RESEARCHING THERAPEUTIC APPRAOCHES TO TREATMENT FOR

CHILDREN IN RESIDENTIAL CARE

By

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Abstract

Children and youth in British Columbia who interact with the child welfare system are often

connected with therapists, counsellors, psychologists, and mental health worker. There is no

formal training on how to interact with this specific population when it pertains to their mental

health. As a result, many do not receive adequate care. Children in care can be a complicated

population to work with due to the complexity of their situation. Their well-being is often

exacerbated by their living situation both pre-contact with the system and while in it. In order to

provide effective care, counsellors should be aware of the difficulty of navigating the child

welfare system, as well as the issues that arise for children who live or have contact with this

system. There is no current single theoretical approach to working with this population, however,

understanding trauma, child development, and the effects of being institutionalized, as well as

approaches that are appropriate for this population is necessary in order to provide proper

treatment and care.

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Dedication and Acknowledgements

I would like to thank my thesis advisor, Colin Sanders, and my faculty reader, Laleh Skrenes, whose experience in the field of child welfare and counselling has been tremendously helpful in shaping this research. Thank you, Cassandra, for your unending support and love, you always inspire me to go further and achieve. To Joan Kennedy, who taught me everything I know about work ethic, and to my friends and family who have supported, and continue to support me, through and through.

It takes a village to raise a child

- African Proverb

Researching Therapeutic Approaches to Treatment for Children in Residential Care

Chapter One: Introduction and Personal Interest

In British Columbia (BC), a large portion of children and families who interact with the

Ministry of Children and Family Development (MCFD) and its delegated agencies are also in

contact with counsellors, therapists, psychologists, psychiatrists, and mental health practitioners,

sometimes willingly and other times as part of their mandate for reunification. As a front-line

worker with children in residential care, I can attest first hand to the relationship between

counselling and those who are bound to the child welfare system. I can also attest to the

difficulty that these children experience when trying to navigate both the world of the child

welfare system and the world outside of it.

Working with children in care has exposed me to the problem of balancing welfare,

business, and politics. Such work often caused me to put into question my values and those of

society, and further exposed me to how difficult it is to implement treatment when not all parties

are in accordance with each other.

Children who are under the care of the MCFD receive services that extend to their mental

health and well-being. It is not uncommon, therefore, for children who reside in residential care

(many programs now refer to themselves as "live-in programs"), such as group homes or foster

care, to attend counselling on a regular basis. Additionally, children who age-out of the child

welfare system often continue to use government resources to maintain a balanced and stable

life. An argument could be made here that this continued interaction with these services may

cause a dependence for clients. Families who have children in the child welfare system are also

commonly in contact with counsellors due to the hardship that it causes in their lives.

Furthermore, workers in the child welfare field, such as social workers, youth workers, and

outreach workers have a commonly high level of work burnout rates and regularly seek

counselling for the burden caused by their work experience.

Children in residential care are often not willing participants of the child welfare system,

which can reveal itself to look like resistance to using services provided, such as counselling.

However, it is often due to the lack of knowledge on *how* to interact with this population that a

divergence occurs between service providers and the children in care. Additionally, the attempts

to understand how to provide better care for these children is often one-sided; the approach

usually follows a progressive and activist form of resistance to the power that be to advocate for

more services and better treatment options. However, there is also a societal and systematic

portion of child welfare that needs to be looked at to successfully implement new strategies.

British Columbia has a deplorable history when it comes to the removal of children from

their families, particularly Indigenous families. Therefore, this topic is often one that is

enmeshed in culture. Conversely, those in charge of the laws and practices come from a place of

politics, law, and economics. Bridging the two requires that both sides be looked at to find not

only what would be the best approach, but how to implement this approach. It could be argued,

therefore, that the best approach would combine both the well-being and needs of children and

families in care, as well as the societal requirements and standards for these implementations.

The focus of this research is first and foremost to benefit children in care, but also those

who work with them; It is intended to benefit the well-being and lives of those who endure the

child welfare system but also those who work tirelessly within it. Front-line professionals such as social workers and youth workers spend most of their time looking after these children and can see both the bureaucratic and political side of this field, but also deal with the raising and well-being of children. This research will investigate both the literature and professional opinions of those who work with children in care.

Social workers have a distinct advantage over other professionals because they can work from within the system while providing direct help and services to families and children in care. This research will therefore ask for the opinion of these professionals to seek what their views of the current model of child welfare is, as well as what could be implemented to improve the treatment and approach. The review of the literature will focus on the historical approaches and treatment success of this field, the systemic issues that are faced by both the children in care and their caregivers as well as the difficulty in implementing progressive and appropriate treatment options. This research will help therapists who work with families involved in the child welfare system to better understand the struggles that are faced on a day today basis, as well as the underlying and less visible limitations that face the children, families, and workers involved with the families.

The stance of the research for this topic needs to be critical. It is not meant as an attack on those who work within the residential care system. But transformative approaches to any institutionalized systems require a critical eye to ensure that positive and progressive changes can be made.

Significance

This study is not intended to provide new treatment approaches for youth-workers or social workers. Rather, its intention is centered around the understanding of the struggle that children in residential care endure, as well as the difficult intricacies that implementing such policies pose on those who are directly involved in the child welfare system. The purpose is to help therapists to gain insight into the current treatment approaches provided for children in BC so that they may more effectively tailor their approach to benefit the children and families that navigate this system. Additionally, it aims to provide a succinct comparison of which therapeutic approaches have shown to be the most beneficial so that therapists who work with children in care can help to facilitate a possible change in the child welfare system.

Definitions

Front-line Worker: Any persons working directly with the identified population. A front-line worker typically has regular contact with the target population or client and is employed in some professional setting.

Age-out: Age-out, or aging-out, refers to children who, on their 19th birthday, are no longer wards of the Ministry and are considered independent adults. This usually means the loss of their housing in residential or foster care but does not mean that all their ties to all the supports are cut off. Some supports continue to be offered. Additionally, new supports previously not available are also made accessible. In British Columbia, youths who age out currently receive support until the age of 24. However, there is a proposal to increase this support until the age of 27.

Youth Agreement: In British Columbia, children 16 to 18 years of age and in need of assistance or protection are directly supported by the government and given resources for things such as

housing, developing life skills, managing mental health problems, education, and managing finances. Children who fall in this category can enter in a contract with the ministry as long as some standards of stability are met.

Out-of-home care: Out of home care describes any living situation that children may live in when they are unable to live with their parents.

Scholarly Context

According to the Canadian Child Welfare Research Portal, there were 7,216 children in out-of-home care in British Columbia in 2016. In a joint report published in August of 2018, the Ministry of Children and Family Development, along with the Representative for Children and Youth, announced that almost 450 children under 12 months of age entered care for the first time this year alone. This statistic does not include the number of children over that age who come into contact with the child welfare system. Currently, children and youth in care may remain in the care of the MCFD until the age of 19, after which they will age-out and no longer be fully taken care of by the ministry and its agencies. When a child in care ages-out, they are no longer under the full care of the MCFD but can receive support through other programs run by the government. However, it is not uncommon to receive reports of these children struggling to survive now that they are on their own (Rutman, Hubberstey, Feduniw, Brown, 2007).

Another issue that has transcended the years of residential care is the overrepresentation of Indigenous children in care (Foster & Wharf, 2007). Indigenous children face a difficult challenge due to this and often find themselves removed from the families, communities, and livelihoods at an alarmingly high rate. Additionally, marginalized groups in society, such as

racial minorities, queer-identifying, and low-income groups, make a majority of the population

in residential care (Lavergne, Dufour, Trocmé, & Larivée, 2008). Another societal issue that De

Finney, Dean, Loiselle, & Saraceno (2011) address is that children who have lived through

residential care in Canada are overrepresented in correctional and treatment facilities. Finding a

link between a child's involvement in residential care and correctional facilities should be

alarming, as it suggests that these children are not receiving the level of care that they require in

order to live a normal life.

A study conducted in the United States by Fechter-Leggett and O'Brien (2010) found that

"former foster children have lower educational achievement; higher rates of unemployment and

underemployment; are overrepresented in the homeless; have higher rates of arrest and

conviction; and suffer from more mental health issues such as PTSD, depression, and substance

use than the matched comparison groups of non-foster children" (p. 207). With this in mind, it is

no surprise that the child welfare system is difficult to navigate, both for those who are

entrenched in it, as well as those who work with it.

Anglin & Anglin (2014) looked at the group home setting of residential care in an

attempt to build a "theoretical framework that would offer an understanding of staffed group

homes for young people that, in turn, could serve as a basis for improved practice, policy

development, education and training, research, and evaluation" (p. 49). They identified that most

group homes had the intention of working in the child's best interest but found that some of these

homes were not guided in their work with this focus. They therefore express that the core

challenge in most of these group homes was to "achieve congruence in service of the children's

best interest" (p. 54). Here we see an issue that plagues progress and the development of

treatment approaches in residential care. The issue is not the intention, but rather, the way that

work is being implemented. If there is a lack in congruency on how to best provide for the children, then the difficulty of bringing this "best" approach is exponentially increased.

