The Delivery of Youth Mental Health Services in Group Homes: Working towards a facilitating therapeutic environment.

By

Heather Carson

A thesis submitted to the Faculty of Graduate and Postdoctoral Affairs in partial fulfillment of the requirements for the degree of

Master of Social Work

Carleton University

Ottawa, Ontario

Library and Archives Canada

Published Heritage Branch

395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque et Archives Canada

Direction du Patrimoine de l'édition

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence
ISBN: 978-0-494-87851-4

Our file Notre référence
ISBN: 978-0-494-87851-4

Abstract

Youth who reside in a child welfare group home have an increased prevalence of mental health problems. The youth's 'circle of care' which includes the child welfare social worker, group home worker and mental health clinician, provide services to address these problems. Using Winnicott's psychoanalytic concepts, Bowlby's attachment theory and the contemporary psychiatric model to examine service delivery, gaps are illustrated that contribute to negative outcomes for youth.

This study uses qualitative methods to provide a front line perspective of residential life and work in the group home environment. Findings illustrate that barriers exist in supporting youth's needs including a lack of placement stability and permanency, inadequate services to transition youth to independence or the adult system and the need for a more therapeutic group home environment. Findings also illustrate that collaboration within the 'circle of care' can address service barriers and unmet mental health needs of youth in group care.

Acknowledgments

It has been my privilege to work with Professor Cecilia Taiana on this project. I would like to extend my personal thanks for her time, support, guidance and feedback throughout this project and my academic career. Additionally I would like to thank my second reader Professor Therese Jennissen for her time and feedback, as well as committee member Dr. S. Bennett.

I am grateful to all research participants who took time from their busy schedules to assist me in this endeavour and provided thoughtful insight into the work that they do. I would also like to thank my friends and colleagues who assisted me throughout this process with words of wisdom, encouragement and thought provoking discussions. Finally, to my husband who dealt with me and my rooms full of paper, your support has been invaluable.

Table of Contents

Chapter One: Introduction

I. Introduction to the Problem

It is widely recognized in current literature that youth who reside in child welfare group homes are exposed to a number of deleterious events including trauma associated with familial abuse and neglect, separation from family members, friends and the community. The likelihood also exists that many disruptions to the primary-caregiver relationship will be experienced once in the care system (Adnopoz, 1998; Boyd-Webb, 2006; Crenshaw & Hardy, 2006; National Youth in Care Network (NYICN), 2009; Prince & Austin, 2005; Tarren-Sweeny, 2008a; Tarren-Sweeny, 2008b; Wotherspoon, O'Neill-Laberge & Pirie, 2008). The results of such experiences undermines healthy development for these youth and has shown to frequently result in an increased diagnosis of mental health problems (Boyd-Webb, 2006; Burge, 2007; Collishaw, Pickles, Messer, Rutter, Shearer & Maughan, 2007; Fedoravicius, McMillen, Rowe, Kagotho & Ware, 2008; NYICN, 2009; Schilling, Aseltine & Gore, 2008; Tarren-Sweeny, 2008a; Tarren-Sweeny, 2008b). Furthermore it has been shown that youth in a child welfare group home are exposed to care settings that potentially exacerbates the continued experience of loss for youth (Briggs, 2004); that they are subject to negative peer groups and affiliation with delinquent peers (Ryan, Marshall, Herz & Hernandez, 2008); they lack permanent stable placements with an absence of enduring bonds to healthy adults and are inadequately prepared for the transition to independence or the adult mental health system (Crenshaw & Hardy, 2006; Freundlich & Avery, 2005; Hawkins-Rodgers, 2007; Ryan et al., 2008; Tomlinson, 2008). Together these findings illustrate the need to

evaluate how care is delivered in the group home model; to consider how this model intersects with the child welfare system and the mental health system; and to identify areas prime for change, development and improvement.

The current system for service delivery involves three main stakeholders: the group home, the child welfare system and the mental health system. For the purposes of this study these stakeholders will be known as the youth's 'circle of care'. Mennen and O'Keefe, (2005) indicate that for professionals working with youth in the child welfare system, the primary goals are to ensure safety and protection from further abuse, to help with the healing process resultant from the effects of experienced maltreatment and to provide opportunities for improved development and functioning. Looking at the germane theoretical and practice perspectives of each system in the 'circle of care' however, uncovers a number of inadequacies which impedes professionals' ability to achieve these goals. Although one may expect that the vulnerabilities and needs exhibited by group home residents would demand that high quality, effective services are available to achieve the above mentioned goals, the reality is a number of significantly negative outcomes for youth remain associated to living in the group home model (Baker, Ashare & Charvat, 2009; Freundlich & Avery, 2005; Hawkins-Rodgers, 2007; Ryan et al., 2008; Wilson & Woods, 2006). These negative outcomes may potentially be mitigated by improved service delivery and collaboration within the 'circle of care'.

There are numerous correlating factors that contribute to and exacerbate deficiencies in the 'circle of care'. One of the most glaring concerns is that these system

are characterized by a lack of co-ordination and fragmentation between stakeholders and that collaboration between treatment providers is ineffective or non-existent (Darlington & Feeney, 2008; Fulcher & Ainsworth, 2005; Leathers McMeel, Prabhughate, & Atkins, 2009; Prince & Austin, 2005). This, despite a strongly recognized need in current research for linkages between mental health and child welfare systems and the illustrated benefits of inter-agency collaboration (Darlington & Feeney, 2008; Darlington, Feeney & Rixon, 2004; Darlington, Feeney & Rixon, 2005; Foster, Stephens, Kivelyova, & Gamfi, 2007; Leathers et al., 2009; Mennen & O'Keefe, 2005; NYICN, 2009; Prince & Austin, 2005; Wakelyn, 2008; Wotherspoon et al., 2008). The gaps and weaknesses identified in current research show that despite our best efforts we are failing these highest risk youth. In fact it is argued that "we recreate the chaos, fragmentation, trauma, and neglect these children have experienced in their homes" (Perry, 2006 p. 29).

As policy makers and service providers design and implement services to support the mental health and well being of children and youth, specific attention must be given to the unique issues of the child welfare population, particularly the very vulnerable population that reside in group care. Strong linkages between the group home, the child welfare system and the mental health system through collaboration within the 'circle of care' are requisites for a society and social welfare system that claims to place primacy on the emotional well being of abused and neglected children. This study endeavours to examine service delivery in the 'circle of care' in Ottawa to illustrate whether gaps found in current research are replicated and in what manner. Particular attention will be given to the collaborative structures and practices within the 'circle of care' and the

contributions these structures have on the mental health outcomes of youth in the group home. Without such an examination, a comprehensive effective care system cannot be ensured and the role that the 'circle of care' and its stakeholders play may arguably contribute to the spiral of deprivation these youth experience (Adnopoz, 1998).

II. Research Question

Given the severe vulnerability and complexity of youth living in group care, as well as the preponderance of negative outcomes and service gaps identified in current research, an examination of youth's 'circle of care' is paramount. This study will provide a deeper understanding into the residential life and residential work in group homes in Ottawa with respect to the need for, and provision of, mental health services. This researcher will use the psychoanalytic work of D.W. Winnicott as a theoretical framework to examine both current research and the group home environment in Ottawa for therapeutic shortcomings are experienced as problematic by group home staff and residents.[1] This study will delve into the frontline experiences of group care workers, as well as that described in current research, to further elucidate occupational challenges in this field, and the impacts to the delivery and outcomes of mental health services for youth. This research will establish if the shortcomings identified by current research are also present in the Ottawa care system and if so, how they are experienced by frontline professionals. As well, collaborative structures between members of the 'circle of care'

[1] D.W. Winnicott (1896-1971) was a British paediatrician, child psychiatrist and psychoanalyst. Winnicott worked with psychically disturbed children and their mothers, contributing a number of concepts to the field of psychoanalysis and beyond (Borden, 2009).

will be considered to determine current practice protocols and the impact on service delivery.

In addition to a review of the group home environment, experiences of child welfare social workers and clinicians in the mental health system will be considered to provide a comprehensive examination of the youth's 'circle of care'. Theoretical postulations on attachment, most notably the contributions of J. Bowlby, will be used to examine the impact of the child welfare experiences for youth in group care and to consider if gaps exist between service delivery and intention.[2] Similarly, this research will consider the influence and dominance of the contemporary psychiatric model on services delivered by the mental health system to demonstrate if areas exist where the current construction of services falls short of achieving the expressed goals of the intervention. Findings in current research will be compared with findings of professionals in the Ottawa care system. Through an investigation into the professional experiences of child welfare social workers, group home workers and mental health clinicians regarding perceived service effectiveness, occupational challenges and collaborative opportunities between systems; it is expected that a deeper understanding of gaps and weaknesses in service delivery will be identified.

This research will address the question: "Do gaps exist in the delivery of mental health services between the group home model, the child welfare system and the

[2] Edward John Mostyn "John" Bowlby (1907-1990) was a British psychologist, psychiatrist and psychoanalyst, He was known for his interest in child development. Based on his clinical work with youth in care he theorized attachment theory (Gerber, 2006).

mental health system and how do collaborative structures between these service providers address or contribute to the experience of these gaps in Ottawa?" The collaborative structures specifically considered are discipline insularity, shared perspectives, knowledge and training of professionals, quality and availability of services and resource allocation. The investigation will also examine if collaborative shortcomings identified in research are replicated in the Ottawa system and if so, how this is experienced by service providers. Research on the practice paradigms of each system will be explored for strengths and shortcomings, with the expectation that areas will be identified where collaborative work between stakeholders would strengthen experiences and outcomes for involved parties.

This study strives to examine service delivery from a systems level and a programmatic level, not an evaluative or practice level investigation, although some overlap is expected. By developing an understanding of mental health concerns and how they are addressed for youth living in group homes, as well as an understanding of how frontline stakeholders manage and collaborate in providing appropriate services; it is hoped that a basis for improved practice, policy development, education, training, and a guide for future research and evaluation will be created.

III. Theoretical Framework

When children are removed from their homes and placed in the system of care, it is done with the assumption that an alternate placement will provide a superior environment to optimize the child or youth's development and well being. The group

home model as an option in this system of care asserts that it provides such an environment. Certainly, a strong voice in current literature asserts that the group home model should be considered a therapeutic treatment option (Yecheskiel, 1984), and current funding frameworks encourage private operators to create programming that support such assertions (Sherwood, 1984). The psychoanalytic theories of D.W. Winnicott will be used to consider the therapeutic experience of the group home and contributions of attachment theory will be used to examine the child welfare system. The contemporary psychiatric model and the impact on mental services will provide a conceptual framework from which to compare, examine and explore gaps between service intentions and service outcomes.

Winnicott's key concepts

D.W. Winnicott contributes to psychoanalytic thinking with concepts that are rooted in the experience of the clinical situation. His concepts help to understand critical aspects of human development, problems that contribute to the development of psychopathology, and curative elements in the therapeutic process. Winnicott's concepts of 'facilitating the maturational process' through the 'holding environment', 'and the 'development of self' are particularly relevant when considering the ability of the group home to provide a setting for a corrective experience of earlier environment and caregiver failures (Winnicott 1956; 1963; 1970).

The term 'holding environment' was used in two ways by Winnicott; to describe the biopsychosocial context in which infants are cared for by their caregivers; and as is

relevant for the scope of this study, as a metaphor for the relational matrix of effective helping efforts (Applegate, 1997). The professional provides the 'holding environment' while the client attempts to make changes, however, first the client must test the professional and the environment to see if it is safe and reliable, or if it will repeat traumatic experiences of the past (Winnicott, 1963). This testing often takes the form of aggression and rage directed towards the youth worker and should be viewed as part of the process in developing a therapeutic relationship. By surviving the test, youth experience the environment and staff as safe and reliable and begin to trust and move on (Tomlinson, 2008). Winnicott's writings on such testing (alternatively termed anti-social behaviours) indicates these behaviours actually result from youth experiencing hope that the environment and caregivers will be able to meet his or her needs (Winnicott, 1956). It is therefore important that caregivers are able to interpret and respond to behaviour with this understanding.

Further requisites of the 'holding environment' elucidated by Winnicott (1956, 1963, 1970) are maintaining a stable, supportive and reliable environment. Continuity being central to the 'holding environment' requires "constant emotional contact with a person who knows how to react and use the life-space events therapeutically" (Yecheskiel, 1984 p. 39). This also requires the guarantee of permanency in a placement as much as is possible. Additionally, staff integration in approach and in managing internal conflicts is crucial to maintain the stable, reliable environment that Winnicott refers to in his literature (Eisenstein-Naveh, 2003).

Winnicott sees the concept of 'good-enough care giving' as the variable which makes the difference between a positive or negative outcome. This involves a cycle of failure and mending of failure which allows the expectation of consistency, reliability and stable mental representations of others to develop (Applegate, 1997). Within this 'good enough' relationship between the youth and his or her caregivers it must be acknowledged that the experience of closeness and trust may elicit "feelings of longing and wishes to be cared for that can be quite frightening and reactivate fears of abandonment and deprivation" (Schore, 1997 p. 87). Awareness and appropriate reaction to acting out behaviours generated by these feelings allows the cycle of failure and mending of failure to occur, which provides youth a sense of safety and security.

Schore (1997) indicates that youth often are unable to communicate verbally what they are experiencing and instead may exhibit hostile, aggressive or other acting out behaviours. This should be understood as an attempt to give youth workers the "experience of being on the receiving end of disinterest, anger or abandonment and to provoke behaviour that replicates that of earlier objects" (Schore, 1997 p. 87). In accordance with Winnicotts' theoretical concepts, understanding and responding to such actions through empathy and connection to the client's inner world can facilitate the change process and development of well-being (Borden, 2009).

As a final point, Borden (2009) summarizes Winnicott's views of the 'maturational process' as follows: individuals are inherently driven to realize their potential and develop a sense of self. If the environment is not 'good enough' to facilitate this development the individual is at risk for psychopathologies and dysfunction. It is also

theorized that a person's development involves a continual interplay between the caregiver, the environment and the individual in which creativity, spontaneity and the ability to recognize and respond to individual needs, facilitates maturation and development of self (Borden, 2009).

Attachment theory's key concepts.

Attachment theory helps explain the impact of placement decisions in child welfare and outcomes for youth involved. This includes an increased likelihood of turning to delinquent peers (Ryan et al., 2008), difficulty establishing long term relationships (Adnopoz, 1998) and a number negative effects on youth's mental health that may last well into adulthood (Hawkins-Rodgers, 2007). The importance of attachments in creating positive outcomes for youth in the child welfare system cannot be overstated. There is little doubt that an understanding of attachment theory is important for the development of healthy children and an essential consideration in child welfare decision making. Research on attachment provides an understanding of the development of psychopathology in youth (Gerber 2006); the challenges youth face establishing trusting, enduring relationships (Freundlich & Avery, 2005); and the risks for affiliation with delinquent peers (Ryan et al., 2008). Recognition, consideration and application of attachment theory can help avoid some of the issues that make child welfare interventions potentially problematic for the children they are trying to serve (Mennen & O'Keefe, 2005).

Attachment theory originates with the work of Bowlby (1969; 1982; 1991) and postulates that the key developmental task of infancy is to form an attachment to the mother, or primary caregiver. The infants early experiences, in regards to relationships and attachments are believed to form the child's mental representations of self, others and relationships. These representations persist over time and act as the foundation for emotional and social development (Bowlby, 1969; 1982; 1991). Researchers have identified four attachment styles: secure attachments, insecure-anxious/ambivalent attachments, insecure-anxious avoidant attachments and insecure-disoriented/disorganized attachments (Ainsworth, Blehar, Waters & Wall, 1978). Evidence exists that maltreated children (i.e. those subject to child welfare interventions) are likely to exhibit insecure attachment patterns, specifically disorganized or disoriented attachments (Boyd-Webb, 2006; Hawkins-Rodgers 2007; Mennen & O'Keefe, 2005; Morton & Brown, 1998; Tarren-Sweeny, 2008a). These maltreated children have endured traumatic events in their lives and as a result experience their world as unpredictable and unsafe. This is reflected through insecure or anxious attachment relationships (Boyd-Webb, 2006). The implications are an increased risk for substance abuse, mental illness and poor developmental trajectories (Boyd-Webb, 2006; Tarren-Sweeney 2008a; Wilson & Woods, 2006).

That positive attachment experiences can provide children and youth with security, confidence and skills needed to cope with the challenges in life is well known. Conversely, poor attachment experiences are highly associated with poor mental health outcomes (NYICN, 2009; Schilling et al., 2008; Tarren-Sweeney 2008a). There is

significant variance between studies regarding type of attachment representations and resultant problem behaviour displayed. Adolescents in care will not always have identical attachment schemas; however, research indicates that overall poor attachment experiences are related to a number of negative behaviours displayed by youth in care. Tarren-Sweeney (2008a), found negative attachment schemas were related to an inability to self-regulate, to an increase in impulsivity and to indiscriminate affection and attention seeking. Shilling and colleagues (2008), report an association between depression, anger, aggression, suicide attempts and substance abuse and attachment adversities. Furthermore, attachment representations have been connected to youth in group care displaying violence towards staff, rule breaking, truancy, maladjustment and defiance of house rules (Zegers , Schuengel, Van IJzendoorn & Janssens, 2008). Although mechanisms and associations may vary, it is clear that attachment schemas are crucial to understand the development of psychopathology for youth in group care. This statement should, however, be tempered with the knowledge that exhibitions of difficult behaviours by youth in care are frequently interpreted according to psychiatric categories, rather than seen as a response to experienced adversities (Hart, Blincow &Thomas, 2008).

Attachment histories are shown to greatly influence a youth's ability to build and maintain relationships, especially with adult caregivers. Children with insecure attachment histories are likely to exhibit a devalued sense of self, a mistrust of others, and a wariness of close relationships (Price & Glad, 2003). This can have a long lasting effect on the quality of relationships the child develops. Although one may expect a child

removed from an abusive or neglectful situation would feel relief once placed in a stable consistent environment, an insecure attachment history will cause the child to approach new adult relationships with the anticipation of rejection and even abuse (Boyd-Webb, 2006). By the time these children reach adolescence they are likely to display a tough exterior to keep others at bay and can be difficult to manage or engage in any kind of trusting relationship (Boyd-Webb, 2006). The difficult behaviour these adolescents display often precipitates a number of broken relationships with key attachment figures in multiple foster home or care facilities and contributes to continued problems developing permanent healthy connections. Unfortunately this is a common account for youth who end up in a group home. The resultant lack of significant, enduring, healthy relationships with adults has been strongly related to negative psychological and social outcomes (Crenshaw & Hardy, 2006; Freundlich & Avery, 2005; Mennen & O'Keefe, 2005). Consideration of these factors and the interplay of attachment theories should be prominent in placement decisions; however, system demands and inadequacies often interfere with this principle.

A further detriment associated with insecure attachment schemas in youth is an increased likelihood of turning to maladaptive or delinquent peers to meet interpersonal needs (Wilson & Woods, 2006). Although this association has been attributed to a number of varying factors, attachment schema plays prominently in this correlation. It is shown that insecurely attached youth are more likely to be selected by deviant peer groups due to the increased likelihood of displaying deviant behaviours (Rosenstein & Horowitz, 1996). They are likely to have lower levels of social skills development,

correlating to increased evidence of delinquency and youth with weak attachments are more likely to find the unity and belonging they crave through association with anti-social peers (Shulman, Seiffge-Krenke, Levy-Shiff, Fabian., 1995).

Through the examination of an attachment paradigm one can see serious iatrogenic effects may arise as a function of placing vulnerable youth into group care (Wilson & Woods, 2006). Specifically attachment theory illustrates how insecure attachment schemas contribute notably to outcomes of mental health status, the quality and quantity of healthy enduring relationships to adults that youth develop and to the type of relationships youth develop with their peers. Without attachment orientation guiding placement and treatment decisions for youth in group care, there is little chance to develop a secure base to work on resilience and coping mechanisms or to overcome and reorient attachment schemas.

Contemporary psychiatric model key concepts.

Current estimates of mental illness for children and youth in the general Canadian population range from 10 to 20% (Burge, 2007; Waddell, Offord, Shepherd, Hua & McEwan, 2002). This rate has shown to be considerably higher for youth in the child welfare system (Burge, 2007; NYICN, 2009). Not only are youth in care more likely to experience and be diagnosed with a mental health concern, it is also likely that their problems will be more complex and involve co-morbid conditions (Tarren-Sweeney, 2008b). A further consequence of the increased diagnosis of mental health problems is an increased exposure to psychotropic medications for this population. More

specifically, it has been shown that youth in group homes are prescribed psychotropic medications at a higher rate than children outside of the system and of children in the system, but placed in a family based environment (Breland-Noble, Elbogen, Farmer, Dubs, Wagner & Burns, 2004).

Reasons suggested for this elevated prevalence of mental health diagnosis and use of psychotropic drugs includes the influence of the biological parents' mental health, from a genetic and environmental perspective; parental substance abuse, child's exposure to maltreatment and neglect and the effects of being separated from families of origin creating attachment difficulties (Burge, 2007; Tarren-Sweeney, 2008a). These statements, however, should be interpreted with caution. Although we may expect that children in care experience more emotional and behavioural problems, research indicates that an over-reliance on inappropriate diagnostic categories may be being used to explain what should be seen as a normal reaction to a traumatic experience (Whitfield 2006). Instead, the dominant influence of allopathic medicine categorizes behaviours and interprets them through a biomedical framework rather than being understood as resulting from previous and current distress (Leo, 2006). Furthermore, critiques indicate that within the child welfare system subpar psychiatric evaluations are used that too quickly label and diagnose children (McMillen, Fedoravicius, Rowe, Zima & Ware., 2007).

Together the psychoanalytic principles of D.W Winnicott, contributions of attachment theory, and a critical analysis of the medical model approach to diagnosis and treatment of problem behaviour, provides insights into gaps identified by research

as existing between the goals of 'circle of care' interventions and the actual experiences and outcomes youth and professionals encounter. This study will examine professional stakeholders experiences in the Ottawa area to further expand on existing gaps in service including collaborative efforts and structures among the systems in the 'circle of care'.

IV. Definition of Terms

Throughout the literature a number of definitions and terms are used that may not be familiar to the reader. An effort was made to identify and define such terms based on the selective review of international literature used for this study. This is in no way meant to be an exhaustive list of relevant terms and it is recognized that minor variance may exist in particular details between municipalities, provinces, states and countries. This list, however, provides a basic understanding for the reader of applicable terms in child welfare, mental health and group home systems as used in this study.

Group Home: A medium sized home housing between 6-9 adolescents in a community based setting. Group homes are less restrictive than in-patient psychiatric clinics and detention centres but more restrictive than family foster care. Group homes are staff secured on a 24 hour basis. The state has placement and care responsibility (Anglin, 2002). Most group homes in Ottawa are private for profit operations offering service for purchase by the Children's Aid Society. The centre used in this study is a blend of 6 residences each with 8 beds that have beds both directly funded by the Ministry of

Children and Youth Services and that are available on a fee for service basis to the Children's Aid Society.

Outside Purchased Institution (OPIs): These are privately run organizations, primarily for profit, that provide children`s residential services. OPI`s negotiate with the Ministry as to what services they will provide and what the *per diem* rate for those services will be. Children's Aid Societies receive funding from the Ministry to pay these *per diem* costs, which cover basic residential costs along with any necessary additional services. OPI`s range from basic residential to highly specialized treatment care (Annual Report of the Office of the Auditor General of Ontario, 2006).

Foster Care: Foster care takes place when a minor who has been made a ward is placed in the private home of a state certified caregiver referred to as a "foster parent". It is a formal system by which a child is cared for, in a foster family, by people other than its own parents, but without being adopted. Foster care families are provided a financial stipend to assist with the costs of caring for children/youth in their homes (Ministry of Children and Youth Services, 2005).

Treatment Foster Care: This is also referred to as therapeutic foster care. A family based placement for youth identified as having specialized needs. Specialized training is given to foster families who sign up for treatment foster care. They are paid a higher rate, than standard foster care parents to care for children with intensive needs and are given access to a variety of supportive services (Ministry of Children and Youth Services, 2005).

Kinship Care: This is the residential care of a child who is placed with a family member, relative or other adult with whom the child has a kinship bond (Child Welfare Program Evaluation Report, 2003).

Crown Ward: This refers to a child that has been made a permanent ward of a Children's Aid Society (CAS) because courts have determined that it is in the best interest of the child. Under court orders, the (CAS) exercises the rights and responsibilities of a parent (Child Welfare Program Evaluation Report, 2003).

Circle of care: For this study the `circle of care` specifically refers to the child welfare worker, the youth worker in the group home and the mental health clinician providing care to a youth in a child welfare group home.

Chapter 2: Literature Review

I. Introduction

The three main stakeholders involved in delivering mental health services to youth in a child welfare group home are: the child welfare system, the mental health system and the group home model. When current research is examined, a number of gaps and weaknesses in each system are found, with implications to the quality and outcomes of mental health services delivered to youth in the group home (Adnopoz, 1998; Boyd-Webb, 2006; Burge, 2007; Crenshaw & Hardy, 2006; NYICN, 2009; Prince & Austin, 2005; Tarren-Sweeny, 2008a; Tarren-Sweeny, 2008b). As well, it has been identified that a number of challenges faced by youth and professionals results from a fragmented, at times ineffective system with no collaborative structures (Cohen, Mannarino, Murray & Igelman, 2006).

