	66	64
Emotional Abuse	61	76*	67	67	68
Family Break-down	50 *	46	42	45	44
Family violence	61	61	65 *	56	60
Medical concerns	0	11	12*	12 *	12

* Indicates highest service proportion among the custody arrangement type
VCA = Voluntary Care Agreement

The proportion of children that were exposed to particular types of family history issues by care/custody arrangement is presented in Table 13 (See above). According to the table, children in continuous custody had the highest proportions associated with sexual abuse (19 percent), physical abuse (38 percent), neglect (74 percent), and medical concerns (12 percent). Those in temporary custody had the highest proportions with respect to substance abuse (67 percent), family violence (65 percent) and medical concerns (12 percent). Emotional abuse was highest for those in interim care, while family break-down was highest for those in VCAs.

In terms of child presenting problems, Table 14 shows that those children in continuous custody had the highest proportions for seven presenting issues including FASD (suspected or diagnosed) (29 percent), attachment issues (25 percent), and developmental delay (24 percent). Those in temporary custody were also primary characterized in terms of developmental delay (24 percent), FASD (suspected or diagnosed) (25 percent), and attachment issues (25 percent), while those in interim care had the highest proportion of

Table 14 – The proportion of child presenting issues by care/custody arrangement, 2008

	VCA (%)	Interim Care (%)	Temporary Custody (%)	Continuous Custody (%)	Total (%)
Developmental delay	17	22	24*	24*	24
Substance abuse	17*	0	10	4	6
FASD (suspected or diagnosed)	11	6	25	29*	25
ADD or ADHD	6	13	14	18*	16
Depression-Anxiety	33*	9	9	8	9
Self-harming behaviour	6	7*	7*	6	7
Suicidal	22*	4	4	2	3
Self-mutilation	0	2	2	4*	3
Negative peer involvement	40*	11	16	11	14
Violence towards others	33*	17	20	13	17
Running away	28*	4	16	7	11
Age-inappropriate sexual behaviour	0	11	12*	12*	12
Autism Spectrum Disorder	0	2	1	3*	2
Psychiatric disorder	6*	0	2	2	2
Criminal involvement	17*	0	6	1	3
Special Education Needs	28*	19	13	20	18
Irregular school attendance	47*	20	23	14	19
Speech-language concerns	11	17*	10	13	12
Extreme defiance-oppositional beh.	17*	6	11	9	9
Verbally abusive	22*	11	13	12	12
Severe sibling conflict	28*	13	10	8	10
Attachment issues	6	13	25*	25*	23
Severe Parent-Child conflict	39*	9	12	11	12

* Indicates highest service proportion among the custody arrangement type
VCA = Voluntary Care Agreement

speech-language concerns (17 percent), and self-harming behaviour (7 percent). Children associated with VCAs had the highest proportions for 14 of the 23 problems presented (it must be noted that there were 18 young people involved with a VCA). Notable problems include irregular school attendance (47 percent), negative peer involvement (40 percent), and severe parent-child conflict (39 percent).

Placement type and ratings of wellness, child age, types of services, mean number of placements, family history issues and presenting problems

Similar to the previous section, various factors were assessed with respect to type of placement (i.e., caregiver home, group home, out of province placement, ILA, or ALA).

According to Table 15, ratings of physical wellness varied significantly by placement type in that those receiving services out of province or living in an ILA were reported to be *less* physically well compared to children in other placement arrangements.

Similar findings were evident for perceived psychological/mental well being (See Table 16) as children receiving services out of province or living in an ILA were reported to be *less* well compared to children in caregiver homes, group homes and ALAs.

Table 15 – Ratings of physical well being by placement type, 2008

Placement Type	N	Mean Rating
Caregiver Home (relative/sig other)	147	2.42
Caregiver Home (non-relative)	325	2.26
Group Home	19	1.89
Receiving services out of province	36	3.10*
ILA	7	3.57*
ALA	33	2.18

Note: Larger scores indicate poorer physical health status
ALA = Alternate Living Arrangement; ILA = Independent Living Arrangement

Table 16 – Ratings of psychological/mental well being by placement type, 2008

Placement Type	N	Mean Rating
Caregiver Home (relative/sig other)	147	3.75
Caregiver Home (non-relative)	322	3.50
Group Home	19	3.58
Receiving services out of province	36	4.54*
ILA	7	4.42*
ALA	33	3.24

Note: Larger scores indicate poorer psychological/mental health status
ALA = Alternate Living Arrangement; ILA = Independent Living Arrangement

Table 17 – Average age by placement type, 2008

Placement Type	N	Mean Age (Years)
Caregiver Home (relative/sig other)	146	8.36
Caregiver Home (non-relative)	325	8.17
Group Home	19	13.26*
Receiving services out of province	36	13.00*
ILA	7	10.86
ALA	33	8.73

ALA = Alternate Living Arrangement; ILA = Independent Living Arrangement

Table 17 provides child age by placement types. The table shows that young people placed in group homes, out of province, or ILAs were significantly older than children placed in caregiver homes and ALAs.

Table 18 – Mean number of placements by placement type, 2008

Placement Type	N	Mean No. of Placements
Caregiver Home (relative/sig other)	147	2.1
Caregiver Home (non-relative)	322	2.6
Group Home	19	3.2*
Receiving services out of province	36	5.0*
ILA	7	6.7*
ALA	33	2.5

Note: Larger scores indicate poorer psychological/mental health status
ALA = Alternate Living Arrangement; ILA = Independent Living Arrangement

The number of placements by placement types is presented in Table 18 where statistical analysis revealed that children placed in ILA situations or those receiving services out of province had experienced significantly more placements (i.e., 6.7 and 5.0 respectively) than young people in other types of placements.

According to Table 19, the highest proportions of children receiving services among the various placement types occurred for those out of province, or placed in ILA or ALA

Table 19 – The proportion of children receiving particular types of services, and for which there is a plan of care, and ISSP by placement type, 2008

	Caregiver Home (Relative/Sig other) (%)	Caregiver Home (Non-relative) (%)	Group Home (%)	Out of Province (%)	ILA (%)	ALA (%)
Psychiatric services	7	11	26	29	43 [a]	15
Psychological services	7	7	15	53 [a]	14	6
Counselling services	22	34	74	44	14	82 [a]
Speech language services	8	16	0	6	29 [a]	0
Recreational services	28	29	63	68 [a]	43	46
Special Education placement	15	14	21	56 [a]	43	3
Specialized Medical services	10	16	0	18 [a]	14	3
Respite	27	43	0	47 [a]	0	0
Behaviour Mangt. Specialist	17	26	21	29	86 [a]	49
Tutoring	14	22	32	32	14	33 [a]
There is a plan of care	88	90	84	100	100	82
There is an ISSP*	30	47	58	56	71	42

[a] Indicates highest service proportion among the custody arrangement type
*Note: notable portion of children not school age
ALA = Alternate Living Arrangement; ILA = Independent Living Arrangement

situations. In particular, services for out of province children included recreational services (68 percent), special educational services (56 percent) and psychological services (53

percent). Relatively high proportions of children in ILAs availed of behaviour management specialists (86 percent), and high proportions of those placed in ALA situations availed of counselling services (82 percent). The table also shows that while the proportions for which there is a plan of care were comparable among the placement categories, there was some variability in terms of whether there was an ISSP.

Reported family history issues are presented by placement type in Table 20. Children placed out of province had the highest proportions associated with neglect, substance abuse, and

Table 20 – The proportion family issues prior to placement by placement type, 2008

	Caregiver Home (Relative/Sig other) (%)	Caregiver Home (Non-relative) (%)	Group Home (%)	Out of Province (%)	ILA (%)	ALA (%)
Sexual abuse	12	18	26	19	29 [a]	18
Physical abuse	31	32	42	28	43	55 [a]
Neglect	70	69	42	78 [a]	57	73
Substance Abuse	80	60	53	72 [a]	43	36
Emotional Abuse	71	66	53	75	57	82 [a]
Family Break-down	45	41	42	67 [a]	43	52
Family violence	65	55	63	61	71	73 [a]
Medical concerns	9	13	0	6	29 [a]	12

[a] Indicates highest service proportion among the custody placement type
ALA = Alternate Living Arrangement; ILA = Independent Living Arrangement

family breakdown (i.e., 78, 72 and 67 percent respectively), while those in ILAs had the highest percentages associated with sexual abuse (29 percent) and medical concerns (29 percent). Children placed in ALAs had the highest proportions associated with emotional abuse (82 percent), family violence (73 percent), and physical abuse (55 percent).

The proportion of child presenting issues by placement type is presented in Table 21 (See below). As the table shows, children placed in group homes, out of province, and ILAs accounted for the highest proportions. For example, those placed in ILAs had the highest proportion for ten of the 23 listed problems, including negative peer involvement (57 percent), violence towards others (57 percent), ADD (or ADHD) (43 percent) and self-harming behaviour (42 percent). For children placed out of province, significant percentages occurred for FASD (suspected or diagnosed) (53 percent), developmental delay (40 percent), and substance abuse (36 percent). High percentages for group home youth included severe child-

parent conflict (43 percent), running away (37 percent), age-inappropriate sexual behaviour (32 percent), and depression-anxiety (26 percent).

Table 21 – The proportion of types of child presenting issues by placement type, 2008

	Caregiver Home (Relative/Sig other) (%)	Caregiver Home (Non-relative) (%)	Group Home (%)	Out of Province (%)	ILA (%)	ALA (%)
Developmental delay	21	25	16	40 [a]	29	9
Substance abuse	4	3	21	36 [a]	0	3
FASD (suspected or diagnosed)	26	23	11	53 [a]	29	9
ADD or ADHD	12	15	21	20	43 [a]	21
Depression-Anxiety	6	10	26 [a]	14	14	3
Self-harming behaviour	5	6	16	14	43 [a]	6
Suicidal	1	2	21 [a]	8	0	6
Self-mutilation	3	2	5	3	29 [a]	3
Negative peer involvement	11	9	42	42	57 [a]	9
Violence towards others	6	14	47	26	57 [a]	39
Running away	6	7	37 [a]	33	14	18
Age-inappropriate sexual behaviour	6	11	32 [a]	25	14	18
Autism Spectrum Disorder	1	2	0	3	29 [a]	3
Psychiatric disorder	1	2	0	6 [a]	0	3
Criminal involvement	3	1	11	14	14 [a]	3
Special Education Needs	15	16	32 [a]	14	29	21
Irregular school attendance	16	15	42	47 [a]	43	12
Speech-language concerns	8	15	0	3	29 [a]	18
Extreme defiance-oppositional beh.	3	9	16	25	57 [a]	3
Verbally abusive	4	10	42	25	43 [a]	27
Severe sibling conflict	4	9	32	3	29	33 [a]
Attachment issues	23	23	16	33 [a]	14	18 [-]
Severe Parent-Child conflict	6	9	42 [a]	25	29	21

[a] Indicates highest presenting issue proportion among the custody placement type
ALA = Alternate Living Arrangement; ILA = Independent Living Arrangement

Children in Care Survey summary

The Children in Care Profile Survey was able to capture information associated with 579 children throughout NL, placing the response rate at 93 percent. Social workers were the primary respondent of the questionnaires. On average they had worked with the child for just over a year. The majority of questionnaires in Labrador-Grenfell were completed by clinical program mangers, foster parents and/or Regional Director.

