WOOD'S HOMES JOURNAL

Evidence to Practice

VOLUME 3, ISSUE 1 | WINTER 2019

WOOD'S HOMES
WORKING FOR CHILDREN'S MENTAL HEALTH
SINCE 1914

Contents

1 **Introduction to Volume 3, Issue 1 of the Wood's Homes Journal – Evidence to Practice**
Bruce MacLaurin

2 **From Magic to Evidence: The Potential of the Wood's Homes Research Chair in Children's Mental Health**
Angelique Jenney

4 **A Renewed Perspective of Group Care and Residential Treatment: An Orientation Toward Therapeutic Group/Residential Care**
Anton Smith, Allen Balser & Bjorn Johansson

13 **Bridging the University/Community Divide: Exploring Ways to Implement Practice-Based Research in Social Work Education**
Angelique Jenney & Christa Sato

16 **Family Systems and Kinship Care: Challenges and Opportunities**
Susan Gardiner

22 **The Implementation Process of Mothers in Mind (MIM) at Wood's Homes**
Angelique Jenney & Kafilat Jimba-Bidmus

25 **Crossover Youth in Alberta: Risk Factors Associated with Dual Involvement in the Child Welfare and Juvenile Justice Systems**
Bruce MacLaurin & Jenna Passi

34 **Policy Implications of ACE Scores**
Jenna Passi, Anita Blackstaffe & the Wood's Homes Trauma-Informed Working Committee

38 **Wood's Homes No Restraint Philosophy: Connecting Practice, Theory and Research Evidence**
Michael Wall & Angelique Jenney

45 **Practice Lessons: Story #39**
Jane Matheson

Wood's Homes Journal – Evidence to Practice is published by Wood's Homes and is designed to showcase leading applied research and practice knowledge of mental health services for children, youth and families in Canada. Articles are the responsibility of the authors.

The photograph on the front cover is Wood's Homes Inglewood Campus. The photograph on the back cover is the original location of Exit Outreach Services in Calgary from the early 1990's.

Questions or inquiries about the *Wood's Homes Journal – Evidence to Practice* should be addressed to:

WOOD'S HOMES
9400 48th Avenue, NW
Calgary, Alberta
T3B 2B2

Attention: Bruce MacLaurin
Phone: (403) 774-1662

© Wood's Homes 2019

Introduction to Vol. 3, Issue 1 of the Wood's Homes Journal – Evidence to Practice

BRUCE MACLAURIN

Volume 3, Issue 1 of the Wood's Home Journal – Evidence to Practice marks the start of a new era in the partnership between Wood's Homes and the University of Calgary with Dr. Angelique Jenney being named as the Wood's Homes Research Chair in Children's Mental Health. Dr. Jenney leads and co-authors a number of articles in this issue that highlights new and emerging practice-based research at Wood's Homes. Please take time to review the article by Dr. Jane Matheson in Volume 2, Issue 1 of this journal which highlights the creation of the Wood's Homes Research Chair in Children's Mental Health, from a dream to reality over a 15-year period. Dr. Jenney will be a regular contributor to this journal so look for her ongoing work in subsequent issues.

Dr. Jenney provides an introductory article that highlights the potential of the Wood's Homes Research Chair in Children's Mental Health to create ways that applied research will inform and support clinical practice. This work will: provide accessible and user friendly information about children's mental health to a spectrum of users; develop research that is driven by practice; and establish innovation in the university/community practice research.

The second article highlights work done by Anton Smith, Allen Balser and Bjorn Johansson on therapeutic group and residential care. There has been recent changes in the design and implementation of campus-based services in Alberta during 2018 that have been informed by this work.

Angelique Jenney and Christa Sato report on ongoing work that bridges the university and community divide, specifically examining ways that practice-based research can be implemented into social work research courses and practica to enhance student learning and practice.

Susan Gardiner provides an in-depth examination of the challenges and opportunities existing with family systems and kinship care. The work highlights key differences between kinship care and traditional foster care and spotlights gaps between research and practice for this complex form of intervention.

Angelique Jenney and Kafilat Jimba-Bidmus report on the implementation of the Mothers in Mind (MIM) program designed to target mothers who have experienced abuse and trauma in order to strengthen the family and teach additional parenting skills. It highlights the challenges of introducing new programs and key learnings for program development.

Bruce MacLaurin and Jenna Passi authored the article on cross-over youth who have concurrent involvement in the child welfare and juvenile justice systems. Analysis was done on the Alberta Incidence Study of Reported Child Abuse and Neglect (AIS) provincial data to highlight the relationship between dual-system involvement with a range of child, household, and case factors.

Jenna Passi, Anita Blackstaffe and the Wood's Homes Trauma-Informed Working Committee developed a brief examining the policy implications of ACE scores in a children's mental health setting.

Michael Wall and Angelique Jenney provide a review of the most recent literature on physical restraint prevention and reduction intervention models and examine how the Wood's Homes' No Restraint Philosophy may be enhanced in the future.

The final article continues the tradition of practice lessons learned over time. Story #39, written by Dr. Jane Matheson, is reproduced with the permission of Clem Martini, editor of "One Hundred Stories for One Hundred Years" published in 2013. The article describes a very important lesson from clinical practice that practitioners should keep in mind at all times - the most important change may come from the simplest things.

This issue of the Wood's Home Journal – Evidence to Practice is an opportunity to share our knowledge with others who are committed to improving mental health services for children and youth. We invite suggestions and discussions on the material in this issue and look forward to learning from your experiences.

From Magic to Evidence: The Potential of the Wood's Homes Research Chair Position

ANGELIQUE JENNEY

As noted by Jane Matheson in the last issue of this journal, the Wood's Homes Research Chair has been in the making for over a decade and now that we are moving forward, there are lots of exciting possibilities ahead. The role of the Chair is three-fold, with the first goal being to produce accessible and user-friendly information, for both families and practitioners, about important issues contributing to children's mental health and well-being. To that end, a monthly blog post is written that relates to current issues surrounding childrens' mental health – from advice for talking to young people about watching controversial shows on Netflix, to talking about racism, grief & loss, and even love and sexuality. The blogs can be accessed at https://www.woodshomes.ca/

The second focus is to develop research that evolves from practice itself with the goal to enhance the development of this knowledge through hypothesis and experimental measures. We've picked up on some of the biggest questions from cutting-edge programs only available at Wood's Homes. Because this is practice-based research, we always start our inquiry at the program level first, meeting with teams to talk about what they think works and the questions they would like to see answered that might benefit them in their practice.

Following consultations with the Temple Program we aspire to explore the following research questions:

1) How are successful client outcomes defined, determined and measured?

2) What are the factors that contribute to the program's success?

3) What are the challenges that hinder the program's success?

4) How can the program enhance its effectiveness in supporting clients within their transition through the program (from referral to discharge)?

The specific objectives of this study are to:

1) describe the characteristics of the Temple program that have been successful in achieving positive client outcomes;

2) identify strategies that have been used by program management and staff in facilitating successful client outcomes;

3) generate "lessons learned" from the program that might be adopted by professionals working with similar populations. Look for future journal articles that will highlight our work with the Temple Program.

We also wanted to learn about how to take programs that were working in other settings and apply them within Wood's – because we don't always have to reinvent the wheel when there are already promising practices out there. To that end, we implemented Mothers in Mind, a program developed by Child Development Institute and researched the process of implementation to answer questions we had about what factors influence the successful implementation of the Mothers in Mind program (e.g. facilitator experience, training, supervision & coaching efforts) and how might these be improved? We were really interested in staff experiences of the implementation fidelity process to understand the factors that led to the successful implementation of the program and challenges faced by program workers in order to inform decision making, program design, and training components. You can learn more about Mothers in Mind in the article by Jenney and Jimba-Bidmus in this issue.

Some other areas of inquiry involve exploring how trauma-informed practice initiatives translate into improved services and outcomes for children. And whether or not there are unique service needs for Indigenous children accessing services. In addition, due to my research interests in childhood exposure to domestic violence (CEDV) I am interested in explor-

ing the mechanisms within children's mental health settings for determining CEDV. This would include the assessment of risk and protective factors (routine screening, assessment information, other disclosure), and related interventions that may inform future practice, as well as the prevalence of CEDV within children/youth accessing services within children's mental health settings.

Wood's Homes Research Chair has been in the making for over a decade and now that we are moving forward, there are lots of exciting possibilities ahead

Finally, it's not just about asking questions and disseminating knowledge, the third goal of the Chair position came out of the desire to strengthen and further develop the long-standing relationship between Wood's Homes and the University of Calgary's Faculty of Social Work. As part of a journey that will eventually involve all programs at Wood's, we started with another dream of partnership wherein we could leverage the skills and resources of both the University of Calgary and Wood's Homes to create a relationship. This would see practicum and coursework appropriately matched to community-based programming to truly support the concept of community-engaged scholarship. To this end, we were successful in obtaining a grant from the Taylor Institute of Teaching and Learning to conduct a research study called, "Bridging the University/Community Divide: Exploring ways to Implement Practice-Based Research in Social Work Education". You can learn more about this project in the related article by Jenney and Sato in this issue. This project explores the research question: In what ways can the implementation of practice-based research into social work research courses and practica enhance student experiential learning?

The project objectives include: 1) to improve teaching/learning by co-developing practice-based research course curricula; 2) to improve students' self-efficacy and attitudes towards research through community-engaged scholarship by facilitating meaninful opportunities for students to apply research knowledge/skills learned in the classroom; and 3) to bridge the divide between academic-community research by nurturing sustainable partnerships. This outcome would bring the intentions of the Wood's Homes Research Chair in Children's Mental Health full circle.

A Renewed Perspective of Group Care and Residential Treatment: An Orientation Toward Therapeutic Group/Residential Care[1]

PART ONE – SETTING THE CONTEXT: ESTABLISHING VALUE IN THE SERVICE SYSTEM AND INITIATING THE CONSTRUCT OF THERAPEUTIC GROUP/RESIDENTIAL CARE.

ANTON SMITH, ALLEN BALSER & BJORN JOHANSSON

ABSTRACT

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

INTRODUCTION

There appears to be a renewed level of optimism within the research and practice communities with respect to group and residential care services offered to young people and families. Group care and residential care are often accessed in the practice environment as a last resort (Anglin, 2002; Lee, Bright, Svoboda, Fakunmoju & Barth, 2011; Whittaker 2011). For practitioners, the debate over "last resort" versus "treatment of choice" (Whittaker, 2011) is a limited one, as many would agree that "treatment of choice" is clearly a better option. This renewed optimism is gaining momentum as service providers invest in models of care that shorten the gap between "what we know and what we do" (Holden, 2009). An emphasis on "Best Practice" has resulted in group care service providers implementing program models that are utilizing "evidence informed practice" and "evidence based practice" within the care environment. This momentum, along with an improved understanding of child trauma (Bloom, 1997; Perry & Szalavitz, 2006), has resulted in a desire to understand and improve upon the critical components of therapeutic group care.

Criticisms about group care and residential service have been typically focused towards the areas of high service costs, outcome limitations, and an overall concern for staff and client safety (Lee et al., 2011; Whittaker, 2012; Whittaker & Pfeiffer, 1994). Although these criticisms may have some validity, many of the empirical studies were one group design. Several of these critical studies have over-generalized group care and residential care and do not detail the important characteristics of the group care condition (Lee et al., 2011). A recent example of an over-generalization is found within the article by the Anne E. Casey Foundation entitled ("Right Sizing Congregate

1 This article was previously published in the Journal for Services to Children and Families and is reprinted with the permission of ALIGN and the authors. This article should be referenced: Smith, A., Balser, A. & Johansson, B. (2015). A Renewed Perspective of Group Care and Residential Treatment: An Orientation toward Therapeutic Group/Residential Care, Part One – Setting the Context: Establishing Value in the Service System and Initiating the Construct of Therapeutic Group/Residential Care, ALIGN Journal for Services to Children and Families, Special Edition, March, 2015, p. 17-33

Care", 2010) (Whittaker, 2011). In this article the writers make little attempt to discriminate between the levels and types of group care and utilize confusing descriptors such as, "congregate care and institutional care", terms that have not been commonly used in group care since the 19th century (Whittaker, 2011). These criticisms have sparked a wave of interest in the use of other resources, such as earlier intervention services, kinship care, and family-based services. Few would argue that young people are served better through early intervention services and family-based services. However, there is a population of young people and families where group care and residential services should be the "treatment of choice" and in some situations the "first choice" (Whittaker, 2011). Often children and families experience a series of failures in non-residential alternatives prior to being referred to group care and residential services (Durrant, 1993; Whittaker, 2011). These failures compound an already entrenched pessimism, while adding to the complexity of the initial referring problems (Durrant, 1993). A shift in thinking about residential service as a "last resort" to a "service of choice" is needed to effectively serve many of the young people and families with complex challenges. It is the authors' unwavering belief that group and residential care has an important, if not vital, role in the future of all care services. It is their hope that this article will provide a coherent and leveraged perspective into the discussion.

Empowered practices, such as client and family ownership of the treatment, along with a client advocacy movement, ensured the voice of the young person and family were valued in the treatment process.

VALUING THE WISDOM OF OUR CHILD AND YOUTH CARE PIONEERS

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

One of the greatest pioneers of the 20th Century was a Polish child and youth care worker, pediatrician and writer by the name of Janus Korczack (Brendtro, 1999). Korczack published his first book entitled, "Children of the Streets" in 1901 and established a "House of Children" which provided care for over 200 Jewish street children (Brendtro, 1999). He was so dedicated to his work that the Catholic Church appointed him to the position of associate worker to the Catholic orphanages (Brendtro, 1999). When Hitler invaded Poland, the Nazi's didn't know what to do with this famous Child and Youth Care worker and presented him with a chance to get away. His reply to their offer was, "who would leave children at a time like this?" (Brendtro, 1999). They were moved to the ghetto in Warsaw and later put on a train and transported to Treblinka where Korczack perished along with his beloved children. During this time in the ghetto, he kept a diary which was entitled, "Ghetto Diary" (1978) (Brendtro, 1999). His last entry in this diary stated simply but powerfully, "I exist, not to be served or loved, but to love and act" (Brendtro, 1999).

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

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

These writers and pioneers have provided a context for the discipline of Child and Youth Care. What is most salient in the evolution of the discipline and subsequent practice is a coherent, cohesive thread of connection. This thread binds what the pioneers discovered and what we now more richly understand from research. These connections are impressive. Fritz Redl, who introduced the concept of the life space interview, was a student of Anna Freud who in turn, was the daughter of Sigmund Freud (Brendtro, 1999). Larry Brendtro, a renowned child and youth care professional and writer was a student of Fritz Redl (Brendtro, 1999). Today, most practitioners in the field are students of Larry Brendtro and today's practitioner is both student and teacher as they continue to strengthen these connections - connections that evolve, as we collectively challenge, advocate, support, research and develop services and resources that impact the lives of the children and youth who have experienced exceptional levels of hardship, trauma, neglect and abuse.

THE EVOLUTION OF GROUP CARE IN CANADA

Charles & Gabor (2009) suggested that the roots of North American group living environments for children followed five distinct waves. The first wave of residential care, referred to as the "Moralistic-Saviour Era" started in the late 18th Century and continued well into the middle of the 19th Century. The resource began in response to a moralistic motivation that believed society had a moral obligation to provide basic care to children who had been abandoned or orphaned. Further dispensation was offered to children who were seen to have significant mental or physical disabilities. Provision of these services was often provided within an adult population and blended without consideration of special need or circumstances. Often the motivation for these paternalistic programs was to "save the souls" of young people and this mission was served by religious organizations. By similar process, it was during this time that mission schools were beginning to be established on First Nation reserves.

During the middle part of the 1800s and lasting until the first part of the 20th Century, the second generation of residential services evolved from a "Reformation-Rescue" perspective (Charles & Gabor, 2009). Within this paradigm, the moralistic motivations were still involved in the care of children. However, the difference was the desire to protect and rescue children. During this time, formal institutions such as the early Children's Aid Societies as well as preliminary, rudimentary child welfare legislation developed with a focus on protecting, reforming and training children. It is important to note these programs were designed to replace family involvement and essentially began institutionalizing care (Charles & Gabor, 2009).

A third wave of reform brought a philosophy referred to as the "Protection-Segregation Era," starting in the late 1800s and lasting until the 1940s (Charles & Gabor, 2009). In this time period the inklings of service specialization were being applied to residential services. One legacy of categorization leading to segregation was the emergence of the Residential School System and its subsequent impact upon the children of many First Nation communities. Some other characteristics of specialization included the categorizing of care into distinct areas such as adult, child, insane, delinquent, orphans and poor/homeless. The philosophy focused on the impact of one's environment

setting the stage for a treatment focused perspective. There was also a growing awareness that interventions needed to be adapted to meet the emerging needs of the child (Charles & Gabor, 2009).