Group homes predominantly house older youth, who have been in care for longer periods and are likely to have experienced a number of placements (Barth, 2002). This model often provides care to the most troubled youth, who present the most need for mental health services (Tarren-Sweeney, 2008a). Unfortunately, when the group home environment is examined using the theoretical concepts of D.W. Winnicott to reflect on the therapeutic value of the model, the care environment is less than optimal. Challenges are evidenced for youth receiving care as well as for professionals who work in this setting. In fact, in its current conception there is little evidence that group homes adequately provide a positive therapeutic intervention (Barth, Courtney, Berrick & Albert, 1994; Bush, 1980; Anglin, 2002a; Freundlich & Avery, 2005).

Similarly, the child welfare system when examined under the lens of attachment theory has policies and structures which contribute to less than optimal conditions for youth receiving care (Mennen & O`Keefe, 2005). Demands and challenges in the system and faced by child welfare professionals hamper the ability to provide optimal services, creating lasting, if not lifelong disadvantages for youth in care (Webb & Harden, 2003). Indeed, results suggest that despite best intentions, youth in the child welfare system do not benefit from processes that deliver targeted treatment for mental health needs (Fedoravicius et al., 2008).

Irrefutably, unmet mental health needs must be addressed for youth in group homes; however, the mental health system itself is inefficacious in many regards. Despite identified need, current literature indicates that the mental health system and its reliance on a medical model approach may be responding to youth in group care in a manner that creates an over diagnosis of mental illness, an overreliance on psychiatric medications and offers a lack of appropriate, effective interventions (McMillen, et al., 2007; NYICN, 2009; Whyte & Campbell, 2008).

Given the identified gaps associated with the group home model, the child welfare system, the mental health system and the resultant impact on mental health outcomes for youth; it is arguable that the 'circle of care' at times, causes more harm than good. Additionally, a lack of collaborative linkages and structures between these systems has been identified as a potential contributor to the negative outcomes experienced by youth in care (Darlington & Feeney, 2008; Darlington et al., 2004; Darlington et al., 2005; Foster et al., 2007; Leathers et al., 2009; Mennen & O'Keefe, 2004; NYICN, 2009; Prince

& Austin, 2005; Wakelyn, 2008; Wotherspoon et al., 2008) Therefore by strengthening collaborative work and structures within the 'circle of care', the goal of fostering well-being for this vulnerable population can be better realized (Foster et al., 2007; Fulcher & Ainsworth, 2005; Wakelyn, 2008; Wotherspoon et al., 2008). To do this, the gaps and weaknesses of each system must be elicited and explored for areas where collaboration in the 'circle of care' may mitigate some of the current negative outcomes, especially the mental health outcomes, of youth in the care system.

Winnicott's Key Concepts and the Group Home Model

A number of negative outcomes and increased risks for youth are associated with the group home environment. These include: an increase in delinquent behaviour (Ryan et al., 2008), increased incidence of substance use problems (Baker et al., 2009), educational problems (Ryan et. al., 2008), placement instability and a lack of permanency (Freundlich & Avery, 2005), negative effects of peer contagion and affiliation with delinquent peers (Wilson & Woods, 2006), as well as attachment difficulties (Hawkins-Rodgers, 2007). Additionally, and most prominent for this study is that youth living in group homes manifest an exceptional frequency and severity of mental health problems over that found in the general population (Burge, 2007). Youth in group homes are also diagnosed and medicated at a higher rate relative to peers not in care, and youth with mental health concerns are more likely to be placed in a group home (Barth et al., 1994; Burge, 2007; Fedoravicius et al., 2008; Moses, 2008; NYICN, 2009; Pentecost & Wood, 2002; Tarren-Sweeny, 2008a; Tarren-Sweeney 2008b; Whyte & Campbell, 2008). Given the range of negative correlations between group care and

poor mental health of youth in such facilities, a review of the care environment for contributing and mitigating factors is warranted. What emerges is a complex view of a multifarious care option.

Historically group homes were seen merely as accommodations (Ainsworth, 2005). This conception has been challenged by those who assert that small scale, privately run group homes are a way to maintain aspects of a therapeutic milieu in conjunction with a more family-like setting (Reichertz, Kislowicz & Stalinski, 1978). Proponents of group homes as a therapeutic options claim the setting provides youth with a consistent, controlled, supportive care environment (Hawkins-Rodgers, 2007). They argue that group homes afford an environment that is emotionally neutral for youth who cannot tolerate the emotional intimacy of a foster family, or for those who have primary allegiance to their biological family (Hawkins-Rodgers, 2007). It is also argued that group care environments are better able to manage difficult behaviours that could not be tolerated elsewhere (Curtis, Alexander & Lunghofer, 2001). Finally, these proponents illustrate that through a stay in a group home, youth have access to more sophisticated treatment programs such as psychiatrists, nurses and special educators (Barth et al., 1994).

Conversely, opponents of the private operator's community group home model argue that it is simply a small scale institution, with the same detrimental aspects seen in larger institutions: stigmatization, isolation and a lack of individualized care plans (Barth et al., 1994; Bush, 1980). They question whether quality services can be delivered when the bottom line for private operators is profit, arguing that cost of care issues affect the

level of skill and training of employees, the availability and quality of clinical services and the overall environment for the youth in care (Anglin, 2002a; Freundlich & Avery, 2005).

Currently, child welfare is a component of the Ministry of Children and Youth services in Ontario. The Ministry is responsible under the *Child and Family Services Act* to establish service standards and program service delivery. The Ministry does this through the 52 Children`s Aid Societies (CAS) in Ontario to which they provide transfer payments in order for the Society to carry out child protection services (Child Welfare Program Evaluation, 2003). Children`s Aid Societies use this funding to purchase alternative care settings when a child is not able to remain in their biological home. When a family based placement is not available the youth is placed in a group home. Group homes are either operated by Children`s Aid Societies, by non-profit organizations governed by community volunteer boards or by private for profit operators (Nolan & Lewis, 2007). The Ministry of Children and Youth is responsible to licence homes, monitor standards, inspect and set the rates for Outside Purchased Institutions (OPIs). In Ottawa, group homes are mainly private for profit OPIs and CAS purchases services directly from the OPI. Some argue that the private contracting out of this service has reduced the quality of care that youth receive; has created poor working conditions for those employed in these facilities; and tends not to focus on the emotional and developmental needs of the youth (Farris-Manning & Zandstra, 2003). The Ontario Association of Children`s Aid Societies has argued that the Ministry needs to provide stronger licensing requirements and set higher standards for group homes including the availability mental health professionals to increase the clinical

competencies within group homes (Nolan & Lewis, 2007). Further, challenging these contentions from a Winnicottian perspective demonstrates gaps in the therapeutic viability of the group home model.

Using the theoretical formulations of D.W. Winnicott one can see that demands of the group care setting, as well as limitation of skills, training and clinical support for group home workers impacts the ability of staff to create ideal therapeutic conditions, or to deliver a high quality, comprehensive level of care. These limitations are shown to have negative repercussions for youth who reside in group homes. Specifically examining Winnicott's conceptions of 'the holding environment', 'facilitation of the maturational process' and 'development of the self', illustrates major gaps and weaknesses in the model.

The Holding Environment

In describing the 'holding environment' Winnicott highlights the need to create an environment that is safe, reliable and protective from internal and external infringements (Schore, 1997). He identifies continuity of care, integration in approach and management of internal and external conflicts as particularly relevant in providing a setting for a corrective experience of earlier environment and caregiver failures (Winnicott 1956; 1963; 1970). Winnicott further emphasizes the role of the caretaker in this process indicating that the caregiver "must recognize the point at which development has been compromised and create conditions that facilitate growth and development" (Borden, 2009 p. 99). Without such structures, the risk of developing

psychopathologies exists and individuals are not able to address their past trauma's and move forward (Schore, 1997). While this may be the ideal that youth workers and operators of residential group care strive to attain, research indicates that gaps and weakness exist which prevent the actualization of these goals.

Occupational demands and the reality of group care employment make it difficult to meet the ideals of a 'holding environment'. Youth workers face the challenge of providing service for extremely complex clients with limited skills, training and clinical support; as well as the burden of a profession often devalued in the professional hierarchy of care (Anglin, 2002a). They must balance competing demands of maintaining safety and security for staff and residents while also managing the requirements of daily routines and care activities. These competing demands place staff in a conflicting role while they also work to create therapeutic alliances and opportunities. Often these demands result in a setting where staff control and safety is paramount and youth workers simply attempt to control and manage the youth and the environment; frequently at the expense of recognizing and dealing with the underlying emotional pain resident youth are experiencing (Anglin, 2002a).

The interpretation of and reaction to youth's acting out behaviours by group home staff, has been identified as problematic in group care and is often contrary to Winnicott's concepts. Winnicott indicates that in residential care, all behaviour is meaningful and that difficult, acting out behaviour should be interpreted as a message of hope (Winnicott 1956, 1963). Youth care professionals should expect that youth will test the environment to see if it is able to contain them and provide safe, secure and

'good enough' care, the model must fulfill these requirements for youth in order to be considered an appropriate 'holding environment' (Applegate, 1997). Furthermore, Winnicott views youth's behaviour as representative of the internal difficulties he or she is experiencing when faced with the external world of the caring environment (Briggs, 2004). If the youth worker misses the point of the youth's behaviour or becomes overwhelmed by the youth's communication through challenging behaviours, the group home fails to be a safe therapeutic 'holding environment' and instead becomes emotionally depriving (Briggs, 2004).

The challenge of reacting to underlying motives, context and intent behind a youth's acting out behaviour requires the youth worker be mindful and reflective of his or her practice. It also requires adequate education and supervision of workers, to permit awareness of the psychodynamic concepts at play (Briggs, 2004). The environment of group care, however, often does not facilitate such practice due to a lack of training and preparation of youth workers, the absence of clinical consultation and support and the economic reality that training, debriefing and clinical support all directly increase operating costs (Anglin 2002a; Sherwood, 1984).

Further shortcomings in the group home model are a lack of consistency and reliability; both key components of Winnicotts 'holding environment'. Reliability and consistency can be difficult to achieve given staff are on shift rotations, have different individual approaches and that turnover rate is known to be high in group home employment (Anglin, 2002a; Barth et. al., 1994; Coulton & Roberts, 2007). Given the lack of clinical support offered to the team, as well as the fluidity of staff team members in

the group home, it is likely that staff integration and therefore consistency in caregiver response will suffer. Yet, constancy in emotional support and in therapeutic intervention has been identified as essential in building the residential care centre into a therapeutic 'holding environment' (Yecheskiel, 1984).

That many group home workers view their work as temporary due to poor employment conditions, low status of the work, insufficient training, poor salary level and the demands of the environment also contributes to a lack of consistency (Anglin 2002a; Barth et al., 1994). As Coulton and Roberts (2007), conclude this is of great significance given the importance of stability and continuity of care that should be provided to such a vulnerable population. These authors also report that staff changes intensify youth's feelings of being neglected, can result in behaviour that impacts the therapeutic environment and can lead to an increase in aggressive, violent or resistant behaviours.

Finally, the 'holding environment' requires flexibility to individualize each client and his or her situation. This is highly criticized as not being present in group care due to competing demands that necessitate rigid adherence to prescribed routines (Bush, 1980). Winnicott's research indicates that in order to 'facilitate the maturational process' and the 'development of self' there must be room for individual negotiation and programming and the environment must create conditions that facilitate growth and development (Borden, 2009).

The Maturational Process and Development of Self

The fact that most group care facilities are organized around an extensive system of rules and consequences, that are often risk focused, also limits the ability for individual negotiation and programming, therefore limiting 'facilitation of the maturational process' and 'development of self'. From the standpoint of a youth's psychological health this is less than favourable as it hampers one of the essential goals for adolescence which is to develop a sense of self-efficacy, or what Winnicott defines as the 'maturational process' (Winnicott, 1963).

Bush (1980) illustrates that group home programs often operate using behaviour modification therapies that fail to address individual behaviours and issues. He illustrates how group homes frequently function on a reward system that serves to keep the environment operating, but does not provide consistent emotional support or encourage adaptive behaviour for youth (Bush, 1980). Furthermore, the group home environment is often regulated by daily routines around getting up, taking medications, and completing prescribed programming. These routines often overshadow and detract from therapeutic opportunities (Anglin, 2002a). The overemphasis on operational issues places staff in the role of enforcer, emphasizes childishness in the youth, and can be detrimental to the development of the youth's autonomous personality (Yecheskiel, 1984).

Although, one of the major concerns of the group home is to assist in adequately preparing adolescents to "age out" of the protection system and develop independent

living skills; one of the highly criticised observations in current research is that group home services do not prepare youth to reintegrate to the community, to adult services, or to their biological family once released from the residential program (Ainsworth, 2005; Courtney, Barth, Berrick, Brooks, Needell & Park, 1996; Freundlich & Avery, 2005; Hawkins-Rodgers, 2007). As outlined by Cohen (1984), because these youth have had interference in their development resultant from abuse and/or neglect they experienced, their maturational process has been delayed and they have not developed a cohesive sense of self. He illustrates that it is necessary for the environment to develop individuation, autonomy and 'facilitate maturation' however, concludes that often residential care fails to provide such an environment.

This is echoed by Anglin (2002a), who concurs that the highly regimented routines of group home life can be detrimental for the development of self-efficacy and independence youth need. In Winnicottian terms the challenge of the intervention (i.e. the group home) is to recognize and address the youth's needs in a way that 'facilitates the maturational process' that has been disrupted and delayed by the negative care giving experiences. The lack of individuation and autonomy of group home routines, however, often fails to provide such an intervention (Borden, 2009).

Using the theoretical formulations of D.W. Winnicott one can see that demands of the group care setting and limits to the skills, training and clinical support available for group home workers impacts the ability of staff working in the group home to create ideal therapeutic conditions and to deliver a high quality comprehensive level of care. The challenges indicated in the research shows that when inexperienced, unskilled,

unsupported workers, with limited resources are required to manage the behaviour of a group of aggressive, difficult youth; implications exist for the quality of care delivered to resident youth and the resultant mental health outcomes youth experience. One such implication is that youth are improperly diagnosed and potentially over medicated as a result of deficiencies in the group home environment (Hart et al., 2008). The importance of examining if these gaps are experienced in group homes in the Ottawa area, how these gaps are experienced by professionals who work in such settings and ways that collaboration between the 'circle of care' can address and strengthen these inadequacies is crucial.

Attachment Theory and the Child Welfare System

Although youth in group care have individual experiences with their biological family and in the child welfare system, some generalizations observed in research are relevant for most, if not all youth. These include the experience of loss, the influence and affiliation with delinquent peers and a lack of placement permanency and enduring connections to healthy adults (Crenshaw & Hardy, 2006; Freundlich & Avery, 2005; Ryan et al., 2008; Tomlinson, 2008). Applying the principles of attachment theory to these experiences, one can see that the child welfare system and its structures and policies, can contribute to an unhealthy internal attachment schema in the adolescent (Zegers et al., 2008). Implications of an unhealthy attachment schema are many and include an increased risk for mental illness and poor developmental trajectories (Boyd-Webb, 2006; Tarren-Sweeny 2008a; Wilson & Woods, 2006).

The Experience of Loss.

A great many youth come to the group care model having experienced inadequate parenting in the biological home, as well as numerous placement breakdowns within the child welfare system. Continued breakdown in continuity of care creates a scenario where youth internalise the expectation of breakdown, of rejection, of failure and exhibit a strong lack of trust (Tomlinson, 2008). Recognition that cumulative effects of unstable environments can have negative impacts on vulnerable children and youth should mean that placements decisions are clinically informed. Placements, however, are often driven by the accessibility and availability of an open bed, not a thorough assessment of the youth's risks and needs (Adnopoz, 1998). The result is these youth "find their traumatic experiences of separation from parents compounded by subsequent experiences of loss" (Briggs, 2004 p. 34).

With each new placement youth are likely to experience the loss of family/caregiver, loss of friends, school peers and the loss of community (Crenshaw & Hardy, 2006). Continued exposure to loss often manifests in delinquent and acting out behaviour by the youth which may lead to further placement breakdowns and a move up the continuum of secure care (Briggs, 2004). Children in care are already at high risk for attachment insecurity and attachment disturbances, exacerbated by the succession of losses experienced in the care system. Continued moves can trigger the youth's feelings of being removed from his or her family, the loss of being passed along by professionals and foster carers, as well as the experience of being profoundly different from the majority their peers. In addition, on a daily basis youth in the group home

endure being left by their care-workers who finish their shift and return to their own families (Briggs, 2004).

Continued exposure to insensitive, rejecting or inconsistent care giving patterns means youth may "build internal working models of attachment relationships which guide their attention and behaviour to minimize rejection and distress, or to maximize caregiver attention" (Zegers et al., 2008 p 92). The development of insecure and disorganized attachment schemas is common and intensified by frequent losses experienced through the care system (Crowell & Hauser, 2008). This negatively impacts a youth's capacity to develop trusting, supportive long term relationships (Adnopoz, 1998). It is also associated with low socioeconomic status, less education, impaired relationships and ongoing mental and physical illness (Bardone, Moffitt, Caspi & Dickson, 1996; Gotlib, Lewinsohn & Seeley, 1998).

Providing a secure base and safe haven becomes of utmost importance for the development of secure attachment and should be central to decisions made by the child welfare system, as well as the therapeutic interventions of the group home. However, research indicates this gap is not addressed by the current system due to the primacy of protection and risk management in the current child welfare system (Anglin, 2002b; Stuck, Small & Ainsworth, 2000); due to a lack of families available to care for youth (Barth et al., 1994; Mennen & O'Keefe, 2005; NYICN, 2009); due to a lack of support for placements struggling to manage challenging youth (Adnopoz, 1998; Landsverk, Burns, Stambaug & Rolls-Reutz, 2009; Wotherspoon et al., 2008) and due to a limited focus on work with families (Ainsworth, 2005).

Negative peer influence

The relationship between attachment and propensity to affiliate with negative or delinquent peers must also be considered by the child welfare system when making placement decisions. A study by Ryan and colleagues (2008) identified peer contagion as a contributing factor to increased delinquency in group home youth. Wilson & Woods (2006) echo the risk of negative peer affiliation between youth in group care and Zegers and colleagues (2008) demonstrate that attachment difficulties in adolescents contributes to truancy, violence to staff, delinquency and breaking of house rules.

Shulman, Seiffge-Krenke, Levy-Shifff & Fabian (1995), explain that weak parent-child attachment increases the risk for involvement with anti-social peers because anti-social behaviour contributes to the group's sense of unity and provides perceived support, security and sense of belonging the youth craves. Additionally, Osgood and Briddell (2006), show that group home placements often sever ties between more prosocial youth and keep the adolescent with peers that are delinquent and more likely to have emotional and behavioural difficulties.

Although a move into group placement operates on the idea that moving a child from a foster home to a 24 hour staff monitored group home will provide more safety, structure and adult supervision, in practice this ideal does not hold true. Surveyed children in the study by Bush (1980) indicated that, the dominant peer culture within the home did not reward good behaviour. A cycle is created whereby the youth's inability to tolerate continued feelings of loss creates an affinity to turning to delinquent peers, an

increased likelihood of acting out and delinquent behaviour, which in turn threatens the youth's ability to remain in a stable placement (Zegers et al., 2008). The group home environment therefore may not be the most appropriate alternative for adolescents when many of the youth that move from maltreating families or other placement breakdowns into group homes are exposed to deviant peer influences (Wilson & Woods, 2006).

Placement permanency and Enduring Connections

Despite the emphasis on permanency and family reunification in current child welfare policy, research continually indicates that neither construct exists for youth living in a group home. This can have far reaching detrimental implications to the mental health and well being of the youth (Crowell & Hauser, 2008; NYICN, 2009; Schilling et al., 2008; Tarren-Sweeney 2008a). Research documents that placement impermanency and a lack of ongoing family and adult connections contributes to mental health problems, to educational and economic disadvantages and a higher risk for homelessness and victimization for youth (Freundlich & Avery, 2005; Tarren-Sweeney, 2008b).

Children's Aid Societies struggle to recruit an adequate number of family based foster homes, especially for older youth which is a contributing factor to the lack of permanency and entrenchment of attachment difficulties youth experience (Barth, 2002; Mennen & O'Keefe, 2005; NYICN, 2009). Despite this, both the child welfare system and the group home model are criticized for a lack of work with biological families, even though it may represent the only opportunity youth have for permanent

adult connections (Ainsworth, 2005). The gap identified here illustrates that youth are not offered long-term connections to someone specifically interested in their wellbeing and progress, or someone for the youth to come back to (Freundlich & Avery, 2005).

It has been identified that a lack of co-ordinated treatment planning and an individual to provide informed consent for and longitudinal oversight of treatment is lacking in the current child welfare system (Naylor, Davidson, Ortega-Pirou, Bass, Gutierres & Hall, 2007). Participants in the study by the National Youth in Care Network (NYICN), (2009) indicate that youth raised in their parent's care, or with a strong permanent attachment to an alternate caregiver, have an advocate on their behalf who is consistently there for them, aware of their background and history, and able to regularly monitor day to day situations and symptoms. Concern regarding this omission for youth in group care is raised by Moses (2008), who echoes the sentiment that youth in the child welfare system lack a committed guardian or caretaker to closely monitor their status and protect their best interests, and by McMillen and colleagues (2007) who indicates that residential care employees, child welfare social workers and foster parents are not adequately filling this role.

These findings illustrate that when considered from an attachment paradigm, iatrogenic effects can occur as a function of the child welfare system placing vulnerable youth into group care. The continued experience of loss, association with delinquent peers and lack of permanency and enduring adult connections flags the possibility that children experience deterioration in mental health whilst in care. The possibility and opportunity for these gaps and weaknesses to be addressed through the collaboration

of services and resources with mental health professionals, is also illustrated (Landsverk et al., 2009).

The Contemporary Psychiatric Model and the Mental Health System

While it is difficult to nail down the exact number of youth in care with mental health problems, some clear trends are highlighted in the literature. Namely, that youth in the child welfare system are disproportionately represented in clinical populations receiving psychiatric services (Burge, 2007; Foster, et al., 2007; Pentecost & Wood, 2002; Tarren-Sweeney 2008a; Tarren-Sweeney, 2008b; Whyte & Campbell, 2008; Wotherspoon et al., 2008); and that psychotropic medications are prescribed at a significantly higher rate to this population (Fedoravicius et al., 2008; Moses, 2008; NYICN, 2009). Just as the psychoanalytic theories of D.W. Winnicott and the contributions of attachment theory shed light on some shortcomings in the group home model and the child welfare system; the dominant reliance on the contemporary psychiatric model for diagnosis and treatment of mental health concerns illustrates some of the challenges and weaknesses in the mental health services delivered to youth in care. Given the implications of such facts, a review of the mental health system as it relates to youth in care is warranted.

Increased Diagnosis and Labelling

Recent literature indicates an alarming increase in the number of youth diagnosed with mental health concerns (Fedoravicius et al, 2008) and an equally alarming increase in the use of psychotropic medications to address these concerns (McMillen et al., 2007;

Rawal, Lyons, MacIntyre, & Hunter., 2004). Current estimates of mental illness for children and youth in the general Canadian population range from 10 to 20% (Burge, 2007; Waddell, et al., 2002). Contrast this with the Canadian study carried out by (NYICN), (2009) where 70% of subjects (all of whom had been in the care system for an average of 7.5 years) reported being prescribed psychotropic medications. Similarly Burge (2007), looking specifically at permanent wards in Ontario reported a 31.7% prevalence of mental disorders with 28% of subjects being prescribed psychotropic medications. These statistics clearly illustrate the increase in mental health diagnosis for youth in care.

Not only are youth in care more likely to experience and be diagnosed with a mental health concern, it is also likely, as mentioned above, that their problems will be more complex and involve co-morbid conditions (Tarren-Sweeney, 2008b). Reasons suggested for this elevated prevalence include the influence of the biological parents' mental health, from a genetic and an environmental perspective, parental substance abuse, child's exposure to maltreatment and neglect, and the effects of being separated from families of origin creating attachment difficulties (Burge, 2007; Tarren-Sweeney, 2008a). These statements, however, should be interpreted with caution as research also suggests that that an over-reliance on inappropriate diagnostic categories may be being used to explain what should be seen as a normal reaction to a traumatic experience (Whitfield 2006).

The dominant influence of allopathic medicine categorizes behaviours and interprets them through a biomedical frame rather than being understood as resulting

from previous and current distress (Leo, 2006). In fact, use of the DSM-IV-R to diagnose youth has been criticized as inaccurate, culturally inappropriate and deficit focused (Timimi, 2006). This is particularly relevant for youth in protective services who may be having what should be considered a reasonable reaction given their extremely adverse conditions. The notion that distressing behaviours may only be interpreted as disordered is extremely problematic (Mitchell, 2003). That psychological evaluations often miss the complex historical and environmental influences on a child's behaviour and rely heavily on psychiatric labels, introduces an additional possibility to explain the increased prevalence of mental health concerns of children in care (Mitchell, 2003; Whyte & Campbell, 2008). Unfortunately, many youth in the child welfare system end up with negative, stigmatizing labels to explain behaviour, labels that offer little in the way of real understanding or compassion for the youth's experience. Crenshaw and Hardy (2006) perhaps illustrate this best when they state "no existing diagnostic label elucidates the multidetermined and complicated biopsychosocial factors influencing the children's development, let alone societal and cultural influences that exert a major impact on these typically disenfranchised children" (Crenshaw & Hardy, 2006 p. 192).