Of the 579 children accounted for in the survey, 44 percent were from Eastern Health, 29 percent were from Labrador-Grenfell Health, 18 percent were from Western Health, and 9 percent were from Central Health. There were generally more boys placed in care than girls, regardless of Health Authority. The children were an average age of 8.8 years, and children placed in Eastern Health tended to be younger than children in the other health authorities. In

fact, Eastern Health had the highest proportion of children less than 2 years of age, Central Health had the highest proportion of children between 2 and 4 years, and Western Health and Labrador-Grenfell Health had the highest proportions of children 10 years of age and greater.

In terms of the ethno-racial characteristics, while the Eastern, Central and Western children were predominantly Caucasian, the vast majority of children placed in Labrador-Grenfell were Aboriginal. In fact, almost one third of all children place in care in NL were Aboriginal children. Further, for the entire province, Innu aimun was the first language for approximately 15 percent, and 16.5 percent of children in care were not placed within a caregiver home of the same culture.

Slightly more than half of the in care children were identified as being in continuous custody, 35 percent were in temporary custody, almost 10 percent of children were in interim care, and a relatively slight proportion were in a VCA. In terms of Health Authority, Western had the greatest proportion of children in continuous care while Central had the lowest. Further, Eastern and Central had the highest percentages of children in interim care. It was learned that approximately 7 percent of children were placed out of the province, with the majority coming from the Labrador-Grenfell Authority.

On a provincial basis, approximately 82 percent of children were placed within a caregiver home either characterized as "non-relative" or "relatives or significant others." The remaining placements involved group homes, ILAs and ALAs. In terms of how long the child had been in his/her current placement, the provincial average was determined to be roughly 2 years.

It was reported that most NL children in care did keep in regular contact with their birth parent(s), but this also varied among the authorities. Approximately three-quarters of all children (with siblings) in care maintained regular contact, and just over half maintained regular contact with relatives, and 64 percent maintain regular contact with significant others.

While more than half of the children in care were judged as having "Excellent" or "Very Good" physical health status, there was notable variation among health authorities. Similarly, just over half of NL's children in care were judged as having either, "Excellent", "Very

Good", or "Good" mental/ psychological health, and these statistics also varied among the health authorities.

Sixty-nine percent of all NL children in care attended school. While statistics about school performance were somewhat precarious, approximately 40 percent of NL's in care children were seen as performing "very well" or "well" in school, while 36 percent were seen as performing "average."

The NL percentage of children acknowledged as having an ISSP in place was just over half, with slight variation among the Health Authorities, particularly between Western Health and Labrador-Grenfell Health.

Statistical analyses revealed that provincially, the average number of placements in care children had was almost 3 per child, varying between 2.2 placements for Central Health 3.1 in Labrador-Grenfell Health. Further, almost 29 percent of children spent between 2 and 5 years in care, while 18 percent have spent between 1 to 6 months and 5 and 10 years in care.

On a provincial basis, there was an average of 4.7 family history challenges per child. Further, it was observed that children in care from Labrador-Grenfell Health had on average, one more family history challenge than the other authorities (i.e., 5.6). The three primary family history challenges for NL children in care were "neglect", "emotional abuse", and "substance abuse in family."

Provincially, children had an average of 2.8 presenting issues with the primary types being "FASD (suspected or diagnosed)", "developmental delay", and "attachment issues." It was estimated that presenting issues had changed for 62.2 percent of NL's in care children since the child's placement. However, while "change" meant improvement for approximately three-quarters of NL's in care children, it also meant that presenting problems also became more evident as the child aged in approximately one-quarter of the cases. Further, the degree of improvement and problems becoming more evident varied among the Health Authorities. It was also learned that an average of 2 presenting problems persisted for NL in care children following their placement. It was also noteworthy that these numbers were lower than the

average number of presenting problems "at the time of placement" so it seems that some of these issues might have been reduced as a function of in care placement.

A plan of care was acknowledged for approximately 90 percent of the NL children in care, but this statistic varied between 94 percent of children for Eastern Health and 78 percent in Western Health. Further, it was revealed that for more than half of the children in care, the model of coordination of services was working. However, these statistics varied among the Health Authorities where it was reported that the model of coordination of services was working for only 37 percent of children in Labrador-Grenfell Health.

On a provincial level, the primary services reported to be received by in care children were "counselling services", "recreational services", and "respite." "Respite" and "babysitting" were the most common services reported to be utilized by caregiver/foster families on a provincial level.

There were no differences in perceived physical wellness among care/custody type suggesting that regardless of whether a child was in continuous custody, temporary custody, interim care, or in a voluntary care agreement, the physical health of children did not vary. There was some variability in psychological and mental wellness in that children in VCA and temporary custody situations were rated more poorly than those in interim care and continuous custody. However, the difference was not statistically significant.

The greatest amount of time social workers reported working with children was for those in continuous custody arrangements, and the lowest was for those in VCAs. The average number of placements per child also varied significantly with type of care/custody arrangement whereby those in continuous custody had the highest while those in VCAs had the lowest. Children in interim care and temporary custody had a comparable number of placements.

In terms of the proportion of children who maintain some contact with parents by care/ custody arrangement, the highest percentage represented VCAs and the lowest was associated with continuous custody. It was also observed that the proportion of children with regular contact with siblings and significant others was quite comparable among the care/custody arrangements.

In terms of type of services availed of by care/custody arrangement, it is clearly evident that children in continuous custody received the highest number services available, including psychological services, recreational services, special educational services, specialized medical services, respite, behaviour management specialist services, and tutoring. Further, children in continuous custody also had the highest percentage for which there was an acknowledged plan of care, and ISSP.

With respect to the types of family history issues by care/custody arrangement, children in continuous custody had the highest proportions with respect to sexual abuse, physical abuse, neglect, and medical concerns. Those in temporary custody had the highest proportions with respect to "family violence" and "medical concerns, while emotional abuse was highest for those in interim care. Family break-down was highest for those in VCAs.

Children in continuous custody had the highest proportions for seven presenting problems including FASD (suspected or diagnosed), attachment issues, and developmental delay. Those in temporary custody also had high percentages of those with a developmental delay, FASD (suspected or diagnosed), and attachment issues (25 percent), while those in interim care had the highest proportion of speech-language concerns and self-harming behaviour. Children in VCAs had the highest proportions for 14 of the 23 issues presented whereby notable problems included irregular school attendance, negative peer involvement, and severe parent-child conflict.

When placement type was considered, it was observed that ratings of physical wellness varied significantly in that those receiving services out of province and living in an ILA were reported to be *less* physically well compared to children in other placement arrangements. Similar findings were evident for perceived psychological/mental well being.

Young people placed in group homes, out of province, and in ILAs were also significantly older than children placed in caregiver homes and ALAs, and the number of placements for those in ILA situations and receiving services out of province were approximately twice the number of placement of young people in other types of in care situations.

The highest proportions of children receiving services among the various placement types occurred for those out of province, or placed in ILA or ALA situations.

In terms of reported family history issues, children placed out of province had the highest proportions associated with neglect and family breakdown, while those in ILAs had the highest percentages associated with sexual abuse and medical concerns. Children placed in ALAs had the highest proportions associated with emotional abuse, family violence, and physical abuse. An analysis of child presenting issues by placement type also found that children placed in group homes, out of province, and ILAs accounted for the highest proportions.

KEY INFORMANT INTERVIEWS WITH PROVINCIAL OFFICIALS, CYFS DIRECTORS, MANAGERS, SOCIAL WORKERS, AND PROFESSIONALS & FOSTER FAMILIES

Results – Key Informant Interviews with Provincial Officials, CYFS Directors, Managers, Social Workers, Professionals, and Foster Families

Once it is decided by the Court that a child be placed in the care/custody of a Director of CYFS, most would agree that that child is entering a system that can best be characterized as complicated, intricate and uncertain. It is a system that has all the best intentions to do what is optimal for each child; e.g., to find the most appropriate caregiver environment that does not compromise family and other significant social networks, and to provide the most timely and effective resources and supports to address any presenting issues. It is a system that also tries to ensure that planning about the child's future occurs quickly while considering such questions as: Is reunification with birth parent(s) an option? If so, what has to occur for this to happen? If reunification is not an option, what is involved with establishing a more permanent solution in terms of a nurturing, supportive family environment?

It seems widely contended that, while NL's in care program is a system with remarkable strengths, it also has persistent and frustrating challenges. And, despite that fact that the province has one apparent "in care program", its ability to meet the needs of children and youth varies significantly depending such things as the child's age and mental, physical and emotional status, the availability of caregiver homes and other resources and services, degree of ruralness or geographic isolation, and the child's culture. As a context for the present review, we are reminded that while we may discuss the in care program as a "system", it is ultimately a network of people tasked with providing the best care possible for the province's children. What is insinuated in this suggestion is that all those involved need to provide *and* receive support to do the best they can.

Operating within change

The context within which the in care program exists is very important to be cognizant of in order to develop a program that is responsive to the ever-changing needs of the province's children and youth. Further, it is important to provide some insight into program context because it is useful to differentiate between those influences that tend to occur outside the in

care program (i.e., beyond the control of program managers and professionals) and those that can be modified to create the most responsive system possible.

According to respondents throughout the province, it would seem that operating within a context of significant change over the past several years has led to an in care program that can best be described as "reactive." The responsiveness and stability of the in care program were not only challenged by the changing needs of the children requiring intervention but also by significant system and legislative restructuring within the past 10 years. Indeed, many managers spoke of notable alterations in the CYFS Act, Adoption Act, and health board restructuring, which had major implications for the in care program.

During this time of change, respondents also discussed other occurrences that had a major influence on the in care program, such as the introduction of the Youth Criminal Justice Act. According to several, this particular event led to the transition of young people from one system to another, and hence increases in number of teenagers in care as fewer young people were incarcerated for criminal behaviour.

Another influential change discussed primarily by those outside St. John's involved significant community demographic shifts which had implications for the availability of caregivers. For example, some spoke of the out migration of men from rural communities, leaving many female-run households, a context which served to challenge foster family recruitment.