It is also important not to forget that there is a strong cultural aspect to child welfare in British Columbia since Indigenous populations make up a large majority of children in care. According to a report released in 2015 by the Aboriginal Children in Care Working Group, only 8% of children in BC are of Indigenous, Aboriginal, or First Nations descent but 55% of them live outside of their parental home. Furthermore, one in five of all Indigenous children will be involved in the child welfare system during their lifetime. These children are clearly overrepresented in the child welfare system. This evidence points to a problem with the current system in place, as well as the societal pressures faced by Indigenous children in BC.

Changing legislation and treatment approaches to child care in BC is not a new concept and has been done multiple times in the past (Anglin & Anglin, 2014) and this is something we can draw information from: how has it been done in the past? How did it get implemented? And how successful were the implementations of new practices? Furthermore, analyzing the historical changes to child welfare can show the trend that society is taking when it comes to the well-being of children and families involved in the child welfare system. There has also often been a question of theory versus practice, and which makes a better approach to treating children in care. Anglin & Anglin (2014) talk about knowing *what* and knowing *how* and make a clear distinction between the two, concluding that building a theoretical framework for children in care is not necessarily practical, and that theories do not always stand the test of time, nor the test of implementation.

James (2011) looked at theoretical models that have been developed and implemented in residential care and noted that models can differ and still be effective. An issue that quickly arose

however, was the evidence of effectiveness being scarce due to little research being conducted

on certain models, while others receive plenty of attention. In addition to the lack of research,

James (2011) identified one of the limitations of their study as being informed by dated evidence.

Much like the issues of using dated approaches to support clients, research also struggles to

remain relevant due to the ever changing and evolving approaches. This, however, should be

seen as a reason to continue to study this topic and to encourage progress in the field so that it

can ensure the most up to date practice approaches. Furthermore, "there does not appear to be

much progression of knowledge with regard to other models, and the emphasis on the

development of less expensive community-based interventions is unlikely to encourage

development and implementation of new group care models" (p. 10). Community-based

interventions need more attention BC, many children that are heavily affected by the child

welfare system live in remote communities that do not have access to diverse or expensive

treatment options.

Another issue that plagues efforts to research the effectiveness of these models is the

difficulty in conducting experiments on such vulnerable populations which is "often abandoned

for pragmatic as well as ethical reasons" (p. 10). Therefore, we can conclude that not only is

research on these populations extremely difficult to conduct, but it remains to be inconclusive in

terms of scientific research rigor. James' (2011) highlight of community-based intervention also

suggests that treatment approaches should perhaps not come from a "lab grown" theoretical

framework, but instead form one that works for a particular community. This begs the question

of whether successful treatment models can be applied cross-culturally. Multiculturalism is

rooted in the history of British Columbia and this continues to be a factor that needs to be

considered. According to the government of British Columbia (2019), the province is the most

ethnically diverse one in the country. Almost 30 percent of people living in BC have immigrated

from another country and almost 25 percent of them are a visible minority. In places like BC,

where child welfare is very much intertwined with ethnicity and a colonial past, treatment

approaches may have a more difficult time being implemented due to the considerations that

need to be made for these populations.

Data Collection and Analysis

This research paper will look at the current and ongoing issues pertaining to the care of

children in the child welfare system in British Columbia. The research will be looking at the

history of British Columbia's child welfare system, the treatment approaches that have been used

in the past, as well as the ones that are used today. The philosophy of the MCFD and its

delegated agencies have been partially informed by historical practices, therefore, it is important

to recognize how the past has affected the present and what lingering treatments remain in use

today (Poole, Talbot, Nathoo, 2016) This information will mostly be gathered through publicly

available resources published by the British Columbian government, MCFD, and advocacy

groups that monitor this information. Books and articles on the history of child welfare,

residential care, the child welfare system, and therapeutic approaches used when working with

this population will also be used in order to build a clear history of the child welfare system and

how it has affected families in British Columbia. The research regarding the therapeutic

approaches to child welfare and treatment for children in residential care will not be limited to

published works in British Columbia or Canada – it is important to recognize that therapeutic

approaches from all around the world can be evaluated to see if they would fit within the context

of British Columbian children in residential care. Another variable that will be researched is the

process of implementing new treatment approaches in the child welfare system. For this, input

from social workers currently working with children involved in the child welfare system will be

instrumental. Their position in the field is incredibly advantageous in regard to gathering

information both on the satisfaction of their clients, their own views of how beneficial the

treatment approaches currently are, as well as the difficulty of implementing treatment

approaches in our political and economic climate. This information will be gathered in a survey.

The survey will be developed to ask a series of questions about the child welfare system and the

opinion on the application of treatment approaches.

The data from the survey will be compiled to analyze the answers and see whether there

is a trend in the answers. Regardless of whether there is a trend or not, the answers will provide

information on social worker's opinions of working with children in care and provide a good

foundation to discuss the topic.

Assumptions

This thesis assumes that the MCFD and its delegated agencies as well as the government

in Canada today works with the intention to bring children in residential care the most

therapeutic approach available. Although there may be improvements that can be made, the

assumption is that the primary focus is the well-being of these children.

Chapter Two: Selected Literature Review

Searching for the most fitting treatment approach for children in residential care is not singularly defined by the research and literature. The specific situations which children in care find themselves in means that the answer to this problem is an amalgamation of comprehensive literature and experience. It requires an understanding of fundamental childhood development, but also the intricacies of the child welfare system, and the history of the communities which influence the stigma, development, and practices that children and youth experience within the residential child welfare system. The content of this literature review is garnered from research across multiple locations. Although the focus of this review is primarily focused on the welfare system as it pertains to British Columbian children, aspects of it can certainly be considered for systems that are outside of this community. However, it is imperative to remember that the history of the child welfare system in this province may impose different standards and complications due to the reality of its past and the continued effects of the trauma that has been felt by thousands of children and families who have and continue to interact with the child welfare system. Particularly, the cultural piece of recognizing that British Columbia needs to work together with indigenous and multicultural folks in order to address the cultural problems within the child welfare system. Similarly, a lot of the research is primarily, but not limited to, articles and reports that focus on the child welfare system in British Columbia.

Conceptual Framework

The conceptual framework for this research is rooted in a transformative approach. It will follow a structure of advocacy for child welfare but also its interaction with the societal model we currently live in. The framework does not follow a particular theory but instead attempts to

bridge the gap between advocacy, progress, and activism with that of politics, standards of practice, and applicability.

Review of the Research Question

Finding the most effective way to ensure the well-being of children who reside in government funded residential care is an on-going and evolving problem that requires constant re-evaluation and critique to meet appropriate standards.

Restating the Question

What therapeutic treatment approaches are most beneficial for British Columbian children living in residential care and how can this be implemented in a counselling setting?

The literature review will address this by comparing therapeutic approaches that have been used in a multitude of settings across the world, as well as the history of child welfare as it pertains to British Columbia. This will address the most current and evidence backed approaches that have been successful, as well as highlighting other forms of approaches that have been damaging or unsuccessful so as to classify which therapeutic treatments are most beneficial for children and youth in care.

In their analysis of the effectiveness of children living in residential group homes, James (2011) looked at the available research present on the effectiveness that group homes have on the outcome of group care. The result was that there is little research on this, and of that research, most lack good design. The consensus is that the available research is non-representative of the majority of children and youth in care. There are however, some results that can be drawn from

these studies. Namely, that children and youth who have a lower level of dysfunction and who experience acute rather than chronic issues fair better in the residential care system (Landsman, Groza, Tyler & Malone, 2001; Wilmshurst, 2002). Moreover, those who spend less time in residential care also experience more positive outcomes overall (Larzelere et al., 2001). Counsellors who work with these children need to be able to understand that this concept resembles that of entrenchment. Much like trauma, living in residential care for extended periods of time has a cumulative effect; children who spend more time in these settings tend to have more complex issues. The research also appears to show that there is a negative trend correlated between time spent in residential care and negative outcomes, suggesting that finding alternative modes of residential living as well as decreasing the time that children spend in these settings are crucial in ensuring a healthier outcome.

There is evidence that in-home services are increasing (as opposed to in-care), yet, it appears that this approach lacks any significant evidence-based results on its benefit (Barthe et al., 2007). There is also evidence that children who are placed in residential care often did not receive any other form of less intensive treatment (James et al., 2006). Meaning that currently, the residential care living is, in many cases, one of the first means of interventions that children receive as opposed to supports that may otherwise be less intrusive. This must be understood when working with this client population, as it is often implied that children in group home care are ones that have not been successful and are the "worst of the worst". The evidence presents that this is not always the case, and that residential care is sometimes the immediate approach, which can be detrimental to their success.