The gap identified by this research indicates that an overreliance on the contemporary psychiatric model approach risks the creation of labels to explain behaviour, which offer a gateway into the mental health system. For youth in care, this approach is experienced from a clinical disease model rather than one that is strengths-based or nurtures a model of recovery (NYICN, 2009). Youth are blamed for having trauma induced behaviours and their difficulties are ascribed to something intrinsic to

them: not to the environment or system in which they are ensconced (Whitfield, 2006). In many ways this re-victimizes youth further and contributes to continued negative self-esteem and self-concepts.

The use of Medications vs. Psychosocial Treatments

Increased exposure to psychotropic medications is a further consequence of the reliance on medical model interpretations of mental health behaviours. More specifically youth in group homes are prescribed psychotropic medications at a higher rate than children outside of the system and of children in the system, but placed in a family based environment (Breland-Noble et al., 2004). While the use of medications to treat emotional and psychiatric disorders in youth has been considered controversial in general (Pavkov & Walrath, 2008), concerns specific to youth in care involves exposure to medications that result from misdiagnosis or contextually deprived diagnosis, the use of medication for social control, the lack of youth involvement in treatment decisions and the absence of a consistent caregiver to monitor and participate in treatment regimes (NYICN, 2009).

Research indicates that youth in care are more likely to be prescribed mood-stabilizing medication, anti-psychotic medication and more than one class of medication (Moses, 2008). A study by McMillen and colleagues (2007) not only found increased use of medications, but also raised concerns of over medication; youth receiving too many medications or medications at doses perceived to be too high. The propensity for medication is further concerning given the findings of Moses (2008), who indicates that

medication benefits are lower for youth in the system, than those in the general population.

As discussed previously, managing a group of difficult clients in the group home environment is a significant challenge for youth care workers. It is conceivable that at times medication management of youth simplifies the demands on the environment. In fact in some studies psychiatrists have reported receiving referrals with implicit requests for medication resulting from pressure on the child welfare worker and the staff at residential facilities who find the child's behaviour difficult to manage (McMillen et al., 2007). Moses (2008) supports the notion that child welfare clients are medicated due to environmental constraints and limitations to staff resources and youth in the NYICN study (2009) report feeling they were prescribed psychotropics as a way to control and modify their behaviours, enforce compliance and restrain aggression in the care setting. Furthermore, administering medications is perceived as a straightforward, cost effective approach compared to intensive psychotherapeutic services that require time and attention from caregivers and consistency of caregiver participation (NYICN, 2009).

Given the controversies that exist in the use of psychotropic medications for youth who live in group homes, the use of psychosocial treatments may seem preferable; however, barriers to such interventions exist as well. Despite strong evidence that treating mental health concerns with interventions that are largely behavioural or cognitive is effective, even as a standalone treatment (Brown, Antonuccio, DuPaul, Fristad, King, Leslie et al., 2008; Cohen et al., 2006; Landsverk, et al., 2009; NYICN, 2009)

problems arise because psychosocial treatments often require a consistent involved caregiver (Crismon & Argo, 2009) an intensive long term commitment (Landsverk et al., 2009; McMillen, 2007; NYICN, 2009) and raise liability concerns in managing challenging behaviours in the interim (McMillen et al., 2007). As has been discussed most youth in the group home do not benefit from an individualized treatment program, nor do they have high levels of consistency in caregivers. Additionally, the lack of permanency in many child welfare placements, especially in group homes, means carers may not be able or willing to invest time or resources for therapy in a youth placed with them temporarily (Brown et al., 2008; Landsverk et al., 2009).

To best meet the immediate and long term needs of each youth an integrated approach is necessary. This integration requires collaboration within the 'circle of care and includes care co-ordination between social workers, psychiatrists, psychologists, caregivers and the young person. In order to attain optimal service outcomes integration and collaboration is of utmost importance.

Collaboration between Systems in 'The Circle of Care'

Indisputably the literature indicates that strong linkages and inter-agency collaboration is required to deliver comprehensive, effective mental health services for youth in group care (Darlington & Feeney, 2008; Darlington et al., 2004; Darlington et al., 2005; Foster et al., 2007; Leathers et al., 2009; Mennen & O'Keefe, 2005; NYICN, 2009; Prince & Austin, 2005;). In current practice, professional systems continue to set up plans and operate under a false dichotomy between care and therapy (Fulcher &

Ainsworth, 2005). Youth workers are often seen as providing care which takes the form of providing food, safety, shelter, transportation, and a certain level of emotional nurturance and support; while child protection social workers co-ordinate care providers and legal requirements; and clinicians address the therapeutic treatment required by problem behaviours and mental health concerns youth display. Recognition for the overlap in these constructs is greatly needed to provide a more comprehensive frame work of care. Areas that must be considered when examining collaboration in the circle of care are: discipline insularity and shared perspectives, skills and training required of professionals, quality and accessibility of services and resource allocation.

Discipline insularity and a shared perspective

A lack of understanding of each system's perspective and a desire for organizational autonomy and freedom has been identified as a factor that impedes collaborative work in the 'circle of care' (Adnopoz, 1998; Leather et al., 2009; Darlington et al., 2005). Darlington and colleagues, (2004) indicate that when workers are informed through different paradigms, have different priorities and different practice approaches communication can be disrupted and conflict may arise. In current professional literature, mental health professionals note a lack of understanding of how the child welfare system operates, indicating this can impede the ability to form and maintain therapeutic relationships due to a lack of understanding of what the child faces (Prince & Austin, 2005). As well, despite the knowledge that mental health issues for youth in care have been increasing, content on mental health services has not increased in child welfare discourse. Finally, at times professionals may have differing missions, where

child welfare is focused on youth protection and mental health clinicians are concerned with the youth's development and mental health stability (Prince & Austin, 2005). This lack of shared perspective and understanding of mental health, of child welfare and of the group home environment can create discord on how best to engage or intervene with service recipients. Clearly time spent learning each systems philosophies, language and practices is necessary to lead to more effective consultation, understanding and improved care for the system's youth (Adnopoz, 1998).

The desire for organization autonomy and freedom in decision making has also been identified as a barrier to collaboration (Prince & Austin, 2005). This is especially relevant for child protection workers who may feel the most at risk due to their requirement to fulfill legal mandates and obligations. Child welfare workers may therefore be the most controlling in the decision making process (Webb & Harden, 2003). It has been noted that individual child welfare workers are often exposed to high levels of accountability regarding the care decisions they make. This can block opportunities to liaise with other professionals, and lead to high levels of discipline insularity (Boyd-Webb, 2006). That the child welfare system acts in seclusion of other community helping agencies has been identified as problematic, especially in regards to the lack of connections with the mental health system (Adnopoz, 1998). For child welfare social workers a situation is created where decisions are made in isolation, this is an awesome responsibility for a worker, indeed for one community agency to assume on its own. While the legal system provides guidelines and partnerships with professionals and psychiatrists provide input

into the decision making process, the responsibility and required knowledge to make such decisions remains cumbersome.

Professionals Knowledge and training

Child welfare workers are subject to a staggering responsibility of knowledge acquisition, not only for decisions regarding protection, but also for making placement and treatment decisions once a child is in care. The scope of knowledge, skills and training required to make informed decisions of this magnitude is confounding for individual workers, indeed for an individual system. When the child welfare social workers act as legal guardians for the children in care (which is commonly the case for youth in group home placements) they are responsible to authorize and approve treatments including the use of psychotropic medications (Naylor et al., 2007). A required level of training and knowledge of medications therefore is needed, however, a recent survey of social work students indicated concern regarding the level of knowledge of psychotropic drugs (Bentley, Farmer & Phillips, 1991) and the same holds true for child welfare workers who report a lack of knowledge of medications, side effects and even a lack of knowledge of the youth's behaviour (Fedoravicius et al, 2008; McMillen et al., 2007).

For mental health professionals providing care to children in the child welfare system an understanding of the system has been identified as an important variable in the quality of care offered (Fedoravicius et al., 2008; Prince & Austin, 2005; Tarren-Sweeney 2008b; Whyte & Campbell, 2008). Issues presented by individuals in the

welfare system are unique and complex and without knowledge of the system's processes, or the child's status and future care plan, the clinician may experience a hindrance in forming and maintaining a therapeutic relationship. Mental health service providers have also expressed feeling they do not receive the necessary clinical feedback regarding a child's functioning and medication side effects (McMillen et al., 2007).

Considering the unique challenges faced by all professionals delivering mental health services for youth in care, we see concerns regarding the knowledge and training of professionals in regards to interagency collaboration. In order to increase knowledge between professionals the need for increased communication and increased interagency training has been identified (Darlington et al., 2004; Webb & Harden, 2003). It has been proposed that specific mechanisms are required to facilitate strategies to increase communication, to increase the dissemination of new knowledge and best practices and to increase shared training opportunities (Leathers et al., 2009).

The quality and availability of services

Despite the recognized need to work together, barriers in the quality and availability of services have made noteworthy collaboration between systems difficult. For mental health clinicians, that the legal system and courtroom have become main stages in mental health decision making through the discretion to order mental health evaluations and treatments for consumers is laden with problems. Professionals must contend with the reality that mental health evaluations are used not only to determine what a family needs, but also to build a legal case to terminate parent's rights

(Fedoravicius et al., 2008). Additionally, one must question the capacity for success of a therapeutic intervention that is ordered and scrutinized by systems (i.e. the legal and child welfare system) that the individual likely experiences as disempowering, even threatening.

For professionals in the child welfare system a lack of available mental health services exist to meet the present demand. As well, access to mental health -treatment during non-traditional work hours when youth or group home staff may be more available, or most in need, is lacking (Prince & Austin, 2005). Furthermore, critiques indicate that within the child welfare system subpar psychiatric evaluations are used that too quickly label and diagnose children (McMillen et al., 2007).

Finally, for youth in the group home model, it has been identified that a lack of co-ordinated treatment planning and an individual to provide informed consent for and longitudinal oversight of treatment is lacking (Naylor, et al., 2007). To address these shortcomings Webb & Harden (2003) indicate that the legal mandates of the child welfare system must be better known by other involved parties; while McMillen and colleagues (2007), argue that some professionals require increased knowledge regarding medications and child welfare workers and group home workers need assistance to better partner with psychiatrists.

Resource allocation

Insufficient funding has been identified as problematic by all involved systems. The lack of adequate resources has been identified as a contributing factor in the hesitancy

towards, or shortage of collaborative work between child welfare and mental health services (Darlington et al., 2004; Darlington et al., 2005 Prince & Austin, 2005). Children's Aid Societies consistently claim that the level of funding does not cover the costs for the number of children currently in care. For the year, 2003-2004, Ottawa Children's Aid Society had a 4.5 million dollar deficit and the operating budget has increased annually (www.casott.on.ca/publications/104.pdf). That decisions made by child protection workers are driven by the actuality of underfunding is a detestable reality. CAS`s operating under budget constraints must make decisions based on funding realities. Unfortunately this often impacts placement decisions. OPI *per diem* rates range in Ontario from a low of $82 to a high of $739 (Annual Report of the Office of the Auditor General of Ontario, 2006), while the auditor general emphasizes the importance of assessing, documenting and appropriately placing youth, the resultant reality may be that youth are placed in homes under resourced for their needs due to financial constraints. In fact the Auditor General criticizes the current system for providing no incentive for Societies to place children in settings that most economically meet their needs (Annual Report of the Office of the Auditor General of Ontario, 2006). The reality of such a focus means youth are provided minimal support until it has failed, then a higher level of service will be offered. The outcome to the youth is a delay in receiving supports needed and the entrenchment of failure, attachment disorders, relationship ruptures along the way.

This system of resource allocation not only affects youth in group homes, but it is clear that although legislative and policy initiatives may encourage otherwise, current

funding patterns do "not encourage reunification of families with adequate supports, or permanency with adequate supports, in fact it does little to prevent child welfare in the first place" (Farris-Manning & Zandstra, 2003 p. 7). Additionally, workload pressures continue to be a major problem for staff at Children's Aid Societies; front line and management staff are increasingly concerned about the size of caseloads and the reduced amount of time workers are able to spend with clients (Farris-Manning & Zandstra, 2003).

The issue of inadequate funding for both the mental health and child welfare systems is ongoing. Currently, in Canada mental health and child welfare services receive separate federal funding. Mental health service are commonly delivered through the Ministry of Health and Long Term Care, while child welfare services fall under the Ministry of Community and Youth Services, both operating under budget constraints and cutbacks. Additionally some mental health and addiction services are offered under the Ministry of Community and Social Services. This presents a challenge in that services are fragmented, spread across several ministries and offered in a variety of settings (Open Minds, Healthy Minds, 2011). A difference in organization cultures may also exist as child welfare staffs are funded on a caseload basis, while mental health professionals are likely to be funded on a fee-for-service basis (Prince & Austin, 2005). When resources are tight competition can arise for access to limited resources; gate keeping disputes regarding taking on new clients may occur and the claim of insufficient time to begin and maintain collaborative practices are touted as barriers to interagency work (Darlington et al., 2004). The integration between Ministries, services and systems is clearly needed

to provide more targeted interventions and close service gaps currently experienced by a very vulnerable population.

Although collaborative work can increase costs due to team discussions, regular supervision and co-working, the expense can be construed as an investment, without which the result may be placement breakdown, continued long term reliance on the helping system, adult psychopathology and potential multigenerational contact with child protective services (Wakelyn, 2008). Given the current climate of economic restraint it is unlikely that funding increases will be seen, however, it cannot be understated that the mental health and well being of the vulnerable population of youth in care endure the ramifications of such short-sighted funding. As Mennen and O'Keefe (2005) indicate "prevention of serious problems is less expensive than later treatment or incarceration" (p. 589). Given the challenges faced by those providing mental health care for youth in the child welfare system, Whyte and Campbell (2008) argue that administrators in mental health agencies, psychiatrists and other mental health clinicians need to begin a dialogue for increased capacity to co-ordinate services to youth in care.

Weakness in the Literature

Despite a large body of research on outcomes for child protection services, the mental health of children in care and the group home environment, few studies consider collaboration between these three professional systems even though studies continually report a need for linkages between the mental health and the child welfare system for

youth in group care (Foster et al., 2007; McMillen et al., 2007; Mennen & O'Keefe, 2005; Leathers et al., 2009; Webb & Harden, 2003; Wotherspoon et al., 2008). A review of relevant research of each involved system, illustrates gaps within the 'circle of care' that could be addressed through enhanced collaborative efforts. Despite the profusion of research critiquing the mental health of youth in a child welfare group home, methodological limitations are noted. These include a lack of definitional agreement of what constitutes group care and complications with study design.

Lack of Definitional Clarity

The most frequently observed challenge to reviewing relevant literature on the group care model is a lack of defined clarity of what constitutes group care (Barth et al., 1994; Bush, 1980; Curtis et al., 2001; Knorth, Harder, Zandberg & Kendrick, 2008; Wilson & Woods, 2006). When attempting to consider the impact of the group home environment on the mental health of youth who reside in this model, it is imperative that time is spent delineating the group care environment. In some research, examining outcomes and experiences in out of home placements, family based placements and staff run group care placements are combined under the term "foster care"; while others identify these placements as distinctly different. To further add to this confusion research often overlaps the terms residential treatment facility and group care. Residential treatment, congregate care, group care, group home are used interchangeably within the literature, however, such terms can apply to large scale institutions or to small scale community based group homes. The importance of

distinguishing and disentangling placement type is critical, especially to be able to understand and overcome the potential negative outcomes of each placement type.

In addition to what defines a group home, the varied roles of such models make analysis of its efficacy difficult (Barth et al., 1994). The types of specialized services and programs offered by different care models, the intensity of service offered and the level of restriction youth have varies significantly between programs making a commonly accepted definition in research virtually impossible (Curtis et al., 2001).

Study Design

Not only is there confusion and overlap in the definition of placement types, but sample size and a lack of longitudinal studies is an identified limitation to effectiveness studies (Baker et al., 2009; Knorth, et al., 2008; Wilson & Woods, 2006). As a result of such challenges, rigorous comparison studies for children in out of home placements in the child welfare system, receiving mental health services are limited (Barth et al., 1994). In existing research on group care, staff assumptions and opinions are often used as comparison of the youth's adaptation to the rules, routines and discipline provided by the program, leaving significant interpretation open to the subjectivity of the reporter (Wilson & Woods, 2006).

A final critique of research examined in this review involves the gap between the official and unofficial agendas in child welfare, mental health and group home environment. It is commonly the case that a policy or ideological principle created at an administrative level is interpreted and experienced in a significantly different manner

then intended by frontline professional or the youth. That a difference exists between what policy makers and administrators believe happens in group homes and what youth believe happens is identified as concerning by Bush (1980) especially because, in a number of cases, the successes of child welfare interventions are open to question. Further investigation and research into what does and does not work in the delivery of mental health services for youth in group care, affords the opportunity to begin promoting a national standard of care and best practice models so that all youth are provided the most comprehensive effective services available.

There will always be youth for whom decision making is complex and others who will not be cared for appropriately by the social care system. However, as evidenced by this review of the group home model, the child welfare system and the mental health system certain gaps in and between systems can and should be addressed, particularly how collaborative structures between the 'circle of care' can address systemic deficits demonstrated by the poor outcomes in mental health status that youth in group care exhibit.

Chapter 3: Methodology

Introduction

To explore the delivery of mental health services for youth in care, living in a residential group home in Ottawa, the roles and experiences of frontline service providers were examined. This included youth workers, previous child protection social workers and mental health clinicians.[3] The three professional groups are considered the youths 'circle of care'. The study also considered collaborative practices within the youths 'circle of care'. To meet these objectives a comprehensive literature review was conducted, as well as interviews and focus groups with professional participants. A qualitative, exploratory approach to conducting interviews and focus groups and principles of grounded theory were used both when collecting and analyzing the data.

Using qualitative exploratory methods congruent with the grounded theory approach, there were two facets to this study. First, an extensive examination of current literature was conducted on group care services, the child welfare system and the mental health system. This review considered the psychoanalytic principles of D. W. Winnicott, attachment theory and the dominance of the contemporary psychiatric model to critique and illustrate gaps identified in current research between these three systems. This review also identified factors in the system of care framework that impact the collaborative delivery of mental health and child protection services and areas where the need for increased collaboration has been identified. Second, focus groups

[3] As is further discussed under methodological limitations, previous child welfare social workers were interviewed due to the unwillingness of the Ottawa CAS to participate in this research.

were conducted with youth workers in the group home and with former child welfare social workers. Finally interviews were conducted with mental health clinicians (i.e. Psychiatrists and MA Counselling) in Ottawa who provide mental health services to youth in group homes. Focus groups and interviews with professional stakeholders were used to determine if the gaps found in the literature are experienced by professionals in the Ottawa area and if so, how they are experienced by frontline workers. Stakeholders were asked to reflect on how collaborative structures or a lack thereof, contribute to these gaps and areas where enhanced collaboration may improve service delivery.

Personal Bias and Assumptions

As a previous youth worker in a private operator's group home for youth in care and a current employee of a mental health agency as a case manager, I bring a number of personal experiences to this research. Additionally, I have previously completed a student placement as a protection worker for the Children's Aid Society. I am cognizant that these experiences have created personal biases and assumptions.

A first assumption I recognize is that many youth within group care facilities are in need of, or are receiving mental health services. As outlined in the literature review, this is clearly substantiated in current research. My second assumption is that competing demands within professional roles impact the quality of mental health services provided. Finally it has been my experience that resource limitations and discipline insularity creates a reality that negatively impacts mental health service delivery, despite the best

efforts of frontline workers. Throughout the research process I was mindful of these assumptions and biases.

Participants

Five **(5)** youth workers were recruited from a centre in Ottawa that provides residential services for youth in care using a flyer distributed through a personal contact at the centre and through the agencies executive director (see Appendix A). Two additional private operator group homes (OPIs) were contacted to participate, however, declined. [4] The reasons given by these two group homes were staffing limitations and concern regarding a negative portrayal of their agencies. Participants were informed of the nature and purpose of the focus groups and the group was conducted at their place of employment. Each participant was provided a written copy of the letter of information and consent (Appendix B) and an outline of the questions to guide the focus group discussion (Appendix C). The Letter of consent was explained and reviewed verbally and permission was obtained to audio record the focus group.

The second focus group was conducted with six **(6)** social workers who were previously employed as Child Protection Workers with a Children's Aid Society (CAS) in Ontario and are currently employed as mental health social workers in a community agency. Participants were recruited via the researchers employee email. Unfortunately, efforts to interview current Children's Aid Society social workers were not successful. The Ottawa Children's Aid Society was not willing to support the researcher's effort to

[4] This created a methodological limitation explored later in the chapter.

recruit participants from the agency citing concern that the study may result in the exposure and stigmatization of a vulnerable population (for further discussion please see methodological limitations). The focus group took place at the participant's workplace. Participants were given the Letter of Information and Consent, which was reviewed verbally and a copy of the focus group questions was provided. Permission was obtained to audio record the group for later transcription.

In both focus groups with youth workers and former CAS social workers, participants were asked to reflect on the work that they do as youth workers, or did as CAS workers. No financial compensation was offered for participation in either focus group.

Finally, three **(3)** semi-structured interviews were conducted with clinicians in Ottawa. Twelve **(12)** clinicians: eight **(8)** psychiatrists, **(1)** psychologist, **(1)** Intake worker for mental health services in the Ottawa region **(1)** MA in clinical psychology and **(1)** Masters of Counselling in Ottawa were contacted via phone and invited to participate in the research. A message was left briefly outlining the research project and requesting to meet in person, or to respond to questions via email. Two **(2)** Child and Youth Psychiatrists in Ottawa and **(1)** MA counselling clinician through the participating youth centre agreed to participate and took part in a semi-structured interview. Participants were provided a written copy of the letter of information and consent and an outline of the interview questions (Appendix D) by email before the interview date. Participants were asked to reflect on their experiences regarding the work they do. Once permission was granted, interviews were audio recorded.

Data Collection procedures

Focus group participants were asked qualitative exploratory questions regarding their experience providing services to youth living in a child welfare group home, and in the collaboration with other service providers (ice. youth workers, CAS social workers and mental health clinicians). To ensure accurate recording of responses focus groups were audio recorded (with consent) for later transcription. It was explained to participants that anonymity was limited due to the small number of participants in the sample, however, confidentiality (attribution of responses) was ensured.

Clinicians were asked exploratory questions regarding their experiences in providing services to youth living in a CAS group home. They were also asked to comment on their experiences collaborating with the youth's 'circle of care' (i.e. youth workers and CAS social workers). Interviews were audio recorded (with consent) for later transcription. Confidentiality was ensured for all interview participants.

Data from focus groups and interviews were kept at the researcher's house in a locked filing cabinet. Data was also stored on the researcher's removable USB device that is password protected. This was kept in the researcher's home in a locked filing cabinet.

It was acknowledged that participant's views may not be parallel to the views of their supervisors or government funders, as such no supervisors were present in the focus groups and all identifying attributes were removed from participant's responses. Because the objective of this research study was to examine mental health services as

they are delivered today; no evaluative questions were introduced by the researcher in the focus group discussions. All question explored only the aspects of participant's professional work.

All methods used in the procedure of the focus group were in accordance with ethical standards and received approval from the Carleton University Ethics committee.

Method of Analysis

As previously stated I undertook this research study with personal biases and assumptions. As a result of my experiences in this field I also had a working hypothesis that gaps in the intersection of child protection and mental health services exist and that the challenges and demands of working with this population can be mediated through collaboration between system's stakeholders. Although a level of assumption and hypothesis did exist; this study sought to approach the problem from a unique perspective that is grounded in the participants experience and context. By using the grounded theory approach, it allowed for greater latitude in discovering unanticipated concepts and patterns.

Data analysis began with the transcription of all focus group and interview recordings. Following the methods of grounded theory after the data was transcribed; the process of coding the data was undertaken. This involved analysing and conceptualizing the data into meaningful patterns (Yegidis, Weinbach & Morrison-Rodriquez, 1999). By transcribing the data it was possible to identify codes that were prominent and pertinent to the research question, such as those that the majority of

participants identified regarding the nature of group care settings for youth and the practices of collaborating on the delivery of mental health services within this setting. Data was then collapsed into meaning units that were categorized, coded and patterns were summarized to interpret the data. The constant comparison method was used where units of data with the same characteristics were considered as fitting within the same category and given the same code; meanings that were different were put into different categories and given different codes (Brun, 2005). This process was repeated until theoretical saturation was achieved. A localised theory was then created by sorting categories into an order that makes sense and explicating the links between them and between findings in current research.

Methodological Limitations

There are three main methodological limitations to this research study that must be acknowledged: size of sample being interviewed and limitations on the people who make up the youth's 'circle of care'; the use of previous child protection social workers, not those currently employed in this capacity and the presence of personal bias.

Most notably the sample size of this research project presents a methodological limitation. I contacted three agencies that provide residential services for youth in care in the Ottawa area to participate in this study, however, was only able to secure the participation of one agency. It must be acknowledged that the agency that participated in this study offers a number of services that other agencies do not. The agency is well established in the community, provides a unionized environment and has a range of

program options and a range of funding streams through the Ministry of Children and Youth Services including Youth Justice, Children in Care and Child and Family Intervention). The agency operates a variety of homes and has beds that are directly funded by the Ministry as well as beds that are purchased on a per diem basis as "Outside Purchased Institutions" by the Children's Aid Societies. The agency offers a clinician for each home to provide clinical support to the youth and the staff team and the agency has the services of a child and youth psychiatrist for assessments and treatment protocols for youth requiring mental health services and for further clinical support to the staff team. In addition to offering a stronger clinical component to their program the agency also offers staff a unionized environment providing a more favourable work environment for staff. As a result there is less staff turnover (the agency has an average years of service of 11.25), higher qualified staff and more consistency in the care youth receive. These additions allow the agency to provide a stronger focus on the therapeutic components of care for youth.