Conversely, others proposed that there have been unanticipated benefits from significant demographic change in rural areas of the province. According to a respondent from Labrador-Grenfell, as a means of counteracting economic challenge and remaining in communities, some have decided to become involved in fostering children from other areas of the Authority.

Matching programs and services with need

A lack of in care options

Based on the interview transcripts, it was widely acknowledged that it is a very complicated undertaking to try to develop a system that can be responsive to the particular needs of

individuals and their specific situations. It seemed well accepted by most that such an in care program does not currently exist in the province. In particular, many professionals felt that the system is not broad enough to meet the needs of the province's children and youth, citing a limited number of in care options throughout NL, especially foster homes. As a consequence, individuals acknowledged that some children become inappropriately placed, and a variety of potentially negative consequences were proposed, including frequent transitions from one placement situation to another. Indeed, it was questioned whether the inappropriate placement of a children might be causing more distress than if they had remained within their original homes.

Family support services

Whether the plan is to support children in their homes, or reunification after removal, it was widely acknowledged that there was insufficient support for birth parents. Further, it is only when children are in care that services and support tend to exist, but there is little preventive resources directed towards parents and families. Others suggested that the "Family Support Services" component of the CYFS Manual remains to be developed. Parent coaching was one type of family support service offered by respondents as a potentially viable measure that might be effective in some situations in avoiding the removal of a child. Versions of other such services associated with family support are currently offered in some areas of the province. Western Health, for instance, employs Family Support Workers who provide support to families based on the results of risk assessments. This particular program is currently being evaluated and it is expected that some changes will result in order to provide a more effective intervention. One major concern is the outdated provincial policy that requires much attention such that it will help guide the Family Support Worker practice in the future.

The placement continuum

Out of home options – The Child Welfare Allowance Program

It was a general contention that all options must be investigated to determine the best means possible to mitigate the risk to the child without causing a significant disruption. As previously mentioned, this might mean providing services and resources to families to enhance the capacity of parents to care for and support their child(ren). Nonetheless, if a child's safety and wellness cannot be ensured in the home, an out of home placement will be

required. Respondents indicated that one of the least intrusive out of home placement options that should be explored is the availability of a suitable relative or significant other who is willing to provide (and assessed as capable of providing) care. The child would be placed in the care of the relative/significant other and not in the care or custody of a Director. This is an important option to explore as it allows the child to be placed in safe, familiar environment without having to be legally removed from the family. Support and financial services are provided to relatives or significant others of the child(ren) through the Child Welfare Allowance Program.

Emergency placements/approvals

Due to an insufficient number and range of placement resources, most respondents from all Health Authorities did acknowledge the fact that children have had to be placed on an emergency basis. This may be in an apartment or hotel with staff, with a foster family who already has children placed in their home, or in a foster home that has not been fully approved. Further, it has been noted that attempts to place children for the short term can indeed evolve into extended periods of time simply because there is a lack of longer-term options. Several foster families have in fact reported accepting an emergency placement only to have the child stay for a longer period, leading caregivers to have the child taken from their home as they were unable to deal with the unanticipated lengthy stay. In such situations, many contend that these are not true emergencies, but rather the result of very limited options for longer-term placements.

The demand for specific types of emergency placements seemed to vary around the province. In the St. John's area, for instance, based on an identified need, there have been efforts aimed at designing emergency placements (with a more residential feel) for younger children under the age of 12 years. In other regions, depending on their particular philosophy and resource capacity, some have opted to grant initial approval for emergency homes for immediate placement of children in order to avoid placement within hotels.

Therapeutic foster homes

Therapeutic foster homes represent a particular type of in care option along the continuum of care. They are a "family environment models of care" that tend to fall in between the

standard foster families and residential treatment. Therapeutic foster homes also require that the caregiver have experience and/or training around particular complex issues of the child. Children for whom this type of option might be most suitable are those with complex needs, or issues that are too challenging for typical foster home arrangements. Further, given the particular challenges of the child, a group home environment may not appropriate either, so these children tend to be placed in ILAs.

It was widely asserted that the provincial foster care system would be more responsive and comprehensive if there therapeutic foster homes were available to children. However, it was proposed that regular and comprehensive social worker support is essential to ensure they function effectively.

Group homes

The group home was widely discussed as another option along the in care continuum. They tend to be appropriate when children have significant emotional or behavioural issues which would render foster homes unsuitable. Many also stated that a number of young people residing in group homes have had a history of frequent transitions among a variety of failed foster home placements. It was also suggested that group homes might be more of a benefit to older children, who may have clear ideas about where they might wish to be placed. It was specifically noted that young people may find it difficult to adjust to a foster family's environment, and that group homes may be easier to connect with. Having said this, group homes may be detrimental to children who may be better suited to a foster home placement.

In addition to the residential aspect of group homes, organizations responsible for them (particularly in the Eastern Region) also provide opportunities to keep young people involved socially, build relationships and feel a general sense of attachment.

There are no child welfare group homes outside St. John's and some perceived this as a potential gap across the province because foster families are not for every child, and the outcomes of inappropriate placements quite often translate into frequent breakdowns and disillusioned foster families who decide to opt out of the in care program. It was suggested that children often assume fault in terms of the string of failed arrangements that they might have experienced over the course of being in care.

Accordingly, it was proposed that group homes be considered by other regions of the province, arguing that they would be more appropriate as ALAs tend to be reactionary, lacking standardization.

Residential treatment

While respondents were quite wary of suggestions that residential treatment be conceived of as institutionalizing children, many remarked that there are certainly children in the province that could benefit from this type of therapeutic intervention suggesting that it has its place along the continuum of potential options for children. It was also revealed that there are a number of children who have been placed in centers across Canada and the United States, suggesting that there is a significant need for such interventions that the Janeway (the province's tertiary child medical facility) is not designed to address.

In terms of out of province placements in residential care, coupled with the significant expense, it was argued that there is very little in the way of after care once children return to the province. A further disadvantage offered was that families are not able to participate in the care and treatment of the child. It was also a contention that the placement may not be meeting the needs of the child and it is difficult to keep track of this from a distance.

Overall, while there was unanimous support for a small and short term residential treatment centre for the province, there were cautions offered by several in terms of its potential design and purpose.

Resources and services for children in care

It was a wide-spread contention in each Health Authority that availability and access of resources and services required to meet the needs of children in care could be strengthened, and this was especially the case for children residing within rural or remote settings.

Among all the Authorities, inadequate services and resources was perhaps the main issue raised by those from the Grenfell-Labrador Health. While it was acknowledged that services such speech-language pathology and mental health counselling, as well as a "rainbow team"

did exist for the "Grenfell portion" of the Authority, (i.e., a multidisciplinary team of various professionals from the local hospital which operates on an outpatient basis and includes occupational therapy, physiotherapy, and pediatrics), extensive travel is typically involved to avail of such resources.

According to managers and frontline staff from the "Labrador portion" of the Authority, health resources and services for children and youth are much more limited. Despite much planning and the provision of budgets for mental health services, the benefit of such efforts has not yet been realized. Hence several spoke about the importance of the province providing frequent and recurring support by means of supplementary services from the Janeway.

Individuals from Labrador also offered experiences and perspectives of situations where children had been referred to St. John's (i.e., the Janeway) for assessment and treatment, suggesting that this can be a frustrating and tedious process. It was acknowledged that since there are limited local services to perform initial assessments, children are quickly screened out for services at the Janeway. It was also stated that the Janeway is quite limited in the support it can provide as it only performs assessments and does not offer inpatient treatment. And since treatment is only offered on an outpatient basis, caregivers must be prepared to relocate to St. John's for the duration of treatment, something that very few can afford the time or finances to do.

Overall, it was generally contended that while there is a clear and significant need for mental health services for Labrador's in care children, it was felt that is there currently not a provincial program that can provide support to this part of the region.

There was also some discussion about a proposed "Foster Clinic" very similar to the Janeway's Child Protection Team that could help remedy the fact that medical and health histories of children in care are virtually unknown.

The courts

It was noted that the provincial court process can have major implications for permanency planning for children in care, and overall child adjustment and wellness. While the legislation

is clear and comprehensive, and there is an obvious attempt to act in the child's best interest, it was commonly suggested that there may still be variations in court decisions rendering the process rather uncertain and counterintuitive. And, the authority of the judge's ruling can have enormous resource and planning implications.

It was also argued by CYFS professionals that the lack of resources to support the Act typically means that the timelines associated with court processes are seldom met. Indeed, the time it takes to move cases through the court system and obtain a ruling on the future of a child taken into care was perhaps one of the most salient findings of the review, regardless of Health Authority. There were a number of cases discussed where children were removed, placed in "interim care" without a custody status because there were delays in the ruling.

Lags in the court process can also impact a child's "adoption viability" simply because children age as the legal system slowly processes the case. In some situations, drawn out court processes have meant that infants remain in the temporary care until they are school age, before the court renders a decision regarding continuous custody. Despite the fact that the foster parents are the only parents known to the child, there are other families on an adoption waitlist thus creating a dilemma in terms of what is the best long-term plan for the child. In terms of child comfort and wellness, court delays also create unnecessary anxiety and anger in children who are old enough to understand the process.

Overall, it was proposed that, despite the best efforts of the courts, there should be a court system that is responsive, knowledgeable and sensitive to permanency planning for children and families throughout the province.

Caregiver system/foster care

It is widely contended that parenting is perhaps one of the most demanding, yet rewarding challenges anyone might ever face. However, in the case of being a caregiver of a child in care, it is even more arduous, particularly since the children usually have so much to contend with despite their young years. Children will have most likely experienced significant trauma, have complex needs which may be difficult to address, and have to deal with being placed in a foreign environment. However, there are additional challenges that have very little to do with fostering. That is, there are numerous systemic shortcomings such as a lack of services to

support the children in care, poor communication with social workers, and the often significant financial burden without clear understanding of whether reimbursement might occur. In addition, fostering is very emotional work and the needs of a child tend to create situations where some feel they have no other choice but to comply with requests of the system to accept children at a moment's notice, and/or support them for an undetermined amount of time. Further, since caregivers are expected to respond to a system that is quite often reactionary, very little planning or information sharing may occur around the placement of a child.

Contemporary realities of fostering

It was widely acknowledged by CYFS professionals that those who choose to foster children are quite special, particularly given the sacrifices they make, the economic realities, etc. While foster parents also spoke about the unique characteristics required and duties to perform, such was offered with reference to an in care system that "is not always kind."

Coupled with logistical and financial responsibilities of being foster parents, there are often very difficult realities that often go against one's intuition and comfort, such as coming to terms with birth parent/children visitations and involvement, particularly when that parent has maltreated their child. Other issues many foster parents reported having to contend with were reunification (particularly when they feel it is too early or potentially harmful to the child), and the implicit feeling that foster parents seem more closely scrutinized by "the system" than the birth parent. Regardless of the child's particular circumstances, however, foster parents do tend to recognize and be respectful of the bond between child and parent.

