Child, Youth and Family Services
2017-10-01
Child, Youth and Family Services Standard Technical Committee:

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PREVIEW
Child, Youth and Family Services

Background

The children and families who become involved in the child welfare system may be facing challenging circumstances such as; child/youth abuse and neglect, child/youth mental health, child developmental risk, violence in the home, intergenerational trauma, child/youth rights infringements, family dysfunction, loss of family-community connections, psycho-social functioning, youth justice, and substance abuse.

The proper management of these issues requires a multidisciplinary approach, which not only involves several different disciplines but also, different organizations. To assist clients as best as possible, it is important for lines of communication to remain open between child welfare organizations and community support programs to ensure that the children are receiving the best quality of care in a timely manner.

Child welfare services provide support and programs for children, youth and families. Programs and services may include family development support programs, child/youth protection services and services for youth in conflict with the law. Organizations using the Child, Youth and Family Services Standard may provide oversight and/or provide supportive programs and services for this population. The Child, Youth and Family Services Standard has been informed by literature and developed by a Technical Committee of experts. This standard provides guidelines of excellence to help organizations assist children and families in managing their lives and achieving positive outcomes.

Introduction

The exact number of families receiving services from child welfare organizations across the system is hard to determine. In Canada, statistics are gathered by individual provinces and rarely include all types of programs. In 2013, there were an estimated 62,428 children in out-of-home care across Canada (Jones, Sinha, & Trocmé, 2015). This does not include the children that are involved in the system via prevention programs or strength-based practices in which the child remains with their parents/caregivers. It is estimated that in the European Union (EU) about 1% of children are under public care, approximately 1 million children (Eurochild, 2010). In Australia, nearly 152,000 children received child protection services in 2014-2015 (Australian Institute of Health and Welfare, 2016). With such large numbers of children and their families requiring services, it is important that these services provide the quality of care that the clients require and deserve.

Worldwide, there is an over-representation of children from marginal populations in child welfare systems (Australian Government, 2016; Eurochild, 2010; McDavid, 2015; Tilbury, 2009). In Canada, it is particularly evident for Indigenous children (Farris-Manning and Zandstra, 2003; Public Health Agency of Canada, 2010). Fallon et al., 2016; Trocmé et al., 2004, Antwi-Boasiako et al., 2016, Sinha, Trocmé, Fallon, & MacLaurin, 2013).

Children’s mental health and special needs

Children requiring out-of-home care often have higher needs, emotionally and physically. They may have more behavioural problems, chronic health problems and require prescription medications (Farris-Manning and Zandstra, 2003; Leloux-Opmeer, Kuiper, Swaab, & Scholte, 2016). The continuity of health care for children in foster care, including evaluations, preventive care and supervision can help to reduce health risks (McDavid, 2015, Ponti, 2008; Public Health Agency of Canada, 2010). Children in out-of-home care may have a higher prevalence of emotional and behavioural problems than their peers in the community (Searle, Sawyer, Robinson, & Carbone, 2007).

Mental health treatment is needed for children who have been maltreated and they don’t necessarily receive the service. In one study, about half of the population investigated had clinically significant emotional or behavioural problems, and only 25% of the group received mental health services prior to the study interviews (Burns et al., 2004). Children experiencing disruption in placements or multiple placements in out-of-home care tend to be higher users of mental health services. In one study looking at children in foster care, the author noted they used 25-41% of mental health expenditures (McDavid, 2015).

Trauma

Children requiring child welfare services have often been exposed to trauma. Children in foster care may come from broken families with a background of poverty, maltreatment and violence. Children may have been exposed to parents that
may have had challenges including mental illness, addiction and incarceration.

Trauma may be acute, complex or intergenerational (historical). Intergenerational or historical trauma is cumulative and affects populations who have experienced it collectively through several generations. Examples of intergenerational trauma are seen within Indigenous populations in North America (Child Welfare Information Gateway, 2015; Trocmé, Knoke, & Blackstock, 2004).