Due to resource limitations other private operator group homes are not able to provide the same level of service or the same conditions for employees and as a result are likely to face increased challenges providing improved clinical outcomes for youth and an inferior environment for youth workers performing their professional roles. It is feasible that findings would have varied significantly if more youth workers had participated in focus groups representing a number of different agencies in the Ottawa area. This is evidenced in the discussions of former CAS social workers speaking of their experiences with various group care facilities and in current research findings on the

group care environment. This factor is examined and considered throughout the findings and discussion of the study.

Unfortunately it was also difficult to recruit mental health professionals as most simply did not respond to invitations to participate. Twelve clinicians were contacted to participate in this study however, only three participants were recruited. A larger sample population would provide a more diverse set of data as differing clinicians may have varying approaches and certainly differing experiences.

The limited definition of the youth's 'circle of care' is a further sample size restriction. It is recognized that a number of other service providers are routinely involved with youth living in the care system including representatives of the legal system, the education system and of course biological and foster families that are involved to differing degrees with the youth. In the interest of time and manageability this study chose to focus on those with the most contact with these youth (youth workers in the group home) those who generally have the most power in terms of decisions regarding youths placement and service received (the CAS social worker) and the mental health clinician who are responsible for therapeutic treatment. Most significantly the experience of the youth themselves in receiving service is not represented in this research; however, a similar study examining the use of psychotropic medications with youth in care is addressed in the literature review which includes systems youth as participants.

A further methodological limitation is that this study uses former child protection social workers and not those currently employed. The researcher made attempts to obtain permission to recruit participants from the Ottawa Branch of the Children's Aid Society, however, the agency was unwilling to support the research project due to concerns that the study may result in the exposure and stigmatization of a vulnerable population. The researcher recognizes that all participants who spoke of their experiences when employed at the Children's Aid Society have chosen to leave that role which may bias the experiences they report and their perception of their roles in that job. It should be noted, however, that all such participants have chosen to stay in the field of social work and are now practising as mental health social workers. Additionally the researcher finds it somewhat telling that the Children's Aid Society was unwilling to participate in a study investigating professional collaboration as current literature critiques the child protection system as being highly insular and disconnected from other parts of the care community.

A final limitation lies in the fact that I was the only researcher gathering and analysing data. Although I have guidance from my thesis supervisor, the potential for bias and misinterpretation of data exists. As already acknowledged my previous professional experience in many facets of this study lends itself to the presence of preconceived notions that could influence the collection and analysis of data. Throughout this study I was cognizant of these assumptions and biases so as not to influence the research process.

Chapter 4: Findings and Discussion

Introduction

This study investigates the delivery of services to youth in group homes and the experience of professionals who deliver them. All participants **(14)** spoke of challenges they experience in their day to day roles in the 'circle of care'. They expressed concerns with shortcomings inherent in the systems in which they work, in particular difficulties they encounter working collaboratively with other partners and the resultant impacts they see for the youth and families receiving services.

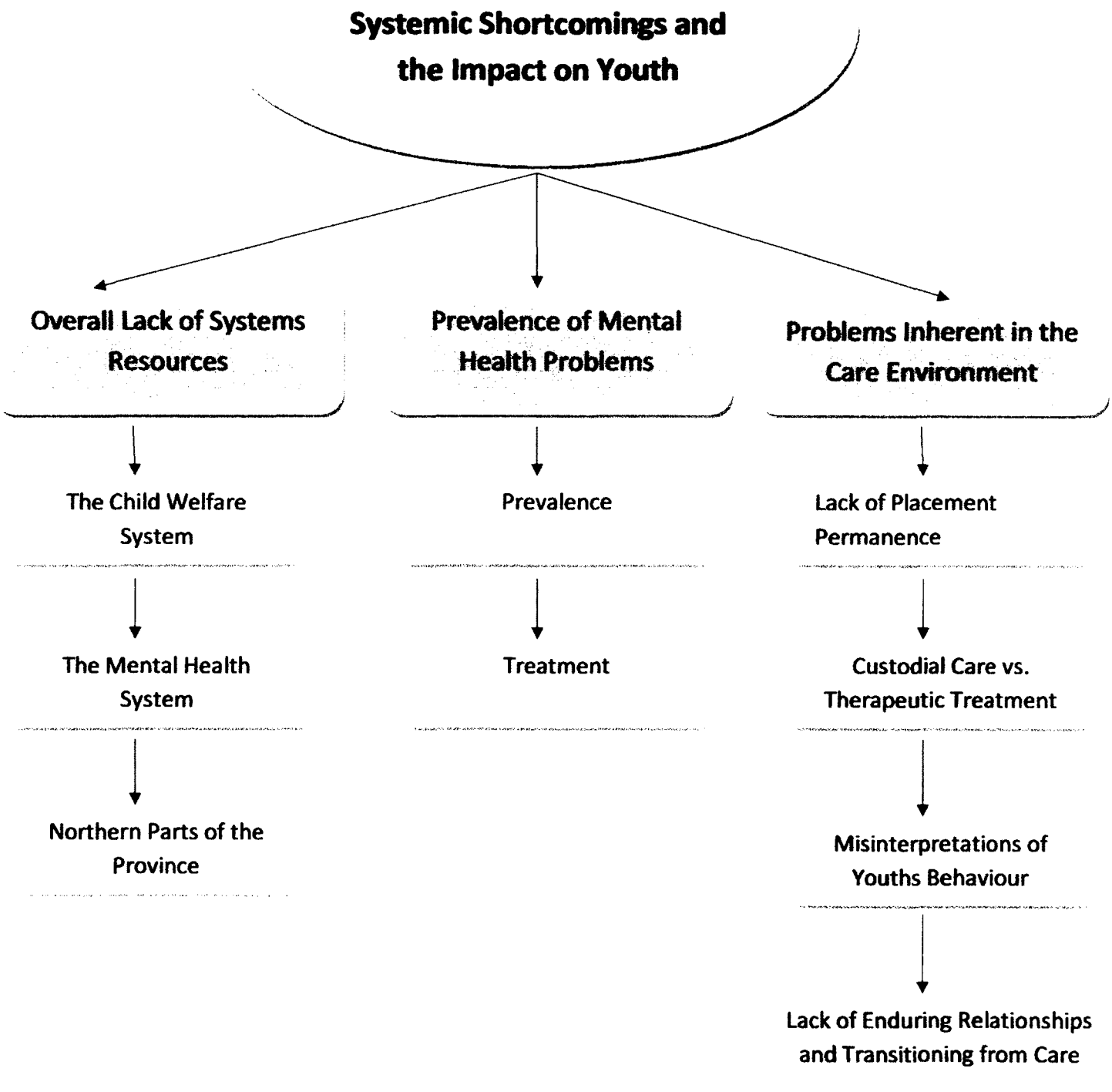
Two themes emerged from the research data: **(1)** *Systemic Shortcomings and the Impact on Youth* and **(2)** *Professional Challenges and the Impact on Professionals* (see the following themes charts for illustration of the themes, categories and subcategories). In the first theme, three categories are found. The first is an **overall lack of systems resources** with sub-categories specific to the child welfare system, the mental health system and particularly in Northern parts of the province. This category clearly illustrates the challenges of operating a system that is largely underfunded and the negative impact youth experience as a result. The second category in this theme, involves the **prevalence of mental health problems** in the child welfare system and in group care in particular with concern regarding what treatment is available to systems youth. This category illustrates both the level of problems seen within these systems and the significant challenges and deficiencies of current treatment protocols. The third category in systems shortcomings is **problems inherent in the care environment. W**ithin

this category there are four sub-categories including a lack of placement permanence creating problems in attachment for youth; tensions between custodial care and therapeutic treatment provided in the group home; misinterpretations of youth's behaviour and a lack of enduring relationships and transitioning from care. All four sub-categories illustrate how service gaps are experienced by youth in group care. These gaps result from an inability of the system to provide appropriate alternate care in the child welfare system, from group homes that are unable to provide therapeutic environments, from exposure to under skilled, under supported professionals and from a system that is short sighted in terms of providing the necessary long term requirements youth need as they move to independence or adult services.

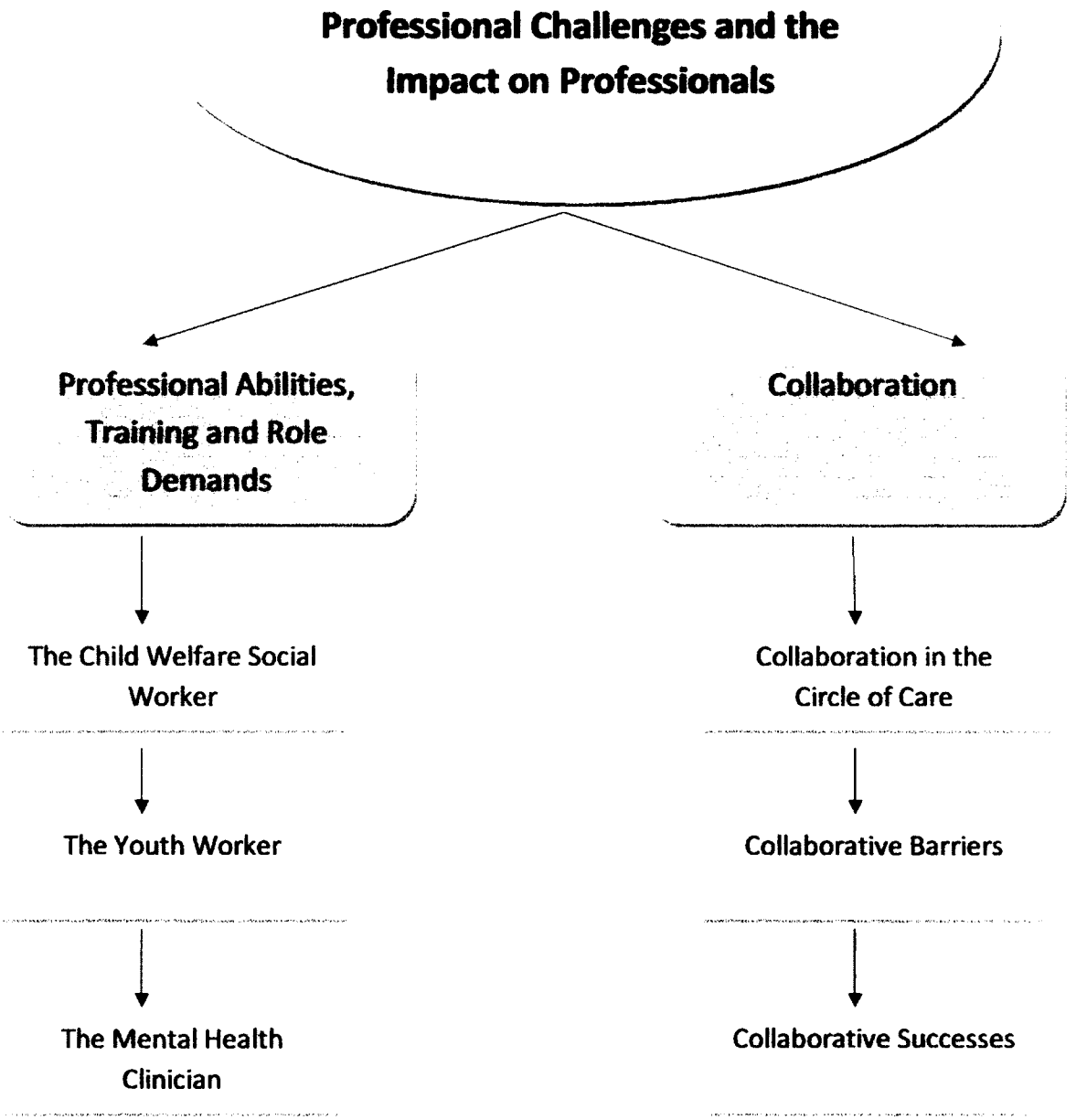
The second theme that emerged from the data was *professional challenges and the impact on professionals* working with this population (See following theme chart to illustrate the categories and sub-categories of this theme). In this theme two categories emerged. The first was **professional abilities, training and role demands** where professionals indicated a lack of skill, training and support available for the work they are required to provide. The challenges are seen by all three components of the 'circle of care': the child welfare social worker, the youth worker and the mental health clinician. These challenges create feelings of futility and frustration for professionals trying to provide a demanding service and prevent optimal service delivery. The second category is **collaboration**, within this category, three sub-categories looked at the collaborative experiences in the 'circle of care' and how collaborative practices are viewed in the Ottawa area; barriers to collaboration and; collaborative successes. While barriers and

challenges to collaboration are prevalent and routinely impede service delivery it should be noted that participants also spoke of the great work being done in an attempt to best assist a very vulnerable and complex population. Looking at service gaps and challenges highlights what does work and what professionals have been able to do to make it work despite many inadequacies. This chapter concludes with an examination of areas where participants have identified successful collaborations. Throughout the chapter themes emerging from the findings of this project and statements drawn from information shared by participants are examined in relation to that of current relevant scholarly literature.

Theme #1


Systemic Shortcomings and the Impact on Youth
Overall Lack of Systems Resources
Prevalence of Mental Health Problems
Problems Inherent in the Care Environment
The Child Welfare System
The Mental Health System
Northern Parts of the Province
Prevalence
Treatment
Lack of Placement Permanence
Custodial Care vs. Therapeutic Treatment
Misinterpretations of Youths Behaviour
Lack of Enduring Relationships and Transitioning from Care

Theme # 2


Professional Challenges and the Impact on Professionals
Professional Abilities, Training and Role Demands
Collaboration
The Child Welfare Social Worker
The Youth Worker
The Mental Health Clinician
Collaboration in the Circle of Care
Collaborative Barriers
Collaborative Successes

Systems Shortcomings and the Impact on Youth

An Overall Lack of Resources

All participants of this study continually referred to a lack of available resources and severely under resourced systems as a barrier to providing services for youth in group care with a mental health problem. Shortcomings noted in the child welfare system, include a lack of placement availability, and a lack of alternative or specialized placement for high needs youth. A lack of resources also made transitions between placements problematic and at times traumatic for the youth. In the mental health system a lack of available psychiatrists and mental health supports was noted meaning youth cannot access the services needed to address their needs. Additionally, participants continually remarked on the challenges of working with youth placed from Northern areas of the province and the lack of services and supports in Northern Ontario. The combinations of these shortcomings were noted to negatively impact service delivery and outcomes for the youth in care.

In the child welfare system

The most commonly reported resource lacking in the child welfare system was available placements for youth. This was noted by all **(6)** former child welfare social workers and **(5)** youth workers. Similar to what current research illustrates, participants found that placements for teenagers were limited and few, if any, foster homes were available; additionally, adoption for teenagers was noted as extremely unlikely. As a result of the lack of family based placement available for older youth many are placed in

group care because it is the only available option (Freundlich & Avery, 2005). When searching for placement, former child welfare social workers agreed that although some placements were preferable to others or that matching youth to certain placements was ideal, this was rarely possible.

> *You just called and took what was available, it's not specialized, it's just what comes up.*
>
> *...there was a lot of negotiating and hoping stuff would come up, knowing that the resources weren't there or there wouldn't be a turnover quickly enough; meaning kids were kept in a holding spot, like emergency beds.*

The negative impact this creates for the youth was further discussed by one former CAS social worker:

> *They are not settled anywhere, their plan is not kicking in, it's unfortunate, you know they don't have their regular clothes and their allowance and all those things, they are big for teenagers. I found it really challenging to find good places.*

Not only were placement options difficult to find, but it was noted to be especially difficult for youth with high needs:

> *...fetal alcohol syndrome kids or kids with developmental delays of various sorts; finding them an appropriate placement is hard because they have limitations and aren't able to self-regulate or comprehension is impaired. Also youth with Borderline Personality Disorder or PTSD, highly traumatized with dissociation. They are highly volatile, self-harming, sometimes suicidal or aggressive; it can be intimidating to other care providers.*

One participating psychiatrist remarked on the challenge of placement resources commenting on a child he felt would benefit therapeutically from being the only child in the home due the deprivation he had previously experienced.

> *So you don't want to put him in a group home, you want to find a place where he is the only kid. But even if you find a foster placement it's very hard because of course you want a talented foster parent to look after three or four kids at once. You can recommend wonderful things, but if there are no resources then the kids get the best people can do. Sometimes that is not good enough.*

A further barrier presented by a lack of placement options was experienced when problems arose in current placements, the prevailing perception was there was nowhere for youth to go. Comments by former child welfare social workers illustrate this gap and its impact for youth which included use of medication to maintain placement or even temporary incarceration as a form of respite; not to mention that in these instances the therapeutic needs of the youth are not being addressed.

> *There is no an alternative placement so medication helps control behaviour and allows the youth to maintain placement.*
>
> *If there was a problem in the group home, there is nowhere for the youth to go, so they would spend a couple hours in the isolation room to calm down, or we had a piece of paper I could sign and it gave consent to hold the youth in a jail cell overnight.*
>
> *If the group home couldn't tolerate the youth or they were running away, we would ship them to Elliot Lake, so they couldn't run anywhere but the bush. Sometimes they still did. It wasn't a solution.*

Faced with the challenge of not having suitable placement options for these youth, the social workers focus is not on how best to help the youth address his or her needs, but simply on where this person will go.

When transitioning a child to a new placement or towards independence the lack of placement resources and lack of resources within the placement are noted. Although this task falls to the CAS worker, the clinician and youth workers from the participating

residential youth centre recognized this area as a gap. Problems centred on finding a placement that could meet the youth's treatment needs and finding placements in time to provide an adequate transition period. These professionals spoke of the challenge youth face moving from a structured, highly monitored environment in the group home to a setting with less, or no structure or support. These participants expressed feeling that a transitional type of placement was needed:

> *Some sort of step-down or halfway house would be ideal, but funding is always the issue. The resources aren't there.*
>
> *The lack of programs out there is a huge issue, because there are not a lot of transitions for youth when they leave. Maybe a semi-independent program but there is a big gap in that service. Its group home or family or foster, there is no in between. A lot of kids are 17 or 18 when they leave and there is no kind of transition to help them function in society and bridge the gap from youth to adult services, it's a huge problem there too.*

Without appropriate placements for the youth to move on to, the feeling was that work accomplished in the current placement was likely to be undone.

> *The problem is that there are not a lot of resources right. So it's like, okay we've had this kid for 6 or 8 months, they are doing fantastic, it's time for them to move on, but there isn't a suitable place, so they go back to the bad environment they came from, or a place they've tried before that didn't work. Chances are even though they have learned new skills and formed new relationships; they can't transfer it because it was such a bad experience before.*
>
> *A lot of times we just throw them back into the fire.*

In addition to not having a suitable placement, transition time to a new placement was impacted by available resources in the system. When a youth is able to reunite with a family after the group home, the transition period can be lengthened and family is able to come to the centre and work collaboratively with staff for a longer duration of time.

When, however, a private operator requires payment for a bed or to have a bed held in anticipation of a youth's move, the transition is often quicker. The participating clinician noted that:

> *There is more exposure, more often (*when transitioning to a family home*). Whereas if they are going to a group home it usually just a week or two at the end where they go and visit.*
>
> *With family discharges we may block out two months for discharge planning and the last month may be that they are going home, except if a problem occurs then they can come back for a bit.*

This finding was also commented on by a youth worker who states:

> *When a youth was moving back with his parents, they (*the parents*) came to meetings and got regular updates so when it was time to go he (*the youth*) slowly had visits weekly, then an overnight, then a whole weekend then you kind of phase them out. Otherwise they just leave, to another group home, a friends, a shelter, jail, wherever.*

It was noted that the lack of placement options is exacerbated when a youth comes from a CAS struggling with budget constraints.

> *Some CAS's have limited options and we've had some real difficulties getting a kid in a discharge bed on time. We had one kid, the bed was found the day before she left. She was a really accelerated, high profile, high needs case and it was just horrible. It can be traumatizing.*

Current literature indicates that group care placements are the most expensive care option for the child welfare system (Ryan et al., 2008). Studies indicate that group care is between 6-10 times the costs of a foster home and 3-5 times the cost of treatment foster homes (Chamberlain, 2000). Yet, for youth it is often the only option. Failure to provide adequate placement options to meet youth's needs undermines the

achievements that professionals work tirelessly to accomplish. To address these challenges the child welfare system must focus efforts to recruit families willing to foster or adopt, especially those willing to work with adolescents. This should also involve collaboration with the mental health system so that supports are offered to foster or adoptive families allowing them to better manage the challenging behaviours youth may exhibit and to minimize movements between placements.

In discussing a lack of resources, it must be noted that in recent decades, child welfare practice has experienced increased growth in demand for service, along with simultaneous pressures of budget cuts and increasing public scepticism of social programs (Rice & Prince, 2003). This has resulted in a move away from intensive in-patient hospitalizations, or commitments to detention centres, in favour of smaller, less expensive staff secured, community based group homes (Sherwood, 1984). Additionally services to provide such group homes were contracted out of the public sector into private for profit business whose services are purchased by the Children's Aid Society (Anglin, 2002a). Although this type of welfare pluralism has proven to be less expensive, as is argued by Rice and Prince (2003), often costs are realigned in a different direction. As is identified by participants of this study, this cost comes at the expense of services available for youth. Adequate placement options are not available, the ability to carefully select and support optimal placement for a youth's needs is limited and the time and resources required to properly transition a youth to new placements is not available.

It should also be noted that resource constraints have become entwined with the child welfare systems standard of "least restrictive intervention". This standard indicates that in the continuum of care, youth are offered less intensive services until deemed otherwise necessary. Within the group home model this continuum exists in homes that are considered treatment oriented and offer more services and more restrictions when a youth has failed in other placements. As noted by Anglin (2002a), current ministry guidelines approve operators budgets based on what is submitted and what the operator agrees to provide for this fee. The operator participating in this study provides a higher level of mental health services and supports for an increased fee, not only does the operator feel the tension between providing a high level of service while remaining competitive in the fee for service market; the reality that CAS is the purchaser of this service and often operates with budget shortfalls, means youths placements will first be in more basic, less expensive homes. As Stuck and colleagues (2000) indicate "the result is an incremental approach to practice intervention wherein individual assessments are overridden by the systemic bias to begin with step-down helping options" (p. 84). This creates a system that reacts in response to crisis rather than proactively intervenes and where youth are moved along by failure. As youth move along this continuum it is likely to create the internalization of blame and failure; that relational connections are eroded or broken; and that other resource options are destroyed along the way (Stuck et. al., 2000). Additionally, as participants from the Roberts Smart Centre indicated even when a youth has moved along this continuum to a higher level of service, there are no

services to transition the youth back to less intensive services, to the community, or to reunite with family.

Within the group home, resources were also noted as being under resourced. Commonly youth workers remarked on the difficulty of managing a number of complex clients with limited staff:

> *A lot of things aren't addressed as much as they could be and should be, but you know every house has like 8 kids, time, services it's all really limited.*
>
> *You know a kid wants to sit down and open up, but you look and you've got to get moving, there is dinner, appointments, shift change, or someone else is having a crisis, whatever. I mean there are 8 kids and two staff. That's what is going to happen. So then you feel like you are sticking a band aid on or whatever, but its reality.*

This challenge was also felt by the agency clinician who concurred:

> *We have 8 beds so when there is full house staff are more stretched, it impacts the ability to of offer more services.*
>
> *We get the whole spectrum too, someone who is fetal alcohol spectrum; someone is borderline personality disorder and someone who is more on the ADHD or oppositional defiant disorder scale. Staff have to try to manage all these traits and challenges together, help them not trigger and traumatize each other with their behaviours.*

Both participating psychiatrists also remarked on the limitations of group home resources:

> *It's hard, you know the kids went on a rampage last night and one staff has to go get groceries and the other can't bring all the kids to the appointment. It makes it hard to get and provide services to these kids.*
>
> *...group homes suffer from being under resourced and underappreciated and that is a major problem. You know the best ones take charge of their responsibilities very well, have staff*

> *development programs and really lobby for their kids. Others under the grind of the daily business of keeping your beds full so you can afford to pay the bills found they never quite had enough in the way of resources; they couldn't keep highly qualified staff because they couldn't pay them well. The worst case scenario is you get a very dysfunctional group home where kids get abused and it's a mess. I come back to the common denominator for failure is under resourcing. It's expensive to look after children properly and go the extra mile.*
>
> *I tell the group home, I don't want a driver, I want someone who knows the file that can be part of the appointment, but sometimes it's not what you get It's a new staff, or someone filling in.*

As is illustrated in the above quotations the for profit group home model creates an additional tension between demands to contain costs and ensure operational efficiency, while providing services to youth and a safe environment for staff (Anglin, 2002a). Limiting the number of youth to a home or increasing supports and services makes the group home financially inoperable given current funding rates. Although, private group home operators are able to create service frameworks which include treatment oriented services and programming to optimize development for an increased per diem rate, they do so in an environment of competition for the limited resources of the provincial government. This in effect puts children in competition for scarce resources while putting at risk the quality of care provided in the group home (Sherwood, 1984). Given the high costs of group home placements program effectiveness is of great concern. Yet, as we have seen these programs continue to experience the need to be more accountable with fewer dollars available; to ensure quality services without adequate licensing and legislation and to care for high level complex needs youth with major financial restrictions. The ironic outcome of this situation is perhaps best captured by a psychiatrist in this study who states:

> *It's pay me now, or pay me later. It's $385 for a day in prison, which is the final stomping ground for our failures quite often [...] The resourcing priorities are not correct in Canada, I would put money into early intervention, if you can spend $385 a day on prison can you not spend at least half that on a kid in a group home. I mean the per diem rate is nowhere near that.*

In the Mental Health System

Resource limitations were also expressed in the availability of mental health supports and services. As shown by comments of this study's psychiatrists:

> *There is an overall gap of mental health services for children and youth, there are not enough child psychiatrists. We are not graduating enough of them. In terms of mental health services in general they tend to be underfunded.*
>
> *We unearth a lot of cases (of mental illness) and label them and don't provide sufficient treatment sometimes. I suppose it's better than pretending the problem isn't there, but that's cruel to say well here is your diagnosis, but go away and don't bother me. One in five kids in Ontario according to some studies say that is what happens to them.*
>
> *In mental health we say, well there is not enough care for everyone so there is a justification for standing back because you can't possibly respond to it anyway.*

The lack of mental health services to meet the demands of the child welfare system also figures prominently in current literature (Darlington & Feeney, 2008; McMillen et al., 2007; Price & Austin, 2005). Darlington and colleagues (2004) remark that when resources are tight competition can arise for access to limited resources. A psychiatrist in this study illustrated this clearly when speaking of reasons for professional insularity:

> *I think its fear driven in the sense that we are already over running the capacity to deal with what we have and we don't want to take on more. It's like we don't want the people in the community to know that we have an open door.*

Both psychiatrists spoke of fractured systems and fragmented services, from having only two psychiatrists in the Ottawa community working through the Children's Hospital of Eastern Ontario (CHEO) to provide consultations to CAS, to CHEO not being able to do conduct disorder or forensic work, and that services that do exist are continually narrowing or closing.