Trying to strike a balance between work and family life was another reality of fostering proposed by respondents, something made all the more challenging since children tend to have many appointments and sessions to help manage their challenges. According to some, families have had to use annual leave for such purposes, resulting in no leave left for vacation. Such scenarios led some to question whether there might be a program to reimburse the employer of a foster parent so that time can be taken from work to help support their fostering.

Among the many roles foster parents play, it was also noted that they are often (much to their annoyance) "an employer" for service providers, and as a result, there are tax implications as they have to track and account for payments of services required by the children which were funded by the Authority, but made personally by them.

The PRIDE Program

PRIDE (Parent Resources for Information, Development & Education) is a competency based model for the development and support of foster and adoptive families. It provides a standardized framework for recruiting, preparing and selecting foster and adoptive parents. It also provides foster parents with in service training and ongoing professional development.

NL has implemented the Pride assessment process (which includes 27 hours of the pre service training/sessions and a home assessment) as a requirement for the approval of non-relative caregiver/foster homes. The ongoing and professional development components of the PRIDE Model have not been implemented as this part of the program has not been resourced.

Professionals generally felt that the Program's pre-service content contained important information for caregivers, as it deals with such things as child behaviour in response to loss, trauma, developmental milestones, issues around discipline, etc. While many foster parents found the PRIDE Program to be a very thorough and inquisitive process, it was also characterized as a "reality check" as it could make individuals question their intention to be caregivers. Despite the fact that PRIDE could be a potential deterrent, it was accepted that it is required to ensure the security and safety of the province's children.

Even though PRIDE is a requirement for approving foster homes, there are some areas throughout the province (particularly rural areas) where homes are providing care to children without participation in the PRIDE program. In such cases, Authorities grant temporary approval which may be discontinued if the caregivers do not complete the program.

In terms of the PRIDE pre-service sessions, many felt that they had improved notably, particularly since local stories have been added along with legislation and statistical information relevant to the province. Other modifications, such as condensed scheduling of

sessions, have also been introduced to meet the needs of particular client groups. It was also widely proposed that some components of the PRIDE Program might be of particular benefit to birth parents as well.

Due to a lack of dedicated resources, and challenging social worker workloads it can be difficult to offer the PRIDE program in some areas of the province. Many also spoke of the need for developing ongoing training programs including the implementation of more advanced components of PRIDE training that can be offered as a support to foster parents while they are fostering.

Rates currently provided to caregivers

A primary point of contention for many foster parents concerned inadequate funding provided to support the children in their care. Similarly, several reported feeling frustrated in attempting to recoup personal funds from the Authority after items and/or services have been purchased for the children. Respondents argued that this was a troublesome predicament as many caregivers are not able to afford covering costs without the up front financial support of the region.

Foster parents also reported that they found it difficult to accept what they felt was limited financial support for children in care as they seemed keenly aware of the seemingly enormous amounts of funding directed toward ad hoc practices such as paying for hotel placements with 24 hour care; funds that could be provided to caregiver homes in a more proactive manner.

The manner in which caregiver homes are currently funded was also discussed as something that required significant rethinking. Several talked about funding strategies that operate based on the child's needs, and how this might serve to reduce financial support if the need was not demonstrated. Further, if a child's condition improved, financial support from the Authority could decline as the need was no longer relevant.

Availability of foster homes

In every Health Authority, a very pervasive observation related to major challenges recruiting and retaining foster homes. While some proposed that advertising campaigns might be beneficial in generating interest, most suggested that the most effective way to recruit foster

parents is actually through other foster families. In terms of retention, it was argued that the primary reasons for caregivers to terminate their involvement in the in care program was burn out, and a complete lack of supports and resources for both the children and caregivers.

Make fostering truly a part of the in care team

Foster parents are extremely important to the in care program in providing a safe and nurturing family environment to children removed from their homes. Nonetheless, it was revealed that many caregivers do not feel part of the in care system. For instance, while they have both the approval and authorization to care for children in their homes, they do not have the authority to consent to things like medical treatment or school events. Similarly, many perceived a general disconnect between the caregiver's understanding of the child's issues, needs and adjustment, and the frontline practitioner's perspective. While this may be a function of insufficient communication between the caregiver and frontline staff, there still exists a lack of consultation between caregivers and social workers.

Overall, it would appear that caregiver's authority is quite limited with respect to decision-making on the child's behalf. Perhaps the "voluntary" context of becoming a foster parent is no longer appropriate as the concept of "professional caregiver" seems more warranted.

The Front Line

Social worker work loads

It was a well accepted view that Child Welfare social work can be quite challenging and, at times, be perceived as the least attractive area of social work practice. It was suggested that a notable number of frontline workers have adopted a sense of pessimism. That is, in addition to the challenging nature of the work, they must also deal with "system challenges." It was revealed that such pessimism might partly be a function of large, often unmanageable work loads, where there is the persistent ordeal of trying to strike a balance between working with clients and performing other duties such as managing financial paperwork and requests for payments, and managing and transporting children for supervised visits with birth parents, something that can be particularly time consuming in rural parts of the province. It was therefore suggested that, due to competing responsibilities, the communication between social

worker and client is limited and the children are not receiving or benefiting from the social worker's skills and training.

Social workers and front line managers throughout the province emphasized the importance of having positions like Social Work Assistants and Financial Administration staff to alleviate the work pressures of non-social work related tasks such as managing financial requests. However, it was cautioned that provincial guidelines needed to be established to define the credentials and duties for these positions.

High social worker turnover, a limited supply and incentive programs

Respondents from all regions discussed challenges associated with high social worker turnover rates. It was widely contended that high staff turnover has resulted in very young and inexperienced frontline staff who might have not realized their full proficiency as professionals. High turnover has also led to a lack of familiarity with children and families resulting in less confidence and comfort in decision-making. From the child's perspective, it was argued (most notably by foster parents) that high staff turnover tends to reinforce a negative perspective of short-term, failed relationships that many foster children become all too familiar with.

In addition to issues associated with high worker turnover, a very salient finding concerned province-wide difficulties in recruiting front line social workers to staff the in care program, a problem that is even more pronounced in remote regions, such as in Coastal Labrador.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

Summary of Findings and Recommendations

How were the recommendations developed?

This report utilized a number of information sources in order to characterize NL's current in care system, and inform its future structure, programs, services and resources from a provincial and regional perspective. In addition to existing policy, best practices child welfare literature, and the Children in Care Profile Survey, central to the present review were the interviews with provincial officials, regional directors, managers, social workers and other front line personnel, representatives of the courts, the Child & Youth Advocate, foster parents and the Foster Families Associations, and former in care clients. This process provided an extremely rich source of information which informed a variety of topics associated with the province's system. While the interviews served as *the* primary source in framing the recommendations, results from the Children in Care Profile Survey, policy and procedure documents, other government reports, and best practices literature provided them with objectivity and credibility. Hence, for the sections that follow (and where appropriate), recommendations born out of the interview process are offered, with support from the other information sources documented in the report.

It is also worth noting that while salient findings from the review are summarized in this section, recommendations are provided *only* for observations that fall within the scope/objectives of the study (i.e., within the domain of CYFS programs, services and policies). As a consequence, while issues pertaining to the courts, and human resources surfaced during the interviews, they are provided to inform subsequent efforts beyond the breadth of this research.

Supporting and strengthening the foster care system

It is an understatement to suggest that foster parents are vital to the in care program, acting on behalf of a Director of CYFS in providing a stable and nurturing family environment to children removed from their homes. However, regardless of Health Authority (and as previously mentioned), a very salient observation of this review concerned major challenges in recruiting and retaining foster homes.

In terms of retention, it was proposed that attrition places a significant strain on the in care program. It was revealed that some of the primary reasons why caregivers tend to terminate their involvement were burn out, a lack of supports and resources for both the children and caregivers, and a prevailing sense that they do not feel part of, or valued by the system. Many actually reported a sense of demoralization as they felt more closely scrutinized by the system than the parents who were required to forego their parental rights.

There was also evidence to suggest that the philosophy of fostering (i.e., that the child's placement is a temporary measure) is, at times, difficult to accept. For some, this can give rise to very difficult scenarios that go against one's intuition and comfort, such as negotiating birth parent/children visitations and involvement, particularly given the knowledge of the child's history with the parent. Nonetheless, according to best practices literature, it is widely accepted that it is important to recognize and accept the fact that birth families will always play a significant role in children's lives as these connections are vital to children's sense of self, ability to cope with and resolve loss, and ability to form new and more lasting attachments (Dougherty, 2001; Fahlberg, 1991).

Further, many foster parents also acknowledged a general disagreement between their understanding of the child's issues, needs and adjustment, and those of the frontline practitioner, perhaps a function of a need for more communication between the caregiver and frontline social workers.

It is widely contended that foster family attrition translates into recruitment challenges. More specifically, it was generally regarded that the most effective way to recruit foster parents is actually through other foster families. As was acknowledged by respondents of this review, and based on the literature review, currently active foster parents are the most proficient recruiters of new foster parents, and when there is pervasive dissatisfaction, this can have very seriously consequences for the recruitment of new foster parents (e.g., Barbell & Sheikh, 2000).

Addressing financial challenges of foster families

A primary point of contention for many foster parents concerned inadequate funding to support the children in their care, and the frustrating prospect of attempting to recoup out of pocket funds after items and/or services were acquired for the children. Indeed, this concern has been identified in the literature as one of the primary reason why attrition rates among foster parents is so high (e.g., Barbell & Freundlich, 2001).

The manner in which caregiver homes are currently funded was also discussed as something that required notable redevelopment. When a child is placed with a foster family, the family receives a standard basic foster care rate based on the child's age. If it is identified that a child has special needs that may result in the family needing additional financial or supportive services, a special needs assessment can be completed. It was strongly suggested by foster families and CYFS staff that this assessment tool is outdated and more importantly it labels/stigmatizes children. It was argued that if an adequate basic rate structure was in place there were be no need to use a deficit based tool to more adequately remunerate foster families.

It is clear that current caregiver rates are not sufficient to adequately support children in their care. It is also clear that the practice of expecting caregivers to provide initial payment for essential items and services is frustrating and not financially possible for many. Finally, to vary caregiver funding based on demonstrated needs of the child creates unnecessary bureaucratic barriers. These observations serve to challenge the retention and recruitment of caregiver homes in the province.

The Department of Health and Community Services and the Regional Health Authorities have also recognized the need to review the current foster care rate structure. There currently exists a Rates and Services committee consisting of representatives from the Department, the four Regional Health Authorities and the Newfoundland & Labrador Foster Families Association. The vision of this committee is the development of a consistent, comprehensive service and support package for foster parents with the first objective being to recommend a new rate structure. This committee has recommended a new rates structure which is currently being reviewed by the Department.