Research also shows that children in care face a critical problem of needing therapeutic treatment for a multitude of complex issues including complex trauma, attachment concerns,

poor affect regulation, delayed development, behavioural concerns, delayed cognition, and self-concept issues. All of which require a tremendous amount of specially tailored therapeutic treatment (Knoverek, Briggs, Underwood, & Hartman, 2013). Finding professionals who are qualified and trained in this aspect is complicated and expensive, making it an unviable option, especially for communities that lack funding.

A suggestion that may prove to be beneficial is having mental health clinicians and behavioural intervention specialists directly contracted and servicing organizations that manage and run residential group homes. Instead of employing a traditional therapeutic approach (clients accessing services in an office once a week), being able to interact with clients when needed could prove to be a more economic use of time and resources as well as giving a sense of community between client and therapist. Furthermore, children in these settings often have developmental incongruencies and delays that do not mesh well with one on one talk therapy. To give this context, a significant number of children in care have symptoms of Fetal Alcohol Syndrome Disorder (FASD), a condition that affects physical and cognitive developments which have significant effects on normal functioning. Children with FASD do not typically engage well in traditional therapy and need a more involved forms of intervention. Research shows that in Canada, FASD prevalence is underreported and lacks current, valid research. However, the most current research does suggest that children in care across Canada have higher rates of FASD than the general population. Furthermore, although inconclusive, some research suggests that indigenous children have a higher prevalence for FASD than non-indigenous children. (Flannigan, Unsworth, & Harding, 2018). This same report also concluded that most children who are diagnosed with FASD do not live with their biological parents, meaning that there is a likelihood that they were, at one point, in contact with the child welfare system.

History of Approaches in Residential Care

To understand why the residential care system is how it is today we have to understand the context of its history. Although it can be argued that residential care is intrinsically there to benefit the welfare of the child, the history of its implementation is marred in the abuse of basic human rights and continues to be felt by those who have previously, or continue, to interact with it.

One of the first interactions that saw the removal of children by the Canadian government occurred in the late 19th century and was aimed at increasing the assimilation of Indigenous children. These residential schools also served as official governmental care for children who had been deemed to have experienced abuse and neglect (Milloy, 2017). It is no secret that the treatment of indigenous children by the Canadian and British Columbian government, as well as its delegated child welfare agencies, have caused permanent damage on the lives of many. Some critics of the child welfare system have compared the mistreatment of these children as akin to cultural genocide (Blackstock, Brown, & Bennet, 2007).

Residential schools were mostly operated by religious Christian institutions but were backed by the Canadian government Through the British North American Act of 1867. This church-state partnership saw the Canadian government as the provider funding, standard of care, provided administrative supervision, and claimed these children as ward of the state (Milloy 2017). Children were effectively taken from the communities and families and imposed into institutionalised schools that attempted to eradicate the culture and livelihood of Indigenous, Metis, and Inuit peoples. Residential schools continued to operate in all across Canada until the

last one closed in 1996 in Saskatchewan (Miller, 2012). In BC, the last residential school closed in 1984 (The BC Teacher's Federation, 2015).

The first piece of legislature that focused on the welfare of children in British Columbia was the Infants Act of 1901. The intent was to ensure the safety and well-being of children and helped to formalize the governing of child welfare in British Columbia. The premise behind removing children (non-indigenous) was that some families and homes were so detrimental to their development that it was the government's duty to remove them and place them in more appropriate settings (de Leeuw, 2014). Regardless of the intent, which was often to offer a subjectively 'better' life to children, the governments and organizations that implemented these policies seem to always assume that a child's well-being can be assessed based on the "hygiene of a home, morality of parents, future potential afforded to the children by living in the home, and behaviors of parents and relatives towards each other and children" (de Leeuw, 2014, p. 63). Although these factors are all important measures to consider, they oversimplify the reality of the complex development of children.

The Infants Act of 1901 was succeeded by the Protection of Children Act in 1939. Between 1930 and 1960, significant changes were made to the institutionalization of child welfare. Social work became a recognized university degree and residential schools began to shut down. However, by 1960, a major trend in the introduction of children, primarily Indigenous children, in the child welfare system shifted. What is now known as the sixties scoop, involved a major increase of Indigenous children being brought into the system. For context purposes, in 1955, 29 Indigenous children were placed in the system, by 1964, that number increased to 1446 in British Columbia (de Leeuw, 2014).

The 1970's public dissatisfaction of the standard of the child welfare system propelled a reform. The reform was supported by the New Democratic Party in power, but their successor in provincial power dubbed this reform as a "partisan political document" (Armitage, 1998, p. 94) and saw little progress towards modernizing and reforming the child welfare system. Child welfare became a politicized talking point that took precedence over the welfare of children in care. It was not until 1991 that a formal review and change of process began to take form again. This new review was conducted through a community panel and allowed Aboriginal communities to hold independent hearings in addition to their own reports. The result of these new reports and consultations pointed towards issues of social policy rather than child welfare law and practice. Racism and colonialism were addressed in the system and were deemed the main problems to be solved. By 1994, new acts in the legislature moved further along in ameliorating the welfare of children in care and less intrusive forms of care were finally being considered. Recognition that the family's home community was the preferred environment for childrearing made its way into policy and recognition of Aboriginal culture and rights finally became part of the policies that inform appropriate practice. Children and families in care now also had the ability to file complaints at any time during their interaction with the child welfare system. Furthermore, a new officer of legislature position was created – the child, youth, and family advocate – which plays a central role in overseeing policies and practice as well as making for recommendations for improvements (Armitage, 1998).

The stance of the efficacy and benefit of residential care is no longer static. In 1990, a FICE (International Federation of Educative Communities) conference, which gathers and collaborates with government and agencies world-wide that work with children in care, published a statement that residential care had developed into qualified and efficient care for

children and youth. They posed that those working with youth in need should urge to see residential care as a good alternative for those in need. Just 13 years later, the UN Convention of the Rights of the Child, deemed that institutional care should only be a last resort and temporary response and that there is evidence residential care has a negative influence on children and the community (Knorth, Harder, Zandberg & Kendrick, 2008). In B.C., circumstances and practices also change, and are not immune to the influence of society. As views change and evidence emerges, it is our duty as clinicians to understand and advocate for the best treatment available for our clients.

Agencies today continue to be scrutinized for their past transgressions and for the ongoing problems that continue to plague this system. However, it appears that government and private agencies are now more concerned with ethical practice. Giving Indigenous agencies the right to make decision in their communities and with their own people is one example of how the government is making strides to reconcile problematic practices.

This does not absolve previous wrong-doings. What it does, however, is show that through transparency and connection, communities can begin to heal their people and support children who are in need or protection. It should be noted that this work is never easy and that child welfare is not a perfect practice. Decisions that have long term negative effects on children cannot always be predicted. There are occasions where a lack of care and foresight have caused irreversible harm to children living in care. However, it can only be through timely consideration and planning, which is unfortunately not always an option, that negative consequences can be avoided. There is also an element of error that needs to be accepted. Systems are designed by people, and people make mistakes. Criticism is easy, finding a solution is not.

Growing Needs of Children in Care

A report published by the Child Welfare League of Canada (Farris-Manning & Zanstra, 2003) highlights the need to explore the changing dynamic of children and youth who interact with the child welfare system. As it has been mentioned previously, a key component that influences this research is the ever changing and evolving society *and* children of our time. That same report expresses that children living in the child welfare system have expanding 'special' needs that need to be considered. In this report, special needs are defined as a child that requires additional resources that extend beyond what a child would be expected to receive in order to be adequately supported and to have a healthy development. This is represented by mental health and behavioural concerns, youth who are queer identifying, children living with significant developmental delays such as Fetal Alcohol Spectrum Disorder, youth involved in the criminal justice system, and other physical, developmental, and societal barriers and marginalization. This leads to a higher level of demand and higher level of practice. This report suggests that previously, these concerns were often not addressed in the child welfare system, at least not officially. Nowadays, due to the changing and progressive climate around human rights, these concerns take a central role in the consideration for healthy living and have become an integral part of the mandate of the child welfare system.

British Columbian Trends for Children in Care

In contrast, there appears to be a decrease of children in care over the last decade. According to the Ministry of Children and Family Development (2019), the latest reported

numbers show that, in British Columbia, both indigenous and non-indigenous children in care have been consistently decreasing. Officially, only three in 1000 non-indigenous children are in care whereas 46 in 1000 indigenous children are in care. Although the numbers point to a huge discrepancy between indigenous and non-indigenous children, they also show that there has been an 18% reduction of number of indigenous children in care since 2002, from 64 per 1,000 to 46 per 1,000. When looking at the overall numbers since 2002, there has been a total reduction of 6.7%, from 10,049 to 6,698. In the year 2002, 10.7 out of every 1,000 BC child were in care. Today, these numbers are closer 7.4 per 1,000. The numbers can be viewed in table format in the Appendix under Figure 1.