> *You know the system doesn't allow for adequate help. You can get a momentary on the spot consultation, but you can't put some kind of logistical support around the people that need it. You have teachers, family support workers, CAS social workers all seeing these kids, then the youth workers in the group home, all these people working with these kids and they are not in the mental health system. They are the care and resource system. When they feel, oh my God I'm uncomfortable with what I am seeing here, who can they go to, CHEO emergency? That is not an adequate response.*

These findings support what is noted in current research, that as more mental health services are offered in community based settings, care for complex, challenging clients falls on overburdened, under skilled workers. As is suggested by the NYICN (2009) study, these cutbacks exist in a climate where more and more youth, and especially youth in care are prescribed psychotropic medications (NYICN, 2009). This is explored in further detail in the following category on mental health treatment. Ontario`s report on mental health and addiction strategy indicates that historically services have been delivered

separately from other services making it difficult to navigate the system and access all the services needed. This also creates services gaps, unnecessary duplication of service or the inappropriate use of services (Open Minds, Healthy Minds, 2011).

Despite the fact that current literature clearly indicates an increased need for mental health services in the child welfare system (Adnopoz, 1998); as study participants show, this need has not translated into an increase in services available. In fact in *Open Minds, Healthy Minds* (2011) despite the identified need to integrate and collaborate service the strategy outlined to address service for child and youth mental health does not include any mention of enhancing service for the child welfare population. The impact can be devastating for those involved. A lack of comprehensive mental health services is a missed opportunity to look at what is really happening for a youth and to begin the process of turning things around. It is the mental health and well being of a vulnerable population that endures the ramifications of such short sighted funding. As a result, the systems designed to care, protect and optimize development for youth do not fulfill the obligations to their clients. Referring to the lack of mental health services for youth in care one psychiatrist summarizes the situation well:

> *It is dismaying that these organizations are under resourced. They do extremely important work with a huge financial and emotional benefit to society. We need to wake up and figure out that mental health issues are extremely important.*

Challenges in the North

In terms of a lack of overall resources, a further finding, commonly noted by this study's participants was the shortage of services available for communities in Northern Ontario. Two of the study's participants had previously worked as child welfare social workers in Northern communities, but even former CAS social workers from Ottawa spoke of the ancillary challenges providing cross jurisdictional support for native youth sent to Ottawa for placement. This challenge was similarly experienced by youth workers and the clinician at the participating residential centre. Children are moved to the Ottawa area because they have exhausted the limited resources available in their community or the specialized services required do not exist. Former child welfare social workers spoke of the difficulties providing support to out of area placements:

> *We would get kids from up north placed in our district and we would go out on behalf of that agency, it was a strange thing. I mean how do you stay involved with a kid that no longer lives in your jurisdiction?*
>
> *Dealing with kids from up North or from another jurisdiction, there is not great communication, it feels like a lot of behind covering, like I'm going to call and make sure they are there, but you don't check on them nearly as often.*

The cultural challenges this presents was also expressed by both former CAS social workers and youth workers:

> *Often Native kids are shipped down, which creates a whole new problem that no one identifies or addresses, you suddenly have a native youth living in the group home who is likely the only non-white kid.*

> *The thing I find challenging is we take a lot of Native children from up North, very isolated places and just the cultural differences are hard, trying to understand.*

Social workers who had previously worked in these communities spoke of the lack of resources in comparison to those available in Ottawa:

> *I mean up North there are no mental health professionals to see the kids up there. Services are really limited. There is no psychiatrist for children; you have to pay for them to see a psychologist, so the services weren't great.*
>
> *We had a mental health Social Worker for a couple of months, but the position was closed, it was terminated.*

This finding should be considered in the context that currently Canada is the only G8 Country without a national mental health strategy for youth and that services available for youth vary widely across the country, even within provinces (NYICN, 2009). As this study's participants attest to, services available within Ontario vary. While participants clearly indicate that in the Ottawa area there are insufficient mental health services for youth in the care system, this seems even more problematic for youth in remote and rural areas in Northern parts of the province.

Prevalence of Mental Health Problems

The second category emerging from this study's data addresses the prevalence of mental health concerns in the child welfare system and the challenges providing treatment for youth in group care. Current literature examining mental health concerns for youth in care indicates an overall increase in the prevalence of youth diagnosed with a mental health concern and use of psychotropic medications to address these concerns (Fedoravicius et al., 2008; McMillen et al., 2007; Rawal et al., 2004) Additionally, youth

in the care system have a further increased incidence of mental illness to that of the general population (Burge, 2007; NYICN, 2009).

Prevalence

Similar to the finding of current research, participants indicated that mental health concerns are commonly seen in the youth they serve.

> *I have learned that the child welfare organizations have the largest collection of disturbed kids of any other organization of whatever city you are in. These are organizations that are responsible for the largest amount of kids with mental health problems.*
>
> *Families with mental illnesses tend statistically to produce children with mental illnesses, to take Canada's most popular mental illness, alcoholism and addiction disorder, it means that life is going to be pretty disorderly, it's hard not to be marked by that disorder. These are the kids we see in the system.*

That the group home environment provides a care setting which potentially contributes to acting out behaviours and the risk of being diagnosed with a mental health problem was also observed by participants. One former child welfare social worker commented that:

> *I think some of the kids that ended up in these homes didn't have mental health issues when they went in but ended up with them from being there; ended up with anxiety, depression.*

One of this project's psychiatrists speaking of youth in group care commented that:

> *I've often seen kids in a situation where they feel stuck. Where there is no validation, you have models of learned helplessness or burnout which really apply to their situation. As their levels of rage, frustration and despair go up, you end up with a greater potential to reach major depression and a role for anti-depressants becomes conceivable.*

From this statement we see that not only does the care system potentially increase the prevalence of mental health concerns but an increased likelihood for the reliance on psychiatric medications for treatment exists as well. This concern was voiced most strongly by former CAS social workers who reported feeling medications were at times a result of the group home environment needing to control behaviours.

> *I felt sometimes youth were over medicated because of behaviours that were present, the child was already frustrated and didn't want to be in the group home and on occasion staff just weren't able, I mean they weren't trying to minimize things, they were actually exacerbating things.*
>
> *What I found was that the group home would report behaviours to the GP and they would prescribe medication and often they were used as a tool to manage the behaviour in the home. I mean the kids were angry, they were upset and they were expressing that, then suddenly they were on medication.*

Youth Workers added that peer influence in group homes can be problematic and contribute to the increase in problematic behaviours as is argued by Wilson and Woods (2006). They indicate that youth in the group home environment are at increased risk of negative effects of peer contagion and affiliation with delinquent peers. This finding is consistent with the observations of youth workers of this study.

> *The environment can definitely contribute to the need for medication and diagnosis, a lot of times behaviours are learned, sometimes kids stay too long. Just living in a group home, I mean it can be positive, but it can really push the other way too.*
>
> *Depends on the group of kids you have at the time right, if you have kids not buying into the program and having issues, then you have these young kids coming in picking up negative behaviours. You learn things that you wouldn't have learned in the home or foster care.*

It has also been noted that poor attachment schemas increase the risk for involvement with anti-social peers and affiliation to delinquent peers, further illuminating the risks of exposing vulnerable youth to the group care environment (Ryan et al., 2008; Shulman et al., 1995; Zegers et al., 2008). The clinician in this study noted the challenge of continued placement breakdowns also contributes to kids acting out behaviours:

> *It can be a quick break, a big change, you would expect some acting out as a result, but then that acting out can result in further placement change. The kid traumatizes himself again, or they are traumatized by the situation, rather. Then their behaviour will build more trauma into that and they end up in multiple services, you know, hospital emergency, psychiatric wards or detention centres.*

This is consistent with Freundlich and Avery (2005) who found that placement instability and a lack of permanency increases the risk of negative outcomes for youth in group care. This is also consistent with the tenets of attachment theory and the recognition that cumulative effects of an unstable environment can negatively impact vulnerable children and youth with implications for a poor developmental trajectory and risk for mental illness (Boyd-Webb, 2006; Tarren-Sweeny, 2008a; Wilson & Woods, 2006). That an increased prevalence of mental health problems exists for youth in care is evidenced both in this study and in current literature; that the care environment increases opportunities and risks for the development of a mental health concerns is also confirmed by this study`s participants.

Treatment

In addition to the prevalence of mental health concerns for youth in care, the resultant increased exposure to psychotropic medications is shown in current literature (McMillen et al., 2007; Rawal et al., 2004). Unique challenges exist when using medications with youth in care including a lack of consistent follow up due to the absence of a consistent caregiver and concern that evaluations miss the complex historical and environmental influence on a youth's behaviour (Mitchell, 2003). As was identified by youth workers in this study subjective interpretations of youth's behaviours between workers can be problematic, and the changing shifts that youth workers have contributes to the challenge of consistently monitoring symptoms and relaying information to clinicians, doctors and psychiatrists:

> *The way shifts and stuff work too, I mean I come in and work three days then off for three or four, the Doctor has to take what I say with a grain of salt. Our opinions can all be different too, so which staff do you listen to, right?*

Numerous studies express concern regarding the prevalence of medication use for youth in care (Breland-Noble et al., 2004; NYICN, 2009; Whitfield, 2006). Although this finding was present and expressed by former CAS social workers and psychiatrists, participating youth workers did not identify this as a significant concern. It should be noted, however, that the group home participating in this study is different in that they have a dedicated psychiatrist for their centre. Additionally each group home in the centre has access to a clinician that youth see weekly for therapeutic counselling; and who is also in regular contact with the psychiatrist. Many group home operators do not

have this ability and rely solely on the family medicine doctor in their community for mental health care. All involved parties identified this collaboration as beneficial in the job they do and in feeling confident that youth receive the care they require:

> *Our centre psychiatrist will do sessions with our clients and he'll want staff opinions and perspectives.*
>
> *[*The psychiatrist*] makes himself available and we have a fast track to him and access through email or phone too. He meets with us regularly. He tends to be very strength based, he tends not to overmedicate. He knows the region and the resources. It is really necessary.*

The discrepancy between youth workers reporting feeling comfortable and confident in the medication regimes of the youth in their care at the residential youth centre and former CAS social workers reporting concerns of overmedication and use of medications for control of the environment in group homes, can be attributed to the agencies collaboration with a psychiatrist and use of a clinical team. This illustrates the variation of services offered within the group home model. As has been discussed it is an unfortunate reality that the upper level (and more costly) services that the agency in this study provides are offered in most cases once youth have burned through other placement options.

Contrary to the findings that youth are at risk of overmedication, one of the studies participating psychiatrist also indicated that at times youth may go untreated.

> *Most cases of depression in children are undertreated, not over treated and there are a lot of undiagnosed kids with ADHD that don't get the chance to ever get near a psychotropic medication that might help them stay in school. But there are also times*

> *people look at short cuts and say let's fix the problem of a violent kid with a heavy duty tranquillizer.*

This psychiatrist went on to states the importance of medication being only part of the solution:

> *Using ADHD as the most common example, it isn't just giving the kid his Ritalin, what is the education plan? What is the recreation plan? How can we help the family live with a challenging kid and improve their ability to cope? There is a lot that goes into a comprehensive treatment plan.*

He continues this discussion illustrating that at times medications are used for control in a hectic group home environment that is not operating well, reflecting the lack of resources and a desire to provide a quick cheap solution.

> *Reversing years of damage doesn't happen with a prescription pad and 6 months in a group home, although that can be a start.*

As is found by the National Youth in Care Network study (2009), medications can be seen as a straightforward, cost effective approach compared to intensive psychotherapeutic services that require the time and attention of a consistent caregiver. Liability concerns of managing challenging behaviours is also noted in the literature as a possible explanation for medication use (McMillen et al., 2007) and was acknowledged as a barrier in finding placements for youth after completing their stay in a structured secure home when moving to less intensive services:

> *When it comes time for discharge, most foster carers are a little leery and there are definitely liability concerns with other group homes if a kid is particularly suicidal or aggressive at times, it's intimidating to other care providers.*

In conjunction with concern regarding the frequency with which psychotropic medications are prescribed, the impact this treatment can have on youth must be

considered as well. Not only are there commonly noted side effects associated with psychotropic medications, including weight gain or loss, stunted growth, cognitive dulling, fatigue, nausea, disturbed sleep patterns and dependency on prescription drugs (NYICN, 2009), but the use of medications as control can have significant impact on a youth's psyche as well. This was identified by a psychiatrist in this study:

> *If you are placed in custody under the Mental Health Act, it can feel like you've been found guilty without a trial; or if you are treated with medications without consent, that you have been assaulted. It's been very humbling to hear my now adult patients who were treated as teenagers at CHEO who received that kind of treatment from myself and my colleagues. You have really affected their relationship with authority. Now that's not to say that we stop doing it, but at least allows you to understand how it can be perceived and to be very mindful when using restraints like that. [...] You have to be accountable for the fact that this isn't just what's in their best interest. No one can be traumatized at that level and it be in their best interest.*

If not managed properly the youth is also inappropriately exposed to negative, stigmatizing labels and a reliance on powerful psychotropic medications at the expense of developing alternative coping strategies. This risk was identified by the clinician when speaking of other group homes where staff are paid less, or have lower educational requirements and may not necessarily have developed the skills to manage the extent of the issues youth have.

> *I think that is problematic. Staff will react to a behaviour that may be based on perhaps trauma or attachment issues or whatever, and it can cause more problems without the understanding. If the kid gets punished too much for stuff like that they start to self-label as "I'm a bad kid", or they take the stance of "screw you all" and think they can't trust people.*

That these youth may end up with negative, stigmatizing, detrimental labels was recognized by one psychiatrist:

> *The stigmatization exists as a CAS ward, having a mental illness is double. Sometimes they are just seen as a kid in the system.*

As has been identified youth often have fragmented histories hindering psychiatrists in diagnosis; or the psychiatrist or prescribing physician may not be familiar with the specific challenges of being in a group care facility. These challenges increase the likelihood that youth are misdiagnosed, or given a diagnosis or treatment recommendation that is contextually deprived (Pavkov & Walrath, 2008).

Youth in care are not likely to feel as though they have a strong consistent guardian involved in their treatment. When a child is a Crown ward (which many, if not most are when in group care) the child welfare social worker assumes the guardianship role. Although ideally the social worker is able to develop a service regime to assist and treat the youth's development, this is often not the case. A lack of co-ordinated treatment, planning and an individual to provide consent and longitudinal oversight of treatment is lacking in the system (Naylor, 2007; NYICN, 2009). This reality is reflected by a former CAS social worker participating in this study:

> *Technically CAS is the parent, as a parent I would be far more involved, but given the number of kids and the volume of the work, there is no parent. We are saying okay make sure that you do this, but no one is really following up to make sure that it happens, or we are focusing on requirements, not the stuff that really matters in the youth's life.*

> *We would always try to talk to involved parties, but given the amount of work required you just can't replicate the job of a parent. You just do the follow up and make sure everything is in line. You tend to just put out fires.*

McMillen and colleagues (2007) indicate that youth care workers and CAS social workers do not adequately fill the role as a committed guardian or caretaker, reinforcing the need for youth to be their own advocates and have strong voices in the services they receive. This emphasizes the importance that the care system facilitates the maturational process as described by Winnicott (1970); something that is questionably achieved by the current group care format.

Overall the findings of this study are consistent with current research in identifying a number of problematic concerns regarding the prevalence and treatment of mental health issues for youth in a group care setting. The group care environment contributes a number of factors that make successful outcomes for youth more challenging. The third major finding of this study outlines problems inherent in the care environment and the subsequent impact for youth receiving services.

Problems Inherent in the Care Environment

It is true that the group care environment cannot replicate a healthy well functioning biological family. Youth in child welfare group homes have complex needs and must negotiate through a complex system. Yet, despite a highly developed system designed to ensure safety, protection and optimize development for youth, a number of factors in the care environment have been identified that challenge successful outcomes for youth in group care. These factors were encountered both in current research and in

this study and include: a lack of permanence and placement stability, challenges in the group care environment resulting from the tension between care and therapy, the misinterpretation of behaviour in the group home due to a lack of skills, training and support given to youth workers and a lack of enduring healthy adult relationships and gaps in services when transitioning out of the care system.

Placement Instability and a lack of Permanence

Through the 1990s child welfare principles focused on the development of permanency planning for kids in care (Stuck et al., 2000). Despite this ideological tenet, youth in care often do not experience any measure of stability or permanency in placement, particularly once they have arrived in a group home. One former CAS social worker in this study stated:

> *There is no permanency plan for teenagers, they just stay in care until they are 16 because no one is going to adopt them and they aren't going to foster care. It's like bandage the situation until they age out of the system.*

As Freundlich & Avery (2005) indicate youth in group care face a lack of permanency and exposure to placement instability. Similar to Barth (2007) who indicates that youth in group care have likely experienced a number of previous placements, professionals in this study commented that the placement history of youth they work with can vary greatly.

> *From zero to a dozen, some of our kids have been in care their whole lives with different foster parents or group homes or jail, it's all a possibility.*

The clinician from the residential care agency used in this study reported that because the setting is often the end of the road for a lot of youth, it is common to see youth arrive having already experienced a large number of former placements:

> *I've heard numbers as high as 30 or 40 and we are talking a teenager.*

When youth are brought into care they experience the loss of family, friends, peers and community; with each placement change this loss plays out over and over, contributing to an unhealthy attachment schema for the adolescent (Zegers et al., 2008). The negative impact on the child is validated by a participant in this study:

> *Children are often caught in a long process of uncertainty in terms of placement. This can create unease in the child and the intensity of their behavioural problems may cause care settings to collapse because the child runs away constantly, or sets a fire, or is just too difficult to manage; then the child welfare organization has to find a higher level of support for that child. These children have the original trauma and neglect and difficulties and losses, many sources of pain (...). They can become extremely hard to look after because they've collected some very difficult behavioural problems.*

Literature indicates that such continued experience of loss is often overlooked when professionals react to the youth's outward behaviour (Briggs, 2004). Continued acting out behaviours often precipitate placement breakdown which can exacerbate an insecure attachment schema and erode the youth's capacity to develop trusting, supportive relationships (Adnopoz, 1998). Instead youth internalize the expectation of breakdown, of rejection and of failure (Tomlinson, 2008). Speaking specifically to

attachment disorder this study's psychiatrist commented on the severe repercussions that can result.

> *With a serious attachment disordered child, love doesn't fix very much. It's never enough, it doesn't seem to penetrate..." Attachment disorder is devastating and it's maybe partially correctable".*

It is known that poor attachment experiences are highly associated with poor mental health outcomes (Crowell & Hauser, 2008; NYICN, 2009; Schilling et al., 2008; Tarren-Sweeney, 2008a). They also have been connected to youth in group care displaying violence towards staff, rule breaking, truancy, maladjustment and defiance of house rules (Zegers et al., 2008). These findings illustrate the importance of a well functioning, well resourced, well supported group care environment to manage youth's behaviour and to minimize placement breakdowns.

The reality, however, is the environment does not always exhibit these strengths. As Winnicott indicates a well functioning care facility should provide a `holding environment` where a client is able to test the environment to ensure it is safe and reliable, this often manifests as rage and aggression directed at the youth worker, but is an essential part of the process in developing a therapeutic relationship (Tomlinson, 2008). Unfortunately, these types of behaviours, when not understood or addressed properly, cause placements to breakdown. Former CAS social workers spoke of some youth going from family, to foster care to group home and the trauma this evoked for the youth. They indicated feeling they were often notified too late to try and prevent a placement breakdown:

> *If placements were breaking down, they were breaking down. Kids just wanted the heck out of there. Usually by the time you knew, you were moving them on. I think they left it too late to try and sort out the issues. That was my sense anyways.*
>
> *There was always a pressure when a placement wasn't working, the group home wanted them moved NOW, you know staff were getting hurt, or the youth was too high risk, problems with the neighbours. It felt like sometimes you're just running out of places for the kid to go.*

Winnicott's concept of 'good enough care giving' illustrates that the cycle of failure and mending of failure allows the development of the expectation for consistency and reliability, and allows youth to develop stable mental representations of others (Applegate, 1997). When a youth's acting out causes a placement to fail resulting in a move (generally up the continuum of care restriction), rather than working through the issues; the opportunity for the youth to develop a sense of safety and security is lost. Instead the youth is likely to internalize the experience as rejection, negative self labelling and failure. Additionally the move up to more secure restrictive care is likely to involve an increase rigid adherence to rules, routines and structure in the environment minimizing the facilitation of the `maturational process` which is essential in the youth's development, especially as they move towards independence.

Custodial Care vs. Therapeutic treatment

One of the most rigorous debates in current research is whether the group care environment is a therapeutic option or merely a last resort on the continuum of child welfare placements. Those who challenge the value of group care point to the tendency

for group care to rigidly adhere to rules and routines at the expense of promoting individual flexibility to meet individuals needs (Anglin, 2002; Barth et al., 1994; Bush, 1980; Freundlich & Avery, 2005). This is further criticized as detracting from the goal of adolescence which is to develop individual autonomy, or what Winnicott (1963) defines as the 'maturational process'. Bush (1980) offers the critique that group homes operate using behaviour modifications of earned rewards or consequences that afford staff control and maintenance of the environment; but interferes with the therapeutic rapport youth workers try to develop and youth so strongly require. While this construct certainly rang true in this study, it was encouraging to note that the agency participating in this study has made significant steps to move away from rules and routines being the sole focus of care. Both Youth Workers and the clinician at the residential care agency spoke positively of using Collaborative Problem Solving as a therapeutic framework to allow clients to take a lead role in their treatment and determine their needs within the guidelines of the facility.[5] A framework that clinically adheres to the principles of Winnicott's 'holding environment' and 'facilitating the maturational process'.

> *Collaborative problem solving allows the youth to be empowered rather than blindly following a routine. It's actually getting to issues we can empathize with, that they can identify and we can work through.*

[5] The Collaborative Problem-Solving Approach (CPS), originated by Dr. Ross Greene, is described in his book *The Explosive Child*, and subsequently in the books *Treating Explosive Kids* and *Lost At School*. This is a practical alternative approach for helping emotionally, behaviourally and socially challenged children. Most standard approaches involve applying techniques [rewards and
punishments] to these children/youth. This collaborative approach is about using new tools together with the youth to optimize development (Greene & Ablon, 2008).

The clinician also referring to the reliance on routines in group care outlined how Collaborative Problem Solving is used when issues arise for the youth, rather than resorting to consequences or loss of privileges to achieve compliance:

> *the expectations are lined out, they are expected to get up, have breakfast, shower, go to school, participate in programming all those things, but if for some reason they are balking at it, then they are helped by Collaborative Problem Solving to find out what it is they are resisting, or what routine will work for them.*

Youth workers in this study felt at times rules and routines create competing role demands through the responsibility to focus on operational tasks while also trying to organize and operate therapeutic activities; and acknowledged that the requirement to enforce rule compliance could detract from the therapeutic alliance. The addition of a clinician at each of the agencies homes, however, was indicated as beneficial in alleviating some of this role conflict.