The primary means by which foster families are retained is if they feel supported by the in care system and they do not have to provide care and support to the children within the context of inadequate resources and services. Based on significant concerns over the rates of financial remuneration, the manner in which financial support is offered and the subsequent impact that this has on recruitment and retention of foster families, the following recommendation is proposed:

Recommendation 1 – That a new rate structure for the caregiver program be implemented immediately.

Dedicated resources to strengthen training and education for foster parents

The completion of the PRIDE assessment process which includes pre service training sessions and a home assessment is an approval requirement for all non relative caregivers in NL (Department of Health and Community Services, 2007). PRIDE is not only used to assess prospective foster families, the process also assists applicants in making a better informed decision about whether fostering is a good fit for them.

Based on this review, it would appear that the PRIDE program is generally well-regarded by most as it contains vital information for caregivers on topics such as grief and loss for children and families, attachment, developmental milestones and appropriate discipline. Foster parents, in particular, found such training to be a very thorough and inquisitive process, and a "reality check."

Perhaps the major challenge identified by respondents is some areas of the province is associated with the delivery of the PRIDE Program. This is due to vacancies, a lack of dedicated resources and challenging social worker caseloads. Given the important role that the PRIDE program plays in screening and preparing prospective caregivers, it is imperative that resources be available to support the delivery of the programs.

Further, the PRIDE model also offers ongoing training and support to foster parents after they are approved and begin caring for children in care. This includes specialized training sessions for foster parents on issues like those identified as presenting issues for children in care in this province. Indeed, the literature suggests that foster parents tend to desire more effective and available preparation and training (National Commission on Family Foster Care, 1991; Waldock, 2001). Currently there is no ongoing training or educational opportunities for foster families, including the specialized sessions that are part of the PRIDE program. Based on this line of reasoning, the following recommendation is offered:

Recommendation 2 – That a strategy be developed and implemented across the province for the provision of ongoing education and training initiatives for foster parents.

Creating a broader continuum of placement options

According to the Child, Youth & Family Services Standards and policy manual (Department of Health and Community Services, 2007), it is explicitly stipulated that a primary goal of the in care program is to ensure appropriate and effective placements. It is also stated that each Health Authority must develop and support a continuum of placement resources to enable the social worker to match the child's needs with the most appropriate placement option. However, in the current review, it was generally accepted that an in care program broad enough to address the specific needs of NL children does not currently exist. It was further contended that a limited placement continuum has translated into inappropriate placements leading into frequent transitions from one placement situation to another. Indeed, the results of the Children in Care Profile Survey supported this perspective in that during their time in care, children moved among placements almost 3 times on average.

Emergency placements

Based on the interviews, the need for more emergency placement resources throughout the province was clear. For instance, many acknowledged the utilization of local hotels as a quick response to some removals as options were unavailable. However, it was also noted that short-term emergency arrangements with foster families tend to evolve into longer term placements, much to the frustration of caregivers as they are unable to deal with the

unanticipated lengthy stay. Accordingly, in these types of scenarios, it has been argued that such circumstances are not true emergencies, but rather the result of very limited options for longer-term placements, particularly foster homes. Hence, a reasonable response to such concerns is to broaden the placement continuum so that there be more readily available in care options.

However, the review did observe that (in the Eastern Health Authority in particular) there is an immediate need for emergency placements, including placement options for children under the age of 12 years. Historically, emergency type placements were typically required for older children with very complex needs. However due to the shortage of foster homes and other placement resources, emergency placements are now required for younger children and sibling groups.

The number and type of emergency placements being utilized seemed to vary among regions depending on the philosophies and resource capacities of each. In some regions, this has resulted in younger children (even infants) being placed in staffed arrangements, and in other regions, foster homes are given emergency approval prior to the completion of PRIDE; neither of which is considered best practice. It is anticipated that by expanding the current placement continuum and increasing supports to the foster care program there will be a decreased need for emergency placements. However, currently there is an urgent need for this type of placement option. Hence, the following recommendation is offered:

Recommendation 3 – That the Department of Health & Community Services focus on establishing standards (and practice guidelines to support them) for the development of emergency placement options, especially for children under 12.

Therapeutic foster care

Therapeutic foster care (TFC) was described in this review as "family environment" models of care that tend to fall between standard foster care and residential treatment. According to the literature, it is considered the least restrictive form of out-of-home therapeutic placement for children with severe emotional disorders (e.g., U.S. Department of Health and Human

Services, 1999), and an alternative to institutional living (Ministry of Social Services, Government of Saskatchewan, 2008).

Programs involving TFC share some defining characteristics. For instance, foster parents in TFC arrangements are a) trained to work with children with special needs, b) are supported with higher stipends (or financial support) than traditional foster parents, and c) tend to receive extensive pre-service training and in-service supervision and support (U.S. Department of Health and Human Services, 1999). Therapeutic foster parents do not need to have a formal education, but rather a genuine commitment to children and the ability to see beyond a child's behaviours and problems (Ministry of Social Services, Government of Saskatchewan, 2008). Foster parents in TFC situations are also seen as part of a professional care team who regularly review and plan for the child's ongoing care and treatment (Butterfield Youth Services, 2008). Families involved in TFC situations usually take one child at a time, and experience more frequent contact with social workers (who usually have small caseloads), and (where appropriate) are supported by additional resources and traditional mental health services (U.S. Department of Health and Human Services, 1999). In other provinces in Canada, TFC homes account for approximately 10 percent of the in care child population (e.g., Ministry of Social Services, Government of Saskatchewan, 2008).

In a randomized clinical trial study looking at the outcomes for 79 males with histories of juvenile delinquency placed in either group homes or therapeutic foster homes, those in therapeutic foster homes were observed to have significantly fewer criminal referrals and returned more often to live with relatives, suggesting this to be a more effective intervention (Chamberlain & Reid, 1998). Hence, if therapeutic foster care is available, this type of option may be a better treatment choice for children who previously would have been placed in more restrictive settings.

In this review, it was indeed noted that responsiveness and diversity of the NL in care system would be much improved if therapeutic foster homes were available to children. This is also in keeping with the literature which tends to endorse family-based care as the most preferential placement alternative. Statistically, the Children in Care Profile Survey revealed a high number of ILAs (i.e., 1.2 percent of cases) and ALAs (i.e., 6 percent of case) in this province. These statistics suggest that, for a significant proportion of these children, a

therapeutic home environment might be a more suitable option. Hence, the following recommendation is offered:

Recommendation 4 - That there is a clear need for the development and implementation of a provincial therapeutic/treatment foster home program as an important component of the placement continuum. This should be developed and implemented based on the unique needs of children in each region.

Group homes

According to the U.S. Department of Health and Human Services (1999), there are two major models of therapeutic group homes. The first is the "teaching family model", developed at the University of Kansas. The second is the "Charley model", developed at the Menninger Clinic. Both models use their staff as the key agents for change in the challenges of youth, and both employ couples who live at the homes 24 hours a day. The teaching family model emphasizes structured behavioural interventions through teaching new skills and positively reinforcing improved behavior, while the other group homes use individual psychotherapy and group interaction.

It is suggested in the literature that, for adolescents with emotional disturbances, the group home provides an environment conducive to learning social and psychological skills, particularly for children under the care of juvenile justice (Butterfield Youth Services, 2008). This type of intervention is provided by specially trained staff in homes located in the community, where local schools can be attended. Each home typically serves 5 to 10 clients and provides an array of therapeutic interventions. Although the types and combinations of treatment vary, individual psychotherapy, group therapy, and behavior modification are usually included (Butterfield Youth Services, 2008).

It was proposed by respondents in this review that group homes tend to be most appropriate when children have significant emotional or behavioural issues which would render a family-based environment such as foster homes unsuitable. Indeed, it was revealed that many young people residing in NL group homes have had a history of frequent transitions among a variety of failed foster home placements. It was also suggested that group homes might be more of a benefit to older children, who may have clear ideas about where they might wish to be placed

as some may find it difficult to adjust to a foster family's environment. According to the Children in Care Survey, children in group homes, placed out of province, or in ILA situations were significantly older than children placed with caregiver families (i.e., one average, 3 to 5 years older).

However, the key informant interviews and the Children in Care Profile Survey revealed that there are currently no child welfare group homes outside St. John's. Indeed, some perceived this as a potential gap across the province because foster families are not suitable for every child. Accordingly, it was proposed that group home arrangements be considered by other regions of the province, suggesting that they would be more optimal as ALAs tend to be reactionary, lacking standardization. Hence, the following recommendation is proposed:

Recommendation 5 - That the Department of Health & Community Services develop standards for a Group Home program for the province. This should be developed and implemented based on the unique needs of children in each region.

A provincial residential treatment program

Once the most appropriate type of in care option is identified for a particular child, there still remains the issue of whether the placement actually exists. It was revealed in this review that that there are a significant number of children placed in treatment centers across Canada and the United States because the services and resource to adequately meet their needs are currently not an option in NL. However, several down sides of such placements were clearly outlined by respondents, including; the significant expense, the little or no after care once children return to the province, the inability of families to participate in the care and treatment of their child, and the difficulty ensuring that the needs of the child are being met given the geographical location of the centers.

Previous work exploring the potential for a residential treatment facility was conducted by the province and other key child welfare officials during 2003. Many of the issues raised in the 2003 Residential Treatment report have also been observed in the present review. For example, both the 2003 report and the current study note the prevalence of serious and complex mix of child behavioural, emotional, psychological, health and wellness issues, as

well as the significant number of children sent out of province for intervention and treatment. Hence, based on the widely cited need to support children with very complex and problematic behavioural, emotional and psychological issues, the following recommendation is proposed:

Recommendation 6 – That the province would benefit from the introduction of a short term residential treatment program as an important component of the continuum of care, and it is recommended that the findings and recommendations of the 2003 Residential Treatment report be used to guide the development of such a program.

A standardized approach to assessment and placement appropriateness

In addition to tracking, it is also vital that the most suitable type of placement not only be available and accessible (as discussed above), but a standardized approach to assessment be adopted by the province in order to conduct more proactive screening and to determine the most suitable placement option "up front." It would seem quite apparent that such an approach is necessary simply based on the number of placement changes that children in this province have experienced. Recall that the Child in Care Survey revealed that children representing all placement types experienced an average of 3 placements. However, further analyses observed that those in ILA situations and receiving service out of province had an average of 7 and 5 placements respectively indicating that there were a number of failed situations prior to their most current.