The "Treatment-Intervention Era" arose in the 1940s and lasted throughout the 1950s and was influenced by the earlier era's specialization of client needs and a specialist approach to treatment (Charles & Gabor, 2009). The greatest change during this time was the formalizing of treatment professions with greater attention to child development. A further development in the specialization movement was terminology shifting to describe children requiring treatment as being "disturbed". It was during the latter part of this era that foster care systems evolved and many orphanages were changed into treatment facilities. Treatment institutions continued to evolve with the development of smaller cottage settings and community-based group homes. The most important shift during this era was in the active use of the milieu as a vigorous force in the child's treatment.

The "Specialization-Intervention Era", evolved from the 1950s treatment interventional approaches and reached a peak during the 1970s (Charles & Gabor, 2009). During this time the focus was to determine what aspects of the milieu were having a positive impact upon the child's life and how a negative milieu could be avoided. This thinking began to generate a shift towards individualized treatment programs that valued the client's personal needs.

A "Consumer-Community Partnership Era" began to materialize in the 1970s and continues to evolve today (Charles & Gabor, 2009). Much of the early impetus for the consumer/community partnership finds its roots in the development of outpatient and aftercare services that emerged from residential treatment facilities.

These early attempts at wrapping around post-care services came from the realization that there needed to be smoother and more effective transitions from the residential setting into community. Another significant development in this time was the recognition of the role the client, family and community played in treatment success. Empowered practices, such as client and family ownership of the treatment, along with a client advocacy movement, ensured the voice of the young person and family were valued in the treatment process.

TOWARDS A DEFINITION OF GROUP/RESIDENTIAL CARE

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

Although residential treatment is now a well-established therapeutic modality, problems in defining the concept, with which pioneers in the field struggled 50 years ago, are no less present today. We act as if there is a consensus on what the term residential treatment means, but the concept remains elusive. It has been applied to modest group homes, leading psychiatric hospitals and to institutions with fewer than 25 beds. Furthermore, the concept of residential treatment ranges from institutions with several hundred beds to smaller group homes for dependent and neglected children. The range of what constitutes residential treatment also includes those offering comprehensive treatment for the most profound psychiatric disorders, to those treatment programs with widely differing philosophies and practices.

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

that formerly provided homes for neglected children, schools for the retarded, or containment for delinquents were redefined as mental health facilities.

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

While these terms and standards provide definition to the dynamics of modern group and residential care, what is meant by residential treatment is, in many ways, less clear now than it was 50 years ago. At that time, the term described an approach to treatment and to some degree it still does. It is, however, difficult to specify precisely what constitutes that treatment approach - largely due to residential programs being oriented around a host of disparate treatment philosophies, with little attention being given to articulating the unifying concepts that underlie them. Residential treatment has also been used to denote a type of facility, yet they differ markedly in program size organizational structure, clientele served, and practices utilized. At times it seems residential treatment is little more than a label applied to diverse programs united only by the distinction that they all provide inpatient treatment and are not licensed as hospitals.

The vast program variations for group care programs present significant challenges and implications for both the practice and research communities. Many empirical studies are one-group designed, which is helpful for describing a population and assessing whether they have improved over time. However, they are unable to determine if the youth would have done just as well or better in an alternative setting (Lee et al., 2011). From a practice perspective, group care programs are at times used as a "last resort" often in instances when a family setting is deemed inappropriate or not available (Lee et al., 2011). Butler and McPherson (2007) argue for the importance of definition for residential treatment and identify components that include: therapeutic milieu, a multidisciplinary team, deliberate client supervision, intense staff supervision and training, and consistent clinical and administrative oversight. These components require further definition as they incorporate a broad range of group care programs. Lee et al. (2011) propose reporting standards that further identify program differences in residential and group care programs. These reporting components include: outcomes (program goal), size of facility and residences, populations served, setting and location, program model, practice elements, staffing, system influences and restrictiveness of setting. In light of what Lee et al. (2011) proposed, these identified reporting standards provide an opportunity for a coherent look into the Alberta service system, by attaching common language and labels that provide a context of understanding.

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

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

Whittaker (2011, 2012) views group care and residential care as suffering from what he terms "benign neglect" in the understanding of how successful residential services operate. This neglect fails to fully understand the critical components or "active ingredients" of residential/group care, such as principles, program models, funding, performance measurement and research. In response to this condition of "benign neglect" Whittaker et al. (in-progress) have a manuscript ready for publication in September 2014 by Jessica Kingsley Publisher, London and Philadelphia, Therapeutic residential care with children and youth: Developing evidence-based international practice. This book views therapeutic residential care as a specialized segment of group care and residential services with the aim of understanding child needs while examining model programs and practices. Ad-

ditional analysis is focused upon the training, evaluation and support structures that constitute therapeutic residential care. Their final investigation examines how programs partner with families, prepare children for transition from residential services and accurately forecast and monitor service costs. What seems to be emerging from this rigorous examination is that the term "therapeutic residential care" has gained traction in the international community (Versa Consulting, 2011; Whittaker, 2011).

Since the emergence of a growing number of alternative family and home-based treatment options, group care has increasingly been challenged to justify its place in the treatment spectrum.

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

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

THREE BROAD DEFINITIONS FOR CONSTRUCTING PRACTICE AND PRACTICE LANGUAGE

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

CAMPUS-BASED THERAPEUTIC CARE

Generally, the goal of campus-based therapeutic care is to return the young person to a community based setting (family, independent living or community group living). In a campus-based facility the group size varies. Usually their population is 20 to 100 children or youth housed in a number of residences with each residence having 4 to 12 occupants. The client characteristics are typically young people who have a chronic history of abuse and neglect and multiple

diagnoses (both psychiatric and psychological). Many have challenges forming attachments and engaging in the intimacy of a family with their overall function ranging from mental retardation to average intelligence. Young people placed in this setting require programming that is targeted at what Henry Maier refers to as a second order of change (Maier, 1987). Typically, the youth in this type of program have struggled in community settings and require a setting that promotes efficacy and regulation through the program's ecology. The program ecology is the strength of a campus based resource as it has its own internal ecology or community that is modified for children to be successful and offers a greater amount of attachment opportunities. These programs may be specialized in their treatment approach or have a developmental orientation, with the setting being either rural or urban. Rural programs may include an agricultural, wilderness or ranch component to their service.

By nature of definition, campus-based facilities are usually quite comprehensive with an onsite school, recreational facilities, intensive activity program using recreation and adventure-based experiential learning. Common practice elements may include family therapy and clinical oversight (e.g. a minimum ratio of 1 Masters level clinical staff to 14 young people), access to a consulting psychiatrist, and they operate within a specific program model that is practice-informed and supported by evidence. Another important element of campus-based treatment includes appropriately educated and trained caregivers who have had a minimum of 40 hours of in-service training that relates to the program model and the child and youth care perspective. Staff ratios will typically range from 1 staff – 1 client to 1 staff – 4 clients. Facilities are generally highly structured and may be open or closed facilities.

THERAPEUTIC COMMUNITY GROUP CARE

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

Similar to campus-based treatment, client characteristics may include a history of trauma, abuse and neglect and multiple diagnoses (both psychiatric and psychological). They may also have challenges forming attachments and struggle to handle the intimacy of a family. As with the clients in campus-based treatment, the young people being served in a therapeutic community-group care setting require what Maier calls second ordered change (Maier, 1987). Additionally, there are qualifications similar to those required in campus-based treatment, with staff ratios ranging from 1 staff – 2 clients to 1 staff – 4 clients.

COMMUNITY GROUP CARE

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

CONCLUDING STATEMENTS/INSIGHTS

Great strength and resolve has flowed from the pioneers of group care. They sparked a quest for excellence two centuries ago and this search continues today as the field embraces a continuous quality improvement commitment, driven by a desire to produce the right outcomes for children served. Group care programs have had a significant, if not auspicious history, along with a rich role caring for children over the past two centuries. From the beginning of formalized group care, the role has undergone several significant iterations. Change continues to be an important theme for group care as the current climate of political will has placed group care programs squarely in the sights of change. Fortunately, the historical experience of group care has demonstrated that this resource can and will change. Those who have been involved with group care over the past 25 years have already witnessed significant change. For those of us who have practised at the frontline level, this change is welcome.

The relevance of the group care resource is not where this debate lies. There are deeper and perhaps more important considerations to be explored, such as what constitutes the critical components of group care and how these important ingredients of care can be enhanced. What are the overall system benefits of a healthy spectrum of group care resources and finally, what optimum care, care that includes group and residential care, would look like? These are the questions the writers will explore in the next two articles.

What has and continues to validate group care as a vital resource is the capacity of these programs to provide stability. A California study, with a sample of 8,933 young people, indicated higher-level residential programs achieved greater placement stability, with stability deteriorating as the level of care decreased (Sanserif, 2005).

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

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

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

REFERENCES

Anglin, J.P. (2002). *Pain, normality, and the struggle for congruence*. U.S.A.: The Hawthorn Press.

Bernard, B. (2004). *Resiliency - what we have learned*. San Francisco, CA: West Ed Publication Center.

Bloom, S.L. (1997). *Creating sanctuary: Toward the evolution of sane societies*. New York: Routledge.

Bloom, S.L. & Farragher, B. (2010). *Destroying sanctuary: The crisis in human service delivery systems*. New York: Oxford University Press.

Brendtro, L.D. (1999). Heroes and pioneers of child and youth care work. *The International Child and Youth Care Network*. Retrieved December 10, 2013, from CYC NET Website: http://www.cyc-net.org/cyc-online/cycol-0499-pioneers.html

Brendtro, L.D., Mitchell, M.L. & McCall, H.J. (2009).

Deep brain learning: Pathways to potential with challenging youth. Albion, Michigan: Starr Commonwealth.

Butler, L.S. & McPherson, P.M. (2007). Is residential retreatment misunderstood? *Journal of Child and Family Studies, 16*(4), 465-472.

Charles, G. & Gabor, P. (2009). A Historical perspective on residential services for troubled and troubling youth in Canada. *The International Child and Youth Care Network*. Retrieved December 3, 2013, from CYC-NET Website: http:/www.cyc-net.org/reference/refs-history-canada.html

Durrant, M. (1993). *Residential treatment: A cooperative competency-based approach to therapy and program design*. U.S.A.: W.W. Norton & Company, Inc.

Holden, M.J. (2009). *Children and residential experiences: Creating conditions for change*. Cornell University, Family Life Development Center, Beebe Hall, Ithaca, NY.

Lee, B. R., Bright, C.L., Svoboda, D.V., Fakunmoju, S. & Barth R.P. (2011). Outcomes for group care for youth: A review of comparative studies. *Research on Social Work Practice, 21(*2), 177-189.

Leichtman, M. (2008). The essence of residential treatment: I. core concepts. *Residential Treatment for Children & Youth, 24*(3), 175-196.

Leichtman, M. (2006). Residential treatment of children and adolescents: Past, present and future. *American Journal of Orthopsychiatry, 76*(3), 285-294.

Maier, H.W. (1987). *Developmental group care of children and youth: Concepts and practice*. Binghamton, NY: The Haworth Press, Inc.

Perry, B.D., & Szalavitz, M. (2006). *The Boy who was raised as a dog*. USA: Basic Books.

Preyde, M., Frensch, K., Cameron, G., Hazineh, L., & Burnham Riosa, P. (2010). Mental health outcomes of children and youth accessing residential programs or a home-based alternative. *Social Work in Mental Health, 9*(1), 1-21.

Sunseri, P. A. (2005). Children referred to residential care: Reducing multiple placements, managing costs and improving treatment outcomes. *Residential Treatment for Children and Youth, 22*(3), 55-66.

Versa Consulting Pty Ltd. (2011). *Evaluation of the therapeutic residential care pilot programs: Final summary & technical report*. Department of Human Services, Victoria, Australia.

Whittaker, J.K. (2011). *Residential treatment services: Is it time for a critical review?* Sounding Board, 21pp.

Whittaker, J.K. (2012). What works in residential treatment: Strengthening family connections in residential treatment to create an empirical based family support resource. In Curtis, P.A., & Alexander, G. (Eds.), *What Works in Child Welfare* (pp. 255-265). Washington, D.C.

Whittaker, J.K., & Pfeiffer, S.I. (1994). Research priorities for residential group child care. *Child Welfare, 73*(5), 583-601.

Whittaker, J.K., Del Valle, J.F., & Holmes L. (in-progress) *Therapeutic residential care with children and youth: Developing evidence-based international practice*. Manuscript accepted for publication, London/Philadelphia: Jessica Kingsley Publishers.

Bridging the University/Community Divide: Exploring Ways to Implement Practice-Based Research in Social Work Education

ANGELIQUE JENNEY AND CHRISTA SATO

A major challenge for social work educators is engaging students in practice-based research. Research is integral to social work education, however, students may be limited in their ability to apply research in their professional practice or uncertain how to translate research findings into daily practice. This project explores the research question: In what ways can the implementation of practice-based research into social work research courses and practica enhance student experiential learning? Project objectives to improve teaching/learning are: 1) co-developing practice-based research course curricula by engaging students in a participatory process with Faculty of Social Work (FSW) educators and research clinicians at Wood's Homes; 2) improving students' self-efficacy and attitudes towards research through community-engaged scholarship by facilitating meaningful opportunities for students to apply research knowledge/skills learned in the classroom; and 3) bridging the divide between academic–community research by nurturing sustainable partnerships.

Building on the work of faculty colleagues (Cameron & Este, 2008; Walsh, Casselman, Hickey, Lee & Pliszka, 2015; Walsh, Gulbrandsen & Lorenzetti, in press), we will explore pedagogical models that incorporate student experiential learning of practice-based research in course curricula. Through a partnership between Wood's Homes and the University of Calgary, Faculty of Social Work, this teaching project seeks to develop a community research-based, high-impact practice pedagogical model designed to enhance social work students' learning about research in applied, professional settings. We will implement and evaluate this innovation in field education and research courses across all levels of the curriculum – BSW (SOWK 410/412: Practicum I/II; SOWK 355: Research in Context), MSW (SOWK 633: Foundational Field practicum/ SOWK 696: Advanced Practicum) and PhD (SOWK 745: Research Methods I – Quantitative). (See sample model below)

Aligning with the faculty's strategic plan to create a rich and diverse learning environment that challenges students to become critical thinkers and skilled practitioners; this innovative teaching initiative is designed to offer students unique learning experiences for community-engaged scholarship, bridging gaps between classroom learning and real world applications of research. The 2017 National Survey of Student Engagement (NSSE) Faculty Report highlights key findings that present opportunities to improve students' learning experiences. For example, FSW students performed lower than comparisons in quantitative reasoning, 23% of FSW students had courses that included service-learning and only 7% had worked with a faculty member on a research project (NSSE, 2017). The research team demonstrates a diverse and complementary range of knowledge and expertise in research, teaching, practice and practicum experiences. We will engage in high-impact practices (e.g., service-learning, research with faculty) and provide more opportunities for students to interact with quantitative data analysis using agency datasets that connect directly to practice.

A major challenge for social work educators is engaging students in practice-based research (Cameron & Este, 2008; Lowe & Clark, 2012; Walsh et al., 2015). Students often experience considerable fear and anxiety when it comes to research (Earley, 2014; Unrau & Grinnell, 2005). Despite these issues, "research training is a key area of social work education and integral to the success of future practitioners"(Walsh et al., in press). While research courses have a major role in shaping students' learning experiences, students' perceptions regarding research can present challenges for social work educators (Unrau & Grinnell, 2005). A growing body of literature suggests that high-impact practices, such as course curriculum structures that integrate an experiential practice component, empower students to apply classroom knowledge to real-life settings, improving learning outcomes (Cam-

eron & Este, 2008; Healy, 2005; Kwong, 2017; Walsh et al., 2015). Therefore, this project seeks to understand in what ways can the implementation of practice-based research into social work research courses and practica enhance student experiential learning. Colleagues at the University of Calgary Faculty of Social Work have engaged in innovative and promising teaching practices to engage students in learning about research methods that are relevant to student learners by using action research in the classroom (see Lorenzetti & Walsh, 2014; Walsh et al., 2010; Walsh et al., 2015) and evaluating research-based practica to improve practices (Hewson et al., 2010; Walsh et al., in press). Further, MacLean and Poole (2010) maintain that viewing students as partners in pedagogical research ensures their learning interests are protected and always at the forefront. It is for this reason that the first objective of this project is the co-development of practice-based research course curricula by engaging students in participatory processes with both FSW educators and research clinicians at Wood's Homes.