This very same report also points that 89% of children who are in care are so because of a court order and that the remaining 11% are either in care by a Voluntary Care Agreement or through a Special Needs Agreements, where the parents are involved in the process. The majority of cases (72%) where children are removed from their homes via a court order is due to neglect. In addition, younger children are more likely to be placed in care than those aged 16-18. This is partially due to the adoption rate of younger children, as well as the potential to return them to parents or permanent transfer of guardianship. Moreover, children aged 16-18 also have the option to be served through a Youth Agreement, which allows them to be able to live independently and therefore not need to have an adult caregiver in the child welfare system. It is also important to point out that the MCFD recognizes that the over-representation of Indigenous children in care is partially due to the lower rate of Youth Agreements that indigenous children receive.

Another factor to consider when analyzing the process of living in the child welfare system is that there appears to be a trend between length of time in care and potential of

reunification or adoption; the longer a child remains in care, the lower the likelihood of them

being reunified with their parents or being adopted. However, the number of children who have

exited to permanency, that is, who have permanently left the child welfare system either through

reunification or adoption, has been steadily increasing.

Those working within the child welfare system know that permanency is a loose term that

does not mean that particular child will not interact with the child welfare system. The MCFD

also accounts the number of children who return into the child welfare system after being

"permanently" exited. In 2018, as many as 17.3% of children who have been permanently

returned to parents or adopted have been reintroduced into the child welfare system due to

maltreatment. Although the official stance of the MCFD is that there is a slight reduction in

recurrence, the available trends suggest that there is no conclusive pattern when looking at the

number on a monthly basis. Figure 2 shows the percentage breakdown of this statistic.

Abuse, Neglect, and Working with Children of Trauma

As noted above, 72% of children who have been removed from their homes are removed

as a direct result of neglect. Neglect is often considered one of the most damaging forms of abuse

for a child's development and is defined as a

> "failure to provide for a child's or youth's basic needs. It involves an act of omission by
>
> the parent or guardian, resulting in (or likely to result in) harm to the child or youth.
>
> Neglect may include failure to provide food, shelter, basic health care, supervision or
>
> protection from risks, to the extent that the child's or youth's physical health,

development or safety is, or is likely to be, harmed" (B.C. Handbook for Action on Child

Abuse and Neglect, 2017, p. 23).

Neglect is a form of abuse and is more common than physical, emotional, or psychological

abuse. Often times, it accompanies other forms of abuse as well. Neurobiologically, neglect may

impair the brain's development. When this occurs at crucial stages in a person's development, it

means that portions of the brain responsible for forming basic understandings and behaviours

simply do not occur. Without an established foundation for positive behaviours, thoughts, and

feelings, the person will have an extremely difficult time reaching appropriate developmental

milestones; this includes a lowered or complete inability to regulate emotions, to form trusting

relationships and bonds with others. This then causes complex skills to lack the building blocks

necessary for their development. It is no surprise then, that children who are removed from their

families because of neglect will often start the process of living in care with a tremendous

disadvantage. For that reason, it is even more crucial that mental health practitioners who interact

with this population be aware of effective and appropriate methods for working with children in

care.

Over the last couple of decades, Bruce Perry and his colleagues have been looking at

brain development in early childhood. Their focus has been on intervention and treatment

approaches for children working with significant trauma. They developed the Neurosequential

Model of Therapeutics (NMT), which is "not a specific therapeutic technique or intervention; it

is an approach to clinical work that is informed by neuroscience (Perry, 2009, p. 248). The

premise of NMT is to focus on both the strengths and problems of the individual and formulate

an individual treatment plan based on the needs and development of that specific individual. In

other words, the approach is less focused on implementing rigid techniques. Instead, it works

with the individual to assess what needs have not been met, and which problematic areas require

the most attention.

Understanding the client is also a crucial aspect of being able to provide successful

treatment. One of NMT's core concepts revolves around assessing the current functioning of the

individual. For example, a 12-year-old child who has the social skills of a 6-year-old, the

language capacity of an 8-year-old, and the emotion-regulation skills of a 4-year-old will require

a specifically tailored approach that will differ from a peer of the same age with age appropriate

capabilities. This comes with its own challenges however, as it requires in depth assessments to

be conducted. Assessments are typically expensive when conducted through a private

practitioners, or can be a lengthy process that could take months to complete due to long wait-

times.

Trauma-Focused Approach

The term "trauma-focused approach" refers to the understanding and application of

therapeutic approaches which considers the effects that trauma has on individuals. This goes

beyond the neurodevelopment and encompasses emotional, physical, psychological, and spiritual

effects of trauma. Trauma-focused approaches should be central to working with children in

residential care. The trauma-informed practice guide developed by the MCFD in 2016 states that

of there are two types of trauma that are particularly relevant to children in care: Developmental

and Intergenerational trauma. These are not the only two forms of trauma that can affect children

in care but are merely the most prominent ones (Poole, Talbot, Nathoo, 2016)

Developmental trauma refers to the exposure of traumatic stress in early stages of a child or youth's life. Events such as witnessing a violent death, neglect, assault, abuse, grief, loss, separation, abandonment are all contributing factors to the development of trauma. Prenatal children are also at risk of trauma if they experience poor prenatal care or difficulties during birth. Recently, the term complex developmental trauma has been used to refer to the chronic or multiple exposures to trauma that some children experience.

Intergenerational trauma describes the effects, both neurological and physiological, of people who have formed close relations to those who have previously experienced trauma. It is now known that particular coping and regulation strategies can be passed on from one generation to the next (The Chadwick Trauma Informed Systems Project, 2012). A caregiver who has developed a certain adaptation to their own experience of trauma can be passed on to the child that they are taking care of. In some situations, this can mean that some maladaptive coping strategies can be passed on, which can complicate the development and coping of the person in the next generation. To give a clear example, a person who has been exposed to a violent assault may develop a poor attachment and relationship with strangers. This can then inadvertently be passed on to their children, who will themselves have a reduced ability to form trusting relationships with people they meet. A child who has this maladaptive coping strategy may fair poorly in a social setting, such as school, where they are exposed to new peers on a regular basis.

"31 cases of critical injury or death of children in care reported to the Office of the Representative for Children and Youth in BC for the period of 2010-2011, all had experienced trauma earlier in their lives" (Poole, Talbot, Nathoo, 2016, p. 5). The same report distinguishes exposure to different forms of trauma based on sex and gender. While boys appear to be exposed to physical assault, physical bullying and physical threats, girls are at increased risks to be

exposed to sexual victimization, both psychological and emotional abuse, internet harassment, and emotional bullying. Although studies on the rates of trauma experienced by children in care in Canada is limited, some studies in the United States have looked at the prevalence rates of exposure to trauma comparing children in care to the general population. Note that these statistics are also both limited and dated. A study conducted by Brady and Caraway (2002) showed that over 97% of their participants had experienced at least one traumatic experience, and that most had experienced multiple traumatic events. Another study looked at the rates of PTSD in children in care placed in residential programs versus children in care who received services while staying in their homes to be significantly different, resulting in almost a 10% increase for children in out-of-home-care (Kolko et al., 2010). In Canada specifically, Collin-Vézina, Coleman, Milne, Sell, & Daigneault (2011) studied the trauma experiences of children in care in Montreal and found that "a majority of them experienced emotional abuse (68%), physical abuse (60%), or emotional neglect (58%). Almost all youth reported some level of physical neglect (98%)" (p. 8).

It is also important to be cautious about pathologizing children and youth who are subjected to the child welfare system. According to the Canadian Mental Health Association – British Columbia Division, only about 15% of people who experience a traumatic event will develop lasting impacts. It is not clear as to why some people develop long lasting negative disorders but it most likely is a multitude of factors. Of course, those who experience multiple traumatic events have an increased chance of developing lasting effects. Children in care are often part of this group. However, assuming that a child in care who has experienced trauma is likely to have a Post-Traumatic Stress Disorder, or some other lingering mental health diagnosis

is an unproductive way of tackling the issues that may arise when working with this population.

This is where appropriate assessment becomes a valuable tool to understand the individual.

assessment as a tool

Assessments of children and youth in a clinical setting can be a tool to screen for

potential mental health, behaviour concerns, or cognitive diagnoses. However, many problematic

issues arise out of using tools to screen individuals for these concerns. Tarren-Sweeney (2008)

discusses the issue of assessing children in care and notes that present classifications are clumsy

and do not represent the complexity of this target population. Clinicians are encouraged to

consider this when working with children and youth who have walked through this system.

Assessments are not problematic for children in care alone. It is something that most clinicians

who use assessments learn.