Not only is it important to identify the most appropriate placement immediately when children come into care, but also as their lives evolve within the in care system. That is, perhaps as a function of a new-found stability, regular counselling, or simply maturation, once optimal placement arrangements may become unsuitable, and there must be a way of determining this. For instance, there may be situations whereby a child receiving services in a residential treatment facility may be deemed ready to move to a less restrictive (and more nurturing) family-based environment. Hence, it is recommended that that there be annual assessments to determine whether the placement is still suitable for the child.

Overall, the need for NL to apply a standard, comprehensive assessment process when children enter care (and as they live through it) is important in order to limit the number of inappropriate placements, establish service and placement requirements throughout the province, and track the progress of children with very problematic issues and behaviors.

A recent search of youth services treatment programs throughout the United States and Canada yielded some public and private program screening processes dedicated to determining the treatment needs of children. In the State of Missouri, a standardized needs assessment scale called the "Child Severity of Psychiatric Illness" (CSPI, 1995) is used to establish a classification of "need level", ranging from the most severe need classification termed "Intensive Need" (or Level IV), "Severe Need" (or Level III), and "Moderate Need" (or Level II). Programs in this State (such as the Butterfield Youth Services Program) identify children in Levels' III and IV as suitable for Residential Treatment, and children at Level II suitable for Therapeutic Foster Homes. Based on such a system, it may be deduced that children identified and a Level I or Level O (using the CSPI) would be appropriate for traditional foster care.

The CSPI (1995) is an assessment tool developed by the Mental Health Services and Policy Program of Northwestern University Medical School, and the Department of Child and Adolescent Psychiatry Children's Memorial Hospital (Department of Child and Adolescent Psychiatry) to assist in the management and planning of mental health services for children and adolescents (See http://www.hfs.illinois.gov/assets/103105_fy05appendix_a.pdf for Manual)**.** The CSPI allows for a standardized assessment of children with potential mental health service needs along a set of dimensions found to be relevant to clinical decision making.

There are several dimensions in the instrument and each is rated on 4-point scales during initial point of contact or review of case files. Fundamentally is that a zero reflects no evidence, a rating of one reflects a mild degree of the dimension, a rating of 2 reflects a moderate degree and a rating of 3 reflects a severe or profound degree of the dimension.

In terms of the types of scales, themes ranges from "Symptoms" (e.g., emotional disturbance, conduct disturbance, or oppositional behavior), to "Risk factors" (e.g., suicide risk, danger to

others, or sexual aggression), to "Functioning" (e.g., school, family or peer dysfunction), to Co-morbidity (e.g., adjustment to original trauma, substance abuse, or learning and developmental disabilities).

Overall, based on the above discussion of assessment need and possible standardized processes, the following is recommended:

Recommendation 7 - That the Department of Health & Community Services develop a standardized process to help determine the most appropriate placement type for children being placed in the care of a CYFS Director. Further, that this assessment process must be culturally sensitive.

Addressing needs and enhancing outcomes for children in care

It was observed in this review that many children in the care of a CYFS Director have experienced maltreatment and trauma that could have had a very negative impact on their mental and psychological wellness. For instance, almost 70 percent of children in care have experienced family histories fraught with emotional abuse and neglect, while 64 percent have dealt with family substance abuse, and 60 percent, family violence. In terms of child presenting problems, it was also reported that significant proportions of children have developmental delays (24 percent), FASD (25 percent), attachment issues (23 percent), violence toward others (17 percent), and ADD (or ADHD) (16 percent).

Adding an additional layer, when regional statistics were explored, the prevalence of presenting problems also varied notably. For example, more than half of the children in care in Labrador-Grenfell had FASD (either suspected or diagnosed). Almost 30 percent of children in care in Central had a developmental delay. More than 20 percent of children in care in Eastern tend to exhibit violence toward others. And almost 20 percent of children in care in Western have speech-language issues. These statistics underscore a very strong requirement for a range of supports and services which need to be provided by all the Health Authorities.

When more specific analyses were conducted involving type of in care arrangement, it was apparent that children in group homes, ILAs, and out of province placements were rated significantly more poorly compared to children in caregiver homes in terms of physical and mental/ psychological health. Further, children in group homes, ILAs and out of province placements also had the highest prevalence (and a more complex mix of) presenting issues. For group home children, for example, issues such as depression and anxiety, suicidal thoughts, and inappropriate sexual behavior represented between 26 and 32 percent. In terms of out of province children, more than half were reported to have FASD, 40 percent with a developmental delay, and 36 percent with substance abuse. For those in ILAs, almost 60 percent were reported to have extreme defiance-oppositional behavior, and exhibit violence towards others. Overall, children in these situations accounted for approximately 12 percent of all young people in care.

Taken together, there is significant evidence to suggest that a notable proportion of children in care require *appropriate* levels of treatment and intervention services. Hence, it is not only important to gauge the types and prevalence of particular issues, but also how needs might vary throughout the province. Based on a model developed in the United Kingdom in the early 1990s, the Canadian Looking After Children Project (CanLAC) seeks to enhance the outcomes of children and youth in care by improving the quality parenting and support that they receive (Child Welfare League of Canada, 2008).

As a key principle of LAC approach, a developmental model is used in order to follow a child's progress in a holistic way by examining seven particular dimensions on a yearly basis through the use of the core LAC tool known as the Assessment and Action Record (AAR). Similar to the Children in Care Survey utilized in this present review, these dimensions include health, education, identity, family and social relationships, social presentation, emotional and behavioral development and self care skills (Child Welfare League of Canada, 2008).

Also similar to this review, in order to establish an accurate and comprehensive representation of the child/youth's development, the AAR uses a set of questions designed for individuals most knowledgeable of the child to answer, such as a child/youth in care, a foster parent/caregiver, child welfare worker and other relevant people (i.e., birth parent, teacher).

Given the importance of tracking and establishing health and social outcomes of children and youth in care in NL, and the need to inform provincial and regional requirements for programs and services, the following is recommended:

Recommendation 8 - That the Department of Health & Community Services develop a plan to implement the Canadian Looking after Children (CanLAC) Model.

Issues specific to Aboriginal children, families and communities

As was demonstrated in the Children in Care Profile Survey, the Labrador-Grenfell Authority has the highest per capita number of children in care compared to the other NL Health Authorities. Similar to the proportion of Aboriginal children in care throughout Canada (Indian and Northern Affairs Canada, 2003), almost one third of all children placed in care in NL were Aboriginal, where Innu aimun was the first language for a significant number. It was also observed that Labrador-Grenfell Health in care children represented the majority of out of province placements, had the highest average number of re-placements, and the lowest proportion where it was believed that the model of coordination of services was working for them among the NL Health Authorities.

Despite recommendations in the *Child, Youth and Family Services Standards and Policy Manual* (Department of Health and Community Services) and the literature (e.g., Dougherty, 2001; Barbell & Freundlich, 2001) advocating that placements occur within a child's culture, it was also learned that roughly 17 percent of Aboriginal children in care were *not* placed within a caregiver home of the same culture, and that parental contact was *most infrequent* for Labrador children.

It was also widely suggested in the interviews that there are many practices and procedures of the in care systems that are either insensitive to Aboriginal culture or completely irrelevant. However, given that one third of the province's in care children are Aboriginal, there is certainly a provincial obligation to closely assess and attempt to establish how the current policies and procedure might 1) impact children and their families, and 2) be altered to be more relevant.

In addition to developing policies and programs that are culturally sensitive, there also seems to be a requirement for Aboriginal awareness training among frontline practitioners. During the interview process this was noted as a serious gap in social work preparedness. While it may be beyond the jurisdiction of this review, there must be efforts made to prepare frontline social workers for potential work within an Aboriginal context.

Addressing complex mental, emotional and behavioural issues

In terms of assessments of physical and mental/psychological health status, this review observed that Labrador-Grenfell's children in care had the lowest ratings among the Health Authorities. Further, these children had the highest average number of family history challenges including "neglect", "family break-down", "family violence", "substance abuse in family", "criminal involvement in family", "mental health concerns in family", and "family history other" whereby the majority of cases were deemed "intergenerational trauma." Labrador-Grenfell Health's in care children also had the highest average *number* of presenting problems, and the highest *proportions* such as "substance abuse", "FASD (suspected or diagnosed)", "suicidal", "negative peer involvement", "running away", and "attachment issues."

Despite Grenfell-Labrador's children in care having more numerous and a complex mental, emotional and behavioural issues, what seems particularly concerning is that the Authority acknowledges the tremendous challenges in being able to respond to and adequately address these complex needs. Among all the health regions, inadequate services and resources were perhaps the main issues raised by those from the Grenfell-Labrador Health, particularly for the "Labrador portion" of the Authority. Despite much planning and the provision of budgets for mental health services, the importance of frequent and recurring support provided by the province (by means of supplementary services from the Janeway) was frequently discussed. It was also acknowledged that the Janeway is quite limited in the support it can provide as it only performs assessments and does not offer inpatient treatment. Since treatment is only offered on an outpatient basis, there are only two options for Aboriginal children: either caregivers relocate or the children are placed out of province to avail of services.

Overall, there is a clear and significant need for health services (particularly mental health services) for Labrador's children in care. This is particularly true for children in care in areas such as coastal Labrador where the per capita in care numbers are so high yet the services so lacking. The significance of the number of family history and presenting issues for the children in care in the Labrador/Grenfell Authority is also illustrated in the Children in Care Profile Survey. Based on this the following is recommended:

Recommendation 9 - Policy and program development related to placement resources and service needs of children in care must be culturally sensitive and responsive to the unique needs of Aboriginal children and their families (i.e., the provision of mental health services).

Human resource implications

While recommendations regarding human resources were beyond the scope of the present review, it is worth noting that a very salient finding of this review concerned professional challenges existing within the frontlines of CYFS. In fact, it was widely suggested across the province that many child welfare workers have adopted a pessimistic view of the work they perform due to heavy workloads and attempting strike a balance between working with clients and performing other logistical duties such as managing financial paperwork, and transporting children for supervised visits. As a consequence, many noted that the communication between social worker and client was drastically impeded resulting in children not receiving or benefiting from the social worker's skills and training.

Province-wide challenges associated with high rates of social worker turnover were also revealed. It was widely suggested that this resulted in a variety of issues including very young, inexperienced frontline staff that have less confidence and comfort in decisions making, as well as frequent worker turnover for children in care. This frequent turnover can reinforce for children in care that this is another failed relationship. It was also observed that there are significant difficulties recruiting front line social workers to staff the in care program, a problem that is even more pronounced in remote regions such as in Coastal Labrador. This problem also seems to exist across the country, as the literature discusses high

worker turnover, shortages of qualified social workers, and high attrition rates as well (e.g., Canadian Association of Social Workers, 2003).