Students from SOWK 355 (2018/19) will be invited to participate in a focus group reflecting on their own learning experiences, to help shape future curriculum changes. Inclusion of students in this process will directly impact teaching practices to improve student learning regarding research knowledge/skills. Additionally, all BSW/MSW students are required to complete a field education practicum. Research practicums are relatively rare, therefore, this project will create research-based practicums for up to four BSW (SOWK 410/412) and two MSW (SOWK 633/696) students. Practicum students will engage in experiential learning by conducting assessments of specific programs at Wood's Homes in order to identify topics for possible research. Practicum students will synthesize their findings and create a Wood's Homes 'database' of mini-research projects (complete with ethics approvals when required), appropriate for various educational levels (BSW, MSW, PhD) and formats (individual, small-group, classroom-based projects).

The second objective of the project is to improve students' attitudes towards research and self-efficacy to engage in research through community-engaged scholarship by facilitating meaningful opportunities for students to apply research knowledge/skills learned in the classroom. Using information from focus-group data, we will pilot implementation of experiential student research assignments using the Wood's Homes database with one section of SOWK 355 (Fall 2019) and student learning outcomes (attitudes towards research/self-efficacy to engage in research) will be compared with the remaining two sections. This will help faculty understand the effectiveness of student experiential learning models when it comes to research courses. The implementation of the Wood's Homes database will also be piloted with BSW and MSW practicum students in 2019/2020. Supervised by Dr. Jenney and Chloe Westelmajer, students will select a suitable research project from the database. With this project, PhD students will benefit from additional access to quantitative data from programs within Wood's Homes. For each practice-based assignment that students complete for their research courses, they will be expected to disseminate findings back to Wood's Homes to facilitate community-engaged scholarship. This process is expected to improve student learning by enhancing student engagement with research, deepen understandings of complex social issues and offer new practice strategies.

The final objective is to bridge the divide between academic–community research by building/nurturing sustainable partnerships. This divide between academics and community practitioners in the field, particularly with respect to research, currently exists (Kwong, 2017). Therefore, one of the project's goals is for faculty and students to strengthen sustainable partnerships through community-engaged scholarship with clinicians at Wood's Homes. This will be achieved through: a) direct engagement of practicum students with Wood's Homes staff during program assessments; b) presentations of research findings back to the agency upon completion of assignments; c) critical dialogue between agency staff, faculty, and students to discuss implications of research for improving practices in the field; and d) site visits and Wood's Homes presentations offered for students to learn about the agency and project opportunities.

Practicum students will participate in community-engaged scholarship by conducting 10–20 program assessments at Wood's Homes to identify three priority issues per program that could be addressed through applied student research. As appropriate, secondary data sets will be created during this process for potential future access to students. After gathering data from the programs, the research team will work with the students to determine appropriate research topics/questions to be developed into a practice-based

research database for future student use. Each practicum student will analyze and synthesize their findings into a four-page summary to be presented back to the agency. This type of teaching is student-centred as it allows students to engage in participatory processes of shaping research curriculum in collaboration with faculty and researchers and clinicians at Wood's Homes.

Utilizing the database created by practicum students in Fall, 2018/Winter, 2019 semesters, a pilot of the practice-based research curriculum will be implemented in Fall semester, 2019. At the beginning of the term, students will be invited to participate in a site visit at Wood's Homes. Students who want to participate can then select an assignment from the database. The assignments will be complementary to the theoretical content being learned in the classroom. Students will have an opportunity to put these learnings into practice while taking the course, to help bridge the gap between classroom and applied learning. The students will have an opportunity to engage in critical reflection in the classroom and with agency staff about their learnings and process of engaging in community-based research.

Upon completion of the pilot, the team will meet to review what types of assignments from the database were (or were not) selected by students in order to reframe/delete these assignments to better meet students' learning objectives. Students who participated in the assignments will be invited to share critical insights such as their rationale for choosing particular assignments from the database and how it contributed to their learning objectives (or not). This will provide important insights for social work educators about student learning and improve future practices to better meet student needs. Student assessments will be collected at the beginning and end of each semester using a variety of methods (focus groups, survey methods, pre-post measures, course evaluations) dependent on the project component. Upon completion of the pilot, the curriculum will be evaluated to identify ways to improve applicability for social work instructors looking to adopt this model in their courses.

REFERENCES

Cameron, P., & Este, D. (2008). Engaging students in social work research education. *Social Work Education, 27(4)*, 390–406.

Earley, M. A. (2014). A synthesis of the literature on research methods education. *Teaching in Higher Education, 19(3)*, 242–253.

Healey, K. (2005). *Social work theories in context: Creating frameworks for practice*, New York: Palgrave MacMillan

Hewson, J., Walsh, C.A., Bradshaw, C. (2010). Enhancing social work research education through research field placements. *Contemporary Issues in Education Research, 3(9)*, 7–16.

Kwong, K. (2017). Advancing social work practice research education – An innovation, experiential pedagogical approach. *International Journal of Higher Education, 6(5)*, 1–13.

Lorenzetti, L., & Walsh, C.A. (2014). Is there an 'F' in your par? Understanding, teaching and doing action research. *Canadian Journal of Action Research, 15(1),* 50–63.

Lowe, L., & Clark, J. (2009). Learning about social work research through service-learning. *Journal of Community Engagement and Scholarship, 2(1),* 50–59.

MacLean, M. (2010). An introduction to ethical considerations for novices to research in teaching and learning in Canada. *The Canadian Journal for the Scholarship of Teaching and Learning, 1(2),* 1–10.

National Survey of Student Engagement. (2017). NSSE 2017 Faculty Report: Faculty of Social Work.

Unrau, Y., & Grinnell, R. (2005). The impact of social work research courses on research self-efficacy for social work students. *Social Work Education, 24(6),* 639–651.

Walsh, C. A., Casselman, P., Hickey, J., Lee, N., & Pliszka, H. (2015). Engaged in research/achieving balance: A case example of teaching research to masters of social work students. *Contemporary Issues in Education Research, 8(2),* 93–102.

Walsh, C.A., Rutherford, G., & Sears, A. (2010). Fostering inclusivity through teaching and learning action research. *Action Research, 8(2),* 191–209.

Walsh, C.A., Gulbrandsen, C., & Lorenzetti, L. (in press). Research practicum: An experiential model of social work research. Open Sage.

Family Systems and Kinship Care: Challenges and Opportunities

SUSAN GARDINER

INTRODUCTION

Wood's Homes is a multi-service non-profit children's mental health centre based in Calgary, Alberta. A continuum of services is offered including crisis phone and walk-in services, family support services, foster care services, specialized learning and therapeutic residential services. Within the Family Support Service, parenting and developmental supports are designed to address child protection issues. The Family Support Network operates as a lead agency in collaboration with Alberta Children's Services in a high-needs area of Calgary. The work is guided by the Signs of Safety Framework in providing integrated support to children by working with parents and kin to promote safety and the conditions for optimal child development. The following article considers family systems issues in kinship care through a literature review and exploratory examination of 10 case files. The intention is to improve practice as a result of this process.

There has been increasing emphasis on placing children with kin when removed from their families (Government of Alberta, 2009; McHugh, 2009). There is also emerging evidence regarding the advantages for children placed with kin over other out-of-home placement types. In a recent review of outcome studies in this area, permanency and safety outcomes were compared for foster care and kinship care. The main finding was children in kinship had greater placement stability and lower risk for re-entry into care (Bell and Romano, 2017; Kiraly & Humphreys, 2013).

Kinship care placements are recognized as more stable than foster care placements given a greater tolerance by relatives for behavioural and mental health concerns (O'Brien, 2012). A meta-analysis of previous studies suggest children with kinship experience have fewer behaviour problems and mental health disorders with overall better well-being than children with foster care experience (Winokur, Holtan and Batchelder 2018).

Kinship care has been largely seen as equivalent to foster care. Many of the processes related to foster care have also been applied to kinship care. There is agreement that research in this area has lagged and as a result there are significant gaps between current research and practice (O'Brien, 2012). There is also an emerging critique that the vision related to constructive practice in kinship care has lagged. Turnell and Essex (2014) suggest this is an area of complex practice and work is needed to develop skilled support for kinship arrangements.

FAMILY SYSTEMS AND KINSHIP CARE

Key differences between kinship care and foster care are slowly being recognized. By definition, kin have family or otherwise significant relationships to the child with current or historical involvement; while foster parents are service providers with no prior relationship. Kin most often have emotional involvement regarding what has happened to the children or family. These factors are critical differences and illustrate unique needs for kinship supports (Bell and Romano, 2017).

Kinship care involves bringing in significant others who may have information and opinions about the family, the children, what has happened before and what should happen now. In addition, kin may also have varying opinions about the merits of child protection involvement (Turnell and Essex, 2014). Birth parents may have concerns about long-standing intergenerational conflict, relatives who have neglected or abused children themselves or involving family due to shame. There is beginning recognition of the need to pay more attention to the relationship between the kin and birth parents and the complications of their relationship (McHugh, 2009).

Assessment for kinship placement is typically focused on capacity to meet the child's needs and to provide a safe and nurturing environment. Safety is understandably the first priority. Assessment for kinship families is rarely focused on the relational as-

pects of the family situation. Dimensions of safe and effective care for children in kinship do not typically include relational dynamics with the parents (Lutman, Hunt & Waterhouse, 2009). For example, The Structured Analysis Family Evaluation (Consortium for Children, 2015).

The quality of the relationship between the kin and birth parents is generally considered in terms of the kin's capacity to protect the child from further maltreatment, to comply with policy and procedures and to not pressure the child about allegations against the parents. (Child Welfare League of America, 2000) Other work emphasizes the expectation that kin support the child's contact with the parent (Alberta Government, 2017). There has been much less attention paid to how the kin and parents can cooperate to support the child's best interest.

THE IMPACT OF FAMILY SYSTEMS ISSUES ON OUTCOMES

Family Systems issues are factors in permanency outcomes related to placement stability and placement breakdown. Family systems issues in this context refers to the way extended family members relate to each other. A dynamic process influences how children come to live with kin and this is determined by factors including;

- Child protection concerns;
- Kin motivation for taking care; and
- The way in which the child was placed with kin (Gleeson, Wesley, Ellis, Seryak, Talley and Robinson, 2009).

Factors related to child protection concerns include what has happened that has resulted in the child being placed away from their parents. Child neglect is recognized as the most common form of child abuse and most frequent reason children are removed from parental care. Underlying factors may include parental substance abuse. Studies suggest children whose parents are not involved in drugs or alcohol are the most likely to be returned home as substance abuse issues are recognized as the most difficult for kin to address (Bell and Romano, 2017; Farmer, 2010).

Kin motivation is most often described as keeping children with the family or out of government care. There is also recognition of emotional ties to the child and family and underlying values related to duty. This is an important variable as growing evidence suggests children do better when there is an emotional bond with the kin provider and the child is familiar with the kin (Lutman et al, 2009). Kin tend to be more optimistic, less problem centred and less likely to report behaviour difficulties when compared to foster parents (O'Brien, 2012), however, they are more likely to struggle with role ambiguity (Turnell and Essex, 2014).

The way the child comes to be placed with kin varies from the best case scenario wherein the birth family approaches kin to a less optimal situation (an estimated 30% of situations) where someone other than the birth family approaches kin (Gleeson et al, 2009). This variance alone could account for significantly different family constellations at different points of willingness to work together for the child.

There is also growing evidence related to the impact of the parents and kin relationship on child outcomes. This is a pivotal relationship for the child and complex given child protection concerns. There are findings supporting stronger natural family contact and sense of belonging for children placed with kin (Bell and Romano, 2017). At the same time, parental contact with the child and conflict between the parents/kin and child is well recognized as a typical problem. Tension is related to problems of parent reliability, child distress from visits as well as high conflict (Kiraly and Humphreys, 2013). Parent feelings of disempowerment and loss and grief are also key issues (Kiraly and Humphreys, 2015). Tension between parents and kin is an important determinant of both child well-being and placement stability.

CHILD FACTORS RELATED TO GOOD OUTCOMES FOR KINSHIP CARE

Child behaviour difficulties are a significant factor in determining both child well-being and placement stability. Child behaviour is the most frequent reason for placement breakdown combined with a lack of support (Lutman et al., 2009). Child behaviour difficulties arise from complex considerations related to individual and family factors such as early developmental and trauma history. It is important to understand the child's needs at placement. At the same time, there is strong evidence to suggest good quality contact with birth parents combined with appropriate individual supports can promote positive outcomes in remediating child behaviour difficulties (Sen & Broadhurst,

2011). The role of supportive kin in assisting both the parents and child is critical.

There has been some work related to reviewing the child's perspective regarding family contact. In most cases, the view of the child reflects the complex emotional challenge of their situation. Parents are generally very important to the child and at the same time, the child may be angry, disappointed and worried about their parents (Kiraly & Humphreys, 2013). This aspect of kinship placement is largely absent from the kinship care discussion.

Farmer (2010) in looking at kinship quality and disruption also found lower levels of disruption when children were placed with grandparents (8% disruption compared to 27-30% with other relatives) and when kin received financial and practical supports. In addition, there were fewer disruptions when children were placed with siblings.

Child outcomes for kinship care compared to foster care have begun to be examined. In a review of 71 studies, children placed in kinship showed stronger behavioural and adaptive development, mental health and wellbeing and placement stability; these children were also likely to experience fewer incidents of abuse in care (Bell & Romano, 2017). There is limited research at present regarding the pre-existing condition of the child as a selection factor in kinship placement.

Kinship Placements are most likely to best support the child when;

- Children are under 10
- Kin are committed to caring for the child
- Contact between the parents and child is supervised by other than kin
- Drug use is not part of the protection concerns
- Children are managing (Farmer, 2010)

OUR JOURNEY

As providers of services to children being placed with kin due to child protection concerns, the authors were interested in determining how key variables could inform this work and lead to good practice. The intent was to examine factors in successful outcomes through systematic file audits and to develop strategies to improve our practice.

A retrospective exploratory file audit of 10 files was conducted. The initial questions included;

- What were the initial child protection concerns?
- What was the kin providers stated motivation?
- How did the child become placed with kin?
- What is known about the relationship and emotional bonds between the parents, kin and child?
- What was happening with parent visits?
- Were there behavioural or emotional concerns for the children?

METHOD

Using a standardized audit process, the records of the first group of families served were examined. The files were chosen on the basis of date of service and the kinship placements included 3 maternal grandparents; 2 maternal aunts; 2 paternal grandparents; one paternal aunt and 2 non relative kin. In total, 13 children were involved; 5 were under 5 years of age; 4 were between 6 and 12 and 4 were over 15 years of age.

FINDINGS

Outcome Variables

Birth and Kin Family information was collected at intake and information regarding key outcome variables was available. The majority of families had presenting concerns including substance issues and domestic violence. Further analysis of this data suggested the level of severity both of substance use and domestic violence had safety implications for the kin provider. Kin were typically asked about their motivation and there is consistency related to responses. The way the children were placed was not examined at intake (See Table 1).

Relational Variables

There was file information regarding the relationship between the kin and parents. This information was largely concentrated on safety concerns and conflict with few details about positive connection or family strengths. There was little information on file regarding how aware the kin were about the presenting problems and extent of difficulties the family was experiencing (see Table 2).

Support Variables

Providing appropriate supports to kin has been identified as an important variable in successful outcomes. In looking further at practice records, it is clear that kin are relied on to provide supervision for the child and family. This is particularly interesting as this occurred even in cases with high conflict. This is an area where practice could be improved by providing pro-active informed support.

Child behaviour issues were also of note as the larger percentage of the children involved were typically developing. For those children who were experiencing developmental difficulties, there is a need to connect their emotional and behavioural issues to the larger family context. Clear assessment was being completed with regards to the child's development and supports were in place. Establishing joint plans for kin and birth parents was a developing promising practice. Outcomes at file closure were examined. Here the importance of tracking placement outcomes is evident given the capacity of kinship to stay with the children (see Table 3).

DISCUSSION AND IMPLICATIONS FOR PRACTICE

The exploratory file audit process was useful for the purpose of examining critical factors and for developing practice improvements. As a starting place, current file records suggest systematic collection and analysis of information related to key variables could be improved.

The findings also demonstrate the need for systematic processes related to initial assessment and intervention with kin and parents. The apprehension and placement of children with kin typically happens under circumstances where there is sufficient time and emotional pressure. Children are generally placed with kin after initial safety screenings. A clear focus on critical factors early on can lead to the development of targeted support plans directed at recognized vulnerabilities.

The combination of domestic violence and substance abuse issues provides clear indication of the need for individualized safety plans including supervised visitation arrangements. In the above cases, eight parents struggled with significant advanced substance abuse problems. While kinship has typically defaulted to providing supervised contact, it is suggested this practice should be informed by individual family circumstances and clear risk assessments. Kin are more apt to be responsible for supervising access with minimal additional safety planning compared to similar situations where children are placed in foster care (O'Brien, 2012). In addition, there was no expectation of documentation from kin with regard to family visits. Kin are therefore placed in the position of protecting the child and the family. A search of the supervised visitation records above indicated very few reports from kin regarding bio parents exhibiting substance abuse issues during supervised contact in spite of significant occurrence of these issues during regular contact with agency staff.