> *Sometimes it's hard for the kids, something happens in the house and they have a hate on for one of us because we have to make him do something, then they have somebody else to go talk to about it. Not to say they have to talk to the clinician, but it makes it easier. It's a person who comes in and there are no hostilities from the situation.*

Youth workers did acknowledge this scenario is not without flaws. Sometimes youth workers reported feeling as though clinicians provided solutions that were not realistic to the environment's demands, or the wish that clinicians could work a shift on the floor to really see and understand how a youth is behaving. Overall, however, it was described as a positive addition to the group home environment and one that workers

missed in work they had done in other facilities. The use of rules and routines was also recognized by youth worker as therapeutic in and of themselves:

> *Those routines are the treatment as well, for a lot of kids that come from totally unstable houses, just getting up and showering is a success. Maintaining proper hygiene or having a meal at a certain time (...) it's all part of trying to give them a stable environment, a baseline where they can open up and start building relationships.*
>
> *It isn't always super successful at first, they go from living at home, to foster parent, then group home that is less structured, then they come here where we put mass amounts of structure in place that they've probably never had before. They buck it at first, but eventually they get used to it and they actually want it and expect it. (...) They really start to appreciate those things and it helps to motivate and work on goals.*

The 'holding environment' described by Winnicott (1963), indicates that a client must test the environment and the professional to see if it is safe and reliable, often taking the form of aggression and rage directed towards the youth worker. While this concept was not explicitly described by participants, it was a recognized pattern by both the youth workers and clinician:

> *Yeah, the kids try all the boundaries and see who they can push and when they can push and that's a really important phase of establishing rules and establishing boundaries (...) they need to know what the boundaries are because inside they become unravelled, they need that kind of structure.*
>
> *When the youth leaves secure treatment we try to brief the new team that they are going to probably have challenges and moments you really need to work so that the youth feels trust that the new team can manage that with them. So the youth can rely on their own inner resources and support around them.*

It is encouraging to observe that the group care environment and its youth workers are aware of this psychodynamic construct, thereby increasing the opportunity to appropriately respond to the exhibited behaviour and recognize if for what it is; a testing phase and expression of hope that the youth has found a safe and secure environment that can manage them (Tomlinson, 2008).

Although reliability and consistency, a further requirement of the 'holding environment', remain difficult to achieve in a group home due to staff turnover, shift rotations and variation in individual approaches, some of the added supports the agency in this study provides to their homes assist in minimizing these barriers. Interpretation of behaviour can vary between team members as can the idea of an appropriate response. When discussing agreement on client goals and treatment plans one youth worker commented:

> *It's subjective, like if we are doing the same job, I might find something very significant and document it and delve into, whereas he doesn't. In that regard there can be big discrepancies because it is very subjective.*
>
> *When you all sit down together, your opinions are going to vary. It's not about who is right or wrong, but it's frustrating because you are getting two different things. Then it's like, who gets the say? Is it me, or him, or the clinican?*

The importance of providing clinical support and time to debrief and debate with team members was emphasized by youth workers as important both for personal support, but especially helping youth to do well.

> *We sit down every day before our shift ends and pass everything back and forth and in team meetings, we battle it out sometimes, we really disagree with each other.*

It is clear these supports are necessary to minimize care giver inconsistencies and more closely adhere to the principles of Winnicott's 'holding environment'.

While the use of group care has been criticized in current research, (Anglin, 2002a; Barth et al., 1994; Bush, 1980) a strong voice also asserts that the group home model should be considered a treatment option (Yecheskiel, 1984). As seen, when operating well, a group facility can adhere to the therapeutic principles of Winnicott (1956, 1963, 1970). Although challenges and deficiencies remain in group care, efforts can be made to ameliorate the consequences of the environment. In this study both psychiatrists felt there was a beneficial role for group homes. One psychiatrist felt that group care can be a superior choice:

> *For an older kid who doesn't want to try being in a family anymore, they may have strong but pathological attachments to their family of origin. ..)These kids don't want to create a loyalty to another family, so CAS has to work out a salvage plan. We will salvage the best we can from this family, for this child and we will provide stable substitute caregivers that are not pretending to take over a parenting role.*

This viewpoint, however, does not consider the loss of enduring healthy relationships the youth will experience upon exiting the care system. Something strongly identified as problematic by all study participants. Unfortunately, when the youth leaves the group home they will have been away from their biological family and have experienced a significant rupture to that relationship. Additionally, they will be unable to maintain relationships to adults and professional carers that were established in group care.

A further criticism of group care as a therapeutic environment decrees that a negative perception and stigmatization exists for youth who reside in this model (Barth et al., 1994). This was shown to exist in the community at large, amongst child welfare workers and with youth themselves. This stigmatization was evidenced in this study as well, particularly in reference to an increased tendency for youth in group homes to end up criminalized.

> *The quality of care sometime lead to criminality, they were criminalized because of their behaviour. Often the group home just called police to de-escalate a situation. They were quick to lay charges. I found that terrible, everyone is traumatized and no one benefits.*

This was supported by one psychiatrist who felt that:

> *in a family setting if police are called they are more likely to talk to the youth, that sort of thing, in a group home the police are more apt to say okay, he's a jerk and press charges.*

Furthermore, CAS workers reported feeling that even within the welfare system the youth was often negatively perceived and targeted. An example was given of when a placement breaks down, that it is always seen as the youth's fault and documented as such.

> *The way information is recorded and reported was all from the child's perspective, not what the trigger was or the role the adult played in it.*

Misinterpretation of behaviours

One of the challenges of providing services to youth in group care is the occupational demands present for youth workers. It has been acknowledged that some of the hardest to serve youth end up placed in group care and that many are likely to be struggling with mental health concerns. Anglin (2002a) argues this creates an environment where the underlying psycho-emotional pain residents are experiencing is often not acknowledged or addressed. One former CAS social worker commented that at times she felt group home staff were unnecessarily adversarial, increasing conflicts and modelling poor behaviours.

> *I remember one client in particular being on the phone to me (...) and I could hear the worker in the background shouting and roaring saying "get off the phone"; not modelling anything. I was thinking, like what is going on there.*

It was also commented that staff at times are required for safety reasons to physically restrain kids, however, former CAS workers indicated that in some scenarios they were concerned that such methods were used for power and control or because staff were angry at the youth's behaviour. One former CAS worker spoke of entering a group home to find inappropriate discipline and another stated that there were a couple of investigations of staff charged with assault on the child in care. These participants also reflected feeling like group home staffs were under a burden to do too much and lacked the skills to appropriately manage the environment.

> *Unfortunately I found that people working in youth group homes were often fresh out of school, it is their first job and they just don't get it. You know, they say "this is my first job, or I'm just*

> *working the overnight so I can do another job at the same time." It's a problem.*

Moreover, a former CAS social worker spoke specifically, of group home staff being poorly trained to deal with mental health issues. She gave an example of a youth diagnosed with schizophrenia and felt staff did not know or understand his illness; as a result the youth was moved four times because:

> *The staff were young people just out of college, not trained to deal with the behaviours and the youth got really short changed because of that, because people were scared of him.*

It is noted by Anglin (2002a) that youth workers, who are tasked with the difficult challenge of managing such complex clients, often do so with the least training and support. Barth and colleagues (1994) note that youth care workers are generally young, poorly paid and highly mobile. Additionally both authors note that youth work is often undervalued by other professionals. This finding is mirrored in the following comments by former CAS social workers:

> *They would try to address issues but it would end up as confrontational because they were not skilled or were perceived as too young; 'You're not the boss of me' that type of thing. When someone is your height and your size and so close in age....*
>
> *It should be older more experienced people in group homes. You are setting yourself up for failure and conflict that way. It's where you should end your social work career, not begin it. You have the hardest to serve kids in a GH with your least experienced workers.*

This finding was not discussed by youth workers or the clinician at participating residential care agency, however, it should again be noted that this centre is unique in the Ottawa area, in that it offers a clinical treatment provider to all homes and a dedicated psychiatrist to the agency. In this sense the ability to provide a stronger clinical component to the program is clear. The ability to offer higher level service can be directly attributed to an agency that is better funded and is committed to providing qualified staff and continued opportunities for professional development. The benefits in terms of outcomes is clear when speaking to the centre's staff, in comparison to data evidenced in recent research and the when compared to the experiences referenced by this studies former CAS social workers referring to work with other group homes.

Lack of Enduring Relationship and Transitioning Out of Care

One of the most significant and troubling findings of this study, repeatedly identified by participants was that options were extremely limited for youth exiting the care system. That youth are ill prepared for independence and lack a permanent network of adult supporters has previously been identified in the literature and has been strongly associated to negative psychological and social outcomes (Crenshaw & Hardy, 2006; Freundlich & Avery, 2005; Hawkins-Rodgers, 2007; Mennen & O'Keefe, 2005). This gap was identified in the Ottawa care system and is a glaring inadequacy in the services currently provided. The child welfare system in Ontario is mandated to provide care up to the age of 16, most group homes will work with youth under a care order, until they are 18 and youth can be supported through an extended care and

maintenance order to the age of 21 (Office of the Auditor General of Ontario, 2006). Responding to these cut-offs one social worker commented:

> *It should not be 16, 16 year olds are not grownups, even 21 year olds are not grownups.*

Even more concerning is that although care can be extended up to the age of 21, this is done only when a youth is willing to continue to work with the system and is meeting expectations. Those who are struggling and fighting the system (who are therefore the most in need of care and support) are frequently allowed to age out of the system often without a support plan or network in place. This proved a heartbreaking reality felt by all social workers in this study. One former CAS social worker recounted a story of a colleague being upset when a youth he had worked with for years who was acting out, because he was over 18 the Society said let the order run out and drove the youth downtown to the shelter system. Another spoke of a youth just over 16 who was running away, they had tried to place the youth somewhere remote, but the youth continued to run, so the file was allowed to terminate.

> *As soon as they turned 16 the order doesn't stand anymore, if the child didn't want to stay in care, they were done. That's the end of it. There is no follow up.*

Additionally if a youth was returning to family, despite recommendations, there often was no intervention or support offered to that youth or the family. Research reports that many youth do return to their biological family after aging out of the care system, however, group homes and the child welfare system have been criticized as doing little work with families when a child has been termed a ward of the state (Courtney et al.,

1998; Hawkins-Rodgers, 2007; Tarren-Sweeny, 2008b). In many ways this denies youth any opportunity to maintain what may be their only permanent adult connections. Additionally, without continued work that includes the biological family, the youth is unlikely to have developed coping skills to manage problems inherent in returning to the biological family. A psychiatrist in this study spoke of the this trend:

> *I find this phenomenon of the youth struggling to get out of the system to go back to their family, whether or not they are capable of handling them. (...) Sometimes when there was contact, with the support of the group home, they were able to recognize as they grew that the family just was not able to manage.*

When the group home can work with the youth and even the family this psychiatrist indicates the powerful effect it can have. He refers to a patient living in group care but still in contact with his mother, and tells a story of the youth using both group home staff and his services to work through limitations the relationship with his mother must have.

> *When a child realizes that I can't depend on my family, I want to have more, but I realize I have to vet things through others to figure out what limits exists, that is really powerful and I think a positive service to get from the care community.*

Likewise, when a youth leaves care for independence or adult services, research recognizes a number of problems with this transition. Cohen (1984) argues that youth in the child welfare system often have delayed maturation due to interference in their development resultant from experienced abuse or neglect. Similarly, Anglin (2002a) speaks to the highly regimented routines of group home living as limiting a youth's

autonomous development. This is especially concerning given the reality that youth in group care will be independent at a younger age than most of their peers living in family situations.

> *Your family is always with you even when you are 25. You can always call them up, or if something happens you can go home for a bit. Not having a functioning family is a huge handicap.*

The group care environment does not provide someone for these individuals to return to if needed or someone particularly interested in their well being once discharged from care (Freundlich & Avery, 2005). The lack of these supports has been associated with economic and educational disadvantages; that youth cannot access necessary physical and mental health services puts them at increased risk of homelessness and victimization (Freundlich & Avery, 2005; Webb & Harden, 2003). The desire to maintain relationships with the group care facility was noted by all participants of the participating residential youth care agency. It was noted that no after care programs existed, but that youth can, and do call back all the time

> *Yeah, kids who fought it all the time they were here, they call and say, I want to come back, but it's like you're too old, you're 20. That's where you really understand that you do affect their lives.*
>
> *I have this girl that has been calling back for 5 years, like she is in her 20's, in college, but she calls back and checks in.*

The gap from youth to adult services was also identified.

> *Having an overlap of service as much as possible would be beneficial. We realize there is a gap between 16-18, between adult and youth services, so that's a bit of a trick. Getting someone in at*

> *discharge so the young person doesn't feel stranded in the community after is something we need to pursue.*

The examination of systems' limitations and the impact on youth shows a number of glaring concerns. Despite a recognized prevalence of mental health concerns of youth in the child welfare group home system, neither child protection nor mental health systems are adequately funded to ensure all youth are provided the services they resolutely require. The services available once ensconced in the system are likely to be subpar, including increased use of psychiatric medications that pose additional risks and harms to the youth. The care environment is rarely permanent creating continued ruptures to relationships and stability for youth. While certainly group care can be beneficial and therapeutic when operated and supported well; it is clear this is not always the case. Current legislative guidelines and funding patterns do not ensure that all youth have access to top notch care environments. Youth workers are over burdened, over worked, underappreciated and perhaps under skilled to manage the roles they are placed in without clinical support and guidance; and when youth mature out of the system little if any support is offered to reconnect the youth to the community or other supports. While at minimum these gaps indicate that youth's mental health and outcomes may deteriorate while in care, experiences resulting from these system may actually create poor mental health status. As one previous child welfare social worker now working in mental health stated:

> *I listen to my clients now and the number that have been apprehended and in care and I think, we did not do a good job with these kids.*

Professional challenges and Impact on Professionals

Recognizing systemic and operational gaps in the child welfare and mental health systems and the impact on youth receiving services, leads one to consider the challenges and impact this presents for professionals delivering services. This is the second theme that emerged from interview data. Looking at the demands of each professional's role and the training and support provided to manage these demands, highlights the difficulties and frustrations youth workers, social workers and mental health providers experience in the 'circle of care'. Despite inadequacies within these services, collaborative practices can and do bridge some service gaps, but they are limited. Considering barriers to collaborative practices and individual examples of successful initiatives illuminates a hopeful direction for the future.

Professional's abilities, training and role demands

Deficiencies in the child welfare, mental health and group care system impact and create problems for youth. However, they also have consequences for professionals delivering services. These challenges make it difficult for workers to perform their tasks, make professionals feel inadequately prepared or supported for the tasks they are required to perform and can lead to professional burnout, which ultimately affects how service delivery.

The child welfare social worker

Overall child welfare social workers stated they felt comfortable and confident when in the role of an intake social worker. When making a determination for protection or caregiver capacity they felt prepared with interviewing and investigation skills. In working with kids once in the care system, however, all workers reported feeling ill equipped to fulfill their role obligations.

> *I felt a lot of pressure and expectation that I would know what to do and have the answers, but I had no idea what I was doing.*

Social workers commented that most of the training they received focused on the court process, the investigation process and agency assessment tools. This is consistent with assertions of Stuck and colleagues (2000), who feel the child welfare system focuses predominately on the protection of children and not enough on ensuring the child's well being. CAS social workers illustrated this with the following quote referring to the training and information they were provided.

> *Not mental health, or treatment, not very much was focused on the program for those kids in care.*

The volume of knowledge, information and skill required of child welfare social workers to meet the demands of such challenging youth is noted in current research to be so demanding it is virtually impossible (Fontana & Gonzales, 2006). It is also suggested that the high levels of discipline insularity and professional accountability CAS workers face add an additional role burden (Adnopoz, 1998; Barth et al., 1994; Fedoravicius et al.,

2008; Webb & Harden, 2003). As an example, CAS social workers in this study spoke of the responsibility as the youth's guardian to authorize medications.

> *In terms of medications, we had to sign off and I was definitely concerned. I mean some of these meds have huge risks and side effects.*

Fedoravicius and colleagues (2008) indicate that child welfare social workers often report concern regarding their levels of knowledge of psychotropic medications. Workers have reported a lack of knowledge regarding medications, side effects and even knowledge of the youth's behaviour. This rather clearly indicates a need, and a benefit that could result through stronger collaboration with the mental health system. Despite continued recognition in current literature that mental health issues for youth in care has been increasing, content on mental health services has not increased in child welfare discourse (Leather et al., 2009). Leathers and colleagues (2009) also found that child welfare practice has been slow to disseminate new trends in the practice of children's mental health. A concerning finding given that child welfare social workers often hold the responsibility to find and authorize treatment protocols and programs for youth in their care. In addition to the amount of knowledge required in the role, the volume of work CAS social workers were required to perform was acknowledged by mental health providers and the former workers themselves.

> *Due to time constraints and caseloads, it was often difficult to do an accurate assessment. Stuff was going on with the kids, they didn't want to be co-operative, a whole host of things. You would have to get an assessment done within 30 days, but whether it was an accurate assessment of what was going on in that situation, not necessarily.*

> *I think the challenge for social workers is the caseload, the staff rotation, they have a legal mandate, they have a lot of very active cases and don't always have the face to face contact that they would like to have with the youth.*

That the child welfare system often acts in seclusion of other community helping agencies has been identified as problematic, especially regarding the lack of collaboration with the mental health system (Adnopoz, 1998). This researcher was made keenly aware of the reality of this finding when despite repeated attempts; she was denied access to the Children's Aid Society of Ottawa to speak to their worker about the role they perform. The burden on the mind of former CAS social workers in performing this role was evidenced, as the following quote indicates:

> *We were the group that had to do the dirty work in terms of keeping the kids in care. I didn't find it particularly rewarding, I always felt inadequate. I always felt our team was inadequate. We didn't provide services.*

The professional burden for CAS workers, working in isolation from the community care system can create in professionals the potential to sacrifice the long term interest of children and families due to the desire to alleviate risks they may be feeling having a child remain or reunify with the biological family (Adnopoz, 1998). These risks and demands are also felt by the child welfare social worker when current placements are struggling to manage a youth's behaviour and demanding something be done to alleviate the situation or move the youth. Previous CAS workers in this study indicated feeling pressure to meet these demands as well as the economic reality of placement scarcity.

> *It was about farming them out somewhere so they wouldn't be at home, when sometimes home was probably better than where they ended up*

When this risk is shared throughout the community, particularly in collaboration with mental health services, outcomes are likely to be distinctly different. It is known that relationships and ties to parents do not always end with the termination of a parent rights, even if work with the family as a unit does. It is also known that a lack of permanency entrenches attachment difficulties and accounts for further deterioration in mental health status (Tarren-Sweeney, 2008a). Currently, the child welfare social worker carriers the burden of finding and supporting suitable placement options for youth. Through a collaboration of services and resources with mental health professionals, it is possible that frequent moves away from family and community can be minimized (Landsverk et al., 2009). Through such collaboration there is a better chance for the intervention and maintenance of foster care placements; support and work with group home staff could prevent multiple moves between group care facilities or into more secure settings and work with biological families could be expanded, even when parental rights have been terminated; recognizing this may be the youths only real hope at a measure of permanence. The burden of accountability and demand for knowledge, skills and training for child welfare social workers must be shared throughout the youths 'circle of care'. To achieve this requires funding initiatives, legislative policies and collaborative practices that are cognizant of these burdens so all workers are able to provide the best services possible.

The youth worker

In examining occupational demands of group care employment it is clear that the configuration of residential group homes for youth under a child protection order provides a number of adversities for staff working in such a setting. Youth workers have the unique challenge of managing competing demands inherent in a residential setting. They face the challenges of providing service to complex clients with limited skills, training and clinical support and the burden of a profession that is often devalued in the professional hierarchy (Anglin, 2002a). Literature regarding group home employment indicates many workers view their work as temporary due to the challenging conditions. Group home work is generally perceived as low status, with insufficient training, poor salary, demands of shift work and extremely complex clients (Coulton & Roberts, 2007). In addition youth workers are subject to verbally and physically aggressive youth and are often unable to stay involved in their lives long enough to see productive growth. Clinical support for youth workers is also often not available, or is provided by unskilled administrators (Anglin 2002a; Coulton & Roberts, 2007). This finding was not replicated in the current study.

In this study the longest employee at the participating agency had been there for ten years and the shortest for three years. Again it must be noted that this agency is a unique as it is the only operator in the Ottawa area offering a unionized environment with adequate pay, vacation time, training, support and appropriate scheduling. The difficult work environment, however, was noted by one of the study's psychiatrist

indicating that these occupational problems exist for youth workers in other group facilities in the Ottawa area.

> *The people who work in group homes are definitely underpaid, it is very hard work and it requires a high level of skill and a high experience level. Keeping people in child and youth worker positions when you pay them something that doesn't allow them to have a career means you will never really get high quality service*

It was also acknowledged by the clinician who indicated that:

> *I see ads for hiring staff in other group homes and they are paid a smaller amount, the educational requirements are not as high, so I guess you get a lot of keen young people working, but they may not necessarily have gathered the skills that they need for the extent of the issues the kids have.*

Additionally a former CAS social worker noted feeling that:

> *People in adult group homes I work with now, seem to know the medication better and what it's there to treat. Unfortunately I found that people working in youth group homes were often fresh out of school. They didn't really care, or they didn't really get it.*

Also, as has been discussed the Roberts Smart Centre offers clinical support for youth workers through the clinician affiliated to each home and the psychiatrist affiliated to the centre. These findings indicate that when adequately supported and funded some of the challenges and adversities of professional youth work can be ameliorated improving outcomes for both youth and service providers. Unfortunately, indications in current research demonstrate this is not uniformly experienced in all group home environments.

In the group home model used in this study the clinician identified that ongoing professional development was available for staff and at times community professionals

attended the center to provide educational sessions. Youth workers commented that these opportunities have improved over the years.

> *When I first started you came in took first aid, CPR and therapeutic crisis intervention and were thrown into it, but over the years they have offered more things.*

It was acknowledged, however, that the centre would post training opportunities in the residences, but it was up to the individual to go into the community to get it and that it was not always possible for the centre to pay for it. This agency offers a model that ideally would be replicated and built upon by all group care facilities, but unfortunately this is not the case. Inconsistent standards of quality in group care must be addressed by Ministry licensing and regulations (Nolan & Lewis, 2007). Given the incredible demands of a youth workers role and the complexities of the clients they work with, it is crucial that work conditions value, reward and support professionals. When staff are treated well they are likely to feel better about their jobs, perform better in their jobs and remain in the positions. As a result outcomes for youths improve when staff remain consistent and are able to perform to their best abilities.

While youth workers in this study did not report feeling unprepared or overwhelmed by the complexity of their role demands, the sense of being under valued as a profession did exist. Literature indicates that despite the fact that it is frequently the youth worker who spends the most time with the youth and knows the behaviour and symptoms best they are often professionally devalued (Anglin, 2002a).

> *I guess I'm being arrogant when I say this but, it's like we are the expert on the kids but I feel like a lot of times what we say doesn't get as much attention as it should.*
>
> *I mean I feel like people listen to us, like my supervisor, but I don't feel like what I say to a Doctor is really valued.*

The need for shared knowledge between participants in the youth's 'circle of care' has been identified as a hindrance in collaborative practices, which has costly repercussion for all involved (Adnopoz, 1998). This demands an increased acknowledgement and respect for the role youth workers have, perhaps best summarized by one of the studies participants:

> *They (the youth worker) really need to be seen as part of a process that they are involved in and have a role in as part of the team. They have power within, it doesn't matter who this youth connects to, and no one ever said it had to be a person with an M.D., it could be anybody. It's a matter of getting the needs met.*

The mental health clinician

A commonly acknowledged professional demand for mental health service providers was the lack of necessary information and history on a child, due to a lack of involved parents or inconsistent caregivers. This provides a partial explanation for the lack of available mental health services and why many shy away from engaging in this type of work.

> *A lot of doctors do not like working with CAS kids because you get incomplete information and the group home personnel change, or the social worker changes, you can't get the whole story but they want you to do something, maybe prescribe something. Our disciplinary bodies require that we get all the information or else we are not supposed to make decisions. I mean you can't do your work that way with kids in care.*

This barrier is noted by McMillen and colleagues (2007), who indicate that psychiatrists providing service to the child welfare system consistently report not receiving necessary clinical information regarding a child's functioning and history; concern regarding how their services are used within the welfare system and an overall lack of availability to provide appropriate services. Validated by the psychiatrists in this study, one psychiatrist stated:

> *It's another explanation why these cases are unpopular. We all like to be able to practice at a high level without taking risks. When you don't have the information there is a sense of unease. I don't even have an allergy history on this kid, how can I prescribe anything? These are practical concerns that doctors have.*

Research indicates that a lack of information available for child welfare clients may also create a scenario where psychiatric evaluations are too quick to label and diagnose children (McMillen et al., 2007). When evaluations miss the complex historical and environment influences on a child's behaviour, studies indicate they are more likely to interpret behaviour as disordered (Mitchell, 2003).

A second challenge for psychiatrists is, as previously noted, the shortage of practitioners. As identified by one psychiatrist, the interface of the child welfare system with the legal system creates a unique challenge in that:

> *Under the Canada Evidence Act, doctors with their M.D degree, whether it is right or wrong, are allowed to provide a diagnosis which can give some justifications for recommendation being placed before the court.*

This psychiatrist suggests this as an area for service collaboration when a social worker requires a consultation and diagnosis of the youth, to proceed in the legal setting. The feeling however, was not shared by the study's other psychiatrist who cautions that:

> *Consultations are dangerous. You can end up looking through a telescope seeing one thing, one time and assuming you did a good job.*

Additionally when consultations are offered for a youth's treatment protocol one previous CAS social worker commented:

> *We are quick to triage kids and get a consult on what is going on, but the follow through of services just isn't there.*

Youth in the child welfare group home system are unique and complex. The systems processes provide additional challenges felt by all involved professionals. The overall lack of resources, demands of complex clients and caseload or role responsibilities of individual professionals are commonly noted as problematic. Mechanisms to support a team approach and increase multi-disciplinary communication must be considered in order to provide effective, efficient services to a very vulnerable population and increase the achievements, professional health and job satisfaction of service providers.