From the literature it is also clear that such feelings among frontline social workers are not unique to NL. For instance, in Canada and the United States, caseloads have generally been regarded as overwhelming, job duties and timelines unmanageable, and child/family demands numerous and complex (Allen & Bissell, 2004). From a foster parent perspective, the literature also contends that one of the primary frustrations is a lack of social worker availability and, this has served to negatively impact retention and hence recruitment (Barbell & Sheikh, 2000).

Consequently, workers and managers throughout the province emphasized the importance of having positions like Social Work Assistants and Financial Administration staff to alleviate the work pressures of non social work related tasks such as managing financial requests. However, it was cautioned that provincial guidelines needed to be established to define the credentials and duties for these positions.

In summary, supporting front line social workers is a critical element in enhancing the in care program. Based on the literature and findings of this report it is suggested that efforts to decrease worker turnover and increase the time social workers have to spend with children in care and caregivers will only serve to strengthen the in care program.

REFERENCES

References

Aitken G. (2002). *Extending Options in Permanency Planning in Permanency Planning in the Child Welfare System*. Ottawa: Sparrow Lake Alliance: Children in Limbo Task Force.

Allen, M.L. & Bissell, M. (2004). Safety and stability for foster children: The policy context. *The Future of Children*, *14*(1), 49-73.

Badeau, S.H. (2004). Five commentaries: Looking to the future. *The Future of Children*, *14*(1), 175-189.

Bass, S., Shields, M.K., & Behrman, R.E. (2004). Children, Families, and foster care: Analysis and recommendations. *The Future of Children*, *14*(1), 5-29.

Barbell K. & Freundlich, M. (2001). *Foster Care Today*. Casey Family Programs National Center for Resource Family Support. Washington, DC.

Barbell, K., & Sheikh, L. (2000). *A community outreach handbook for recruiting foster parents and volunteers*. Washington, DC: Child Welfare League of America.

Butterfield Youth Services (2008). Programs: Therapeutic Foster Care (TFC), Marshall Missouri<http://www.bys-kids.org/programs/fostercare/ (Accessed July 30, 2008).

Canadian Association of Social Workers (2003). *Canadian Association of Social Workers Child Welfare Project: Creating conditions for good practice*. Ottawa.

Chamberlain, P., & Reid, J. B. (1998). Comparison of two community alternatives to incarceration for chronic juvenile offenders. *Journal of Consulting and Clinical Psychology*, *66*, 624–633.

Child Welfare League of Canada. (2001). *Summary of Child Population, Children in Child Welfare care and Age of Protection – Canada 1999, compiled from Child and Family*

Services Statistical Report 1996-97 to 1998-99. Child and Family Information Services, Secretariat to the Working Group on Child and Family Services Information.

Child Welfare League of Canada (2003). *Children in care in Canada: A summary of current issues and trends with recommendations for future research*. Foster LIFE Inc.

Child Welfare League of Canada (2008). *The Canadian Looking After Children Project (CanLAC)*. Retrieved July 30, 2008 from http://www.cwlc.ca/projects/canlac_e.htm.

Department of Health and Community Services (2007). *Child, Youth and Family Services Standards and Policy Manual: Section 3: Children in Care and Custody.* Government of Newfoundland and Labrador. http//www.health.gov.nl.ca/health/ publications/ pdfiles/child_youth_family_services_manual.pdf (Accessed May 30th 2008).

Department of Health and Community Services (2008). *Data Table – Number of Children In Care in Newfoundland and Labrador.* Division of Children and Youth Services. Government of Newfoundland and Labrador.

Dougherty, S. (2001). *Toolbox no. 2: Expanding the role of foster parents in achieving permanency*. Washington, DC: Child Welfare League of America.

Fahlberg, V. (1991). *A child's journey through placement.* Indianapolis, IN: Perspectives Press.

Gough, P. (2007). *Newfoundland and Labrador's child welfare system.* CECW Information Sheet #49E. Toronto, ON: University of Toronto, Faculty of Social Work. Retrieved July 10 2008 from www.cecw-epb.ca/DocsEng/NfldLabChildWelfareSystem49E.pdf

Government of Canada (2006). *The human face of mental health and mental illness in Canada*. Ottawa, Canada.

Harden-Jones, B. (2004). Safety and stability for foster children: A developmental perspective. *The Future of Children*, *14*(1), 31-47.

Hertzman, C. & Keating, D. (2000). *Developmental health and the wealth of nations*. New York: Guildford Press.

Indian and Northern Affairs Canada (2003). *Basic Departmental Data – 2001*. Minister of Indian and Northern Affairs Canada http://www.inac.gc.ca (Accessed June 4, 2008).

Kluger M.P., Alexander, G., & Curtis, A.P. (2000). *What Works in Child Welfare*. Child Welfare League of America.

National Commission on Family Foster Care. (1991). *A blueprint for fostering infants, children and youths in the 1990s*. Washington, DC: Child Welfare League of America.

National Youth in Care Network (2001). Who Will Teach Me to Learn: Creating Positive School Experiences for youth In Care: Ottawa.

Ponti, M. (2008). Special considerations for the health supervision of children and youth in foster care. *Paediatrics & Child Health. 13*(2), 129-132.

Statistics Canada (2008). *National Longitudinal Survey of Children and Youth (2006-2007): Questionnaire(s) and reporting guide(s)*. Available online at <http://www.statcan.ca/english/sdds/instrument/4450_Q3_V6_E.pdf (Accessed June 4, 2008).

Stein, E., Evans, B., Mazumdar, R., Rae-Grant, N. (1996). The Mental Health of Children in Foster Care: A Comparison with Community and Clinical Samples. *Canadian Journal of Psychiatry*. *41,* 385-391.

Trocmé, N., Fallon, B., MacLaurin, B., Daciuk, J., Felstiner, C., Black, T., Tonmyr, L., Blackstock, C., Barter, K., Turcotte, D., & Cloutier, R. (2003). *Canadian incidence study of reported child abuse and neglect – 2003: Major findings*. <http://www.phac-aspc.gc.ca/cm-vee/csca-ecve/index.html> (Accessed June 4, 2008).

U.S. Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. Available online at http://mentalhealth.samhsa.gov/features/surgeongeneralreport.pdf (Accessed July 31, 2008).

U.S. Department of Health and Human Services (2002). *AFCARS interim estimates for FY 2000 as of August 2002*. Washington DC: DHHS, August, 2002. Available online at www.acf.hhs.gov/programs/cb/publications/afcars/report7.pdf. (Accessed June 4, 2008).

Waldock, T. (2001). Professionalizing foster care: The welfare of children. Canadian Foster Parent Homepage: Articles. Available online at < Http://home.ica.net/~sharyn/ articles.htm> (Accessed August 8 2008).

APPENDIX A

CHILDREN IN CARE PROFILE QUESTIONNAIRE

Children In Care Profile Survey

The Department of Health & Community Services is currently conducting a multi-method research project that will address a variety of issues relating to children in the care and custody of a Director of Child, Youth & Family Services (CYFS) in Newfoundland & Labrador. A primary objective is to compile a profile of all children in the care and custody of a Director of CYFS that will provide an understanding of their needs including: the presenting issues (i.e. FASD, ADD), rating of wellness, the types of supports/services they require, and the types of placements in which they currently reside. Hence, a vital part of our establishment of an accurate profile is your completion of the "Children In Care Profile Survey."

Instructions

To the best of your ability, **individual** questionnaires are to be completed for each young person between 0 and his/her 16th birthday. For term definitions, please see the "Glossary of Terms" section at the end of this questionnaire.

To ensure confidentiality, please do not provide any information that could identify a child or family (e.g., surname). If you feel that you require the input from individuals most knowledgeable of the child, please feel free to include their perspectives in completing this questionnaire.

Completed surveys are to be sealed in an envelope, signed, and returned to your program manager no later than March 20th 2008. If you have specific questions about this questionnaire or any aspect of this research project, please feel free to contact:

Ken Fowler
Department of Psychology
Memorial University of Newfoundland
Tele: 737-7672 Email: kfowler@play.psych.mun.ca

Demographic and general placement information

1) Region

- ☐ Eastern
- ☐ Central
- ☐ Western
- ☐ Labrador/Grenfell

2) Office/Site

_____

3) Child's:

Age_____

Sex

- ☐ Male
- ☐ Female

Ethno-Racial Group

- ☐ White
- ☐ Aboriginal
- ☐ Other

First language

- ☐ English
- ☐ Other (Please specify)

_____

4) Is the child living in a caregiver home of their own culture?

- ☐ Yes
- ☐ No

5) Care/Custody Status

- ☐ VCA (Voluntary Care Agreement)
- ☐ Care/Interim care
- ☐ Temporary Custody
- ☐ Continuous Custody
- ☐ Other (Please specify)

_____

6) Has the child been placed within NL?

- ☐ Yes
- ☐ No

If "Yes", what is the community of placement?

_____

7) Are you the child's social worker?

- ☐ Yes
- ☐ No

If "Yes", how long have you worked with the child?

Years_____ Months _____Weeks_____

If "No", what is your association with this child?

_____

8) Did you consult with others most knowledgeable about this child to complete this questionnaire?

- ☐ Yes
- ☐ No

If "yes", please indicate the title of the person with whom you consulted.

- ☐ Other social worker
- ☐ Regional CYFS Director
- ☐ Caregiver/Foster parent
- ☐ Program Supervisor
- ☐ Other (please specify)

_____

Characteristics of current placement

1) How would you best characterize the child's current placement?

- ☐ Caregiver home (Relative/Significant other)
- ☐ Caregiver home (Non-relative/Regular)
- ☐ Group home
- ☐ Receiving services out of province
- ☐ Individual living arrangement (ILA)
- ☐ Alternate living arrangement (ALA)
- ☐ Other (Please specify)

_____

2) If the child is currently living in a caregiver/foster home, how would you best describe the "family composition" of the child's placement?

Caregivers?

- ☐ Two parents
- ☐ One parent

Other children in caregiver home?

- ☐ Yes
- ☐ No

If "yes", how would they be best characterized?

- ☐ Biological siblings (How many?)_____
- ☐ Children not related to child but also in care (How many?)_____
- ☐ Children of the care giver (How many?)_____

3) How long has the child been in his/her current placement?

Years _____ Months_____ Weeks_____

4) Is the current placement in the community in which the child spent the majority of his/her life (i.e., "home community")?

- ☐ Yes
- ☐ No
- ☐ Don't know

5) Does the child have contact with parent(s)?

- ☐ Yes
- ☐ No
- ☐ Don't know

If "yes", how often per month? _____

If applicable, please indicate the *primary* barrier that limits the degree to which children have access parent(s) (e.g., distance, etc.).

_____

6) Does the child have regular contact with sibling(s)?