There are many approaches to assessment and strategies used may depend on what is

being targeted. There are also many different assessment tools available to assess children who

interact with the child welfare system. D'Andrade, Austin, and Benton (2008) researched

assessments for risk and safety in child welfare and note that, although there appears to be trends

towards which assessment styles may be more valid, there lacks significant research to conclude

which forms of assessments are the most practical and beneficial. Assessing is complicated, and

although efforts are constantly being made to formalize, standardize, and apply these tools to

humans, it is not always as clear as it may appear on paper. This is why clinical expertise is

required in order to interpret the data. Clinicians working with populations that are constantly

being assessed, such as children in care, should do so carefully and expertly and with an

ecological approach (person-in-environment) (Tarren-Sweeney, 2008).

complicating the problem by ignoring culture

Historically, assimilation and the silencing of non-western cultural norms was widely

accepted. In fact, it is no secret that the Canadian government, and by extent, the government of

British Columbia, operated on a platform that attempted to eliminate an entire continent's

indigenous culture and practices. The result of that is decades upon decades of additional trauma

and a soured relationship between groups of people that should, instead, work and live in

collaboration. Today, the child-welfare system has improved tremendously; delegated

Indigenous agencies have gained some autonomy to work and take care of their own youths and

communities. The MCFD now tries to work in collaboration with Indigenous elders and

communities to provide much needed care for children who lack support and resources. Social

workers no longer work strictly for the government; they now have the choice to work directly

for agencies that are either run by indigenous communities, non-profit, for-profit, or are highly

meshed in the culture and practice of Indigenous peoples. Blackstock, Brown, and Bennet (2007)

rank culture and language as one of their five key guiding values to improve child welfare

system and the healthy development of indigenous youths in the Canadian child welfare system.

They explain that culture is central to our identity and instrumental to understanding ourselves

and the world we live in. More importantly, the authors point out a common misconception:

Historically, the child welfare system has developed on Indigenous land and in Indigenous

communities, therefore it must have an Indigenous culture already present in it. On the contrary,

due to Canada's historical maltreatment of Indigenous peoples, the child welfare system in

Canada does not include traditional Indigenous values. Rather, it was created with different values that have been imbued on to Indigenous people for over a century.

That is not to say that Indigenous youths were completely deprived of their culture and language. Quite conversely, through their own resilience and resistance to this assimilation, there continues to be a flourishing culture of pre-European cultures that is now making resurgence in Canada. In BC specifically, Indigenous culture is becoming once again more celebrated through a multitude of mediums. This should be seen as a hopeful and positive step in the right direction for child welfare as it may very well help to drive the culture connection for Indigenous youths in care.

However. Blackstone, Brown, and Bennet (2007) do warn that a particular issue has arisen since the implementation of culturally appropriate child care: there is no clear evidence of the Canadian child welfare system truly embracing Indigenous culture beyond merely speaking about it, which has turned cultural appropriate care into a token surface term rather than a truly implemented approach.

In an attempt to extract whether traditional child raising practices of Indigenous peoples are still in effect, Muir and Bohr (2014) observed child rearing practices from different Aboriginal and Indigenous peoples across the world. For Canadian specific approaches, the authors found that an emerging theme was that of child autonomy, which gave children the ability to make choices and promoted independence. This allowed children to explore their environment more freely and learn life skills at a pace which worked for the individual child. Another theme that emerged was that of the extended family, which goes beyond blood ties, and often includes the community at large. Using the community has been a long-standing practice that has proven itself to be a valuable asset to ensure healthy child development. On the topic of

adjustment and development, Muir and Bohr refer to connectedness as the most accurate term to use for the concept of attachment. It appears that including the community in the child rearing process mitigates some of the stresses that are often the burden of Western parents, and thus automatically allows for a more appropriate co-regulation when the child is in distress.

Some critics of the child welfare system may interpret negative behaviour as needing a certain kind of discipline. Traditionally however, it appears that Aboriginal and Indigenous families practiced positive reinforcement patterns, positive play, affection, and praise of discipline rather than using corporal punishment. The response to aggressive behaviour in Indigenous children was observed to be closely tied to teaching values, life lessons, and rules of society as opposed to strict punishment.

Finding an appropriate approach to work with children in care is more complicated than looking at the history of how children have been raised and treated in our societies. Looking at the past should be used to inform our practice but it should not be used to limit the potential of those who work first-hand with this specific population. Instead, professionals in the field should use this information to sculpt their approach while keeping in mind that humans have innate skills and instincts to building relationships. Theoretical frameworks are useful on paper, but cannot always apply in practice. Adhering to an approach when there are clear signs that it is not working can prove to be more detrimental to a child's well-being and development. Therefore, one should always be open to flexibility.

how working with trauma affects professionals

Professionals who work with people who have experienced trauma can become victim to a very specific form of trauma. The term Vicarious Traumatization is used to describe professionals whose own mental schema is altered through their experience of engaging empathically with people who have experienced trauma. Their perception of their own safety becomes challenged through the stories and experiences of their clients which in turns alters their perception of safety in the world (Baird & Kracen, 2006). It should be noted that the authors refer to this as a normal response for professionals working with this specific population.

Vicarious Trauma is not the sole term used to explain the issues professionals face when working with traumatized populations. Jankoski (2010) offers concepts such as Countertransference, Secondary Traumatic Stress and Burnout along with Vicarious Trauma to explain the impact of psychological trauma on helpers.

Secondary Traumatic Stress was initially referred to as *compassion fatigue* and refers to the idea that individuals who work with those who experiences intense and stressful events may experience similar traumatic stress symptoms as those who have lived it by being exposed to the emotionally taxing stories of the victims of traumatic stress.

Burnout is a concept that emerged in the 1970's and is a broad term which explains the "emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind" (p. 107).

In their study of Vicarious Trauma in child welfare professionals, Jankoski (2010) observed the constructive self-development theory (CSDT). A concept developed by McCann and Pearlman, CSDT poses that "individuals possess an inherent capacity to construct their own personal realities as they interact with their environment" (as cited in Jankoski, 2010, p. 107).

CSDT is a theory with a framework focused on trauma survivors and proposes that three factors contribute to vicarious traumatization: The organization, the clientele, and the worker's own experience. The findings of this study confirmed that the organization and clientele did indeed have a notable contribution to vicarious trauma. Additionally, other factors outside of the CSDT perspective emerged; "Post Traumatic Stress Disorder (PTSD), supervision issues, training concerns, influences of the job on relationships, community misperceptions, and concerns over state and federal regulations" (p. 113) were all themes that participants of this study expressed. Participants in this study expressed permanent changes to their view of self and the world. Some examples include changes in their relationships which caused them to be unable to be intimate with their partners, concerns over their own friends' potential maltreatment of children, and an overall pessimistic view of the general goodness of the world.

This is part of why working in this field is so difficult; those who are willing to do this kind of work often end up becoming victims themselves. Not through their own experience, but by extension of their clients' own stories and witnessing the pain and turmoil that their clients endure on a regular basis. This is a systemic issue that follows this work and recommendations come in the form of increased training, research, and involvement from organizations and governments to ensure the wellness of these workers. If this is not addressed, the mental well-being of professionals will continue to deteriorate, which directly impacts their ability to do their work and, by extension, care for children and youth most in need of caretaking.

Other Working Therapeutic Approaches

Landsman and Groza (2001) looked at the REPARE (Reasonable Efforts to Permanency and Reunification Endeavors) model; a family-centered residential treatment approach. Their research sought to reduce the length of time that children spent in residential care, as well as the severity of both emotional and behavioural problems. The model specifically involves family in order to tackle family functioning and improve reunification chances. "REPARE's theoretical orientation is grounded in empowerment, ecological family development, and community development" (p. 353). The results of this study showed that PREPARE had a better overall outcome for children living in residential care. It accomplished the goal of decreasing time spent in residential care, and increased the family contact with the child. These results are consistent with other research that looks at the effect long-term stay in residential care and a lack of contact with family or community.

Interestingly, their research found that length of stay influenced stability of the participants, meaning that children who spend more time living in residential care have a worse outcome of stability over time. This study's length of stay ranged between 232 to 262 days and compared their length of stay to other programs that ranged from 311 to 443 days. Perhaps even more importantly, what this study showed that it is possible to have effective family-centered programs and does not necessitate long duration stays for children and youth in residential care. Length of stay and ability to interact with family should be a factor that clinicians take into consideration when working with this population.

In their meta-analysis of therapeutic treatment approaches in residential care, Knorth et al. (2008) found that, as early as the 90's, research suggested improvements in the style of aftercare treatment, working with families both in and outside of the residential treatment, and the importance of learning opportunities that can be generalized outside of the residential

environment. Another theme that emerged was that, the longer the follow-up period of post-treatment residential care, the less convincing the evidence of effectiveness of those treatments were further emphasizing the need for post-treatment care.

Therapeutic approaches that showed positive trends among this meta-analysis are dependent on the type of needs that youths have during their treatment, implying that standardizing treatments for youth in care is *not* beneficial. Assuming that placing children and youth who present with similar concerns in a treatment center or residential care setting will provide positive outcomes in 'batches' is inaccurate. Rather, a need to tailor the approach to the specific individual is necessary. For example, the meta-analysis points out different approaches for different presenting concerns such as medication when relevant, empathy training, family therapy and parent training, aftercare, social skills, adapted special education, and cognitive behavioural therapeutic programs.

What this review on meta-analyses found was that the previously stated evidence – that this form of care mainly has negative consequences for individuals – is not supported and that psycho-social functioning improvements are seen throughout residential programs on average. Their most specific results are as follows:

a. Youth with externalizing behaviours appear to make more progress than youth with internalizing behaviours

b. Behaviour modification and family-focused treatment appear to achieve more positive outcomes

c. Residential care appears to have better outcomes than treatment at home *with the same sample group*

d. Specific training of social-cognitive-emotional skills of youth further increases the treatment effect.