Child welfare interventions frequently use a trauma informed practice that focuses on a system approach and includes the child, family, caregivers and service providers. Organizations using this approach use trauma awareness, knowledge and skills of the child/family culture, and trauma informed practices and policies to achieve positive outcomes (Child Welfare Information Gateway, 2015).

The alignment of child welfare and mental health services may help provide appropriate trauma screening, assessment and, trauma-focused mental health services (Conradi, Wherry, & Kisiel, 2011). The importance of treatment for children who have been exposed to abuse and family dysfunction is reflected in the studies of Adverse Childhood Experiences (ACEs) and the strong graded relation to several risk factors for causes of poor health and death in adulthood (Dube, Felitti, Dong, Giles, & Anda, 2003; Felitti et al., 1998).

**Education and training for family-based caregivers**

Given the complexity and special needs of children in out-of-home care, family-based caregivers should have relevant education and access to information to achieve positive outcomes. Children may receive therapeutic interventions administered by family-based caregivers and there should be opportunities for learning and skills development on a regular basis. Opportunities for respite are also important for family-based caregivers who are looking after clients with special needs (Farris-Manning & Zandstra, 2003; Searle et al., 2007).

**Culturally appropriate, safe and competent services**

Caregivers and service workers should have training with a focus on diversity, cultural awareness, and respect of the historical factors in a child’s background and the families and communities in which they serve (Aboriginal Children in Care Working Group, July 2015; The Truth and Reconciliation Commission of Canada 2015). Cultural differences exist and values, beliefs and traditions must be recognized and supported by care providers. Attention to the child’s voice regarding their cultural needs are central to this practice (Brown, St Arnault, George, & Sintzel, 2009). Culturally appropriate, safe and competent services also apply to youth from the lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) community. LGBTQ youth experience discrimination in their lives and potential caregivers should have training in sexual orientation and gender identity (Jacobs & Freundlich, 2006).

**Client- and family-centred services**

A client- and family-centred care approach is recommended in the provision of child welfare services. It should involve children, youth and their families in all stages of their care and decision-making processes to the greatest extent possible (Eurochild, 2010). Collaboration should also include the family and occur across community agencies, and other stakeholders (Alberta Government Child and Family Services Division, 2013-2014).

**Voice of the child**

The voice of the child is emphasized in the client- and family-centered approach. The UN Convention on the Rights of the Child, a global human rights agreement, upholds children’s rights to be heard, protected and supported. It states that children have the right to fully participate in any decisions that may affect their lives (United Nations, 2009). Related to child welfare services, the voice of the child or youth should be heard, acknowledged, and respected, to the greatest extent possible, in all aspects of service delivery (Brunnberg and Visser-Schuurman, 2015).

**Strengths-based practice**

Strengths-based practices are used in the delivery of client- and family-centred care. This philosophy works with families, groups and communities using a perspective that recognizes the importance of a person’s environment and the influences in their lives. Rather than responding to the limits of individuals, it focusses on inherent strengths (Scerra, 2011). The promotion of protective factors through parenting programs and practice can reduce risk factors and result in positive behaviours in parents and positive outcomes for their children (American Psychological Association, 2009). Service workers typically lead with appreciative inquiry as they build upon the positive attributes available to the child, family and community. Family preservation and reunification are recognized as important and primary goals in child intervention work (Alberta Human Services, 2012a).
Primary prevention of child maltreatment through early identification and intervention

Primary prevention programs focus on the capacity of parents and communities to develop protective factors. Early identification and intervention can help to strengthen the abilities of parents and families to care for their children (Alberta Human Services, 2012b).

Population-based, public health models using parent training are effective in primary prevention (Alberta Human Services, 2012b; American Psychological Association, 2009; Chen & Chan, 2016; Richmond-Crum, Joyner, Fogerty, Ellis, & Saul, 2013; Zimmerman and Mercy, 2010).

The Triple P-Positive Parenting Program is an example of a program that may be used in a primary prevention program in early childhood. It is designed as a population level system of parenting and family support (Prinz, Sanders, Shapiro, Whitaker, and Lutzker, 2009; Sanders et al., 2012).

