Child and Youth Care Practitioners Contributions to Evidence-based Practice in Group Care: Final Report

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Case management Interventions and the Relationship to Evidence-Based Treatment

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1 Project Overview

The project overview describes the rationale for the research and briefly summarizes the results of the literature review associated with this project. The purpose of this project was to understand the factors (systemic, organizational, and human) affecting the use of EBP and EBT in group care programs in the province of Ontario and to document the strategies and interventions used by CYC practitioners in the milieu which are linked to EBT and theoretical models of intervention.

1.1 Purpose of Research

This project explored the contribution of Child and Youth Care (CYC) practitioners to Evidence-based Practice (EBP) and documented the differences in EBP and Evidence Based Treatment (EBT) among three service sectors in the province of Ontario that provide group care and treatment to children with mental health concerns. The extent to which CYC practitioners in group care implement best practice literature or scientifically based recommendations is unknown. We do not know if trained and certified CYC practitioners implement evidence-based interventions any more frequently than untrained practitioners. Nor do we know exactly what care strategies in the therapeutic milieu enhance or support EBT’s that occur outside of the therapeutic milieu.

While intervention strategies used in EBTs are commonly used by CYC practitioners in group care programs, systematic implementation and the assessment of outcomes related to specific strategies within the group care milieu has not occurred. In order to identify and replicate specific EBT in group care programs it is essential to first understand and measure what practitioners do, so that specific patterns of interventions can be logically related to specific outcomes for the children and youth. The program’s organizational context and readiness to implement EBP and EBT must also be assessed. Anecdotal reports from the provincial associations representing children’s mental health, child welfare, and private sector operators indicate they believe that any variations in the quality of practice between the sectors is largely a perceived result of differential funding levels, access to information, and entrepreneurial characteristics which affect staffing quality and service implementation. The private sector operators represented by OARTY believe that the membership of their association, representing Private Children’s Residences (PCR) provide highly similar group care services to the OACAS and CMHO association memberships but with a different funding model (per diem). The Ministry for Child and Youth Services (MCYS) review of residential services (Bay Consulting, 2006) supported the anecdotal reporting of the associations and noted that in addition to differences in funding levels, extreme differences in accountability for program outcomes exist between private operators (who typically deliver services on a per diem basis for individual children) and transfer payment operators (Children’s Aid Societies and Children’s Mental Health operators who contract directly with MCYS to deliver programs). The systemic and organizational differences between group care providers have never been systematically surveyed to determine the differences in program design and implementation between the sectors providing group care for children and youth.

The purpose of this project was to understand the factors (systemic, organizational, and human) affecting the use of EBP and EBT in group care programs in the province of Ontario and to document the strategies and interventions used by CYC practitioners in the milieu which are linked to EBT and theoretical models of intervention.

1.2 Summary of the Project

Residential group-care programs are the most intensive and expensive treatment programs, yet evidence-based knowledge about effective milieu-based interventions is lacking. The advent of EBP and the attempt to replicate EBT principles in children’s mental health programs has prompted new research
in this field. The new research in combination with the oscillating government policies on residential care suggests the need for a more evidence-based approach to demonstrating the effectiveness of group care programs. The mechanisms that influence treatment within the therapeutic milieu are largely unknown and untested. CYC practitioners implement many intervention strategies consistent with those used in EBT within the daily life space of children in group care. Further to this, the daily care techniques used in residential care are often planned, purposeful and consistent with the treatment goals. The lack of evidence of the efficacy of CYC interventions and group care has, at times, led to funding restrictions on the use of group care. There are no scientific grounds for assuming that the absence of evidence is the same as evidence of ineffectiveness. By identifying the contributions that CYC practitioners make to assessment, planning and outcome evaluation for clients and describing the specific interventions and strategies that these practitioners implement within the milieu we are then in a position to better assess the efficacy of child and youth work in group care, thereby providing evidence for or against the efficacy of group care programs.