One particular approach that appeared to garner more behavioural progress than residential care was multi-dimensional treatment foster care (MTFC). This treatment approach involves an entire team of workers and clinicians that assist the youth, family, and agency. This very structured approach is designed to involve the entire family unit and members of the community. MTFC is supported by research in many contexts and settings (Chamberlain, Leve, & Degarmo, 2007; Fisher & Chamberlain 2000; Westermark, Hansson, & Olsson, 2011). MTFC also shows promising results in lowering costs to care, increasing emotional regulation and coping, decreasing social aggression, and increasing recognition of anxiety and symptoms related to abuse. Although some aspect of this approach are standardized, the premise of MTFC comes from an individualized approach to care. (Chamberlain, Leve, & Degarmo, 2007).

Chapter Three: Methodology

This chapter will cover the specific methodology of the research for this paper. The first paragraph follows the reasoning behind using transformative approach for this research. Following, the reasoning behind the specific population sample as well as the main idea behind the use of a survey will be discussed. A critical observation on to the limitations of these factors and the overall methodology will also be addressed in order to provide a clearer understanding of what this research covers, and what it does not.

Transformative Approach

As previously stated in Chapter 1, a transformative approach will be used. The reasoning behind this is based on the need to continue to look at child welfare as an evolving, ever-changing area that follows societal trends, therapeutic approaches, and research. As a result, one of the largest errors that can be made is to implement a certain theoretical approach to working with children in care without allowing room for change. Trevors, Pollack, Saier, & Masson (2012) describe transformative research as one which "'transforms' or causes a major change in thought patterns concerning an area of scientific endeavor" (p. 1). Mertens (2012) states that the transformative approach framework is centered around ethics and incorporates cultural responsiveness, strives to promote social change, and addresses issues of power imbalances. This work is not intended to be radical by any means; it does not seek to bring about a "new" and revolutionary idea to the child welfare system. Its intention is to promote the continuation of research into the development and evolution of the residential care system in British Columbia.

Furthermore, it aims to encourage those who interact with the field to endorse therapeutic approaches that evolve in tandem with social progress and the beneficiaries of this system.

Mertens (2012) argues that "cultural competency is a critical disposition that is related to the researcher's ability to accurately represent reality in culturally complex communities" (p. 805). The residential care system is not exactly a *cultural community*, although it can be argued that those who rely on it face issues that more privileged peers have very little understanding of. By that standard, we can attribute that children who have experienced the residential care system form their own community within British Columbia and have access to experiences that other children do not. By extension, those who work or interact within the system have access to these experiences, albeit from a distance. Therefore, it is important to approach this research with a framework that puts value on understanding cultural differences.

On the topic of power imbalances, the same can be said as that of cultural complexities; Children who encounter the residential care system are effectively forced into situations that cause them to lose a lot of control over decisions pertaining to their lives. In an effort to ensure safety and well-being, the government often receives the "final say" in how this safety and well-being is implemented. Although those who make these decisions are accountable to their clients and the community, this accountability does not remove the intricacies and complexities of deciding on the short-term and long-term living situation of an individual. Moreover, children are often put in the care of community members that are not related to them, whether in foster care or in residential group homes. Another component of this power imbalance is that children who come in contact with the child welfare system are automatically assigned a social worker whose duty it is to look after these children. Sometimes, this can lead to these children becoming wards of the Ministry where the legal guardianship is put in the hands of the social worker

responsible for that child. This completely shifts the decisions in which children have over their

own lives and removes the family's ability to make executive decision in the child rearing

aspects of their own children.

Population Sample

Social workers in British Columbia have a unique understanding and perspective of the

child welfare system; not only do they work directly with children and families who interact with

the child welfare system, but they also are held accountable by the system which has been

created to ensure the well-being of this population. Because of this unique insight, on both a

front-line-direct interaction with their clients, and the political and administrative aspect of their

work, they are able to consolidate the gap between policies and the first-hand experience of their

clients.

A common and often overlooked issue in child placements is the amount of times that

children in care is moved from one home to another. Statistics on this in BC are reported: In

2018, 65.3% of children in care were not moved at all in their first year in care while 10.2% were

moved two or more times. The statistic of children who have been moved once since in care is

not available, neither is the statistic of children who have been in care for longer than a year. The

latest available statistic on children who were moved multiple times date back to 2012, in which

40% of children in care at that time had been moved 4 or more times. 11% had been moved 10 or

more times (Residential Review Project, 2012). No statistic has been found for children who

were moved less than 4 times.

Population Target

The population target for this research is both children living in care as well as professionals who provide mental health services to children in care. The target of the survey research is Social Workers because they can provide a bridge between systems and children. Social Workers can be involved long term with children in care and see their development over the years. They have access both to the bureaucratic and social aspect of the child welfare system and therefore provide an excellent liaison between the child welfare system and the welfare of their clients. Clinicians, front-line worker, and other professionals involved in the care of children and youth in the child welfare system should be aware of the barriers that children and caregivers face when trying to bring a therapeutic approach. This research paper aims to highlight and provide a deeper understanding of the present issues.

Using and Applying A Survey

The survey approach to this topic is three-fold; ease of access, reducing variability, and ability to compare results.

By employing a survey, it allows participants to complete it quickly yet at their own pace. This can reduce the discrepancies that may arise if it is completed in a rushed manner. It also negates the difficulty of organizing interviews that typically last longer than answering a survey. Additionally, it gives the researcher more control over the variables; having the instructions clearly written removes the chance of mistakes being made when explaining the instructions, purpose, and format of the survey. It also ensures that all participants receive the same approach to the research without being influenced by biases that may arise within the researcher. Using a

survey also ensures that the same questions are answered by all participants (unless omission is used) which gives the research a consistent set of data to compare an interpret.

The reasoning behind giving participants a two-question survey is to keep the data relevant to the question this research paper aims to answer. Additionally, it provides more thorough answers by not asking participants to volunteer too much of their time answering long surveys. Providing these two answers provides the research an idea of what front-line professionals are observing.

The first question gives information as to which therapeutic approaches emerge as relevant and necessary in the eyes of workers who have a fist hand experience with children and youth in care. Additionally, observing the emerging themes gives and idea as to whether a particular approach has validity in the field: If it is used and vetted. That is, it provides a possibility to look at the therapeutic approaches that social workers either employ or would like to see being implemented. This, in turn, suggests whether further research into these therapeutic approaches would benefit the field of child welfare, and how counsellors should approach children, youth, and families in the child welfare system.

The second question also enables participants to divulge which obstacles interfere with front-line workers providing good care. As research shows, the child welfare system is riddled with obstacles, both for clients and workers. By opening this survey to allow participants to divulge the specifics of what barriers are in the way of providing appropriate care, we can better understand, and better advocate for useful changes to be made to the system.

Limitations of the survey

The questions asked in the survey are influenced by my understanding of the current working system of child welfare and are therefore influenced by my own beliefs on the matter. The questions could be interpreted as leading to someone who may view the child welfare system and residential programs differently.

The sample size of this survey is small (6) and encompasses the views of social workers who practice in the Lower Mainland region of the province of British Columbia.

The size of the survey itself, being restricted to asking two questions, could be interpreted as being limited by in its scope to uncover details about the therapeutic approaches to children and youth who interact with the child welfare system.

Chapter Four: Results

Process of Data Collection

The data of this research is collected through a survey, which is included in the appendix. The survey is split into two questions. The first, inquires about which therapeutic approaches social workers believe should be used when working with children in care. Its intent is to seek what social workers have observed to be an effective therapeutic approach to providing ethical and successful care for children, youth, and families in the child welfare system

The second question asks if any participants believe any changes need to be made to the way that the child welfare system approaches children in care. This questions allows participants to elaborate on the problems they have observed regarding therapeutic approaches to children in care, and which barriers are in the way of providing good, ethical, and effective treatment to their clients.

Emerging Themes of the Survey

funding

Interpreting the survey answers revealed six major emerging themes. The first, is that of funding. This is, of course, an issue that plagues most areas of social welfare. Therapeutic approaches are as much victims to this problem. For appropriate care to be implemented, they first need to be tested. This testing requires research, proper set-up, and the consultation of professionals who understand the limits and application of a therapeutic approach. As is evident in research discussed earlier, children in the child welfare system require very specific

approaches. Not specific in the sense that one approach could target and be beneficial for all children and youth, but in the sense that every child and youth needs a tailored approach to their treatment. Participants in this survey made clear allusion to issues of funding when it comes to providing services to children in care. If funding is limited, important factors that would otherwise allow for a more comprehensive treatment approach quickly become whisked away in order to manage what can best support the children in need.