There is often contact between the biological and kin families outside of "professional" awareness. While this is often cited as a strength of kinship from the perspective of the child remaining engaged with their family network, it is also clear that the lived experience of the family systems often lies outside of our understanding. Greater attention to patterns of family interaction, family dynamics, family conflict and family systems issues could lead to better, more effective support to the child, parent and kin. Family strengths would be more obvious and areas of family challenges would also be more available for intervention. Family engagement could be strengthened.

These findings have informed the development of new processes for assessment, intervention planning and contact with kin. It became obvious that intensity during the initial stage of connection with kin is needed in order to get a clear picture, to establish connection and to provide meaningful immediate support. In addition, the findings have informed safety planning as greater focus has been directed at understanding substance abuse and domestic violence concerns in the context of family visits. A more deliberate process has evolved that has potential for higher levels of support, stronger placement stability and greater engagement of all parties.

CONCLUSION

Historical relationship challenges, tension about parenting rivalry, loss and grief issues for the parents and child protection involvement are significant elements in managing kinship care. It is important to support the long-term capacity of the extended family to work well together in the best interest of the child first and foremost.

There is very limited research regarding relational issues prior to placement in kinship care as factors in outcomes. In practice, these issues are critical. Flegg (2014) makes an interesting argument suggesting our tendency is to start by justifying a kinship placement as opposed to assessing historical data and risk to develop remedies.

Kinship capacity to meet the child's needs and to provide a safe environment must be considered necessary but not sufficient criteria towards optimal outcomes. Greater consideration needs to be given to individual family dynamics in developing appropriate supports for children placed with kin. Providing family guidelines and family mediation could be very helpful to extended families struggling with complex dynamics and loyalties. Identifying potential risk issues and providing responsive support could enhance positive outcomes. Family group conferencing where kin are engaged and the parent is part of the solution for the child is recognized as an important component of successful kinship care (McHugh, 2009).

Kinship families, when compared to foster families, typically have fewer resources and receive less training, services and support. The provision of support to kinship is a factor in positive outcomes (Cuddleback, 2004; Farmer, 2010). Tools for kinship mirror tools for foster care and there is no current agreement on the specific domains that need to be addressed. Further research is needed with regard to the underlying family systems and dynamics issues in terms of positive outcomes. In the meantime, practice can be informed by what is known and strategic intervention developed based on our current understanding.

REFERENCES

Alberta Government. (2017). Kinship care handbook: A tool kit for kinship caregivers. Retrieved from www.humanservices.alberta.ca/documents/kinship-care-handbook.pdf (accessed February, 2018).

Bell, T. & Romano, E. (2017). Permanency and safety among children in foster family care and kinship care: A scoping review. *Trauma, Violence & Abuse, Vol. 18(3)*, 268-286.

Boetto, H. (2010). Family matters. *Newsletter of the Australian Institute of Family Studies, 85*, 60-67.

Child Welfare League of America. (2000). *CWLA standards of excellence for kinship care*. Washington, D.C: Author.

Consortium for Children, (2015). *SAFE workbook: Structured analysis family evaluation etc*. San Rafael, CA: Consortium for Children.

Cuddleback, G. S. (2004). Kinship family foster care: a methodological and substantive synthesis of research. *Children and Youth Services Review, 26*, 623-639.

Farmer, E. (2010). What factors relate to good placement outcomes in kinship care? *British Journal of Social Work, 40*, 426-444.

Flegg, E. (2014). The position of mothers when a child is placed with a grandmother. , In Pitcher, D. (Ed), *Inside Kinship Care,* Jessica Kingsley Publishers, London: 96-121.

Gleeson, J.P., Wesley, J.M., Ellis, R., Seryak, C., Talley, G. & Robinson, J. (2009). Becoming involved in raising a relative's child: Reasons, caregiver motivations and pathways to informal kinship care. *Child and Family Social Work, 14,* 300-310.

Government of Alberta (2009). Kinship care review report. Retrieved from www.humanservices.alberta.ca/documents/kinship-care-review-report.pdf (accessed February 2018).

Kiraly, M. & Humphreys, C. (2013). Family contact for children in kinship care: A literature review. *Australian Social Work, Vol. 66, No. 3,* 358-374.

Kiraly, M. & Humphreys, C. (2013). Perspectives from young people about family contact in kinship care: " Don't push us - listen more" *Australian Social Work, Vol. 66, No. 3,* 314-327.

Kiraly, M. & Humphreys, C. (2015). A tangled web: parental contact with children in kinship care. *Child and Family Social Work, 20,* 106-115.

Lutman, E., Hunt, J. and Waterhouse, S. (2009). Placement Stability for children in Kinship Care; A long-term follow-up of children placed in kinship care through care proceedings. *Adoption and Fostering, Volume 33, Number 3,* 28-39.

McHugh, M. (2009) *A framework of practice for implementing a kinship care program*. Social Policy Research Centre, University of New South Wales Retrieved from www.fcq.com.au/images/resources/kinsip_care_Program_Descriptionpdf (accessed January 2018).

O'Brien, V. (2012). The benefits and challenges of kinship care. *Child Care in Practice. 18(2)*, 127-146.

Sen, R. & Broadhurst, K. (2011). Contact between children in out of home placements and their family and friends: A research review. *Child and Family Social Work 16*, 298-309.

Turnell, A. and Essex, S. (2014). "It takes a village" Placing grandparents and extended family at the center of safeguarding vulnerable children, In Pitcher, D. (Ed), *Inside Kinship Care*, Jessica Kingsley Publishers, London: 96-121.

Winokur, M., Holtan, A. and Batchelder, K. (2018). Systematic review of kinship care effects on safety, permanency, and well-being outcomes. *Research on Social Work Practice, Vol. 28 (1)*, 19-32.

TABLE 1

OUTCOME VARIABLE	FILE RECORD INFORMATION
The reasons the parents were not able to care for the child	8/10 neglect due to drug and alcohol issues 7/10 domestic violence issues
Kinship motivation for assuming responsibility	9/10 clearly stated preventing the child from going to strangers or the system and maintaining connection with family
The way the children were placed with kin	Limited information on file about this. 9/10 parents agreed with the placement but the process of how this happened is not clear on file.

TABLE 2

RELATIONAL VARIABLE	FILE RECORD INFORMATION
Prior emotional bonds between child and kin	Data is weak. Suggests prior bond in 5/10, some connection 2/10, weak bond 2/10 and no info 1/10
Existing relationship and attachment between kin and parents	4/10 good relationship generally and functional communication 5/10 high conflict 1 no contact
Impact of shame and kin awareness of child protection concerns	Limited information on file

TABLE 3

SUPPORT VARIABLE	FILE RECORD
Family visit and supervision arrangements	5 families where all supervision was provided by kin 2 families supervised by kin and agency staff 3 families supervised by agency staff
Child behaviour Issues	8/13 children are typically developing 5/13 have behavioural issues
Placement outcome on case closure	4 families where children went home 4 families where children remained with kin 1 kinship breakdown due to conflict with birth parents 1 kinship breakdown due to child behaviour issues

The Implementation Process of Mothers in Mind (MIM) at Wood's Homes

ANGELIQUE JENNEY & KAFILAT JIMBA-BIDMUS

Part of the challenge of delivering programs and services is choosing which programs to implement and when. This article illustrates the process of implementing a new manualized program into existing services at Wood's Homes.

BACKGROUND

Mothers in Mind (MIM) is a 10-week program designed to target mothers who have experienced abuse and trauma including sexual assault, childhood abuse and neglect. It is a trauma-informed, relationship-focused, and mother-child intervention group program that targets parents with children under the age of four years. The goal is to intervene early to strengthen parent-child relationships, enhance parental skills, teach stress management skills and boost parents' self-confidence and efficacy. Regardless of the nature of trauma, interventions developed to support the mothers with trauma experiences need to accommodate different elements to have successful outcomes. For example, Muzik et al., (2015) suggested that "...the approach needs to be welcoming and strengths-based, multi-modal, and incorporate features of treatments for depression, trauma and anxiety, while at the same support parenting skills" (p. 4). It is important to note that despite challenges in reaching and retaining mothers with trauma experiences in such supportive programs, efforts need to be continually geared to improving healthy child development, enhancing parenting skills, improving parent child relationships, and assisting mothers in improving self-esteem and confidence. The objective of this study was to understand the experience of implementing the Mothers in Mind (MIM) program at Wood's Homes. The derivation of this information will help to inform future implementation strategies, including training and processes.

WHY IS IMPLEMENTATION IMPORTANT?

Meyers, Durlak and Wandersman (2012), state that "implementation science is growing in importance among funders, researchers, and practitioners as an approach to bridging the gap between science and practice" (p.462). In supporting this claim, the authors asserted that "in recognition of its critical importance, various professional groups have determined that one of the criteria related to identifying evidenced-based interventions should involve documentation of effective implementation (e.g. Society for Prevention Research, Division 16 of the American Psychological Association)" (Meyers et al., 2012, p. 462). To achieve the desired outcomes of building positive, long-lasting relationships with children, and building parents' confidence and self-esteem in child rearing, it is important to properly transfer knowledge of parenting tactics to the targeted audience. In order to do this effectively, service providers need to be appropriately trained in both the development and delivery of such programs (Shapiro, Prinz & Sanders, 2015).

To this end, several stages of implementation have been proven to be instrumental to the successful maintenance of fidelity to such programs. These stages include: exploration, installation, initial implementation, and full implementation (Bertram, Blase, & Fixsen, 2014). These stages effectively guide in the planning, implementation, and evaluation phases of program and service delivery. Overall, the development of frameworks for an intervention is necessary in order to guide the practice of implementation and to that end we developed an Implementation Framework to be referenced throughout the process (Breitenstein et al., 2010b). In their work to examine implementation fidelity of the Chicago Parent Program (CPP), Breitenstein et al. (2010a) utilized a fidelity checklist and audio recordings to capture adherence to protocol and competent delivery of intervention. Such processes ensuring "implementation fidelity provides confidence that the intervention is being delivered as intended to effect the desired change and improve the lives of parents and young children" (Breitenstein et al., 2010a, p.10).

However, despite the growing evidence and studies on implementation fidelity, the literature reveals gaps in the knowledge of implementation and challenges in the implementation process. For example, Furlong

and McGilloway (2015) examined barriers and facilitating factors associated with implementing Incredible Years Parenting Program (IYPP) in five health care services based in disadvantaged areas in Ireland. The qualitative study investigated the organizational and fidelity processes that may have influenced trial outcomes. To understand their experiences in implementing the IYPP, group facilitators and service managers were interviewed on two occasions: (1) following the delivery of program and (2) at the end of program delivery. The results revealed some key drivers of effective implementation: monitoring fidelity, initial engagement of parents (screening and group composition), optimising recruitment and retention of parents. Some of the challenges in implementing IYPP include: retention issues (i.e. parental attitude, screening issues). The authors emphasized that attrition is a challenging factor in implementing IYPP and it varies among parenting groups. However, factors such as appropriate screening, adequate support and supervision can be vital in reducing attrition issues in implementing parenting programs. Similar issues were experienced by Wood's staff as they delivered their first group sessions. Implementation science reveals that important aspects of implementation occur at various levels that help in successful implementation and improved outcomes (Akin et al., 2016, p. 873).

Interventions developed to support the mothers with trauma experiences need to accommodate different elements to have successful outcomes.

Guided by the implementation framework developed for the Mothers in Mind (MIM) program (See Figure 1), the purpose of the study was to detail the process taken in implementing the MIM program at Wood's Homes in an effort to explore and understand factors that may hinder or contribute to positive outcomes.

METHODOLOGY

The study population was the facilitators of the MIM program at Wood's Homes. In order to understand the process of MIM's implementation fidelity, stages or critical steps in the implementation were developed as a guide. Staff participants were recruited to participate in a brief survey as well as the option to participate in a personal interview to understand staff experiences of the implementation process.

Scudder and Herschell (2015) examined different approaches in training practices and determined that training manuals and workshops alone are deemed insufficient in transferring skills to service provision. However, in-person training coupled with continued consultation and workshop followups can be effective training practices in gaining the desired outcomes (Scudder & Herschell, 2015, p. 86). Evidence-Based Practice (EBP) implementation along with supportive consultation to support fidelity is associated with significantly greater staff retention relative to EBP implementation without consultation (Aaron et al., 2012, p. 75). That is, supportive consultation plays an important role in the implementation fidelity process of a program. In light of this, in-person training and consultation was provided to facilitators and program workers at Wood's Homes on recognition of impact of trauma and trauma-informed practice principles. Also, training was provided on how to deliver program contents and materials in an appropriate manner, engaging mothers in discussion, encouraging playtime between mothers and children while at the same time, being sensitive to the needs of the targeted population. In addition, facilitators were required to complete fidelity checklists each week, consultation was provided three times each session as well as on an as-needed basis. In pre-brief session, facilitators discussed plans to effectively deliver programs activities and provide updates and/or concerns on families based on followup sessions. While in debrief session, facilitators discussed components of the program, reflected on overall contents, provided updates on each family in terms of recognition of issues and progress, planned on how to address concerns, planned on followup, and strategized on improving practices.

FINDINGS

Both Wood's Homes locations (Forest Lawn and Lethbridge) were able to effectively begin MIM groups and feedback indicated that both mothers and facilitators enjoyed the program. Small group sizes allowed for connections with other group members as well as staff. As this was the first round of groups it was understandable that in some cases, group attrition be-

came a concern. This is also the reality of offering a program for mothers with very young children who may also be facing additional life stressors (such as housing issues and court appearances). Facilitators indicated challenges with attrition, age ranges of children attending could sometimes make content delivery problematic and children did not always have a peer to play with. It was a universal experience to consider taking more time to complete intakes and consider group composition to ensure cohesion for mothers in the program and reduce dropout rates. Space was also considered important.

DISCUSSION

The literature on implementation is clear that there are a myriad of challenges faced by both individuals and institutions when introducing a new program model. This small study of the implementation process of Mothers in Mind at Wood's Homes illustrated similar challenges and provides opportunities for improving future implementation efforts. Results indicated that more structure and clarity in the training and group implementation process are necessary, including the process of consultation, which may be more beneficial if offered as a structured process as opposed to ad-hoc sessions. Ensuring more time for a thorough assessment process as well as clarity around fidelity may also prove useful. Implementation is not a single event, but rather a process that takes place over time. We are excited about the possibilities of this process at Wood's Homes.

REFERENCES

Aarons, G.A., Fettes, D.L., Sommerfeld, D.H. & Palinkas, L.A. (2012). Mixed methods for implementation research: Application to evidence-based practice implementation and staff turnover in community-based organizations providing child welfare services. *Child Maltreatment 17(1), 67-79.*

Akin, B., Brook, J., Byers, K., & Lloyd, M. (2016). Worker perspectives from the front line: implementation of evidence-based interventions in child welfare settings. *Journal of Child & Family Studies, 25(3),* 870-882.

Bertram, R.M., Blase, K.A., & Fixsen, D.L. (2014). Improving programs and outcomes: Implementation frameworks and organization change. *Research on Social Work Practice, 25(4),* 477-487.

Breitenstein, S. M., Fogg, L., Garvey, C., Hill, C., Resnick, B., & Gross, D. (2010a). Measuring implementation fidelity in a community-based parenting intervention. *Nursing Research, 59(3),* 158-165.

Breitenstein, S.M., Gross, D., Garvey, C., Hill, C., Fogg, L., & Resnick, B. (2010b). Implementation fidelity in community-based interventions. *Research Nursing Health, 33(2),* 164–173.

Furlong, M., & McGilloway, S. (2015). Barriers and facilitators to implementing evidence-based parenting programs in disadvantaged settings: A qualitative study. *Journal of Child & Family Studies, 24(6),* 1809-1818.

Meyers, D., Durlak, J., & Wandersman, A. (2012). The quality implementation framework: A synthesis of critical steps in the implementation process. *American Journal of Community Psychology, 50(3/4),* 462-480.

Murray, M., Culver, T., Farmer, E., Jackson, L., & Rixon, B. (2014). From theory to practice: One agency's experience with implementing an evidence-based model. *Journal of Child & Family Studies, 23(5),* 844-853.

Muzik, M., Rosenblum, K., Alfafara, E., Schuster, M., Miller, N., Waddell, R., & Kohler, E. (2015). Mom power: Preliminary outcomes of a group intervention to improve mental health and parenting among high-risk mothers. *Archives of Women's Mental Health, 18(3),* 507-521.