Collaboration

That the child welfare and mental health systems are inextricably interlinked is clear, however, it is noted that collaborative structures between systems can and should be improved. An examination of current practices and requirements in terms of shared information and reporting illustrates both glaring inadequacies and gaps that must be

addressed. This study exemplifies where barriers to collaboration are currently experienced and elucidates reasons for such barriers. This study, however, also found examples where independent collaborative efforts exist and certainly unearthed a spirit amongst participants to improve current collaborations.

Collaboration in the 'circle of care'

A lack of co-ordination between systems and demands of other systems' stakeholders has been identified as hampering professional's role functioning (McMillen, 2007; Whyte & Campbell, 2008). In this study both former CAS social workers and youth workers felt the reporting responsibilities in their internal teams was adequate. Youth workers are required to document daily logs of youth's routines and behaviours for all staff to review before shift, they verbally exchange updates at the beginning and end of each shift, have weekly team meetings and the clinicians have clinical meetings twice a month for peer consultation and support. Previous CAS social workers also felt internal resources for consultations from supervisors and other team members when required were adequate; unfortunately collaboration between services was less than optimal.

Considering the exchange of information between the group home and the child welfare social worker reporting requirements included the group home providing on-going monthly progress reports on the youth, as well as reports of any serious occurrences such as a disclosure, use of a restraint, an AWOL or self-harm incident. Additionally the group home is required to inform and update the social worker on any medical or therapeutic visits. Regular plans of care were required with the group home

team. In plan of care meetings, the CAS worker and the group home workers, as well as other involved parties including the youth get together to discuss and determine treatment goals. Former CAS social workers identified that their role was to oversee the care of the youth.

> *The role of the worker is to go in and do a plan of care and come up with a plan for all the different life domains and then the group home staff go and do it and report back. You make sure the plan is being followed.*

They reported having little or no contact with psychiatrists, psychologists, doctors or other treatment providers but that group home staff were required to relay and report anything of significance in these appointments. Reacting to how this reporting worked one social worker commented that:

> *The group home was required to provide regular feedback to CAS as the lead caretaker but that wasn't always what happened. It wasn't always reported on time, the feedback that was given, it wasn't always useful or accurate.*
>
> *I found there was a sort of generalized jargon used. Like so and so had a comfortable night, well what does that mean? Unless there was a major clash you didn't get a real sense of it. Even then, when you met the client their version of things was very different and you sort of felt, who is really right? There's got to be a level of accuracy somewhere in between.*

The social workers did not always feel welcome in the group care facility.

> *With the group home staff I felt they often saw us as interfering. We were there as someone to report something too but otherwise we just messed up their day.*

And both former CAS social workers and youth workers indicated that reporting requirements predominately were reactive rather than pro-actively working together on what the youth was struggling with. CAS workers additionally reported feeling that mandated requirements to meet with youth to follow through on how the placements was going did not allow for quality follow up or assessment.

> *We were mandated so we had to fit it in, but often between one period and the next, the quality of the interaction may not have been good enough to create really good follow up report. You wanted to write all kinds of things but it was really hard to keep on top of making changes (...) there was lots of reporting but it didn't always feel like we know what was going on at the group home. There would have been times when it was appropriate to have more involvement.*

Looking at how psychiatrists and mental health clinicians collaborated with others in the 'circle of care' both psychiatrists spoke of providing consultations to general practitioners in this study. One psychiatrist spoke of providing support to foster parents living with the day to day behaviours of difficult kids, in the form of seminars and workshops. This was identified as beneficial and ideally something that should be expanded.

> *This is very helpful because there are a lot of questions, what is the deep background to these behaviours? How best to deal with it on a day to day basis? Does medicine have anything to offer in terms of helping with these situations?*

The clinician also spoke of having other professionals in to discuss certain mental health traits or address specifically problematic youth. These sessions, however, were available for clinicians and program co-ordinators to then pass to youth workers. Curious, as it is youth workers with the most face to face interaction with these traits and problems.

This, however, identifies the challenge of limited resources because youth workers must be replaced to attend these training as youth require 24 hour supervision.

Current literature indicates that many youth in group care move placements due to a failure of the setting to understand and manage externalized symptoms of a youth's behaviour (Adnopoz, 1998; NYICN, 2009; Wotherspoon et al., 2008). With increased education and support there is a better chance for successful intervention and maintenance of the placement. While one psychiatrist in this study indicated he has on occasion spoken to group care staff about various issues or problem cases, it is not done often enough.

> *We are trying to do more education based on the fact that you can't see them all one on one, then maybe you can do therapy for the therapist type thing. It's a good idea.*

He acknowledged however, that the onus was on individual group homes to reach out for this service and that the group home may not do this due to a sense of discouragement knowing resources are limited and they have little to offer in terms of compensation. Given the previously noted ramifications of placement insecurity on youth's outcomes it seems an expansion of these types of collaborative and educational supports should be entrenched structures rather than left to the impetus of individual group care facilities.

Collaborative Barriers

The overall underfunding and lack of systems resources has been identified as an obstacle to collaborative practice. When resources are tight, Darlington and colleagues (2004) indicate that competition arises for access to limited resources. Gate keeping disputes around providing service to new clients can occur and agencies may claim a lack of time available to undertake inter-agency collaboration. One psychiatrist working in community based psychiatry for children and youth offered a number of examples where he felt this frustration. He spoke of a young patient he was working with whom he referred to forensic services due to concern regarding the patient exhibiting symptoms of aggression and obsession with violence. The intention was to collaborate with some additional expertise in forensic psychiatry. The outcome for this patient was that he was able to be seen, however, due to a lack of resources it was only for a few visits and no one was available to collaborate and follow this patient for a significant amount of time. In another instance a psychiatrist spoke of referring a patient for an opinion when he was feeling at a loss of what else could be done to assist her, only for the patient to be told that it seems you are doing well with your psychiatrist go back and continue seeing him. He attributes these challenges to unwillingness to take on new cases due to everyone feeling they are running at capacity.

> *It's usually user demand issues. (..) I'm not affiliated with the Ottawa Hospital so I can't pull that pass card for referrals, but I don't want it either because then they can pull on me and I'm already at capacity.*

The desire for organizational autonomy and freedom in decision making has also been identified as a barrier in collaboration. This may be particularly true for CAS workers who feel the pressure of legal mandates and requirements; and therefore are often the most controlling in their decision making processes (Prince & Austin, 2005). The feeling of risk may increase when the work with one client is shared between agencies. These conflicts can disrupt communication as workers may be informed through different paradigms, may have different priorities and may have different practice approaches (Darlington et al., 2004). One psychiatrist as an example spoke of referring a patient to a group in another organization who was then required to see an internal psychiatrist of that agency. This kind of agency protectionism creates redundancy in a system already burdened by a significant lack of resources. It also creates negative feelings and animosities between professionals and towards working together.

> *Communication is abysmal and it's silos, independent organisms within their own logistical structures which do not connect. You need to pull people together, to create relationships, to create that synergy of purpose.*

Additional concerns identified pertained to professionally driven barriers such as privacy, confidentiality or were related to the involvement of the legal system.

> *There are definitely barriers around privacy. I release as much as I can if the patient wants me to.*

The interface with the legal system can cause issues in collaboration as well and was referred to by one psychiatrist:

> *CAS is sometimes handicapped by confidentiality limits. They are well meaning, but it prevents a social worker from providing useful information ... sometimes they are restricted to vagueness because a case is before the courts and you can't say anything about what is going on because it might prejudice the action. So legal delays can be anti-therapeutic.*

That collaborative work can be labour intensive is a realistic concern:

> *The work I do is really care intensive, I don't work with just the patient but the network and you can lose energy in all those discussion.*

The counter argument, however, is this time should be seen as an investment without which outcomes are less than optimal for youth. Wakelyn (2008) demonstrates that these shortcomings can result in placement breakdowns, create adult psychopathology, long term reliance on the helping system and potential multi-generational contact with the child welfare system.

Participants in this study had varied opinions with regard to collaborative practices within the Ottawa area. One psychiatrist felt the surrounding areas outside of Ottawa were more collaborative and able to offer each other more support and flexibility. Another participant remarked that:

> *In Ottawa a lot of barriers are establishment driven, you know the Ottawa Hospital vs. the Children's hospital. You would think they were connected as they are on the same campus, but they are not. So if you don't have status within the Ottawa hospital, then you can't refer patients to any of their programs.*

They went on to express the feeling that Ottawa is very territorial, very "Us vs. Them".

> *It's like the House of Commons where they shout back and forth and every other agency takes its lead from that. It's like I want to be a bigger Prima Donna than you are. Those are some of the things that really create barriers and the inability to work well with your patients.*

Collaborative Successes

Despite the significant challenges and barriers to collaborative practice, all participants spoke of ways they had independently organized collaborative relationships to some degree. One psychiatrist relayed a story of a patient being with his group home staff at emergency, the key worker paged for assistance and he was able to speak with the hospital psychiatrist and provide background information, resulting in a seamless admission. This happened because he went that extra step and provided his contact to the group home. The result was much improved for the patient, the group home, the hospital and the psychiatrist.

Another participant also spoke of the beneficial notion of continuous case conferencing.

> *Most of the time we see a case conference offered as an opportunity to sum things up. Get a whole bunch of people in to deal with one thing once. It might be at the end of an admission, it might be at the beginning of care planning and then its delegated off to a certain partner agency, but you don't come back and meet with everybody regularly(...) I think that's the way it should be done. By continuous consultation you can refine your information and get rid of what doesn't make sense or renew it and update it.*

In another participant's example one psychiatrist was successful in getting a collaborative forensic assessment for a patient with concerning behaviours. This opinion relayed that the patient was not at high risk to offend which provided assurance to the group home, the school and other relevant services to continue working with this patient and no one felt alone in the decision making process.

As previously discussed, when clinical teams are developed to support youth workers and the group care facility, superior services can be provided. When knowledge and skills are shared within the 'circle of care', professionals are likely to feel better about the jobs they do. Increasing effective, purposeful communication, disseminating information between services, increased availability of inter-agency training, all allow the 'circle of care' to function better (Adnopoz, 1998; Leather et al., 2009; McMillen et al., 2007). Examples provided in this study of psychiatrists and mental health professionals providing training and education services to the group home, or psychiatrists providing consultations to general practitioners in the community illustrate that interagency linkages enhance the knowledge base of professionals in all sectors and assist in enhancing resources and services. The need for increased interagency training has been identified in current research (Darlington et al., 2004; Webb & Harden, 2003). Mechanisms to support and require this communication and dissemination of information must be developed and entrenched within practices within the 'circle of care'.

In Canada a successful example of collaborative practice is shown by Wotherspoon and colleagues (2008), who describe a partnership between Collaborative Mental Health Care (CMHC) in Calgary and local child welfare authorities. In the partnership the CMHC team offers caregivers, child protection workers, physicians, teachers and others, screenings, assessments and consultations in order to support placements and enhance clinical practice in mental health.

Without a doubt, at the most basic level, every professional involved in providing protection and well being for youth in care can agree on a shared vision of an emotionally, physically and spiritually healthy young person. It is in the details, in how this will be accomplished and who will do what, that the picture becomes fragmented and complex. Although limited examples of collaborative programs exist in current research, evidence that does exist indicates that linkages between agencies can make service delivery better for professionals and service outcomes better for youth. Additionally, inadequate funding for both the mental health and child welfare systems has been ongoing. That some of the funding shortfalls can be ameliorated by increased collaboration is true, it is also true that a stronger voice is created when all systems in the 'circle of care' unite in the request for policy makers and government funders to adequately resource and support the mental health and well being of children and youth in the child welfare population.

Conclusion

It has been argued that the lack of a comprehensive, effective service delivery system for youth in care contributes to the spiral of deprivation these youth experience and may in fact recreate the damaging maltreatment they experienced in their homes (Perry, 2006). The findings of this project, undertaken in Ottawa, illustrates that weaknesses in the service delivery system make this statement an unfortunate reality for many youth. Children are brought into the child welfare system with the intention that they will be brought up by people who can provide the care and services they require. Given current circumstances and functioning of the group home, the child welfare system and the mental health system, it is clear the goal of fostering well being for this vulnerable population is not being realized.

The purpose of this study was to examine the group care environment, the child welfare system and the mental health system to ascertain where gaps in the delivery of mental health services exist and identify areas where collaboration between systems would strengthen service outcomes. This was achieved through interviews and focus groups with fourteen (14) professionals currently working, or previously employed in the youths 'circle of care'.

Using the psychodynamic concepts of Winnicott, the key tenets of attachment theory and analyzing the role of the contemporary psychiatric model in the delivery of mental health supports allowed for the illustration of gaps and weaknesses in and

amongst these systems. How these are gaps are experienced by youth receiving services and professionals delivering services was also evidenced.

The significant lack of resources to all involved systems was a major finding of this study and a major barrier in adequately supporting youth. It is not enough to simply protect children and youth by the removal from an abusive or neglectful situation. Child welfare is about more than rescuing children, it is about providing the appropriate care and resources for children through to adulthood if necessary; especially the very vulnerable youth with mental health problems. The system must be adequately funded to allow for the development of these children and youth to reach their full potential.

Current funding patterns and shortfalls mean youth are not offered this opportunity. The lack of resources impacts the group care model in terms of placement stability, quality of therapeutic outcomes permanency and transitions through and out of service. As this study has shown the attachment experiences of youth are often negatively impacted by frequent moves through various placements in the child welfare continuum of care. Continued placement instability and the lack of a consistent environment can be detrimental for vulnerable youth increasing their experience of loss; rupturing relationships and connections to healthy adults and other community resources; increasing the risk for affiliation with delinquent peers, poor developmental outcomes and an increased risk for mental health problems (Boyd-Webb, 2006; Tarren-Sweeny, 2008a; Wilson & Woods, 2006). A greater reliance on attachment theory for direction in policy development can help to alleviate some of the problems that make welfare interventions potentially harmful. For placement decisions to be clinically

informed through the tenets of attachment theory, however requires the recruitment and training of foster families who are provided the necessary support to understand and manage the therapeutic needs presented by challenging youth. It requires that group care options provide well trained clinically informed and supported staff teams with supportive administration, to facilitate permanency and consistency in the care environment and minimize placement disruptions. It also requires financial resources for youth to successfully transition to independent living, to reunify with their biological family or to move into the adult service sector.

The possibility of a dedicated mental health service team to support families, social workers and group home workers should be further investigated. Mechanisms that support this type of team approach and increase multi-disciplinary communication are needed to assist in providing direct mental health services for youth in need, as well as to provide connections with community based mental health services

That group care for adolescents will remain an important, if not primary care option is a reality. If the goal is to alter disrupted attachment behaviours and create resilient adolescents, an effective, safe, secure, stable environment that optimizes therapeutic interventions and support must be created and ensured. The group care model for youth cannot operate from a single model for all residents or focus on custodial care aspects of the environment at the expense of therapeutic opportunities and growth. Using the concepts of Winnicott to examine the group care environment in Ottawa illustrates that group care facilities can adhere to these principles and deliver a therapeutic milieu that offers a consistent, controlled, supportive environment as was

seen in the examination of the work done by the Roberts Smart Centre. Given experiences discussed by mental health clinicians and CAS social workers it was also shown that gaps do exist in group care environments that challenge the therapeutic viability of the group care model , similar to what is shown in current research.

Youth in care must receive high quality support and care, no matter where they live; whether it is in our Northern communities or in different group care environments and we should not be waiting until things fall apart to provide these services. The Ministry of Children and Youth Services must create licensing and regulations that focus on ensuring all group home operators provide a healthy atmosphere for youth, with fully trained staff and the necessary clinical support. A shift to a focus on outcomes rather than processes; and on performance and results rather than expectations and monitoring would aid in creating and emphasizing therapeutic aspects in the group home model.

Adherence to a 'holding environment' requires continuity of care, integration in approach between workers and an environment that allows the youth to safely and supportively work through their problems and the pain and anger associated with them. Short sighted underfunding to both the mental health and child welfare system contributes to the challenge of meeting this ideal. When a private operator views the group home primarily as a business, it is likely that gaps similar to those found in current research will be experienced; including a lack of consistency, a lack of flexibility in the environment, inaccurate interpretation and response to youth's externalizing behaviour and the increased use of psychotropic medications. Implications of these shortcomings

have been well discussed throughout this study and are shown to be extremely detrimental to outcomes and long term well being of youth receiving services.

Employment conditions in the group care model are also problematic when the group home operator is underfunded. This includes: poor salary levels, challenging shift rotations, high levels of staff turnover, insufficient skills, training and clinical supervision. When staff are underpaid, highly transient and feel incapable to manage the competing demands of their role, the care environment becomes one which focuses on rigid adherence to rules and routines, behaviour modification techniques of reward and punishment and is not able to provide an appropriate 'holding environment' for youth to heal and move forward from past harms and does little to facilitate the 'maturational process' for youth (Anglin, 2002).

Although this study used a group care environment clearly superior to many described in current literature, it is equally clear that group care requires stronger provincial funding and licensing standards so this type of environment is available to all youth in care. Currently the Roberts Smart Centre has twenty-five fee- for- service beds available for CAS to purchase throughout the entire province of Ontario. Through better, although still inadequate, funding the centre offers a more collaborative, therapeutic approach to care. Mental health resources are available for youth, support, training and professional development is available for staff and the focus is on creating an environment that adhere to Winnicott's psychodynamic concepts rather than simply custodial care. It must be noted that RSC participants indicated many youth come to the centre after failing in a number of previous placements where a well functioning care

environment or clinical care team was not available. It is unacceptable and indeed illogical to continue to offer this type of services in a reactive manner.

That youth are placed based on availability, not suitability of placement, or that placement decisions are based on economically driven adherence to the principle of 'least restrictive environment' means needed services are denied or offered only in response to numerous breakdowns and crisis experiences. This principle means youth are moved towards more intensive services through failure and a negatively biased system "adept at recognizing risk, weakness and pathology far more effectively than strengths in individuals and families" (Stuck et al., 2000 p. 850. Continuing to operate under such a system is clearly problematic.

A further reality of underfunded group care environments and systemic shortcomings has been the increased use of mental health diagnosis and the administration of psychotropic medications. Rather than locate current systems gaps in the broader political and social systems and inadequacies in resource allocation; arguably the problem has been located in youth themselves through an increase in the diagnosis of mental health problems for youth in care. Additionally, rather than recognize the shortfalls in collaborative efforts to overcome and work towards recovery and health for these youths, the gap has been filled with the use of psychotropic medications which is often seen as a more straightforward, cost effective approach that requires less time, attention and consistency from caregivers (NYICN, 2009).

That youth are subject to powerful, stigmatizing, detrimental labels and medicated due to limitations in the care environment and shortage of staff resources is unacceptable. Given the high rate of youth in the child welfare system being prescribed psychotropic drugs, especially those in the group home model; one must question whether medications are being unnecessarily prescribed to this population. Although this finding was not presented by the group care facility participating in this study, the presences of these concerns were noted by other professionals working in the 'circle of care' and should be investigated further. The study by the National Youth in Care Network (2009) shows that 70% of participants reported taking psychotropic medications while in care, only 30 % reported continuing medications once out of the care system. Although no explanation is offered for this reduction of usage that participants were either taking medications they did not need, or were taking medications because of challenges in the care environment is distinctly possible. It is also possible that with a more thorough assessment; with a more comprehensive, high quality, effective care system; stronger collaborative structures between the mental health, the child welfare and the group home model; and more referrals and support for the use psychosocial treatments the use of psychotropic medications may decline.

Despite the improved services offered through the RSC, gaps and challenges continue to exist and be experienced by youth receiving services and professionals in the 'circle of care'. In particular the transition out of care to adult service, return to the biological family or to independence was a gap equally experienced in the Ottawa system and found in current research literature. Collaborative methods that support co-

ordinated services for youth as they transition between acute and community service or to independent or adult services must be created; likely requiring a commitment between the Ministry of Health and Long Term Care and the Ministry of Children and Youth Services as well as individual service providers and community care agencies. Better coordination between child protection agencies and the mental health system and other helping agencies need to be created. Services also need to involve families as partners in a less confrontational way.

The reality is many youth do return to their biological family as their only support once they have aged out of the system. Recognizing this reality, collaborative work should be extended to include biological families to a much greater extent. Stuck and colleagues (2000) argue that without an expanded definition of family reunification and family preservation, family connections "are compromised by a hierarchical continuum of intervention and practice methods within which reunification and preservation is a pass fail event (p. 86). Child protection and the well being of youth in care demands all players do their part to optimize outcomes. Given the scope of this work, the expanded financial pressures and waiting lists service integration and collaboration will be essential for success.

Reunifying youth to the community through independent living illustrates a further aspect of this service gap. Adolescents are released from the care system often ill prepared and without supports. This illustrates a major area for collaboration within the 'circle of care'. Services are needed to bridge youth through this process through an expansion of available resources as well as an overlapping support person to assist with

this transition. A partnership between child welfare and the mental health system may provide a solution for creating and offering this service.

An expansion of these services will likely require and increased tolerance of risk by incorporating families into the care plan; by increasing youth's individual flexibility within group care programs to facilitate the 'maturational process'; and by increasing collaboration and input of community agencies into the child protection system to prepare the youth for independence. The current primacy of protection and risk management in child welfare practice is problematic. It interferes with the system's ability to address the development, attachment and therapeutic needs of the child and the family unit as a whole (Anglin, 2002b). It also focuses interactions between the group home, the mental health system and the protection system on reporting requirements to illustrate adherence to mandated care requirement rather than focusing on a shared perspective to adequately, therapeutically address the needs of youth.

Risk is something the child welfare system currently spends the bulk of its resources trying to avoid and prevent. It must be acknowledged; however, that risk is tolerated, even overlooked when a child is apprehended despite the clearly demonstrated risks to the child's development and mental health. This focus on risk has also created a burden of accountability for all members of the 'circle of care', but particularly for child welfare social workers. Interestingly it was child welfare social workers who, in this study, reported the most discomfort with their role and its responsibilities. In this study and in current research they are also viewed as the agency

least open to collaborative community work. Indeed it was noted that collaboration between the child welfare and group care model often primarily revolves around reactive reporting, and ensuring compliance to outlined standards rather than collaborative interactions focused on the achievement of a targeted therapeutic outcome. That the Society was unwilling to participate in this study exemplifies the insularity of the agency. Providing care to vulnerable, complex youth is difficult work. The burden of this responsibility must be shared between all available support systems through interagency linkages and collaborative efforts.

Collaborative programs that do exist have shown to be more comprehensive, more efficient and most importantly more effective. Unfortunately, most current examples and certainly the examples provided by this study's participant's result from initiatives of individual agencies or practitioners. This study illustrates that structural changes requiring collaboration at the highest level of policy development and even legislative change can and should be developed in order to offer more integrated, seamless and effective services (Darlington & Feeney, 2008). Effective communication strategies at the organizational and service delivery level can enhance professional's knowledge and skills and should be undertaken at both a formal and informal level. Ongoing professional development, in particular joint training can be a further structural support to improve shared knowledge, visions and resources. In particular collaborative efforts were noted to be most necessary for youth in the group care environment who are unlikely to have supports for transitioning out of the care system (Prince & Austin, 2005).

Limitations and Recommendations for Future Research

This research illustrates gaps that exist for youth receiving mental health services in a child welfare group home model and considers collaborative practices in the 'circle of care as ameliorating or contributing to experienced gaps. A volume of research currently exists examining the group care environment, the child welfare system and the mental health system, however, the intersection of these systems is rarely considered. The finding that many of the service gaps indicated in current research are also experienced in the Ottawa area validates the continued need to explore how current service delivery impacts youth and professionals and search for ways to address systems gaps and weaknesses.

The challenge recruiting participants is both a finding and a limitation of this study. For reasons explored in methodological limitations, participants from all three systems were difficult to recruit. While this limits outcome data, it reinforces the findings that these systems currently operate with a high level of discipline insularity and resource constraints which contribute to a lack of co-ordination and fragmentation between stakeholders. Furthermore that youth themselves were not included as part of this research excludes an important voice in this study.

The mental health and well being of youth in group care is a subject that research must continue to examine in order to continually provide best practices to a very vulnerable population and to elucidate reasons for the number of pernicious outcomes youth in group care currently experience. Considering the group care

environment it is clear that current Ministry funding protocols and practices must be reconsidered. For a group care environment to provide a therapeutic environment that adheres to the principles of D.W. Winnicott and constructs of attachment theory it must be well funded and well supported. The addition of mental health clinical support, flexible individualized programming for youth and the assurance that a well qualified, well skilled, well supported staff team is available in every group care environment is imperative. These services should be available to all youth in group care and not only be accessible after a number of other failures and crisis outcomes have caused placement breakdowns. Enhanced funding of the group home environment will also create an improved environment for youth workers also improving service delivery outcome.

The group home and child welfare social workers must also be supported by other helping agencies in the community, particularly in regards to mental health supports. This should take place through education and consultation opportunities with mental health providers that will enhance service provisions and outcomes. Particularly noted is the recommendation that linkages are developed for youth exiting the care system and the need to provide an overlapping service as youth move towards and through this transition.

In both the group home model and the child welfare system increased knowledge and training should be developed regarding the use of psychotropic medications and youth should be more informed and involved in this process. This illustrates greatly the need for enhanced collaboration with the mental health system. This will hopefully empower workers in the roles they performing and reduce any

inappropriate reliance on psychotropic medications. The mental health system too must take an active role in considering the amount of medications and diagnostic labelling that exists for youth in group care. Here the group home and child welfare system can help the clinician to differentiate what are symptoms of the environment in which the youth resides and what results from previous experiences.