The Hawaii’s Healthy Start program is an example of an intensive home visitation model. The screening and assessment protocol determines levels of risk in families to help prevent maltreatment (Dew and Breakey, 2014). The use of professional home visitors within a multidisciplinary team in home visitation models has been shown to be cost effective (Dalziel and Segal 2012).

Permanency and kinship

Children appear to experience less placement disruption and greater permanency when placed in kinship foster care (Bell and Romano, 2015; Fernandez & Atwool, 2014; Lin, 2014; Winokur, Holtan, and Batchelder 2014). In Europe, the deinstitutionalization of child and youth care is recommended and should include early intervention and family-type care, particularly for children who are under three years of age (Eurochild, 2010). It is recognized that family-based settings for care are not always the best solution and kinship care can have its own set of challenges. Depending on the child, sometimes residential care is preferable and in their best interests (Leloux-Opmeer et al., 2016). In kinship care, the caregivers engage with the social service workers and the child’s parents. Kinship programs should have more investment to provide compensation, resources, training and support from social services (Burke & Schmidt, 2009; Lin, 2014).

Child and youth safety issues

The home

Keeping children safe is central to child welfare services. It is important that the child’s home be a safe place in which to live. Household risk factors include unhealthy/unsafe living conditions, access to drugs or drug paraphernalia and accessible weapons. At least one household hazard has been detected in 12% of home investigations. Safety is an important issue for child welfare agencies to focus on, in preventing the recurrence of maltreatment and identifying other conditions that might endanger the child’s well-being (Bell and Romano, 2015; Public Health Agency of Canada, 2010).

Suicide and self-harm

Children and youth in the child welfare system are more at risk to attempt suicide than their peers, and to be hospitalized for suicide attempts, or serious psychiatric disorders (Searle et al., 2007; Vinnerljung et al., 2006). Past foster/group home placement, child welfare guardianship, and abuse history were predictors for documented suicide attempts and returns to the emergency room (Stewart, Manion, Davidson, & Cloutier, 2001). Assessment for suicide risk and safety plans are recommended for children and youth in care.

Restraint use

Hospitalization and treatment may be required for children with serious mental health issues. Foster children admitted to psychiatric hospitals have been shown to be more vulnerable than other hospitalized children. When compared to other children, they had lower social competence and higher rates of externalizing problems and diagnoses (Persi & Sisson, 2008). In some cases, restraints may be used for children to help control their physical activities or behaviour in efforts to keep them safe. Restraint use should be reviewed with consideration of potential negative implications and alternatives (Persi & Sisson, 2008).

Integration and service transitions

Integration and service transitions are highlighted in the literature as potential points of risk to children and youth in care. Effective communication of information needs to be accurate and timely, and include information related to health, psycho-
social needs, support persons, and culture. Geographic jurisdictional differences have been known to contribute to poor coordination of service delivery (Farris-Manning and Zandstra, 2003).

Resource shortages can make cooperation a challenge, despite having protocols that address the movement of children and families between regions. Integration problems typically occur between services such as child welfare and mental health sectors. Problems cited are; repeating a child’s story over and over to different professionals; lack of information about services; navigating the health and social services system; long wait lists for assessments; and overall lack of services (McLennan J. D. et al., 2003).

The use of Hub models for integrated service delivery may help address integration of child and youth services from the prenatal period to transitions to adulthood and independent living (Brownell et al., 2012).

Transition to independent living

As youth age out of care in child welfare systems, there are gaps in the successful transition to adulthood and independent living (Fernandez & Atwood, 2014; Solberg, 2014).

Key needs for successful transition include; ongoing financial support; mentoring and peer support; individualized support; mechanisms for transition and post-transition periods; support to access education; employment and training; training on independent living; and opportunities to develop decision-making and problem solving skills (Goyette, 2007; Reid, 2007; Tweddle 2007).

Measuring for improvement - Indicators

The quest for quality improvement in service delivery relies on the identification of performance indicators that can be measured and monitored.