Funding also means supporting those who work with this population appropriately. The current statistic on social worker burnout rates in British Columbia are higher than average across government jobs (Bennet et al., 2009). Bennet et al. studied the contributing factors to this high burnout rate. They found that "unmanageable caseloads, a lack of confidence in all levels of leadership and management, high stress levels, and a lack of preventative and supportive resources for children and families" (para. 4). As for youth care workers, although the research remains scant on the topic, most last, on average, two to five years before changing professions (Barford & Whelton, 2010).

When those working directly with children and youth in care are unable to fulfill their mandate or work to the best of their abilities, the result is in a decreased level of care and, by extension, a less positive experience or outcome for the children and youth themselves.

trauma-informed and family-centered approach.

Another theme that emerged is that of approaching this line of work with a trauma-informed practice and a family focused philosophy. The fact that this was a common answer in the survey shows that social workers are up to date on their relevant research for best practice. Additionally,

it shows that front-line workers are ahead of the trend in policies and implementation of

appropriate therapeutic approach. This means that social workers are both limited by the

institution and bureaucracy, *and* actively pushing for better treatment for their clients. This

points to the importance of working collaboratively with the team of support that clinicians

working with these clients have. Not all social workers are extensively trained in mental health

or counselling practice. However, their interaction with children in the child welfare system is

enough for them to understand the impact that trauma has on development. Additionally, through

their work, they perceive that intervening in a family-focused approach is central to providing

children and youth with the supports needed to maximize positive outcomes.

As part of the trauma-focused approach advocacy, another theme that appeared from

participants was the need for caregivers to be trained in the impact of trauma which directly ties

to the increased funding that participants of the survey advocate for.

indigenous youth.

Social workers who responded to this survey also noted a trend in the difference between

indigenous and non-indigenous youth. Although the purpose of their research paper is not

focused on this difference, it needs to be noted as it provides an added layer of difficulty for

clinicians who work with indigenous clients. The participants were not asked to express in which

way indigenous clients were treated differently, or which solutions could be implemented.

Therefore, this research paper has no data on possible solutions to consider. However,

emphasizing that social workers are noticing a difference in treatment for children and youth

based on their ethnicity points out the particularity of the ongoing cultural and racial problems

that the child welfare system faces. This reinforces the notion that extra care may be necessary

for indigenous youths and that clinicians should also advocate for changes in the way the system

responds to Indigenous children and youth needs.

bureaucracy vs. care.

Participants also expressed the need for bureaucratic policies and practices to promote

children's well-being instead of if hindering the ability to provide care. Participants stated that

often, focusing on bureaucratic policies prevent children from receiving the care they deserve

because the attention has been shifted from their needs to that of policies.

smaller caseloads.

Social workers often find themselves restricted to do the work that is asked of them due to

the lack of funding but also due to the overloaded caseloads that they carry. Participants voiced

their concerns over having too many children to look after, not having enough time, and not

having enough resources to provide appropriate care for each child. The resources that

participants referred were of being able to spend enough time catering to individual clients'

needs

room for improvement.

The last theme that emerged among participants is desire for improvement and the belief that

our society could do better to support this population. This has been a major theme influencing

this research. This task was taken because I believe that there is room for improvement.

Enhancing the research of what we can do to better support children and youth in the residential

care system is the first step to understanding how we can serve this population in need more

appropriately.

Improving the child welfare system requires funding. Like all other social services, this is something that governments must balance accordingly. In order to increase the amount of funding available to this field, education about the child welfare system and its effects also needs to be expanded. It is both our responsibility as clinicians and members of our communities to increase the awareness of the cycle of the child welfare system. The statistics speak for themselves: If British Columbians care about reducing the amount of money that they invest in social services, if they want to decrease crime rates, if they want to decrease the homelessness and drug crisis currently affecting countless people and communities, then providing families who struggles with raising their children with appropriate supports is necessary.

I explained earlier how this research was less about finding the most appropriate therapeutic approach but instead to continue the trend of research and development into the care of the child welfare system. If social workers, who are some of the people who work most closely with this population, feel that they are limited by policies, and therefore cannot bring the best care for their clients, there needs to be shift in the way that policies are implemented. The implications of these issues are that it exacerbates the problem of the child welfare system: If policies restrict good care, the outcome will continue to be cyclical and progress towards minimizing the number of children and families that are forced to interact with the child welfare system will be slowed.

implication for counselling clinicians

What does this mean for counsellors who work with this population? First, it shows the many factors that influence the well-being of children in care. The process of living though the child welfare system is layered, as are the problems that arise for these children. Clinicians who work

with this population have the responsibility to assess whether they are adept enough in the

complex field that these children live in before taking on clients for treatment. A certain level of

understanding of the system is necessary in order to comprehend the difficulties that these

children and families face. Clinicians should educate themselves and seek opportunities to

explore the child welfare system if working with this population is within this interest. Much like

one would not take on intensive family work without an understanding of family dynamics,

relationships, communication, and development; it would be imprudent to work with these

clients without and understanding of the child welfare system, its history, and its effects on

others. Additionally, it requires a continuing education on the behalf of clinicians. As new

research emerges, and the needs of children in care changes, clinicians should be willing to

change their approach and advocate for changes in therapeutic practice when appropriate.

Moreover, clinicians should also note that new research does not necessarily mean new

approaches. As stated in previous chapters, some traditional and ancient child rearing practices

are now considered more progressive and appropriate than what has developed in the last

century. New research refers to the proven methods that decrease children, youths, and families

in contact with the child welfare system, and increase the successes of these same individuals.

Chapter Five: Discussion

The purpose of this study was to research best-outcome therapeutic approaches for children in residential care. Its intention was to analyze current patterns, historical approaches, and front-line worker perspectives on the treatment, effectiveness, and success of children and youth in residential care. What can be deduced from the literature review and the human subject research is that there are specific approaches to treatment in child welfare that is evidence based and fruitful. Approaches that are informed by trauma-focused intervention and employ a family-oriented focus typically show better results. Additionally, this research also shows that child rearing encompasses more complex factors than finding one orientation of practice. We must move away from *administering* therapeutic approaches. Rather, we need to observe the system as a whole, as it factors heavily on the individual clients (and families) who interact with this system. For clinicians specifically, it means that flexibility, creativity, and individualized approaches is necessary to ensure ethical and successful practice. The child welfare system is not a diagnosis that requires clear-cut ideological therapeutic intervention. Instead, it is a precursor to *potential* development of symptoms that transcend a mere diagnosis. Taking steps to remove the stigma that children in care are delinquent, but rather a result of a missed opportunity to develop according to societal standards. Not by their own doing, but by a lack of appropriate modeling from those around them, and a failure as a society to support community members most in need.

Re-routing our approach to look at these children as unfulfilled potential rather than an issue that needs to be fixed is central to working with this population. There are implications of that must not be forgotten: From a biological stand-point, their development is still in the process of growing. Nurturing this development and allowing them to access supports to foster appropriate

behavioural and cognitive development is the over-arching answer to successful treatment. From a societal stand-point, their behavioural, cognitive, and emotional level is a direct result of their environment. Continuing to fail to provide them with the appropriate environment necessary is now our failure too.

The research highlighted in Chapter 2 shows that most empirical research does not support the traditional method of placing children in residential treatment programs until their behavioural or mental health has been improved. Although some positive trends have been noted, specifically for short-term behavioural interventions, the overall evidence proposes that an overarching framework of focus on trauma and family yields better results. Additionally, tailoring treatment for individuals and working collaboratively with a team of professionals has shown more promise in finding success for these children. Above all of these approaches however, what appears to be the highest factor in lowering long-term effects for children in care is decreasing the amount of time that children and youth spend in residential or live-in programs. By that notion, if applying trauma-focused and family-focused approaches to this area of care, while expanding that services that these children can use during their time interacting with the system is able to decrease their time spent in care, then efforts to implement these approaches is the most ethical approach currently backed by research. In a way, this proposes that tenets of child-rearing practices used by numerous Indigenous peoples to be more therapeutic than the approaches used in institutionalized settings for the past couple centuries.

In this research, therapeutic does not mean theoretical. Rather, therapeutic refers to evidence-based approaches that increases children's well-being and lowers any side-effects taken on by clients during their interaction with the child welfare system. By that standard, James' (2011) previously stated concern about "lab grown" theoretical approaches should be re-visited.

We should be de-standardizing treatment programs and increasing approaches that are tailored to specific client needs. Moving away from a pathologizing framework of looking at children and youth in care as needing (in a 'fix it' way) services and instead approaching it as them being *deserving* of receiving the same level of care as any other child is a way of reducing the institutionalized outline so often used.

Children in care are not patients that need to be treated. They are children who, as the research suggests, need to be connected to their families and communities. They are children who deserve to be seen as individuals with specific concerns and who require a caring environment that tailors to their precise needs.

Implications for Further Research

Research into the successful implementation of therapeutic approaches in the residential care system of BC is necessary. There currently lacks an overall available research into therapeutic approaches used in BC. While the government has clear guidelines on how the child welfare system should be navigated by agencies and organizations that look after children and youth, there is very little information on the current methods used. BC has a unique opportunity to look at ways to implement traditional Indigenous practices into our therapeutic approach with children in residential care.