Finally, enhanced collaboration within the circle of care must be developed to present a united, strong voice advocating government funders to address the short sighted, inadequate funding of current systems. Through continued research and investigations of the gaps and inconsistencies in the collaborative delivery of mental service to youth in group care it is hoped that we can work towards the development of a national standard of care and best practice model that ensures the most comprehensive, effective services are available.

Role of this Study in the Literature

This research provides a deeper understanding of residential work and residential life for youth living in a group care environment in Ottawa. It also provides an examination of the 'circle of care' and the collaborative ways in which service delivery is provided. This study provides insight into the intersection of the child welfare system, the mental health system and the group home environment and how service delivery is experienced by professional in the Ottawa area. It is hoped that this study begins a much needed dialogue between service providers to consider ways of enhancing service delivery through collaborative efforts.

References

Adnopoz, J., (1998). Crisis placement. *Child and Adolescent Psychiatric Clinics of North America* 7(2), 335- 344.

Anglin, James. P., (2002a). *Pain, normality, and the struggle for congruence: Reinterpreting residential care for children and youth.* New York: The Hawthorne Press Inc.

Anglin, James P., (2002b). Risk, well-being and paramountcy in child protection: The need for transformation. *Child & Youth Care Forum,* 31 (4), 233-255.

Ainsworth, F., (2005). Group care practitioners as family workers. *Child and Youth Services* 27(1-2), 75-86.

Ainsworth, M. S., Blehar, M. C., Waters, E., & Wall, S. (1978). A psychological study of the strange situation. Oxford, England: Lawrence Erlbaum.

Applegate, J., (1997). The holding environment: An organizing metaphor for social work theory and practice. *Smith College Studies in Social Work,* 68 (1), 7-29.

Baker, Ashare & Charvat, (2009). Substance use and dependency disorders in adolescent girls in group living programs: Prevalence and associations with milieu factors. *Residential Treatment for Children & Youth,* 26 (4), 42-57.

Bardone, A., Moffitt, T., Caspi, A., & Dickson, N., (1996). Adult mental health and social outcomes of adolescent girls with depression and conduct disorder. *Development and Psychopathology,* 8 (4), 811-829.

Barth, R.P., Courtney, M., Berrick, J., & Albert, V., (1994). *From child abuse to permanency planning: Child welfare services pathways and placements.* New York: Aldine De Gruyter.

Barth, R.P. (2002). *Institutions vs. Foster homes: The empirical base for a century of action.* Chapel Hill, NC: UNC, School of Social Work, Jordan Institute for Families.

Bentley, K.J., Farmer, R.L., & Phillips, E., (1991). Student knowledge of and attitudes toward psychotropic drugs. *Journal of Social Work Education,* 27 (3), 279-289.

Borden, W. (2009) Contemporary psychodynamic theory and practice. Chicago Illinos: Lyceum Books, Inc.

Boyd-Webb, N., (2006). The impact of trauma on youth and families in the child welfare system. In N. Boyd-Webb (Ed.), Working with traumatized youth in child welfare (pp. 13-27). New York: The Guilford Press.

Bowlby, J. (1969). Attachment and loss: Attachment, vol. 1. New York: Basic Books.

Bowlby, J. (1982). Attachment and loss: Separation—Anxiety and anger, vol. 2. New York: Basic Books.

Bowlby, J. (1991). Attachment and loss: Sadness and depression, vol. 3. New York: Basic Books.

Breland-Noble, A.M, Elbogen, E.B., Farmer, E.M., Dubs, M.S., Wagner, H.R., & Burns, B.J., (2004) Use of psychotropic medications by youths in therapeutic foster care and group homes. *Psychiatric Services,* 55, 706-708.

Briggs, A., (2004). Reversing a spiral of deprivation: Working to ameliorate the relationship of staff and boys in a residential home. *Journal of Social Work Practice* 18 (1), 33-48.

Brown, R., Antonuccio, D., DuPaul, G., Fristad, M., King, C., Leslie, L., et al., (2008) Depressive disorders and suicidality. In Childhood mental health disorders: Evidence base and contextual factors for psychosocial, psychopharmacological and combined interventions. (pp.69-85). Washington, DC: American Psychological Association.

Burge, P., (2007). Prevalence of mental disorders and associated service variables among Ontario children who are permanent wards. *Canadian Journal of Psychiatry,* 52 (5), 305-314.

Brun, Carl F. (2005). *A Practical Guide to Social Service Evaluation.* Lyceum Books, Inc. Chicago Illinois

Bush, M. (1980). Institutions for dependent and neglected children: Therapeutic option of choice or last resort? *American Journal of Orthopsychiatry,* 50 (2), 239-255.

Child Welfare Program Evaluation (2003). Ministry of Children's Services. Retrieved from http://www.kidsmentalhealth.ca/documents/Res_Child_Welfare_Eval_Nov_2003.pdf.

Cohen, J., Mannarino, A., Murray, L., Igelman, R., (2006). Psychosocial Interventions for Maltreated and Violence-Exposed Children. *Journal of Social Issues,* 62 (4), 737-766.

Collishaw, S., Pickles, A., Messer, J., Rutter,M., Shearer, C., & Maughan, B., (2007). Resilience to adult psyhopathology following childhood maltreatment: Evidence from a community sample. *Child Abuse & Neglect,* 31, 211-229.

Coulton, M., & Roberts, S., (2007). Factors that contribute to high turnover among residential child care staff. *Child and Family Social Work,* 12, 133-142.

Courtney, M.E., Barth, R.P., Berrick, J.D., Brooks, D., Needell, B., & Park, L. (1996). Race and child welfare services: Past research and future directions. *Child Welfare,* 75, 99-137.

Crenshaw, D. & Hardy, K. (2006). Understanding and treating the aggression of traumatized children in out-of-home care. In N. Boyd-Webb (Ed.), Working with traumatized youth in child welfare (pp. 171-195). New York: The Guilford Press.

Crismon, L.M., & Argo, T., (2009). The use of psychotropic medication for children in foster care. *Child Welfare.* 88 (1), 71-100.

Crowell, J., Hauser, S., (2008). AAIs in a high-risk sample: Stability and relation to functioning from adolescence to 39 years. In Clinical Applications of the Adult Attachment Interview. (pp. 341-370). New York, NY, US: Guilford Press.

Curtis, P., Alexander, G. & Lunghofer, L., (2001). A literature review comparing the outcomes of residential group care and therapeutic foster care. *Child and Adolescent Social Work Journal,* 18 (5), 377-392).

Darlington, Y. & Feeney, J., (2008). Collaboration between mental health and child protection services: Professionals perception of best practice. *Children and Youth Services Review,* 30 (2), 187-198.

Darlington, Y., Feeney, J., Rixon, K., (2005). Practice challenges at the intersection of child protection and mental health. *Child and Family Social Work,* 10 (3), 239-247.

Darlington, Y., Feeney, J., Rixon, K., (2004). Complexity, conflict and uncertainty: Issues in collaboration between child protection and mental health services. *Children and Youth Services Review,* 26, 1175-1192.

Edmond, T., Auslander, W., Elze, D.E., McMillen, C., & Thompson, R. (2002). Differences between sexually abused and non-sexually abused adolescent girls in foster care. *Journal of Child Sexual Abuse,* 1 (4), 73-99.

Eisenstein-Naveh, A., (2003). The center for children and families at risk: A facilitating environment. *The Family Journal: Counseling and Therapy for Couples and Families,* 11 (2), 191-201.

Farris-Manning, Cheryl & Zandstra, Marietta (2003). Children in Care in Canada: A summary of current issues and trends with recommendations for future research. Retrieved Oct 13, 2004, from www.nationalchidrensalliance.com/nca/pub/2003/children_in_care_march_2003.pdf

Fedoravicius, N., McMillen, J. C., Rowe, J.E., Kagotho, N., & Ware, N.C., (2008). Funnelling child welfare consumers into and through the mental health system: Assessment referral and quality issues. *Social Service Review,* 82 (2), 273-290.

Freundlich, M., & Avery, R.J., (2005). Planning for permanency for youth in congregate care. *Children and Youth Services Review,* 27, 115-134.

Foster, M., Stephens, R., Krivelyova, A., & Gamfi, P., (2007). Can system integration improve mental health outcomes for children and youth? *Children and Youth Services Review,* 29, 1301-1319

Fulcher, L.C. & Ainsworth, F. (2005). Group care practice with children revisited. *Child and Youth Services,* 27 (1-2), 1-26.

Gerber, A. (2006). Attachment, resilience, and psychoanalysis: Commentary on Hauser and Allen's overcoming adversity in adolescence. *Psychoanalytic Inquiry,* 26 (4), 585-594.

Gotlib, I., Lewinsohn, P., & Seeley, J., (1998). Consequences of depression during adolescence: Marital status and marital functioning in early adulthood. *Journal of Abnormal Psychology,* 107 (4). 686-690.

Green, R.W., & Ablon, S.J., *Treating explosive kids: The collaborative problem solving approach.* New York: Guilford Press

Hart, A., Blincow, D., & Thomas, H., (2008). Resilient therapy: Strategic therapeutic engagement with children in crisis. *Child Care in Practice,* 14(2), 131-145.

Hawkins-Rodgers, Y., (2007). Adolescents adjusting to a group home environment: A residential care model of re-organizing attachment behaviour and building resiliency. *Children and Youth Services Review,* 29, 1131-1141.

Knorth, E.J., Harder, A.T., Zandberg, T., Kendrick, A.J., (2008). Under one roof: A review and selective meta-analysis on the outcomes of residential child and youth care. *Children and Youth Services Review,* 30, 123-140.

Landsverk, J., Burns, B., Stambaug, L., & Rolls-Reutz, J., (2009). Psychosocial interventions for children and adolescents in foster care: Review of research literature. *Child Welfare,* 88 (1), 49-69.

Leathers, S.J., McMeel, L.S., Prabhughate, A., Atkins, M.S., (2009). Trends in child welfare's focus on children's mental health and services 1980-2004. *Children and Youth Services Review,* 31, 445-450.

Leo, J. (2006). The truth about academic medicine: children on psychotropic drugs and the illusion of science. In S. Timimi & B. Maitra (Eds.), *Critical Voices in Child and Adolescent Mental Health* (pp. 107-127). United Kingdom: Free Association Books London.

McMillen, C.J., Fedoravicius, N., Rowe, J., Zima, B.T., & Ware, N., (2007). A crisis of credibility: Professionals concerns about the psychiatric care provided to clients of the child welfare system. *Administration and Policy in Mental Health and Mental Health Services Research,* 34 (3), 203-212.

Mennen, F.E., O'Keefe, M., (2005). Informed decisions in child welfare: The use of Attachment Theory. *Children and Youth Services Review,* 27, 577-593.

Ministry of Children and Youth Services, (2005). Child Welfare Transformations 2005: A strategic plan for a flexible, sustainable and outcome oriented service delivery model. Ottawa: Child Welfare Secretariat.

Mitchell, R., (2003). Ideological reflections on the DSM-IV-R (or pay not attention to that man behind the curtain, Dorothy!). *Child & Youth Care Forum,* 32 (5), 281-298.

Morton, N., & Brown, K. D. (1998). Theory and observation of attachment and its relation to child maltreatment: A review. *Child Abuse and Neglect*, 22, 1093– 1104.

Moses, T., (2008). Psychotropic medication practices for youth in systems of care. *Journal of Child and Family studies,* 17, 567-581.

National Youth in Care Network (NYICN), (2009). Drugs in our system. An exploratory study on the chemical management of Canadian systems youth. Ottawa, Ontario: Lambe, Y., McLennan, R.

Naylor M., Davidson, C., Ortega-Pirou, J., Bass, A., Gutierres, A., & Hall, A., (2007). Psychotropic medication management for youth in states care: Consent, oversight, and policy considerations. *Child Welfare,* 86 (5), 175-192.

Nolan, D., Lewis, J., (2007). Children in group care deserve more: Children`s Aid Societies call for action on standards and quality care. Retrieved from http://www.oacas.org/newsroom/letters/lewiseditorial07mar29.pddards and quality care. Ontario Associations of Children`s Aid Societies publication.

Office of the Auditor General of Ontario (2006). Annual Report. Retrieved from http://www.auditor.on.ca/en/reports_en/en06/306en06.pdf

Open Minds Healthy Minds (2011). Ontario`s Comprehensive Mental Health and Addictions Strategy. Retrieved from http://www.health.gov.on.ca/english/public/pub/mental/pdf/open_minds_healthy_minds_en.pdf

Osgood, W., Briddell, L., (2006). Peer effects in juvenile justice. In Deviant peer influences in programs for youth: Problems and solutions. (pp. 141-161). New York, NY, US: Guilford Press.

Pavkov, T.W. & Walrath, C.M., (2008). Clinical and non-clinical characteristics associated with medication use among children with serious emotional disturbance. *Journal of Child and Family Studies,* 17, 839-852.

Pentecost, D., & Wood, N., (2002). Knowledge and perceptions of child-care social workers about ADHD. *British Journal of Social Work,* 32, 931-943.

Perry, B. (2006). Applying principles of neurodevelopment to clinical work with maltreated and traumatized children. In N. Boyd Webb (Ed.), Working with traumatized youth in child welfare (pp. 27-52). New York: The Guilford Press.

Price, J. M., & Glad, K. (2003). Hostile attributional tendencies in maltreated children. *Journal of Abnormal Child,* 329– 343.

Prince, J., & Austin, M.J., (2005). Inter-agency collaboration in child welfare and child mental health systems. *Social Work in Mental Health,* 4 (1), 1-16

Rawal, P., Lyons, MacIntyre, J & Hunter, J., (2004). Regional variation and clinical indicators of antipsychotic use in residential treatment: A four state comparison. *The journal of Behavioural Health Services & Research,* 31 (2), 178-188.

Reichertz, D., Kislowicz, L., & Stalinski, J. (1978). *Residential Care: The impact of institutioanl policies, structures and staff on resident children.* Montreal QC: McGill University School of Social Work.

Rosenstein, D., & Horowitz, H., (1996). Adolescent attachment and psychopatholoty. *Journal of Consulting and Clinical Psychology,* 64 (2), 244-253.

Ryan, J.P., Marshall, J.M., Herz, D. & Hernandez, P.M. (2008). Juvenile delinquency in child welfare: Investigating group home effects. *Children and Youth Services Review,* 30, 1088-1099.

Schilling, E., Aseltine, R., & Gore, S., (2008). The impact of cumulative childhood adversity on young adult mental health: Measures, models and interpretations. *Social Science & Medicine,* 66, 1140-1151.

Schore, Judith R. (1997) The good enough social worker: Understanding and applying Winnicott's concepts. *Journal of analytic social work,* 4 (1), 83-91.

Sherwood, Lynne (1984). The Kid Business. Unpublished masters dissertation, Carleton University, Ottawa, Ontario.

Shulman, S., Seiffge-Krenke, I., Levy-Shiff, R., Fabian, B., (1995). Peer group and family relationships in early adolescence. *International Journal of Psychology,* 30 (5), 573-590.

Stuck, E. N., Small, R. W. & Ainsworth, F. (2000). Questioning the continuum of care: Toward a reconceptualization of child welfare services. *Residential Treatment for Children & Youth,* 17 (3) 79-92.

Tarren-Sweeney, M., (2008a). Retrospective and concurrent predictors of the mental health of children in care. *Children and Youth Services Review,* 30, 1-25.

Tarren-Sweeney, M., (2008b). The mental health of children in out-of-home care. *Current Opinion in Psychiatry,* 21, 345-349.

Timimi, S., (2006). Childhood depression? In S. Timimi & B. Maitra (Eds.), *Critical Voices in Child and Adolescent Mental Health* (pp. 192-205). United Kingdom: Free Association Books London.

Tomlinson, P. (2008). The experience of breakdown and the breakdown that can't be experienced: Implications for work with traumatised children. *Journal of Social Work Practice,* 22 (1) 15-25.

Waddell, C., Offord, D., Shepherd, C., Hua, J., & McEwan, K., (2002). Child psychiatric epidemiology and Canadian public policy making: The state of the science and the art of the possible. *Canadian Journal of Psychiatry,* 47 (9), 825-832.

Wakelyn, J., (2008). Transitional psychotherapy for looked-after children in 'short-term' foster care. *Journal of Social Work Practice,* 22 (1), 27-36.

Webb, M.B., & Harden, B.J., (2003). Beyond child protection: Promoting mental health for children and families in the child welfare system. *Journal of Emotional and Behavioural Disorders,* 11 (1), 49-58.

Whitfield, C., (2006). Childhood trauma as a cause of ADHD, aggression, violence and anti-social behaviour. In S. Timimi & B. Maitra (Eds.), *Critical Voices in Child and Adolescent Mental Health* (pp. 89-106). United Kingdom: Free Association Books London.

Whyte, S., & Campbell, A., (2008). The strengths and difficulties questionnaire: A useful screening tool to identify mental health strengths and needs in looked after children and inform care plans at looked after children reviews? *Child Care in Practice,* 14 (2), 193-206.

Wilson, M., & Woods, L., (2006). Iatrogenic outcomes of the child welfare system: Vulnerable adolescents, peer influences and instability in foster care arrangements. In Dodge, K.A., Dishion, T. J. Lansford, J. E. (Eds.), Deviant peer influences in programs for youth: Problems and solutions. (pp. 203-214). New York, NY,: Guilford Press.

Winnicott, D.W. (1956) The antisocial tendency, In *Through Paediatric to Psychoanalysis,* by D. W. Winnicott (2002), H. Karnac Ltd, London.

Winnicott, D.W., (1963). The mentally ill in your caseload. In *The maturational processes and the facilitating environment* (pp. 217-229). Madison, CT: International Universities Press, 1965.

Winnicott, D.W. (1970). Residential care as therapy, In *Deprivation and Delinquency,* by D. W. Winnicott (1992), Routledge, London & New York.

Wotherspoon, E., O'Neill-Laberge, M., & Pirie, J., (2008). Meeting the emotional needs of infants and toddlers in foster care: The collaborative mental health care experience. *Infant Mental Health Journal,* 29 (4), 377-397.

Yecheskiel, C., (1984). Residential treatment as a holding environment. *Residential Group Care & Treatment,* 2 (3), 33-43.

Yegidis, B., Weinbach, R., & Morrison-Rodriquez, B., (1999). Research methods for social workers. Needham Heights, MA: Allyn and Bacon.

Zegers, M., Schuengel, C., Van IJzendoorn, M., & Janssens, J. (2008). Attachment and problem behavior of adolescents during residential treatment. *Attachment and Human Development, 10,* 91-103.

Appendix A

Carleton UNIVERSITY

YOUR INPUT IS REQUESTED

WHO: Heather Carson, for her Master's of Social Work Thesis, is conducting a research project to examine the delivery of mental health services to youth in group care settings in Ottawa.

WHAT: I will be conducting a one and a half hour focus group to discuss your experiences working with youth living in a group care environment with a mental health diagnosis. I am hoping to gain a greater understanding of the mental health services received by youth in group care settings in Ottawa.

WHY: An increasing number of youth living in group care environments require mental health services. It is hoped that this research will turn attention to the complexities in the delivery and collaboration of service to this population and illustrate areas for further research and exploration.

WHEN:

1. Date_____ Time_____ Location_____

If you are interested in participating or have any questions please contact:

Heather Carson MSW student at hcarson@connect.carleton.ca

This project has been reviewed by the reviewed by and has received clearance from the Carleton University research Ethics Board.

Thank You

Appendix B

Letter of Information and Consent

(This letter was provided to all three groups; youth workers, social workers and mental health clinicians)

Dear Sir or Madam:

I am conducting a study for my MSW thesis to examine the delivery of mental health services to youth in Ottawa living in a group care environment. I am writing this letter to recruit professionals who have, or are currently working with this population. It is my intent to have the opportunity to meet with youth workers, social workers previously employed as child protection workers with a Children's Aid Society in Ontario and mental health clinicians (i.e. psychologists and psychiatrists).

Purpose: Recognizing the increased rate of mental health concerns that exist for youth living in group care facilities; this study will review current literature to highlight the history, definitions and social policy imperatives that have shaped the delivery of mental health services in group care environments in Ottawa. The study will interview front line social workers, mental health clinicians and youth workers who have, or are currently working with this population to identify factors in the system of care framework that illustrate the collaborative practices in the delivery of mental health and child protection services.

Benefits: The study will provide greater understanding for academics and social work professionals alike of the changing nature of mental health services required in group care settings for youth. It is hoped that the findings of this research will turn attention to these important components of the mental health care system, as well as illustrate areas for further research and exploration.

Procedures: The data for this study will be collected through two focus groups of approximately an hour and a half. Participants will be asked to reflect on their experiences providing services to this population. One focus group will include 5-6 Social Workers previously employed at a Children's Aid Society in Ontario; one with 5-6 youth workers at a residential outside purchased institution for youth in care (Roberts Smart Centre). 3-4 mental health clinicians (ie psychologists and psychiatrists) will also take part in a guided interview of approximately one hour in length, reflecting on his/her role in the 'circle of care' for this population.

Participants will be asked to identify where they work or worked, the previous or current role at the agency, years of experience and education. Participants will then be asked a series of qualitative questions to reflect their experiences working with youth in group homes and with respect to the delivery and collaboration of mental health services to youth in care.

Focus groups and interviews will take place at your place of employment and will be audio recorded with your consent. Participants may at any time decline to answer any questions. Participants may also withdraw at any time and all efforts will be made to not transcribe the segment of their taped contribution. Audio taping will permit me to transcribe answers for data analysis and the development of common themes

Risks, Stress or Discomfort: It is not expected that participants will face more risk than they would in everyday life. However, their views may not always be parallel to the views of their institutions, supervisors or government funders. Knowledge of this situation may create **moderate** risk for the participants. The objective of this research study is to examine the mental health services as they are delivered today; no evaluative questions will be introduced by the researcher in the focus group discussions.

Although anonymity cannot be offered when conducting focus groups and interviews, great efforts will be made to minimize the possibility of inference of identities when writing the final report. It is my hope that the group will provide professionals with an awareness of issues and resources, and the opportunity to liaise and debrief with colleagues. At any time during the study you may withdraw your agreement to participate and all efforts will be made to not transcribe your segment of the taped contribution.

Confidentiality and Security of Data: All data and information collected will be kept confidential and will be available only to myself and Professor Cecilia Taiana. All data will be stored in a locked file cabinet in my home and electronic data will be stored on a removable USB device that is password protected. The data collected will be destroyed at the completion of the project.

Dissemination: The University and/or course professor will receive a copy of the project results and conclusions. The involved agencies will receive a copy of the project results if requested.

Consent section: In signing below, as a participant of this study, you are indicating that you understand and agree to voluntarily participate in the research study discussed in this document.

Participants Name	Signature	Date
Witness/Researcher's Name	Signature	Date

Contact Information: This research project has been reviewed and has received ethics clearance by the Carleton University Research Ethics Committee. If you have any questions, concerns or comments in relation to your involvement in this study, please direct them to:

Researcher:

Heather Carson, M.S.W (candidate)

Carleton University

School of Social Work

hcarson@connect.carleton.ca

Supervisor:

Prof. Cecilia Taiana, Ph.D. (Psychology)

Carleton University, School of Social Work,

Office 620, Dunton Tower

1125 Colonel By Drive,

Ottawa, ON K1S 5B6

(613) 520-2600 ext. 3577

cecilia_taiana@carleton.ca

Ethics Committee Chair:

Prof. Antonio Gaultieri,

Carleton University Research Ethics Committee

Carleton University

1125 Colonel By Drive

Ottawa, ON K1S 5B6

(613) 520-2517

ethics@carleton.ca

Appendix C

Research Instrument

Questions for Focus Group with Social Workers and Youth Workers.

A. Demographic Questions
   1. What was/or is your role at the agency?
   2. How many years experience do you have in this field?
   3. What training was required for your position?

B. Professional Experience
   1. Please describe your role in the 'circle of care' in providing services to youth with mental health concerns living in a group care facility.
   2. What experiences have you had collaborating with other professionals and other agencies (ie. Group home staff, social workers, physicians, hospital emergency personnel and other clinicians.)
   3. What is your role/responsibilities in providing services as the youth moves through the care system?
   4. How are families or caregivers included in the delivery of mental health services to these youth? What experiences have you had working with families or other caregivers
   5. What type of training, and support was available to you to assist in working with these youth?
   6. Please tell me any other information that you feel is relevant to my research.

Appendix D

Research Instrument

Guided Interview with mental health clinicians (ie. psychologists and psychiatrists)

1. Please describe your current role in the delivery of mental health services to youth in care.

2. Please describe your experience, education and training with respect to working with youth with a mental health diagnosis?

3. What challenges have you experienced providing services to this population and how does the youths care status affect service delivery?

4. How do you collaborate with other members of the 'circle of care' (ie social workers, youths workers, hospital emergency personnel and other clinicians), in terms of assessment, diagnosis and treatment planning? What are the strengths/challenges in this collaboration?

5. Are a youth's symptoms and assessments discussed and communicated to treatment providers in the 'circle of care'?

6. What input do youth have for choosing to engage or not in these treatments (psychotropic or psychosocial)?

7. How do the youth's living environment and/or care status impact the ability to offer treatment?

8. When a youth moves to a new placement or leaves the care system how is the continuation of services ensured?

9. When a youth moves or exits the care system how are services transferred? What level of collaboration exists? What are the complexities in facilitating such collaboration?

10. Are there any other thoughts you feel are relevant for my research?