Scudder, A.T., & Herschell, A.D. (2015). Building an evidence-base for the training of evidence-based treatments in community settings: Use of an expert-informed approach. *Children and Youth Services Review, 55,* 84-92.

Shapiro, C.J., Prinz, R.J., & Sanders, M.R. (2015). Sustaining use of an evidence-based parenting intervention: Practitioner perspectives. *Journal of Child & Family Studies, 24,* 1615–1624.

Wandersman, A., Duffy, J., Flaspohler, P., Noonan, R., Lubell, K., Stillman, L., Blachman, M., Dunville, R., & Saul, J. (2008). Bridging the gap between prevention research and practice: The interactive systems framework for dissemination and implementation. *American Journal of Community Psychology 41,* 171-181.

Crossover Youth in Alberta: Risk Factors Associated with Dual Involvement in the Child Welfare and Juvenile Justice Systems

BRUCE MACLAURIN & JENNA PASSI

INTRODUCTION

A high proportion of adolescent youth involved with child welfare have concurrent involvement with the youth criminal justice system (YCJA) (MacLaurin & Trocmé, 2005; Vidal, Prince, Connell, Caron, Kaufman & Tebes, 2017; Goodkind, Shook, Kim, Pohlig & Herrng, 2013). These youth, known as crossover or dual-system youth, pose unique risks however there is a dearth of evidence informing policy and practice (Bala, et al., 2015). This analysis was conducted to highlight key risks associated with these crossover youth compared to those who had no dual involvement (CW status youth).

OVERVIEW OF THE RESEARCH ON CROSSOVER YOUTH

Crossover youth with dual involvement in the child welfare and juvenile justice systems are noted to be at a heightened risk for behavioural, emotional and health concerns (Bala, Finlay, De Filippis & Hunter, 2015; Goodkind, Shook, Kim, Pohlig & Herring, 2013; Ward et al., 2010). There is growing concern that this heightened risk contributes to a continued negative life trajectory for crossover youth (Baglivio et al., 2015; Goodkind et al., 2013; Ward et al., 2010). A review of the literature highlights a complex interaction and interplay between a range of individual, family and system-based factors that contribute to the precarious circumstances of these youth at risk.

Individual Factors

Individual factors relating to risk most often refer to gender, race or ethnicity, and age. Baglivio et al. (2015) found that varying intersectional qualities impact risk and potential resiliency factors differently and that this area in and of itself is an area needing further research. This finding was supported by Goodkind et al., (2013). Studies have noted that while females are more likely to have greater emotional difficulties, males are more likely to exhibit criminal behaviour and are more likely to become dually-involved (Goodkind et al., 2013; Neely-Barnes & Whitted, 2011). Baglivio et al. (2015) found that dually-involved girls have the same offending rates of non-dually involved youth which again suggests that females may not have the same risk for dual involvement between child welfare and youth criminal justice systems. American studies have shown that minorities tend to have an increased likelihood of dual system involvement and often may not show the same heightened severity of behaviours as their Caucasian counterparts before becoming system-involved (Crosby, 2016; Goodkind et al., 2013; Neely-Barnes & Whitted, 2011). Studies show system-involved Caucasian youth maintaining similar or even increased risk and behavioural concerns, whereas minority counterparts may not show the same high level of risk prior to being removed from the home (Baglivio et al., 2015). An individual is also at greater risk if they do not have a network of stable social supports (Ward et al., 2010) and older youth belonging to a minority showed greater difficulty in developing positive peer-ships (Neely-Barnes & Whitted, 2011). Older youth tend to exhibit more entrenched behaviours which can increase the likelihood of becoming dually-involved (Baglivio et al., 2015; Crosby, 2016; Goodkind et al., 2013; Neely-Barnes & Whitted, 2011).

Family Factors

Family-based factors often refer to maltreatment within the home or other adverse childhood experiences (Baglivio et al., 2015; Bala et al., 2015; Crosby, 2016; Goodkind et al., 2013; Neely-Barnes & Whitted, 2011; Ryan, Bashant & Brooks, 2006). Felitti et al. established 10 adverse childhood experiences (ACEs) that can impact multiple facets of an individual's life (e.g., health, education, coping) (*see also* Alberta Human Services, 2015; CAAMHPP, 2016; Palix Foundation, 2018; RFJS, 2018). These 10 ACEs have been used as an indicator of trauma including: physical, emotional, and sexual abuse; physical and emotional neglect; and household dysfunction caused by mental

illness, incarceration, domestic violence, substance abuse, and divorce (CDC, 2016; Felitti et al., 1998). Baglivio et al. (2015) showed that these factors appeared more frequently within disadvantaged communities where there were cycles of intergenerational trauma. These factors can expose a child to toxic stress which can result in the creation of maladaptive coping skills, more commonly referred to as fight-flight-freeze-faint responses (Bloom 2013; CDC, 2016; Ryan, 2005). Some of the subsequent behaviourial concerns are associated with behavioural issues, criminality, and incarceration (National Child Traumatic Stress Network (NCTSN), 2003; Purewal et al., 2016; Ryan, 2005; Wolff & Shi, 2012). The connection between maltreatment, toxic stress and maladaptive behaviours involving criminality is what places children at risk of becoming dually involved with the child welfare and youth criminal justice systems.

System-based Factors

System-based factors include how and when systems become involved in a child's life. Research suggests that risk increased with the involvement of additional systems and more integrated approaches are required between systems (Bala et al.. 2015; Ward et al., 2010). This impact can be more detrimental if systems involvement leads to increased or lengthy disruption to the family (Bala et al., 2015; Crosby, 2016; Goodkind et al., 2013; Neely-Barnes & Whitted, 2011; Ryan, Bashant & Brooks, 2006; Ward et al., 2010). Additionally, children with child welfare involvement often become involved with police and court systems more frequently and for less severe actions (Bala et al., 2015). This can be attributed in part to the contextual factors associated with placement including: the over-reliance on strict rules; the use of police involvement to address behavioural management; the development of negative peer groups; and the risk of volatile group environments (Bala et al., 2015; Crosby, 2016; Goodkind et al., 2013; Neely-Barnes & Whitted, 2011; Ryan, Bashant & Brooks, 2006; Ward et al., 2010). These youth then often see harsher sentencing when compared to their non-child welfare attached counterparts (Baglivio et al., 2015; Bala et al., 2015). These systematic factors can elevate the risk of youth becoming dually involved with multiple systems.

Research is showing that improvement in integrated service delivery and earlier diversion opportunities to engage in positive activities (education and employment), are associated with youth success (Bala et al., 2015; Ryan, Bashant & Brooks, 2006; Ward et al., 2010). The impacts of inter-sectionality means that whenever system involvement has begun it is crucial that cases are viewed independently and that each individual youth's specific needs are addressed appropriately (Crosby, 2016; Neely-Barnes & Whitted, 2011; Ward et al., 2010). Addressing potential barriers to system collaboration is critical and includes financial, resource and time constraints (Bala et al., 2015). Finally, research has indicated that placement types should become safer, increase positive peer and family interaction, be trauma-informed, and consider cross-sectional issues when making treatment plans (Baglivio et al., 2015; Crosby, 2016; Ryan, Bashant & Brooks, 2006; Ward et al., 2010).

METHODOLOGY

This article is based on a secondary analysis of the AIS-2008. The AIS-2008 is the second cycle of a provincial study designed to determine the incidence and characteristics of child maltreatment for children reported to and investigated by Child Intervention in Alberta. Using a multi-stage sampling design, 2,239 child maltreatment investigations were collected from 14 randomly selected Child Intervention Service offices over a three-month case selection period (October 1, 2008 to December 31, 2008). Offices were stratified by jurisdiction and size to ensure that all subpopulations were fairly represented, with additional consideration for Indigenous organizations. Information on the characteristics of investigated children and families was collected directly from the investigating worker using a standardized Maltreatment Assessment Form. Risk factors were noted if confirmed by a diagnoses, observed by a worker, disclosed by the caregiver, or if there was suspicion where there was evidence for a worker of suspected problems but he/she could not verify at the time of the investigation. Data was then weighted using regionalization and annualization weights to provide provincial annualized estimates of child abuse and neglect. A total of 27,147 child maltreatment investigations occurred in Alberta for 2008.

The AIS-2008 dataset provides a unique opportunity to examine the child welfare response to reported maltreatment in Alberta, however several factors should be considered when interpreting findings from this secondary analysis. The AIS-2008: 1) tracked re-

ports investigated by child intervention services and did not include reports that were screened out, only investigated by police, or never reported; 2) examined the investigation phase only and cannot determine what happened following this initial 6-8 week period; 3) was based on the assessments provided by the investigating child intervention workers which could not be independently verified; and 4) is weighted using regionalization and annualization weights. For further information on methodology of the AIS-2008 refer to Chapter 2 of the full report (MacLaurin et al., 2013).

FOCUS OF ANALYSIS

This article reports on secondary data analyses of the most recent cycle of the Alberta Incidence Study of Reported Child Abuse and Neglect (AIS-2008) comparing risk factors associated with crossover status youth (12-17 years of age with concurrent child welfare and YCJA involvement) compared to Child Welfare (CW) status youth (12-17 years of age with only child welfare involvement) (MacLaurin et al., 2013). Chi-Square analyses were conducted to examine the relationship between dual-system status with a range of child factors (age, gender, function and risks), household factors (caregiver risk factors, family status, employment, household risks) and case factors (previous openings, substantiation, and placement). For the Findings and Discussion sections, these comparison groups will be called Crossover and Child Welfare (or CW) status youth.

FINDINGS

Child Factors

There are statistically significant differences noted for the level of child risks associated with Crossover status (see Table 1). Crossover youth have a higher percentage of older teens (35%) compared to Child Welfare (CW) status (21%), however are primarily male (56%). Seventy three percent of youth with CW status are of Indigenous heritage, compared to 67% of Crossover youth. Youth for both categories have elevated risk levels for the series of child functioning concerns, however Crossover youth consistently have higher percentages for all categories. Child functioning concerns for Crossover youth include: Depression/Anxiety (50%), Suicidal Thoughts (27%), Self-harming Behaviours (33%), ADD/ADHD (39%), Attachment Concerns (49%), Aggression to Others (77%), Running Away Behaviour (55%), Inappropriate Sexual Behaviours (33%), Intellectual and Developmental Disability (48%), Failure to Meet Developmental Milestones (19%), Academic Difficulties (81%), FAS/FAE (26%), Alcohol Abuse (55%) and Drug/Solvent Use (62%). As well, 96% of Crossover youth are documented to have three or more child functioning concerns, compared to 39% of youth with CW status only.

Case or Maltreatment Factors

Crossover youth with dual CW and YCJA involvement are seen to have statistically significant differences for case and maltreatment factors compared to those youth with CW status only (see Table 2). A lower percentage of Crossover youth are referred from professional sources (55%) compared to CW status youth (69%). Almost two-thirds of Crossover youth (62%) have 3 or more previous family investigations for child welfare concerns compared to 28% of CW status youth. The primary forms of maltreatment vary greatly as Crossover youth are investigated for neglect most frequently (52%) while CW status youth reflect the provincial norms for all child welfare investigations for Alberta. As well, a higher percentage of these investigations are substantiated for Crossover youth (73%). Investigations for Crossover youth tend to reflect similar levels of physical harm (8%), higher levels of emotional harm (48%), and higher percentages of multiple episodes of maltreatment (64%) prior to this investigation. Service outcomes are consistently higher for Crossover youth for the case remaining open for ongoing services (45%), formal placement in care (22%), and involvement with child welfare court (15%).

Caregiver Factors

There are statistically significant differences between Crossover youth and CW status youth as noted by Chi-square analysis for all caregiver risk factors. Contrary to the child and case and maltreatment factors however, the percentages for Crossover youth are not consistently higher than those for CW status youth (See Table 3). Household factors related to source of household income indicate that Crossover Youth were less likely than CW status youth to live in homes where parents had full-time employment (57%), and higher percentages for benefits or unemployment (26%), or part-time or unstable housing (17%). Twenty-six percent of Crossover youth lived in homes that ran out of money for basic necessities at the end of the month.

Data on caregiver risk factors were collected on a range of factors associated with maltreatment in the

research literature. There was a statistically significant difference in Crossover youth compared to CW status youth for all caregiver risk factors and Crossover youth were consistently lower for all with two exceptions. This included household alcohol use (29%), drug use (13%), cognitive impairment (6%), mental health concerns (24%), physical health concerns (24%), lack of social supports (33%), victim of intimate partner violence 27%), perpetrator of intimate partner violence (20%) and history of foster care placement for either parent/caregiver (9%). Three or more caregiver risks were noted for 27% of Crossover youth and for 40% of CW status youth. A higher percentage of Crossover youth had parents of Caucasian heritage (68%), and lower percentage of parents of other heritage (7%). Twenty four percent of Crossover youth had parents described as Indigenous including First Nations, Metis and Inuit which was the same as CW Status youth.

Household Factors

There are statistically significant differences for household factors for Crossover and CW Status youth, primarily related to poverty and housing (See Table 4). A higher percentage of Crossover youth live with families in either rental housing (43%) or public/band supported housing (19%) compared to CW status youth. As well a higher percentage of crossover youth live in homes described as being overcrowded by the investigating worker (16%). There is no significant difference between the two cohorts for the number of household hazards existing in the residence (dangerous features of the housing unit).

CONCLUSIONS

Crossover youth with dual involvement in Child Welfare as well as CYJA are seen as being a complex cohort of youth with multiple challenges related to the individual youth, their family and household and the impact of the involved systems. Based on secondary analysis of the Alberta Incidence Study of Reported Child Abuse and Neglect (MacLaurin, Trocmé et al., 2013), findings suggest that there are significant differences between Crossover youth and those involved only with CW status.

Crossover youth have similar or lower rates of caregiver risk factors compared to CW status youth and it would appear that the family situations are similar in many ways as parents are challenged with alcohol and substance use, lack of social supports, mental health challenges and physical health concerns, intimate partner violence, and cognitive impairment. Crossover youth had statistically significant higher rates of parental history of foster care, and physical disability. Crossover youth do have slightly higher household factors related to poverty, family employment, housing and safety

There are significant differences for Crossover youth with regards to the higher risk for almost all childhood risk factors related to developmental issues, health and learning, and behaviour. These findings support previous research articulating escalated risk and descriptions for this population (Bala, Finlay, De Filippis & Hunter, 2015; Goodkind, Shook, Kim, Pohlig & Herring, 2013; Ward et al., 2010; Neely-Barnes & Whitted, 2011). Crossover youth are older than CW status youth, more likely to be male, less likely to be Indigenous, and more likely to have 3 or more child functioning concerns (96%). Child functioning concerns rated at a high level include drug use (62%), alcohol use (55%), academic concerns (81%), running away (55%), aggression to others (77%), and depression and anxiety (50%)

Crossover youth have a longer history of multiple family investigations, investigations related to child neglect, and chronic and ongoing issues that may continue to be unresolved over time and supports previous work (Baglivio et al., 2015; Goodkind et al., 2013; Ward et al., 2010). Case dispositions are higher for Crossover youth for substantiation, case remaining open for ongoing services, child welfare court and placement in care.

This analysis highlights the need for intervention at the earliest point of contact in either of the child welfare or YCJA systems, and the need for meaningful efforts to integrate service delivery and diversion opportunities for youth on the Crossover trajectory. Subsequent analyses of this data will examine the relative impact of Crossover status on regression models predictive of child welfare outcomes including placement in formal care, involvement in child welfare court, and the decisions to keep a case open for ongoing service delivery.

REFERENCES

Alberta Human Services. (2015). *Children's Mental Health Learning Series*. Retrieved from http://www.humanservices.alberta.ca/family-community/cmh-learning-series.html.

Baglivio, M.T., Wolff, K.T., Piquero, A.R., Bilcheck, S., Jackowski, K., Greenwald, M.A. & Epps, N. (2015). Maltreatment, child welfare, and recidivism in a sample of deep-end crossover youth. *Journal of Youth Adolescence,* 45, 625-54.

Bala, N., Finlay, J., De Filippis, R. & Hunter, K. (2015). Child welfare adolescents & the Youth Justice System: Failing to respond effectively to crossover youth. *Canadian Criminal Law Review,* 19, 129-151.

Bloom, S.L. (2013). *Creating sanctuary: Toward the evolution of sane societies.* New York, NY: Routledge.

Centers for Disease Control and Prevention (CDC). (June, 2016). *About the CDC-Kaiser ACE study.* Retrieved from https://www.cdc.gov/violenceprevention/acestudy/about.html.

Child & Adolescent Addiction, Mental Health and Psychiatry Program (CAAMHPP). (2016). *Adverse childhood experiences (ACE)/ Trauma informed resource guide*. Retrieved from http://www.albertafamilywellness.org/news/caamhpp-aces-guide.