For some organizations, there have been challenges in integrating child welfare performance indicator results into practice improvement. An organization may not have evaluation processes in place or may have limited ability to integrate their own data and external research into practice improvement (Farris-Manning & Zandstra, 2003).

The National Child Welfare Outcomes Indicator Matrix (NOM) is an example of a framework with common indicators across four domains that can be used to track outcomes for clients and families across jurisdictions. The NOM framework evaluates the four domains of; child safety, child well-being, permanence, and family and community support. Indicators within the child safety domain are; recurrence of maltreatment and serious injuries and deaths. Child well-being indicators are school performance and child behaviour. Permanence indicators consist of the numbers of moves in care and numbers of children in out-of-home placement. Family and community support indicators include family moves, quality of parenting and ethno-cultural placement matching (Trocmé et al., 2009).

Overview

Though the standard applies to programs and services for children, youth, and families, the population of primary concern for high-quality care are the children and youth, from newborns (0 years) to young adults transitioning out of the system (21 years).

The standard for Child, Youth and Family Services requires that services are provided by and coordinated across all relevant agencies, including mental health specialists, social workers, and investigation agencies. An integrated approach to provision of services is necessary to improve the quality of services and care provided to the children, youth and families.

The types of services included in this standard are those designed to address the following; child/youth maltreatment, child/youth mental health, child developmental risk, violence in the home, intergenerational trauma, child/youth rights, family dysfunction, family-community connections, psycho-social functioning, youth justice, and substance abuse. Overseeing and providing child welfare programs are tasks that involve many different disciplines. Some of the main facilitators are;

- Social workers
- Child protection specialists
- Family case workers
- Community health workers
Therapists and counsellors

All of these individuals and more are responsible for respecting the client’s rights, dignity, autonomy, comfort, and safety when they are using child, youth and family services. This standard will assist in improving the effectiveness, experience, and outcomes for individuals involved in the child welfare system by directing workers to helpful tools and resources.

The Child, Youth and Family Services Standard, provides clients and families with a framework for safe and respectful services and includes the following clauses:

1. Services are designed collaboratively to meet the needs of clients and the community.
2. Sufficient resources are available to provide safe, high-quality, and client-centred services.
3. Team members are qualified and have relevant competencies.
4. Services are provided within a collaborative team environment.
5. Well-being and work-life balance is promoted within the team.
6. Access to services for current and potential clients, families, teams, and referring organizations is provided in a timely and coordinated manner.
7. Investigations are performed in suspected cases of child maltreatment.
8. Clients and families are partners in service delivery.
9. Service plans are developed in partnership with the client and family, and based on a comprehensive assessment.
10. Service plans are implemented in partnership with clients and families.
11. Alternative care for children and youth who are unable to remain safely in their homes is provided.
12. Services for child protection, family support, and justice are integrated in the community.
13. Clients and families are partners in planning and preparing for transition to another service or setting.
14. Client records are kept accurate, up-to-date, and secure.
15. Information is managed to support the effective delivery of services.
16. Current research, evidence-informed guidelines, and best practice information is used to improve the quality of services.
17. Client and team safety is promoted within the service environment.
18. Indicator data is collected and used to guide quality improvement activities.

Measures of Success

This standard is expected to contribute to several key outcomes for the clients using child welfare services:

• Programs and interventions are responsive to the needs of the client and are culturally safe, inclusive, and build on their strengths.
• The voice of the child or youth is heard, acknowledged, and respected, to the greatest extent possible, in all aspects of service delivery.
• There are multiple opportunities in the community whereby clients and families may receive services that allow the child to be healthier, better socially integrated and have improved long-term health and social outcomes.
• Family conflict, crises and emergencies are better managed because a plan and a process has been developed with input from clients and families.
• Family-based caregivers such as foster parents and kinship parents have higher confidence in their ability to perform their role because of increased access to ongoing education, training, and support.

It is important that this standard is considered by organizations that provide or oversee programs and services for children, youth, and families along side other policy and guidance documents such as those from the United Nations: Convention on the Rights of the Child, Eurochild: Compendium of inspiring practices- Early intervention and prevention in family, and regional human services bodies.