Another area of research should focus on the difference between delegated indigenous agencies and non-indigenous agencies in Canada. Analyzing the difference in approach and results to see how treatment of indigenous children in the child welfare system differs from non-

indigenous children. This research paper has briefly touched on the perceived difference in treatment that Indigenous children and youth receive through the BC child welfare system

Future studies should also focus on the implementation of new therapeutic approaches, especially approaches that focus on traditional practices that have been cast aside for more "lab grown" approaches implemented.

Studies should also look at different perspective of levels of care. Children in the child welfare system interact with different levels of service provides. There are concerns that affect all these levels, but also some that are unique to a certain category. There is often a disconnect between different service providers as to which concern should be prioritized. Research looking at the most effective way to implement therapeutic approaches should also consider bridging the gab between clinicians, social workers, policy makers, and other front-line workers so as to increase collaboration in ensuring best practice for children and youth in need.

Limitations of The Study

Some of the participants interviewed as part of this research are from a delegated agency, working primarily with Indigenous populations in British Columbia and therefore have an inherent framework of indigenous and culturally informed practice. Although it is important to recognize the overrepresentation and ongoing issues of indigenous children in residential care, there may be an oversight of other children who do not identify as indigenous – including children from other minority groups – but also rely on the child welfare system. Therefore, some responses may be informed by indigenous practice that may not be applicable to all BC children in care. Social workers who work with indigenous youth do however, have a need to be

represented in this research; as professionals who work with the most marginalized and most

represented populations within the residential care system, they have insight into the inner

working of both the child welfare system and the complicated lives of these children.

The results of the research in this thesis is not intended to be used to generalize treatment

practices for children in the child welfare system. The data gathered is also not a full

representation of the opinion of social workers working within the child welfare system and

therefore should not be generalized in this manner. It merely informs the research of certain

themes and opinions that social workers may hold regarding this topic.

As stated multiple times throughout the chapters, there appears to be a lack of research

and statistic on both previous and current methodologies of successful treatment. Treatment of

children is also an ongoing area of research and children development is a continuously growing

field; the effects of the child welfare system on children needs to receive more attention from

government and agencies working within this field so as to better understand the long-term

effects of children and families interacting with the child welfare system.

Commentary and Summary

Researching this topic was, if anything, revealing as to what the trends and complications

of the child welfare system are. As someone who worked directly with children and youth who

interact with the child welfare system, I was able to develop my own theories, prior to beginning

any academic research on the issue, as to what improvements could be made, which areas posed

a problem for both clients and worker, the difficulty in addressing systemic issues, and the

question of how to provide the most appropriate care possible. What I learned most form this

research is that the field is under-researched and riddled with issues that transcend finding a treatment approach. Peer-reviewed articles often cite that one of the issues to implement therapeutic approaches for children in care was the lack of understanding and research to supplement their findings. Despite this lack of research however, there are academics, activists, and researchers who work tirelessly to find and promote the most effective treatment approaches possible. There is evidence available as to what approach is ethical, efficient, and effective. Additionally, to the point made in earlier chapters and the basis for this research paper, critically analyzing and changing the way we approach working with children in care is crucial to the survival and success of these children and youth. Implementing changes that coincide with the evolving needs of children and the child welfare system in necessary. Research on the effectiveness and appropriateness of treatment approaches may never be "enough" due to the constant change and evolution of our youths and of our values as a society. To reiterate: As needs change, so do the requirements to provide appropriate care. There may not be a perfect approach to attending to children and youth in care, but we should continue to strive to achieve excellence and not be stubborn about the theoretical and practical framework which we employ.

Trends in child welfare appear to be somewhat positive however. An overall reduction in the number of children in care and the numerous reports that aim at changing the way children in the child welfare system are being cared for – based on evidence-backed research – should be looked at as a commitment by our government, agencies, and communities to improve the overall success of children and families who interact with the system. This does not mean that we should reduce our advocacy for change when appropriate, but rather, that continuing to pressure government, agencies, and individuals to improve the lives of those affected by the child welfare system is working. Working in social services can seem bleak, and this wears on

the psyche of those who work to improve the level of care we provide for children in need.

Remembering that there is progress, albeit slow, is an encouraging feeling that can reinvigorate

us to continue to do the work of our vocation.

Appendix

Survey Questions

1. What therapeutic approaches do you think need to be used when working with children in

    care?

2. From a therapeutic stand-point, what changes do you think need to be made in how

    children in care are being cared for?

Figures

Figure 1.

Provincial Rate of CYIC per 1,000 Population[1]

As at March 31

	All	Indigenous	Non-Indigenous	Rate of CYIC per 1,000 Population (0-18 Years): All	Rate of CYIC per 1,000 Population (0-18 Years): Indigenous
2002	10,049	4,273	5,776	10.7	64.0
2003	9,479	4,256	5,223	10.2	62.6
2004	9,009	4,170	4,839	9.8	60.2
2005	8,975	4,340	4,635	9.8	61.5
2006	9,056	4,491	4,565	9.9	62.5
2007	9,165	4,663	4,502	10.1	63.5
2008	9,108	4,729	4,379	10.0	63.1
2009	8,832	4,630	4,202	9.7	60.6
2010	8,394	4,576	3,818	9.2	58.7
2011	8,264	4,567	3,697	9.1	57.5
2012	7,952	4,483	3,469	8.8	55.1
2013	7,925	4,171	3,754	8.8	50.1

	All	Indigenous	Non-Indigenous	Rate of CYIC per 1,000 Population (0-18 Years): All	Rate of CYIC per 1,000 Population (0-18 Years): Indigenous
2014	7,934	4,139	3,795	8.9	48.7
2015	7,736	4,417	3,319	8.6	50.8
2016	7,217	4,420	2,797	8.0	49.8
2017	6,951	4,364	2,587	7.7	48.1
2018	6,698	4,252	2,446	7.4	46.0

(*Source:* https://mcfd.gov.bc.ca/reporting/services/child-protection/permanency-for-children-and-youth/performance-indicators/children-in-care)

Figure 2.
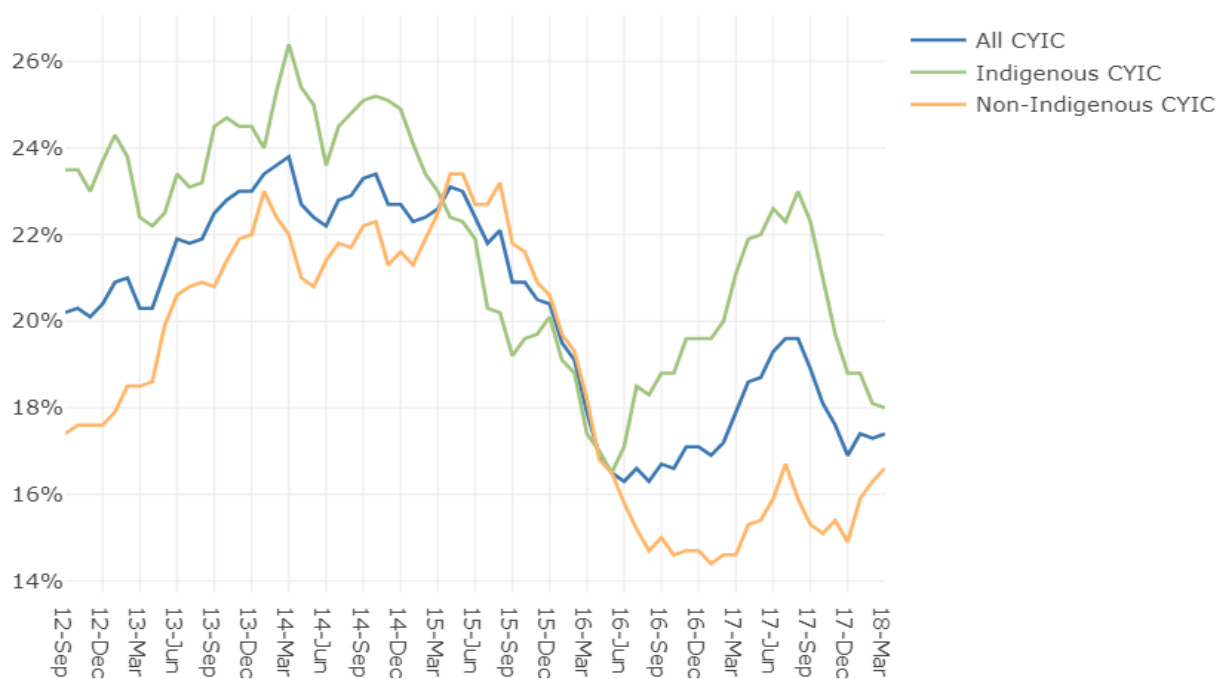
(Source: https://mcfd.gov.bc.ca/reporting/services/child-protection/permanency-for-children-and-youth/performance-indicators/children-in-care)

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