Crosby, S.D. (2016). Trauma-informed approaches to juvenile justice: A critical race perspective. *Juvenile and Family Court Journal, 67*(1), 5-18.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V.,...& Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine, 14*(4), 245-58. doi: 10.1016/S0749-3797(98)00017-8.

Goodkind, S., Shook, J.J., Kim, K.H., Pohlig, R.T., & Herring, D.J. (2013). From child welfare to juvenile justice: Race, gender, and system experiences. *Youth Violence and Juvenile Justice, 11*(3), 294-272. doi: 10.1177/154/1204012463409.

MacLaurin, B., & Trocmé, N., (2005) Child maltreatment in Canada, in John Winderdyk (ED), Issues and Perspectives of Young Offenders in Canada, 3rd Edition, Toronto: HBJ-Holt Canada

MacLaurin, B., Trocme, N., Fallon, B., Sinha, V., Enns, R. Gail, J. Kitt, O. Thomas-Prokop, S., Zelt, C., Daoust, G. Hutcheon, E. & Budgell, D. Budgell. (2013). *Alberta Incidence Study of Reported Child Abuse and Neglect-2008 (AIS-2008): Major Findings*. Calgary, AB: University of Calgary.

National Child Traumatic Stress Network. (2003). *Complex trauma in children and adolescents: White paper from the National Traumatic Stress Network Complex Trauma Task Force.* Durham, NC and Los Angeles, CA: National Center for Child Traumatic Stress.

Neely-Barnes, S. & Whitted, K. (2011). Examining the social, emotional, and behavioral needs of youth involved in the child welfare and juvenile justice systems. Journal of Health & Human Services Administration, 34 (2), 206–238. Retrieved from http://www.spaef.com/jhhsa.php.

Palix Foundation. (2018). *Alberta Family Wellness Initiative*. Website. Retrieved from http://www.albertafamilywellness.org/.

Purewal, S.K., Bucci, M., Wang, L.G., Koita, K., Marques, S.S., Oh, D., & Harris, N.B. (2016). Screening for adverse childhood experiences (ACEs) in an integrated pediatric care model. *Zero to Three, 36*(3), 10-17.

Reforming the Family Justice System (RFJS). (2018). *The initiative*. Retrieved from http://www.rfjs.ca/theinitiative.

Ryan, B., Bashant, C., & Brooks, D. (2006). Protecting and supporting children in the child welfare system and the juvenile court. *Juvenile and Family Court Journal*, 57(1), 61–69. doi:10.1111/j.1755-6988.2006.tb00115.x.

Ryan, G. (2005). Preventing violence and trauma in the next generation. *Journal of interpersonal violence, 20*(1), 1-10.

Vidal, S., Prince, D., Connell, C.M., Caron, C.M., Kaufman, J.S. & Tebes, J.K. (2017). Maltreatment, family environment, and social risk factors: Determinants of the child welfare to juvenile justice transition among maltreated children and adolescents. *Child Abuse and Neglect, 63,* 7-18.

Ward, A.K., Day, D.M., Bevc, I., Sun, Y., Rosenthal, J.S. & Duchesne, T. (2010). Criminal trajectories and risk factors in a Canadian sample of offenders. *Criminal Justice and Behavior, 37*(11), 1278-1300.

Wolff, N., & Shi, J. (2012). Childhood and adult trauma experiences of incarcerated persons and their relationship to adult behavioral health problems and treatment. *International Journal of Environmental Research and Public Health, 9*(5), 1908-26. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3386595/.

TABLE 1: CHILD FACTORS ASSOCIATED WITH YCJA STATUS FOR 12-17 YEAR OLD YOUTH INVESTIGATED FOR MALTREATMENT IN ALBERTA IN 2008

	CW Status		Crossover Youth	
Child Age Category **	**#**	**%**	**#**	**%**
12-15 years	5,358	79%	668	65%
16-17	1,433	21%	354	35%
Child Sex **				
Male	2,870	42%	573	56%
Female	3,921	58%	450	44%
Child Aboriginal Status **				
Aboriginal	1,828	27%	334	33%
Non-Aboriginal	4,963	73%	688	67%
Child Functioning Concerns *				
Depression/Anxiety **	2,303	34%	516	50%
Suicidal Thoughts **	969	14%	274	27%
Self-harming Behaviours **	762	11%	334	33%
ADD/ADHD **	1,083	16%	400	39%
Attachment Concerns **	1,255	18%	505	49%
Aggression to Others **	1,499	22%	790	77%
Running Away **	834	12%	565	55%
Inappropriate Sexual Behaviour **	611	9%	337	33%
Intellectual & Developmental Disability **	1,245	18%	491	48%
Failure to Meet Developmental Milestones **	581	9%	194	19%
Academic Difficulties **	2,689	40%	827	81%
FAS/FAE **	519	8%	264	26%
Alcohol Abuse **	632	9%	565	55%
Drug/Solvent Abuse **	787	12%	634	62%
3 or More CF Concerns **	2,638	39%	980	96%
Total	**6,791**	100%	**1,023**	**100%**

Alberta Incidence Study of Reported Child Abuse and Neglect 2008

Percentages are column percentages, based on the total weighted number of investigations

* p less than or equal to .01

** P less than or equal to .001

TABLE 2: CASE OR MALTREATMENT FACTORS ASSOCIATED WITH YCJA STATUS FOR 12-17 YEAR OLD YOUTH INVESTIGATED FOR MALTREATMENT IN ALBERTA IN 2008

	CW Status		Crossover Youth	
Source of Referral	**#**	**%**	**#**	**%**
Non-professional Referral Source **	1,963	29%	375	37%
Professional Referral Source **	4,670	69%	564	55%
**Previous Investigation ** **				
Family Previously Investigated > 3 Times	1,927	28%	636	62%
**Type of Investigation ** **				
Investigated Incident of Maltreatment	5,813	86%	827	81%
Risk Investigation Only	978	14%	195	19%
**Primary Form of Alleged Maltreatment ** **				
Physical Abuse	1,689	25%	166	16%
Sexual Abuse	257	4%	28	3%
Neglect	2,139	31%	534	52%
Emotional Maltreatment	912	13%	78	8%
Intimate Partner Violence	816	12%	22	2%
Level of Substantiation				
Unfounded	1,635	28%	174	21%
Remains Suspected Following Investigation	439	8%	50	6%
Substantiated	3,739	64%	603	73%
Total Maltreatment Cases	5,813	100%	827	100%
Physical or Emotional Harm Noted				
Physical Harm Noted *	504	9%	64	8%
Emotional Harm Noted **	2,281	39%	397	48%
Total Maltreatment Cases	5,813	100%	827	100%
**Duration of Maltreatment ** **				
Single Event	1,210	21%	124	15%
Multiple Events	2,890	50%	529	64%
Total Maltreatment Cases	5,813	100%	827	100%
**Case Opening for Services ** **				
Case to Remain Open for Services	2,151	32%	458	45%
**Formal Placement in Care ** **				
Placement During the Investigation Phase	683	10%	229	22%
Child Welfare Court *				
Application to Child Welfare Court	831	12%	152	15%
Total	**6,791**	**100%**	**1,023**	**100%**

Alberta Incidence Study of Reported Child Abuse and Neglect 2008

Percentages are column percentages, based on the total weighted number of investigations

* p less than or equal to .01

** P less than or equal to .001

Table 3: Caregiver Factors Associated with YCJA Status for 12-17 Year Old Youth Investigated for Maltreatment in Alberta in 2008

	CW Status		Crossover Youth	
Source of Household Income **	#	%	#	%
Full time	4,377	64%	579	57%
Benefits or Unemployment	1,431	21%	267	26%
Part-time/Seasonal/Unknown or No Income	983	14%	177	17%
Child Custody Dispute **				
Noted	516	8%	30	3%
Not Noted or Unknown	6,275	92%	993	97%
Household Runs Out of Money for Basic Necessities **				
Noted	1,234	18%	266	26%
Not Noted or Unknown	5,556	82%	756	74%
Caregiver Risk Factors				
Household Alcohol Use	2,107	31%	293	29%
Household Drug Use **	1,450	21%	138	13%
Household Cognitive Impairment **	680	10%	57	6%
Household Mental Health Concerns **	2,063	30%	241	24%
Household Physical Health Concerns **	1,001	15%	241	24%
Lack of Household Social Supports	2,353	35%	341	33%
Household Victim of IPV **	2,270	33%	279	27%
Household Perpetrator of IPV *	1,634	24%	208	20%
Household History of Foster Care *	466	7%	97	9%
3 or More Household Caregiver Risks **	2,698	40%	273	27%
Caregiver Ethno-Racial Status **				
Caucasian	4,299	63%	699	68%
First Nations, Metis, Inuit	1,597	24%	250	24%
Other Culture	895	13%	74	7%
Total	**6,791**	**100%**	**1,023**	**100%**

Alberta Incidence Study of Reported Child Abuse and Neglect 2008

Percentages are column percentages, based on the total weighted number of investigations

* p less than or equal to .01

** P less than or equal to .001

TABLE 4: HOUSEHOLD RISK FACTORS ASSOCIATED WITH YCJA STATUS FOR 12-17 YEAR OLD YOUTH INVESTIGATED FOR MALTREATMENT IN ALBERTA IN 2008

	CW Status		Crossover Youth	
Housing Types **	**#**	**%**	**#**	**%**
Own Home	2,799	41%	363	35%
Rental Housing	2,534	37%	445	43%
Public/Band Supported Housing	894	13%	199	19%
Other	576	8%	15	1%
Home Overcrowded **				
Noted	785	12%	165	16%
Not Noted/Unknown	5,907	87%	857	84%
Number of Household Hazards (ns)				
At Least One Household Hazard	896	13%	136	13%
Total	**6,791**	**100%**	**1,023**	**100%**

Alberta Incidence Study of Reported Child Abuse and Neglect 2008

Percentages are column percentages, based on the total weighted number of investigations

* p less than or equal to .01

** P less than or equal to .001

ns - not significant

Policy Implications of ACE Scores

JENNA PASSI, ANITA BLACKSTAFFE AND THE WOOD'S HOMES'
TRAUMA-INFORMED WORKING COMMITTEE

PURPOSE

To provide information regarding adverse childhood experiences (ACEs) and offer some considerations and recommendations that could factor into an agency's decision to implement ACE scoring.

ISSUE

ACEs significantly impact children and youth, and high ACE scores are associated with trajectories that lead to poor health outcomes (CAAMHPP, 2016; Felitti et al., 1988; Halfon et al., 2010). This has policy implications for agencies that are planning to implement and use ACE scores.

A recent initiative by the Wood's Homes Trauma-Informed Working Committee to collect ACE scores for clients under the age of 18 provides insight into the traumatic backgrounds of children being served within the agency. This initiative was started to support Wood's Homes' Trauma-Informed Care approach and how this can translate into the everyday practices of the agency (Trauma-Informed Working Committee, 2018). Such approaches can often lead to improved outcomes and ability to meet client needs through a belief that they are resilient and can recover from their trauma (Trauma-Informed Working Committee, 2018).

BACKGROUND

Several factors make ACEs a concerning social determinant of health that is crucial when considering the health outcomes of children and adolescents:

- Social determinants of health for children include situational and environmental elements present in a child's birth, upbringing, and how and where they engage in different facets of society (i.e., school, work, and play).
- Children have more brain plasticity which creates a heightened period of vulnerability (Halfon et al., 2010; Trauma-Informed Working Committee, 2018). Halfon et al. (2010) note how this can manifest via the 4Ds: developmentally, dependency, differential morbidity and demographically. A trauma-informed care approach, such as the one at Wood's Homes, creates a foundation of understanding around the clients and families while also informing decisions made by service providers regarding the continuum of services for care and interventions (Trauma-Informed Working Committee, 2018).
- A child's inability to cope with an environment can result in toxic stress. Toxic stress can inhibit proper development of the brain (Mikkonen & Raphael, 2010).
- Toxic stress during childhood is often caused by ACEs. ACEs include 10 conditions: physical/ emotional/ and sexual abuse, physical/ and emotional neglect, and household dysfunction caused by mental illness/ incarceration/ domestic violence/ substance abuse/ and divorce (CAAMHPP, 2016; Felitti et al., 1988). Each condition is valued at 1, with a maximum ACE score of 10.
- Those with an ACE score of four or higher are at an increased risk for poor health outcomes (Felitti et al., 1988; McDonald et al., 2015). Informed professionals can help build protective factors within children who have high ACEs, which can influence positive health outcomes and lessen the impacts of ACEs.
- ACEs have a cluster effect, so individuals who experience one are more likely to experience additional ACEs and social determinants of health throughout their childhood, adolescence and adulthood (Felitti et al., 1988; McDonald et al., 2015).

CURRENT USE OF ACES AT WOOD'S HOMES:

In January 2018, the Trauma Committee at Wood's Homes started an initiative to collect ACE scores for clients under the age of 18 as part of their work to develop trauma-informed care. By the end of February 2018, 694 ACE questionnaires had been completed. Table 1 details the aggregated agency results for each ACE question. The most common childhood trauma

experience for Wood's Homes' clients under the age of 18 was parental separation or divorce (81.9%). The second and third most experienced ACEs events involved clients who experienced living with someone who is a problem drinker, alcoholic, or user of street drugs (60.7%), followed by clients who experienced living with someone who is depressed, mentally ill, or has attempted suicide (59.3%).

In the first two months of the Trauma Committee's initiative, 4.3 was the average ACE score for Wood's Homes clients. According to the original findings in the ACE study (Felitti et al., 1988), this means that, on average, children and youth in Wood's Homes are at a greater risk of encountering poor health outcomes and other negative social determinants of health. Table 2 presents the average ACE scores for clients in each program area at Wood's Homes. The majority of program areas serve clients with an average ACE score of four or higher, including Street Services (6.2), Community Based Mental Health Services (5.1), Family Support and Collaborative Service Delivery (4.5), and Campus Based Mental Health Services (4.2). This shows that Wood's Homes and similar agencies are working with populations that would benefit from interventions informed by ACEs.

RECOMMENDED POLICIES TO SUCCESSFULLY UTILIZE ACES WITHIN AGENCIES

Children and youth are populations that could benefit if the agencies that work with these individuals are considerate about traumatic histories. By appropriately adopting and using ACE scores, professionals working with youth at risk or high-risk can help interrupt negative trajectories created between ACEs and poor health outcomes (indirect approaches) and reduce the prevalence of social determinants of health and ACEs within future generations (direct approaches).

Indirect Approaches Intended to Interrupt the Trajectory to Poor Health Outcomes:

- Ensure that professionals are educated about (1) biological changes that occur due to ACEs, (2) how ACEs and social determinant of health cluster and accumulate over time, and (3) how ACEs negatively impact the trajectory of health outcomes (Mikkonen & Raphael, 2010). Service providers who understand the impact of trauma can consider a trauma-informed care philosophy that recognizes that clients "may benefit from services that promote safety, trust, choice and control which are provided with compassion" (Trauma-Informed Working Committee, 2018, p. 23).

- Encourage appropriate implementation of ACE scoring schemes by creating realistic timeframes and considering the developmental stage and physiological needs of the child (Trauma-Informed Working Committee, 2018). Developmental assessments are essential in further contextualizing the trauma history and understanding its impact on each individual child (Trauma-Informed Working Committee, 2018).

- Ensure that agencies understand the importance of protective factors and how to build them within children and adolescents with ACE scores who are accessing services (AHS, 2015; CAAMHPP, 2016). This allows ACE scoring to become a tool to build and enhance protective factors by promoting resilience through strength-based approaches and working to prevent additional ACEs (Trauma-Informed Working Committee, 2018).

Direct Approaches Intended to Reduce the Prevalence of Social Determinants of Health/ACEs in Future Generations:

- Raise awareness among the public about the associations between ACEs, social determinants of health and poor health outcomes (CAAMHPP, 2016). Additionally, discussions and assessments of risk should include information and assessments regarding resilience (Trauma-Informed Working Committee, 2018).

- Create a multi-disciplinary panel across organizations to create wraparound programming for a child or youth with multi-system involvement (Ryan, Bashant & Brooks).

- When collecting ACE scores there needs to be a conscientious effort to ensure that the costs and benefits are being weighed regarding the use of any screening tool and that professionals are screening for the appropriate factors within the appropriate population (Finkelhor, 2017). Agencies interested in collecting data on ACE scores in order to increase the ability to meaningfully target high-risk populations need to also ensure they are doing so in a manner that benefits their clientele while also tracking the effectiveness and outcomes of the in-

terventions (AHS, 2015; Finkelhor, 2017).