- ☐ Yes
- ☐ No
- ☐ Not Applicable
- ☐ Don't know

7) Does the child have regular contact with significant other(s)?

- ☐ Yes
- ☐ No
- ☐ Don't know

8) Does the child have regular contact with relatives(s)?

- ☐ Yes
- ☐ No
- ☐ Don't know

Ratings of physical/emotional/social wellness

1) How would you rate the general physical health of the child?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Child too young to judge
- ☐ Unable to say

2) How physically active is child compared to others of same age/sex?

- ☐ Much More
- ☐ Moderately more
- ☐ Equally
- ☐ Moderately Less
- ☐ Much Less
- ☐ Child too young to say
- ☐ Unable to say

3) How would you rate the general mental/psychological health of the child?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Child too young to judge
- ☐ Unable to say

4) Child's interest in life or level of happiness. - Would you describe the child as being usually:

- ☐ Happy and interested in life
- ☐ Somewhat happy
- ☐ Somewhat unhappy
- ☐ Unhappy with little interest in life
- ☐ Child too young to say
- ☐ Unable to say

5) Is the child in school?

- ☐ Yes
- ☐ No

If "Yes", what grade? _____ Attending Full-time? ____ Part Time? ____

If "No", and the child is school age, please specify why not attending. _____

6) Is there an ISSP (Individual Support Service Plan)?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ N/A - child not school age

7) Based on your knowledge of his/her school work, including his/her report cards, how is the child doing in school?

- ☐ Very well
- ☐ Well
- ☐ Average
- ☐ Poorly
- ☐ Very poorly
- ☐ Due to developmental delay, it's hard to judge
- ☐ N/A - child not school age
- ☐ Unable to say

8) Ease child has in making friends?

- ☐ Somewhat shy
- ☐ About average
- ☐ Very outgoing - makes friends easily
- ☐ Unable to say
- ☐ N/A - child not school age

9) During the past 6 months, how well has the child gotten along with other children, such as friends or classmates (excluding brothers or sisters)?

- ☐ Very well, no problems
- ☐ Quite well, hardly any problems
- ☐ Pretty well, occasional problems
- ☐ Not too well, frequent problems
- ☐ Not well at all, constant problems
- ☐ Unable to say
- ☐ N/A - child not school age

10) During the past 6 months, how well has the child gotten along with teachers?

- ☐ Very well, no problems
- ☐ Quite well, hardly any problems
- ☐ Pretty well, occasional problems
- ☐ Not too well, frequent problems
- ☐ Not well at all, constant problems
- ☐ Unable to say
- ☐ N/A - child not school age

11) During the past 6 months, how well has the child gotten along with caregivers?

- ☐ Very well, no problems
- ☐ Quite well, hardly any problems
- ☐ Pretty well, occasional problems
- ☐ Not too well, frequent problems
- ☐ Not well at all, constant problems
- ☐ Unable to say

12) Please estimate the total number hours/week child attends structured activity (e.g., organized sports, other organized physical activities, clubs/groups/community programs)._____

- ☐ Not applicable
- ☐ Can't say

Child's Family history prior to placement:

1) Please indicate all that may apply:

- ☐ Sexual abuse
- ☐ Physical abuse
- ☐ Neglect
- ☐ Emotional abuse
- ☐ Family break-down
- ☐ Family violence
- ☐ Medical concerns
- ☐ Substance abuse in family
- ☐ Criminal involvement in family
- ☐ Mental health concerns in family
- ☐ Other (Please specify)_____

2) Approximately how many placements has the child experienced? _____

3) Please estimate the child's total time in care/custody of a Director of CYFS?

- ☐ 1-6 months
- ☐ 7 – 12 months
- ☐ 1-2 years
- ☐ 2-5 years
- ☐ 5-10 years
- ☐ More than 10 years

Child's presenting problems at the time of child's initial placement with CYFS

1) Please indicate all that may apply:

- ☐ Developmental delay
- ☐ Substance abuse
- ☐ FASD (diagnosed or suspected)
- ☐ ADD or ADHD
- ☐ Depression-Anxiety
- ☐ Self-harming behaviour
- ☐ Suicidal
- ☐ Self-mutilation
- ☐ Negative peer involvement
- ☐ Violence towards others
- ☐ Running away
- ☐ Involvement in prostitution
- ☐ Age-inappropriate sexual behaviour
- ☐ Autism Spectrun Disorder (diagnosed or suspected)*
- ☐ Psychiatric disorder (diagnosed)
- ☐ Criminal involvement
- ☐ Special education needs
- ☐ Irregular school attendance
- ☐ Speech-Language concerns
- ☐ Extreme defiance-Oppositional Behaviour
- ☐ Verbally Abusive
- ☐ Severe Child-Parent conflict
- ☐ Severe sibling conflict
- ☐ Attachment issues
- ☐ Child too young at time of placement for problems to be detected/reported
- ☐ Other (Please specify)_____

2) Has the existence of these presenting issues changed since his or her placement?

- ☐ Yes
- ☐ No
- ☐ Cant't tell - child too young for such problems to be detected/reported
- ☐ Don't know

3) If 'Yes', have they:

- ☐ Improved?
- ☐ Worsened?
- ☐ Become more evident as the child has gotten older

*Includes Autism, Aspergers, PDD-nos, Rett's, CDD

4) Which presenting problems persist since the child's placement with CYFS? Indicate all that may apply.

- ☐ Developmental delay
- ☐ Substance abuse
- ☐ FASD (diagnosed or suspected)
- ☐ ADD or ADHD
- ☐ Diagnosed Depression-Anxiety
- ☐ Self-harming behaviour
- ☐ Suicidal Ideation
- ☐ Suicidal Attempts
- ☐ Self-mutilation
- ☐ Negative peer involvement
- ☐ Violence towards others
- ☐ Running away
- ☐ Involvement in prostitution
- ☐ Age-inappropriate sexual behaviour
- ☐ Psychiatric disorder (diagnosed)
- ☐ Criminal involvement
- ☐ Autism Spectrun Disorder (diagnosed or suspected)*
- ☐ Special education needs
- ☐ Irregular school attendance
- ☐ Speech-Language concerns
- ☐ Extreme defiance-Oppositional Behaviour
- ☐ Verbally Abusive
- ☐ Severe Child-Parent conflict
- ☐ Severe sibling conflict
- ☐ Child too young for problems to be detected/reported
- ☐ Other (Please specify)_____

*Includes Autism, Aspergers, PDD-nos, Rett's, CDD

5) Is there a plan of care for this child?

- ☐ Yes
- ☐ No
- ☐ Don't know

6) Do you feel the model of coordination of service is working for this child?

- ☐ Yes
- ☐ No
- ☐ Don't know

7) Please indicate any of the following services the child receives:

- ☐ Psychiatric services
- ☐ Psychological services
- ☐ Counseling services
- ☐ Speech-language services
- ☐ Recreational services
- ☐ Special education placement
- ☐ Specialized medical services
- ☐ Respite
- ☐ Behaviour Management Specialist
- ☐ Tutoring
- ☐ Other (Please specify)_____

8) If applicable, please indicate any of the following services the program provides for the caregiver/foster family.

- ☐ Respite
- ☐ Behavioural Aid
- ☐ Behaviour Management Specialist
- ☐ Counseling
- ☐ Babysitting
- ☐ Other (Please specify)_____

A sincere THANK YOU for your involvement!

APPENDIX B

GLOSSARY OF TERMS

Glossary of Terms

ALA:	Refers to an alternate living arrangement designed to provide an emergency or short term placement for a child or children in the care of the Director of CYFS due to the lack of availability of a suitable caregiver home or group home placement.
Care:	means the physical daily care and the nurturing of a child
Caregiver (foster parent):	means a person with whom a child is placed for care with the approval of a director and who, by agreement with a director, has assumed responsibility for the care of the child but does not include a parent; this definition includes family/significant others and those persons approved by the boards to provide caregiver service when a child is in a director's care or custody. The terms caregiver(s) and foster parent(s) are used interchangeably.
Child:	means a person actually or apparently under the age of sixteen years
Continuous Custody Orders	A Continuous Custody Order under paragraph 34(2)(d) of the Child, Youth and Family Services Act transfers the care and custody permanently to a director of child, youth and family services. When a child is in the continuous custody of a director, all parental rights are terminated. Section 42 of the Act outlines the effect of a Continuous Custody Order.
Custody:	means the rights and responsibilities of a parent in respect of a child
Director:	means the director of Child, Youth and Family Services employed by a Health Authority
Individual Support Services Plan:	means a summary of relevant information gathered regarding a child's needs and the program which will be followed. It includes the materials, equipment, relevant health information, strengths, needs, goals and other supports and services identified for the child.
Interim Care:	means the care provided to a child between removal and the presentation hearing order
ILA:	Refers to an individualized living arrangement designed to meet the long term needs of a particular child/youth due to the complex nature of their issues and their inability to be successful in a less structured environment (e.g. Caregiver home or Group Home

Model for Coordination of Services:	means a framework for the coordination and provision of services to children youth and their families.
Maltreatment:	Child maltreatment (physical, sexual, emotional abuse) encompasses a wide range of parental acts that place children at risk. Maltreatment refers to a non accidental infliction of injury or harm to a child by a parent. A child's need for protective intervention is defined in legislation under Section 14 of the Child, Youth & Family Services in the Act (CYFS Act). • Physical abuse is any non-accidental physical force or action that harms a child • Sexual Abuse is the inappropriate exposure of a child to sexual contact, activity or behaviour • Emotional abuse is anything that cause mental or emotional harm to a child
Neglect:	Neglect is not defined specifically under Section 14 of the Child, Youth & family Services Act (CYFS Act). In practice, neglect issues are responded to under Section 14(a) of the CYFS Act. Neglect includes acts of omission or commission on the part of the parent/caregiver. This includes failure to provide for the child's basic needs and appropriate level of care with respect to food, clothing, shelter, health hygiene and safety.
Permanency Planning:	refers to a comprehensive planning process directed towards the goal of a permanent stable home for a child
Relatives:	means a person related by blood, marriage or through a common-law relationship
Significant Other:	means a person who is not a relative but is a person who is familiar and meaningful in a child's life
Temporary Custody Orders	paragraph 34(2)(c) of the Child, Youth and Family Services Act provides for an order that a child be placed in the custody of a director on a temporary basis for a specified period in accordance with Section 36 (duration of temporary orders). A temporary order transfers the custody of the child to a director of child, youth and family services for a specified period of time
Voluntary Care Agreements	a Voluntary Care Agreement, (Form # 14-612), allows a parent to transfer care and supervision of a child to a director of Child, Youth and Family Services. A Voluntary Care Agreement does **not** transfer custody of the child to a director. Children in care under a Voluntary Care Agreement must be placed with approved caregivers