This project used survey methodology to explore the contributions of CYC practitioners and document the differences in EBP among the child welfare, children’s mental health and private provider sectors that provide group care and treatment to children with mental health concerns in the province of Ontario.

1.2.1 Goals and Objectives

The primary goal of the project was: To identify whether and to what extent CYC practitioners in residential and group care programs use EBP and intervention strategies which are theoretically linked to EBT and best practices in children’s mental health.

1. To validate an instrument that identifies and describes the intervention strategies used by CYC practitioners which are: a) linked to EBT, and b) linked to theoretical literature about best practice in residential child and youth care.

2. To identify the differences in the use of EBP for client case management among providers of group care services. Our hypothesis is that group care programs with a reported High Uptake of EBP will report a higher score in case management practices associated with EBP than those with a Low Uptake of EBP.

3. To describe the scope of practice of CYC practitioners in the therapeutic milieu and identify the nature of the activities and the role of CYC practitioners among group care services with a High Uptake of EBP. Our hypothesis is that group care programs with a High Uptake of EBP will report a higher overall frequency of CYC intervention strategies and that there will be clusters of strategies that represent interventions linked to the literature on EBT and best practice.

The second goal of the project is: To determine if there are differences in the reported uptake of EBP among child welfare (CAS), children’s mental health (CMH), and private sector providers (PCR) of group care services. This goal is associated with the following hypothesis:

1. There will be significantly more group care programs reporting a High Uptake of EBP among children’s mental health (CMH) than either child welfare (CAS), or private sector providers (PCR).

The third goal of the project is to identify differences in the educational and experience backgrounds of CYC practitioners among child welfare, children’s mental health, and private service sector providers of group care services. This goal is associated with the following hypotheses:
1. Group care programs that are providing contracted per diem services (PCR) will report significantly fewer CYC practitioners with specific CYW education compared to programs who receive transfer payment funding through either CMH or CAS.

2. Group care programs that are providing contracted per diem services (PCR) will report significantly fewer overall years of experience among CYC practitioners compared to programs who receive transfer payment funding through either CMH or CAS.

Project Outcomes:

1. A survey on the uptake of evidence based practices in group care including case management practices and interventions by CYC practitioners.

2. A description of the evidence-base that CYC practitioner interventions are drawn from.

3. A profile of the uptake of EBP, barriers to the uptake of EBP, and the nature of case management and CYC practitioners interventions reportedly used in three different sectors providing residential treatment and group care in Ontario. This is new information for the child welfare and private sector and provides an update on the uptake of EBP in the children’s mental health sector for comparison to the 2005 results.

4. A profile of the nature of education and experience among CYC practitioners in three different sectors providing residential treatment and group care in Ontario.

5. A profile of the nature of case management practices reported amongst group care programs with a high uptake of evidence-based practices.

Children’s Mental Health Ontario (CMHO) agencies were surveyed in 2005 to discover the extent of EBP within that sector (Barwick et al., 2005). About 1/3rd of the clinical respondents to the original survey represented the group care programs in CMHO. About 20% of those surveyed overall were CYC practitioners, but the relationship between CYC practitioners and implementation of EBP/EBT in group care programs was not explored. Developing an understanding of how CYC practitioners understand EBP/EBT both in both children’s mental health and child welfare group care programs is essential. The results of this study will inform government policy makers, mental health and child welfare service providers, and clinical program managers regarding how existing knowledge and research on practice and treatment has been transferred to CYC practitioners who have the greatest contact and often the most influence on children’s development in the residential milieu.

1.3 Target Population and other stakeholders

The primary stakeholders for this project are the agencies providing residential treatment and group care for children with mental health needs. Most of these agencies aspire to improving their services. This study provides critical information for the networks of agencies that represent those group care services and guides their thinking about EBP and EBT in residential treatment and group care.

A Steering committee comprised of: (a) representatives of child and youth care education; (b) three Provincial Associations (the Ontario Association of Children’s Aid Societies, Children’s Mental Health Ontario and the Ontario Associations of Residences Treating Youth) and (c) Bartimaeus, an agency providing emergency staffing and other services to group care programs serving children throughout the province, met regularly to guide the project.