CONCLUSION:

Individuals with a history of ACEs are likely to have poorer health outcomes in comparison to someone without those experiences (Felitti et al., 1988; McDonald et al., 2015). As part of a trauma-informed care approach Wood's Homes has started collecting ACE scores for clients under the age of 18 and is showing that an agency such as Wood's Homes is likely to see higher than average ACE scores. Agencies should begin thoughtful implementation of ACE scoring to achieve the following: (1) to better treat patients with ACEs; (2) to collect more comprehensive data on these populations; and (3) to become more forward-thinking with regard to precise preventative policies regarding children's health in Canada.

REFERENCES

Alberta Health Services (AHS). (2015). *Zone news: Your health care in your community*. Retrieved from http://www.albertahealthservices.ca/assets/zone/ahs-zone-print-calgary 2015-04.pdf.

Child & Adolescent Addiction, Mental Health and Psychiatry Program (CAAMHPP). (2016). *Adverse childhood experiences (ACE)/ Trauma informed resource guide*. Retrieved from http://www.albertafamilywellness.org/news/caamhpp-aces-guide.

Crosby, S.D. (2016). Trauma-informed approaches to juvenile justice: A critical race perspective. *Juvenile and Family Court Journal*, *67*(1), 5-18.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V.,...& Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventative Medicine*, *14*(4), 245-58. doi: 10.1016/S0749-3797(98)00017-8.

Finkelhor, D. (2017). Screening for adverse childhood experiences (ACEs): Cautions and suggestions. *Child Abuse & Neglect*, doi: 10.1016/j.chiabu.2017.07.016.

Government of Canada. (2013, January). What makes Canadians healthy or unhealthy. Retrieved from https://www.canada.ca/en/public-health/services/health-promotion/populationhealth/what-determines-health/what-makes-canadians-healthyunhealthy.html#healthychild

McDonald, S.W., Manji, S., & Tough, S. (2015). Research-to-practice spotlight: Adverse childhood experiences in Alberta: Results from a population-based telephone survey. *On the Horizon: Child and Adolescent Mental Health*, *8*(2), 1-7.

Mikkonen, J., & Raphael, D. (2010) *Social Determinants of Health: The Canadian Facts*. Toronto: York University School of Health Policy and Management. Retrieved from http://www.thecanadianfacts.org/.

Halfon, N., Larson, K., & Russ, S. (2010). Why social determinants?. *Healthcare Quarterly*, *Special Issue*, *14,* 8-20. doi: 10.12927/hcq.2010.21979.

Public Health Agency of Canada. (2016). *The Chief Public Health Officer's Report on the state of public health in Canada 2016: A focus on family violence in Canada*. Ottawa: Public Health Agency of Canada.

Public Health Agency of Canada Act, Statutes of Canada (2006, c 5). Retrieved from http://canlii.ca/t/52drn.

Ryan, B., Bashant, C., & Brooks, D. (2006). Protecting and supporting children in the child welfare system and the juvenile court. *Juvenile and Family Court Journal, 57*(1), 61–69. doi:10.1111/j.1755-6988.2006.tb00115.x.

Trauma-Informed Working Committee. (2018). *Wood's Homes: Trauma-informed care practice guide*. Calgary: Wood's Homes.

TABLE 1: ACE QUESTIONNAIRE RESULTS FOR WOOD'S HOMES CLIENTS <18 YEARS OLD (JANUARY/FEBRUARY 2018)

ACE QUESTION	Number of Clients with a 'Yes' response	% of Clients with a 'Yes' response
Were their parents ever separated or divorced?	529	81.9
Did they live with anyone who was a problem drinker or alcoholic or used street drugs?	392	60.7
Was a household member depressed or mentally ill, or did a household member attempt suicide?	383	59.3
Did a parent or other adult(s) in the household often or very often... swear at them, insult them, put them down or humiliate them? OR act in a way that made them feel afraid that they might be physically hurt?	351	54.3
Was a family member: often or very often pushed, grabbed, slapped, or had something thrown at him/her? OR Sometimes, often or very often kicked, bitten, hit with a fist, or hit with something hard? OR Ever repeatedly hit or threatened?	319	49.4
Did they often or very often feel that no one in their family loved them or thought they were important or special? OR their family did not look out for each other, feel close to each other, or support each other?	314	48.6
Did they often or very often feel that they didn't have enough to eat, had to wear dirty clothes, and had no one to protect them? OR their parents were too drunk or high to take care of them or take them to the doctor if they needed it?	293	45.4
Did a parent or other adult in the household often or very often push, grab, slap, or throw something at them? OR ever hit them so hard that there were visible marks of they were injured?	199	30.8
Did a household member go to prison?	146	22.6
Did an adult or a person at least 5 years older than them ever... touch or fondle them or have them touch their body in a sexual way? OR attempt to actually have oral, anal, or vaginal intercourse with them?	64	9.9

TABLE 2: AVERAGE ACE SCORES FOR WOOD'S HOMES CLIENTS <18 YEARS OLD (JANUARY/FEBRUARY 2018)

PROGRAM AREA	Number of Clients <18 years with an ACE Score	Average ACE Score
Campus Based Mental Health Services	117	4.2
Community Based Mental Health Services	102	5.1
Crisis and Community Counselling Services	24	2.1
Family Support and Collaborative Service Delivery	278	4.5
Learning Centres	143	3.5
Street Services	30	6.2
TOTAL AGENCY	**694**	**4.3**

Wood's Homes No Restraint Philosophy: Connecting Practice, Theory, and Research Evidence

MICHAEL WALL AND ANGELIQUE JENNEY

INTRODUCTION

The Wood's Homes' initiative to prevent and reduce the utilization of physical restraints across the agency is approaching its 16th year of operation. During this time, the organization committed to policies and practices that worked towards improving client care and preventing and reducing the occurrences of restraints, and situations that may lead to the usage of a restraint. In a previous article featured within the Wood's Homes Journal, Newman and Johansson (2014) described the Wood's Homes' *"Journey Towards Becoming a No-Restraints Organization,"* including a detailed timeline of how the organization shifted practice and the organizational climate to prioritize client wellbeing, children's rights, and successful client treatment (Figure one).

In recent years, there has been a recognition that the utilization of restraints may cause additional harm to children and impact the wellbeing of staff and clinicians involved in the work (Lebel, Huckshorn, Caldwell, 2010). As noted by Day (2002), the therapeutic practices of restraining children and youth are based on outdated paradigms of child mental health treatment. The utilization of restraints may also have severe negative impacts for children who have a history of trauma (especially trauma stemming from violence) and lead to a poor connection between the child and staff and overall program setting. This position on the usage of restraints is further supported by the internal Wood's Homes 2006 qualitative study examining the experiences of youth involved in restraints (Newman & Johansson, 2014). Youth participating in this study "reported increased emotions of anger in the moment of experiencing a restraint event and perceived the practice to be a failure in the treatment process" (Newman & Johansson, 2014, 10). As children's mental health organizations across North America are evolving, there has been an increased focus on preventing and reducing the utilization of restraints, and a shift towards understanding the components that are most important for successful restraint prevention initiatives.

Wood's Homes' No Restraint Philosophy places an emphasis on preventing and reducing restraint occurrences, with the goal of one day becoming a "no-restraints organization." The organization recognizes that this goal may never be achieved, mostly due to the complexities of the programs and services offered, as well as the presenting concerns of the children, youth, and families accessing services. However, the goal serves as an important reminder that practice can always be improved through evaluation and reflection. This article provides a review of the most recent literature on restraint prevention and reduction intervention models, and an exploration of how Wood's Homes' No Restraint Philosophy may be improved through the learned experiences of other children's mental health organizations.

CONNECTING PRACTICE, THEORY, AND RESEARCH EVIDENCE

Recent research literature on the topic of restraint usage within children's mental health organizations across North America highlights a paradigm shift in organizational culture and treatment practices from behavioural theories and approaches to the implementation of trauma-informed theories and practices (Caldwell et al., 2014; Azeem, Reddy, Wudarsky, Carabetta, Gregory, Sarofin, 2015). These shifts in practices and the ways in which we work with the children and families who access our services recognizes the importance of foundational therapeutic practice concepts (e.g., relational bonds, safety, strengths-based approaches) in creating a more supportive and safe treatment climate for children. When describing the important factors that are most predictive of successful restraint-prevention initiatives, it appears that the environmental contexts and treatment climates are

extremely important; in that trauma-informed, safe, supportive, and protective treatment environments may be the foundational components necessary to prevent and reduce restraint occurrences (LeBel, Huckshorn, Caldwell, 2010; Azeem et al., 2015).

Since 2004, Wood's Homes has been implementing, monitoring, and improving its overarching strategy to prevent and reduce restraint occurrences across the organization and its many programs and services. As described in the most recent Wood's Homes (2015) Policy Manual, the No Restraints Philosophy and all the initiatives implemented have been informed by evidence-based practices, as well as internal quality improvement and research studies. These initiatives have led to a dramatic reduction in the number of restraints performed on clients and improvements in staff and client outcomes (Newman & Johansson, 2014). When comparing the data from the initial years (2002-2009) of Wood's Homes' No Restraint Philosophy (as reported by Newman & Johansson, 2014), and the more recent years (2010-2017), we see that there is an approximate 80% decrease in restraint occurrences between the two time periods. On average, 250 physical restraint occurrences were recorded each year across Wood's Homes programs and services between 2002 and 2009. The highest number of restraints were recorded in 2006 (492) and the lowest number of restraints were recorded in 2004 (99) (Newman & Johansson, 2014). When reviewing annual restraint occurrence data between 2010 and 2017, we found that the average number of annual physical restraints drops dramatically to approximately 50 restraint occurrences per year; with the most significant change occurring between 2010 and 2011, where we see annual restraint occurrences drop from 118 (2010) to 28 (2011). These findings highlight the importance of the restraint occurrence tracking and monitoring that is being completed at Wood's Homes, as well as the effectiveness of the evidence-based interventions and the multi-faceted strategy that have been implemented to prevent and reduce physical restraints across the organization.

Wood's Homes' strategy of restraint prevention and reduction has incorporated a multi-faceted approach adopted from the Andrus Children's Centre Approach to Reducing Restraints (Farragher, 2005; Newman & Johansson, 2014). This strategy places an emphasis upon four key components, including: (1) developing the roles of the organization's leadership in the initiative and how they support the staff and the development of an organizational climate conducive towards change; (2) staff professional development through trainings, clinical reviews, and supervision; (3) reviewing programming and shifting towards a focus on trauma and trauma-informed practice; and (4) monitoring and reviewing individual restraint occurrences (through an internal and external restraint occurrence review process), as well as trends within and between programs through data collection, analyses, and knowledge sharing. The Andrus Children's Centre Approach, as described by Farragher (2005), is quite similar to an evidence-based national initiative developed by the National Association of State Mental Health Program Directors (NASMHPD) in the United States, titled the "Six Core Strategies for Reducing Seclusion and Restraint Use" (NASMHPD, 2009). Since the first 'Six Core Strategies' training curriculum (developed in 2002), the program has built an evidence base supporting its effectiveness and has met the criteria for the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices (LeBel, Huckshorn, & Caldwell, 2010; SAMHSA, 2012). The 'Six Core Strategies' model works towards the primary prevention of restraint occurrences. Lebel and others (2010) noted that the model "identifies the risk factors for conflict and violence before they occur, along with the necessary early interventions strategies to immediately respond to conflict before it escalates, so using restraint and seclusion practices can be prevented" (171). Since 2014, the evidence for the Six Core Strategies model of restraint prevention and reduction has been growing, where many organizations across North America and around the world have implemented the model and tracked its effectiveness through program evaluation and research methodologies. These studies have typically shown that the Six Core Strategies can drastically and significantly reduce the occurrences of restraints within children's mental health and psychiatric organizations (LeBel, Huckshorn, Caldwell, 2010; Caldwell, et al., 2014; Valenkamp, Delaney, & Verheij, 2014; Wieman, Camacho-Gonsalves, Huckshorn, and Leff, 2014; Azeem, et al., 2015).

At the time of writing this article, Wood's Homes has already successfully implemented many of the interventions listed under most of the NASMHPD six core strategies. For example, Wood's Homes has commit-

ted to providing additional support for staff around the prevention of restraints by offering trainings, supervision sessions, and the "Meaningful Conversation" sessions (Newman & Johansson, 2014). Wood's Homes has also implemented a rigorous restraint review process, in which each restraint occurrence is reviewed by senior management and, if needed, the agency Risk Officer. When a child or staff are involved in more than three restraint occurrences, these occurrences are further reviewed by internal and external assessors to learn from the incidents and to further improve the overall prevention strategy. In addition, Wood's Homes has also monitored and tracked restraint occurrences and has used this data to inform clinical and organizational practices which is aligned with NASMHPD fifth core strategy for restraint prevention and reduction (see Figure 2). In addition to these successful Wood's Homes interventions, further lessons may be learned from other organizations that have fully implemented the Six Core Strategies Model and have successfully prevented and reduced the number of restraints. For more information on the model and its effectiveness see the publication by the NASMHPD (2009).

MOVING FORWARD: IMPROVING UPON WOOD'S HOMES' MODEL OF RESTRAINT PREVENTION AND REDUCTION

Wood's Homes' No Restraint Philosophy is approaching its sixteenth year of operation. As described by Newman and Johansson (2014), during this time there have been some "bumps in the road;" however there has also been some tremendous work completed by staff, clinicians, and organizational leadership, all of whom have worked together to improve client care and therapeutic outcomes. These successes should be celebrated, as restraint occurrences have been significantly lowered over the last eight years of the initiative. Moving forward, organizational staff and leadership may consider additional areas of improvement within Wood's Homes' restraint prevention/reduction model to further improve client care and outcomes goals. One important consideration is model implementation and fidelity across the many different Wood's Homes programs and services. Variations in how we work may be necessary according to our client populations and the type of work that is being completed. However, the implementation and application of restraint prevention interventions should be rigorously monitored within each program and across the overall Wood's Homes organization. Wieman and others (2014) examined patterns of model fidelity across 43 different psychiatric facilitates across the United States that had implemented the NASMHPD Six Core Strategies Model for restraint prevention and reduction. The Inventory of Seclusion and Restraint Reduction Interventions (ISRRI) was used to measure the extent to which each facility was fully implementing the six core strategies and its interventions (as prescribed by the Six Core Strategies Curriculum) (NASMHPD, 2009; Wieman, et al., 2014). Results from this study found that "differences among facilities in the degree of restraint reduction were related to differences in the extent of implementation" (350). Wood's Homes could consider applying a similar methodology to systemically understand implementation in each program and to consistently support staff and clients within the efforts of preventing and reducing restraint occurrences. The monitoring of implementation and fidelity could be treated as one of many process measurements included into the No Restraints Philosophy logic model, with an understanding that these are some of the many processes that are driving the important outcomes of supporting staff, preventing restraints, and improving client care.

Azeem and others (2015) have described the implementations of an "Assaulted Staff Action Plan" (ASAP) Teams. These teams work towards providing immediate peer support for staff who have been involved in a violent situation with a client. In addition, "STAR Teams" have also played an integral role in preventing and reducing restraint occurrences, as these teams are made up of clinical management and directors who may be more skilled in areas of client conflict de-escalation practices. Both the ASAP and STAR team models are typically designed to be on-call within the organization and can immediately respond to an event when required (Azeem and others, 2015). Another example of further implementing the six core strategies may include fully including both youth and families within the process of restraint prevention and reduction highlighted in NASMHPD fourth core strategy for restraint prevention and reduction (see Figure 2). Including the perspectives of youth and family service users into the overarching restraint prevention strategy is an incredibly important component of the Six Core Strategies model. As shown by the Wood's Homes qualitative study on

experiences of Youth involved in Restraints in 2006, we can gain invaluable information from our children, youth, and families accessing services and their experiences with restraints and other coercive treatment practices (Newman & Johansson, 2014). Participation of children and youth and including their voices and perspectives in all aspects of this process is directly aligned with the United Nations Convention on the Rights of the Child and presents additional opportunities to include clients in the processes of creating a safe, supportive, trauma-informed organization and restraint reduction strategy. In addition, the process of including youth and families within the restraint prevention strategy is even more important within the context of Wood's Homes, as many children who have experienced a restraint have identified as being Indigenous (approximately 36% of all individuals who have experienced a restraint between 2012 and 2017). Incorporating Indigenous Worldviews and experiences will ultimately lead towards opportunities to indigenize the trauma-informed practices and the overarching strategies of preventing and reducing restraint occurrences.

Recent research within the area of restraint utilization has focused upon the client and staff characteristics that may be predictive of a future restraint occurrence. Studies have found that within children's mental health organizations, children with lowered psychosocial functioning, who were of a non-white identity, identified as male, and had experiences of immigration, lowered family functioning, lowered socio-economic status, and severe presenting concerns (measured in number of admissions, lengths of admissions, and psychopathology assessments) were at greater risk of experiencing a restraint occurrence during treatment (De Hert, Dirix, Demunter, Correll, 2011; Furre, Sandvik, Heyerdahl, Friis, Knutzen, Hanssen-Bauer, 2014; Jacob, Sahu, Frankel, Homel, Berman, McAfee, 2015). In addition, within educational settings across the United States, it was found that children with cognitive and physical disabilities, lowered socio-economic status, and the presence of state policies and laws regulating restraint utilization and prohibiting corporal punishment were all factors that were predictive of restraint occurrences (Barnard-Brak, Xiao, & Xiaoya, 2014). Recently, some literature has even identified promising clinical practices (such as the Neurosequential Model of Therapeutics (NMT) and Collaborative Problem Solving (CPS) approaches) that may also contribute to lowering child behaviour problems with lowered use of restraint as a direct result (Hambrick et al, 2018). Keeping these important predictive factors in mind when evaluating Wood's Homes' restraint initiatives is important, as it speaks to the varying levels of supports and interventions that may be applied in protecting the most vulnerable populations accessing services. Opportunities to further examine restraint occurrence patterns and to understand what subpopulations of clients and staff are most likely to experience a restraint event are areas of future exploration.

CONCLUSION

Wood's Homes' initiative to prevent and reduce restraint occurrences has been successfully implementing evidence-informed and multi-faceted strategies for the past 16 years. Despite the successes highlighted in recent years, an organizational change of this magnitude and complexity needs to be understood as a continuously evolving process; one where there are "bumps in the road," but also lessons learned and improvements within the areas of client care and treatment outcomes. A foundational aspect of any restraint prevention model should also consider the systems of support; which may involve how we are supporting our children and youth to improve therapeutic relational bonds, client experiences, and to prevent restraint occurrences. This system of support may also work towards understanding how we can better support staff (e.g., through "ASAP" or "STAR" teams) so they can work towards better supporting our clients (Azeem et al., 2015). Key considerations given towards creating a safe, protective, and trauma-informed climate is conducive towards the prevention of violent situations and restraints. Moreover, the implementation of the policy itself as well as therapeutic models of intervention that may reduce the need of restraint, as well as fidelity between programs could be monitored and factored into future restraint data reviews as well as an overall project logic model. Finding ways to continue including children, youth, and families accessing services into the no-restraints initiative will help us better understand how to improve based on varying world views and perspectives between subpopulations of clients.

REFERENCES

Azeem, M. W., Reddy, B., Wudarsky, M., Carabetta, L., Gregory, F., & Sarofin, M. (2015). Restraint reduction at a pediatric psychiatric hospital: A ten-year journey. *Journal of Child and Adolescent Psychiatric Nursing*, 28(4), 180-184.

Barnard-Brak, L., Xiao, F., & Xiaoya, L. (2014). Factors associated with the use of restraints in the public schools. *Education and Treatment of Children*, 37(3), 461-475.

Caldwell, B., Albert, C., Azeem, M. W., Beck, S., Cocoros, D., Cocoros, T. & Reddy, B. (2014). Successful seclusion and restraint prevention efforts in child and adolescent programs. *Journal of psychosocial nursing and mental health services*, *52(11)*, 30-38.

Day, D. M. (2002). Examining the therapeutic utility of restraints and seclusion with children and youth: The role of theory and research in practice. *American Journal of Orthopsychiatry*, *72*(2), 266.

Farragher, B. (2005). A systematic approach to restraint reduction & elimination. Retrieved from http://asaha.com/ebook/MNjcyNTE-/A-Systematic-Approach-toRestraint-Reduction-Elimination.pdf

Furre, A., Sandvik, L., Heyerdahl, S., Friis, S., Knutzen, M., & Hanssen-Bauer, K. (2014). Characteristics of adolescents subjected to restraint in acute psychiatric units in Norway: a case-control study. *Psychiatric Services*, *65*(11), 1367-1372.

De Hert, M., Dirix, N., Demunter, H., & Correll, C. U. (2011). Prevalence and correlates of seclusion and restraint use in children and adolescents: a systematic review. *European child & adolescent psychiatry*, *20*(5), 221-230.

Hambrick, E.P., Brawner, T.W., Perry, B. D.Wang, E.Y., Griffin, G., DeMarco, T., Capparelli, C., Grove, T., Maikoetter, M., O'Malley, D., Paxton, D., Freedle, L., Friedman, J., Mackenzie, J., Perry, K.M., Cudney, P., Hartman, J., Kuh, E., Morris, J., Polales, C. & Strother, M. (2018) Restraint and Critical Incident Reduction Following Introduction of the Neurosequential Model of Therapeutics (NMT), *Residential Treatment for Children & Youth*, 35:1, 2-23, DOI: 10.1080/0886571X.2018.1425651

Jacob, T., Sahu, G., Frankel, V., Homel, P., Berman, B., & McAfee, S. (2016). Patterns of restraint utilization in a community hospital's psychiatric inpatient units. *Psychiatric Quarterly*, *87*(1), 31-48.

LeBel, J., Huckshorn, K. A., & Caldwell, B. (2010). Restraint use in residential programs: why are best practices ignored?. *Child Welfare*, *89*(2), 169.

National Association of State Mental Health Program Directors. (2009). *National executive training institute: A training curriculum for the reduction of seclusion and restraint (7th ed.)*. Alexandria, VA. National Association of State Mental Health Program Directors, Office of Technical Assistance.

Newman, J., Johansson, B. (2014). The Journey Towards Becoming a No-Restraint Organization. *Wood's Homes Journal: Evidence to Practice, 1(1)*, 7-14.

Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA's national registry of evidence-based programs and practices*. Retrieved from https://nrepp.samhsa.gov/Legacy/ViewIntervention.aspx?id=278

Wieman, D. A., Camacho-Gonsalves, T., Huckshorn, K. A., & Leff, S. (2014). Multi-site study of an evidence-based practice to reduce seclusion and restraint in psychiatric inpatient facilities. *Psychiatric Services*, *65*(3), 345-351.

Valenkamp, M., Delaney, K., & Verheij, F. (2014). Reducing seclusion and restraint during child and adolescent inpatient treatment: Still an underdeveloped area of research. *Journal of Child and Adolescent Psychiatric Nursing*, *27*(4), 169-174.

Wood's Homes. (2015). No Restraint Philosophy at Wood's Homes. *Policy & Procedures Manual, 1.21*, 1-3.

FIGURE ONE. WOOD'S HOMES' NO RESTRAINT PHILOSOPHY TIMELINE (NEWMAN & JOHANSSON, 2014)

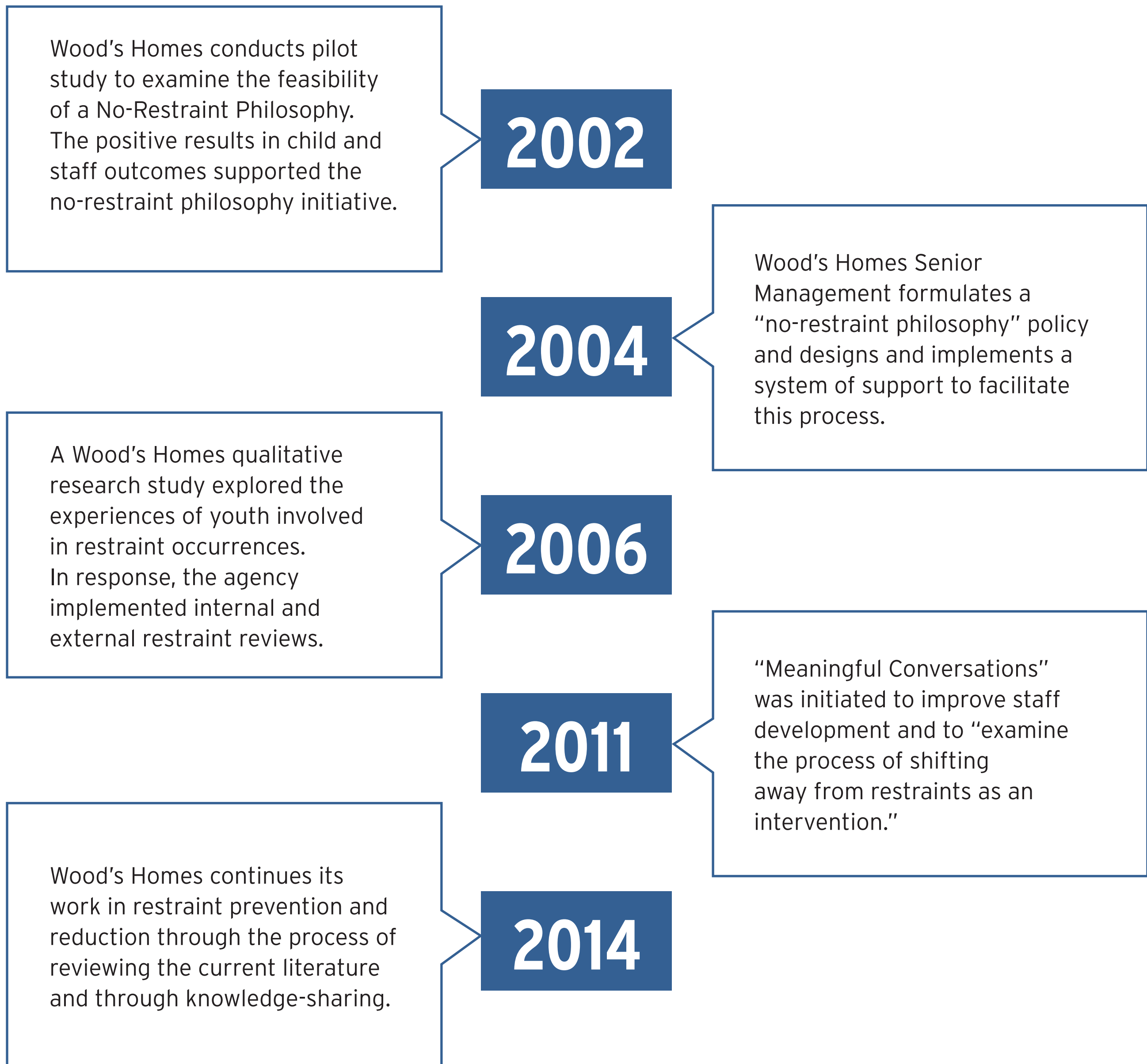

FIGURE TWO. AN OUTLINE OF THE NASMHPD SIX CORE STRATEGIES FOR RESTRAINT PREVENTION AND REDUCTION (NASMHPD, 2009; LEBEL, HUCKSHORN, & CALDWELL, 2010).

SIX CORE STRATEGIES	DESCRIPTION
Leadership Towards Organizational Change	Organizational leaders, directors, and senior management must take an "active consistent, and visible role in implementing a comprehensive plan to prevent conflict and violence." This strategy may include interventions such as policy formation and enforcement. But it also may include organizational leaders taking an active role in staff development, supervision, and modelling clinical practices during situations that may escalate to a restraint occurrence.
Work Force Development	Staff development should be an integral part of the restraint prevention initiative. This may include supervision, and opportunities to practice skills in a safe space. In addition, staff should be provided training on key practice concepts, including trauma-informed and resilience-informed practices, the impacts of trauma (including inter-generation trauma experienced by Indigenous clients). These trainings should also work towards dispelling the myths surrounding restraint utilization.
Using Prevention Tools	Prevention tools (e.g., tools of assessment) to assess for trauma, violence, and other factors that may place a client at risk for experiencing a restraint occurrence should be implemented. Other prevention tools may consist of the formation of clinical staff teams that can immediately attend a crisis event to support both child clients and staff.
Full Inclusion of Youth, Families, and Advocates	LeBel and others (2010) discuss the importance of family-driven and youth-guided interventions. Youth and their families accessing services at Wood's Homes should have their voices and perspectives heard regarding restraint utilizations and should be involved in all areas of treatment to understand each child's supports and triggers. Involving youth and family also provides opportunities to incorporate their worldviews and perspectives.
Using Data to Inform Practice	Restraint data should be collected and used purposefully to drive forward the learning process and to understand how to improve the implemented strategies, as well as which programs and subpopulations of clients may require the most support. Data should be shared with staff regularly and posted in visible areas of the program to further facilitate the restraint prevention interventions. It's important that this information is not used in a punitive manner, but to guide the processes and overarching strategy.
Rigorous Analysis of Events	Every restraint occurrence should be analyzed to understand how and why it occurred and how it could have been prevented. This may involve an immediate post-event review to ensure that all involved are safe and free from injury; as well as a more formal debrief for staff and for children (and their families) involved in the restraint. These reviews can work towards understanding where the processes of restraint prevention went wrong, but also how to further support the children and staff involved (e.g., providing additional skills training or adding to the child's treatment plan).

Practice Lessons: Story # 39

JANE MATHESON

One kid stands out for me. Let's call him Carl. In the early days I had a lot more to do with the kids than I do now. Now I'm more on the administrative end, but at the time I had more to do with the difficult kids, and the older kids tended to be most difficult. There was an older kid who came to Cottage Two. The description of him in the files was that he was "chronically suicidal." I didn't understand that. If you were chronically suicidal, wouldn't you be dead? But that's what it said. It turned out he was very, very smart. His mother was a sex trade worker. He didn't know where any of his family was. For some reason I liked him. He was highly manipulative, unlike a lot of kids in residential treatment who are just acting out and aren't really interested in if you like them or not. So I would enter into banter with him where we would try to win the argument of the day. Luckily, I would win the argument most of the time.

One day he came in and was in a terrible mood. The staff was angry at him. And they would do all the wrong things. I couldn't understand how they couldn't see that he was manipulating them. I remember sitting across from him in my office. He was being belligerent. He wouldn't answer. He was aloof. His hair was hanging over his face. I said to him, "I think you have a cold. Do you have a cold?" He looked daggers at me narrowing his eyes, but didn't reply. I said, "Well, I think you have a cold." He just said, "Ya?" But he looked at me like, why am I talking about this. He said, "Well I've had it for a couple of weeks." I asked, "Are you wearing your mitts, your hat, your scarf?" He said, "What?" I said, "Are you wearing those things? Because your cold will get worse if you don't." He just stared at me and the meeting went on with him staring at me.

A few months later he graduated. He got ready to leave. And Barry, a colleague, invited Carl and me to his place for dinner. Barry made dinner. We went over there. Barry said to him, "What was the one thing you remember about Wood's Homes?" The moment Barry asked, I knew exactly what Carl was going to answer. He said, "It was that day that Jane asked me if I was wearing my hat, my scarf, and my gloves." And I thought to myself, "Okay, you do all the therapeutic training in the world, and in the end, that's what it comes down to. Simply making sure that he's wearing his scarf and hat."

I would see him periodically around the city. He ended up working oil rigs, and he would call me up to talk. But thinking back to that, I would just be amazed by the simplicity of what works to get someone to turn around. There are countless stories from other therapists who will say the same thing: someone says they changed their life and the therapist doesn't remember at all. That kind of thing has driven my work. The simplest things. The simplest stories.

** Editorial note: This story was previously published as Story #39 in One Hundred Stories for One Hundred Years, released in 2013. The story was reprinted with permission and the support of Clem Martini, the Editor of this book. The book citation follows:*

REFERENCES

Martini, C., (2013) One hundred stories for one hundred years: A history of Wood's Homes as told by the people who lived and worked there. Edmonton: Brush Education Ltd.

Author Affiliations

ALLEN BALSER is the Executive Director at Alta Care Resources

ANITA BLACKSTAFFE is a Research Assistant at Wood's Homes Research Department

SUSAN GARDINER is a Director of Programs at Wood's Homes

ANGELIQUE JENNEY is the Wood's Homes Research Chair in Children's Mental Health & an Assistant Professor at the faculty of Social Work, University of Calgary

KAFILAT JIMABA-BIDMUS is a Researcher Assistant with the University of Calgary

BJORN JOHANSSON is a Director of Research and Programs at Wood's Homes

BRUCE MACLAURIN is an Assistant Professor at the Faculty of Social Work, University of Calgary and a Senior Researcher at Wood's Homes

JANE MATHESON is the Chief Executive Officer of Wood's Homes

JENNA PASSI is a Research Assistant at Wood's Homes Research Department

CHRISTA SATO is a Researcher Assistant with the University of Calgary

ANTON SMITH is the Executive Director of Oak Hill Foundation

MICHAEL WALL is a Researcher Assistant with the University of Calgary

WOOD'S HOMES
WORKING FOR CHILDREN'S MENTAL HEALTH
SINCE 1914

Wood's Homes
805 – 37th Street, NW
Calgary Alberta T2N 4N8
Tel: (403) 270-4102
www.woodshomes.ca