The target population included CYC practitioners and program managers in residential treatment centres and group homes that were: (a) licensed as a children’s residence, (b) worked with clients who have mental health needs or diagnoses, (excluding homes whose primary focus was children who were
medically fragile, had moderate developmental disabilities, autism or were placed under the Criminal Youth Justice Act) and (c) were staffed by CYC practitioners (either all CYC practitioners or parents plus CYC practitioners on shift).

This research will assist the MCYS vision of an integrated child and youth mental health system by addressing the uptake of EBP/EBT among CYC practitioners in group care programs across the service delivery spectrum. The Center of Excellence for Child and Youth Mental Health (CHEO) identified EBT and the child welfare sector as priority areas for research in 2007. By studying how the child welfare system is meeting the mental health needs of youth in the care of private operators and in group care programs operated by children’s aid societies and children’s mental health agencies, the research will both enhance our knowledge of EBP in these areas and through the promotion of knowledge exchange increase the understanding and capacity of front-line CYC practitioners to be directly responsible for the implementation of EBP/EBT.

1.4 Review of Related Research

“In its quest to establish a clear professional identity and legitimacy within the human services arena, child and youth care has embraced direct care practice, which is focused around direct personal involvement in the lives or ‘life-space’ of children, youth, and their families, as its most defining characteristic. A second defining characteristic of child and youth care would be its emphasis on the growth and development of children and youth across the life cycle. A third and related characteristic is the conscious use of relationship as a primary therapeutic tool.” (Bellefeuille, McGrath, & Jamieson, 2008, p.719)

At the urging of government and academics, mental health agencies have been promoting EBP and within the context of Ontario’s children’s mental health services have implemented many specific evidence-based treatments (EBT). Most examples of EBT that have been implemented are in clinic-based family treatment programs, non-residential intensive programs (e.g. Multi-system Therapy) and as adjunct treatments provided to youth by psychiatrists, psychologists and social workers (Whittaker, 2004). The Ministry for Children and Youth Services has indicated that EBP/EBT is a policy direction appropriate to the child welfare system and undertook a significant review of residential care service provision in the province across all sectors in 2005.

Two populations have been left out of the evidence-based “revolution”: (a) CYC practitioners who provide direct care to youth in group care and (b) group care providers who work outside the mental health system, specifically in CAS operated group homes and in children’s private residences. These sectors provide care to youth with serious mental health problems who are wards of the child welfare system (Dore, 1999). Very little is known about how CYC practitioners understand or participate in EBP/EBT, in spite of the significant role that they play in the day to day care and treatment of children and youth. It is also well-known that government policy decisions are most often reflective of the economic and structural realities of service delivery rather than any specific data about the outcomes of clients or the quality of the interventions within the group care context (Ainsworth & Hansen, 2005; Whittaker et al., 2006).

In August 2005 MCYS completed a review of residential services for children and youth in Ontario which "addressed the provision of residential services for child welfare, children and youth mental health, children and youth with complex/multiple special needs, children and youth developmental services and youth justice" (Bay Consulting, 2006, p.5). The review lead to an action plan on the part of MCYS toward an integrated system of residential services with a focus on improving standards in residential service provision, increasing accountability for programs and services, and addressing funding issues (MCYS, 2007).
This review of the research focuses on describing the limited literature on successful program outcomes in group care programs and describes what is known about the strategies and interventions used by CYC practitioners in milieu-based group care. It also reviews the EBT literature on programs that are effective with children and youth which could be adapted in a group care context.

1.4.1 The Continuum of Out of Home Care

According to the residential services review as of March 31, 2005 a total of 9,724 homes and 24,846 licensed beds were devoted to providing residential services for children and youth across Ontario. These beds can be divided into those that receive transfer payment funding through an annual contract and those that receive a “per diem” or daily rate when a bed is occupied. The latter are typically referred to as OPR or “outside paid resources” by government officials and are run by private operators (both profit and non-profit/not for profit) who prefer the term Private Children’s Residences (PCR) used throughout this report. In 2004/2005, 72% of all residential beds were for foster care, 16% of beds were for group care in smaller programs (of four to nine beds) and 12% for beds in larger institutional programs (10 or more beds) with approximately 83% of all transfer payment agency beds were for child welfare, 9% for children’s mental health, 7% for youth justice and 1% for child and youth developmental services (Bay Consulting, 2006, p.2). The extent of out of home care is evident.

The full continuum of out of home care ranges from least intrusive with fewer direct support services to the highest level of intrusion and support. The continuum can be described and organized as follows:

1. Receiving Homes: (RH) Families who will take children on short notice for limited periods of time, while long term alternatives are considered.
2. Customary care or Kinship care: (KC) Full time nurturing and protection of children by adults who have a kinship bond with the child.
3. Regular (non-kin) foster care: (FC) Full time nurturing, structure, socialization and guidance in the home of non-kin.
4. Specialized or Treatment Foster Care: (TFC) Full time nurturing, structure, socialization and guidance in the homes of foster parents who are recruited, trained, and reimbursed at a higher rate to care for children with special needs.
5. Family Group Care: (FGC) Similar to TFC, PLUS the foster parents are provided with special supports including CYC practitioners on shift. Often the house is owned by the agency and the foster parents “live-in”. Typically these homes have more beds than TFC.
6. Fully Staffed Group Care: (GC) Community based residential homes, in which CYC practitioners provide the direct care of children on a shift-work basis.
7. Residential Treatment Centre: (RTC) A system of care, in which several fully staffed group homes or a large campus are managed under a common clinical supervisory structure, including day treatment or “on-site classrooms” and a clinical support unit.
8. Psychiatric hospital/secure treatment units: (PH/ST) Institutions with wards which contain all of the ingredients of a residential treatment centre, but with the additional capacity to certify a young person as a danger to self/others.
9. Correctional Facilities: (CF) Locked facilities to which youth are sent by court order as a consequence of criminal misconduct.


The survey undertaken for this research focused on three of the above programs: family group care with staff support; fully staffed group care; and residential treatment centers. We have collectively called these group care; defined as a program in which five or more unrelated children or youth live together in
a home and the employed staff have specific training in providing care and treatment. These three types of programs are often considered homogeneous by researchers reporting on outcomes.

Group care where the sample populations included juvenile offenders, as well as emotionally and behaviourally disturbed clients was the focus of the following literature review. Much of the published literature is about juvenile offenders. Research on program outcomes for youth with criminal histories has used recidivism as a measure of success (Dowden & Andrews, 2000; Frensch & Cameron, 2002), following the pattern of research on adult offenders, even though most young offenders out grow problems and do not re-offend as adults (Doob, Marinos, & Varma, 1995). It was useful to consider the literature in this review because juveniles are not housed in large jails as adults are and therefore those programs are similar to programs for children with emotional and behavioural disorders and offer some insight into factors of success. Behavioural disorders often manifest in illegal activity so the population of children and youth is also similar. “Emotional disorders constitute just under half of all mental disorders occurring in childhood and adolescence (Action, 1997; Esser, 1990; Rutter, 1970; Yule, 1981), and there is evidence to suggest that they may be the most common problems within each age group (Bernstein & Borchardt, 1991; Costello, 1989; Kashani & Orvaschel, 1990; McGee et al., 1990)” (Dunnachie, 2007, p.14). Examples of the most commonly noted emotional disorders include: anxiety, post-traumatic stress, and depression. "Disruptive behaviour disorders encompass children showing high rates of non-compliant, hostile and defiant behaviours, often including aggressiveness and hyperactivity (APA, 1994). In the DSM-IV (APA, 1994), these behaviours are described under three broad categories: Attention Deficit Hyperactivity Disorders (ADHD), Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD)” (p.26). The following section outlines the approaches to group care programming for children and youth with emotional and behavioural disorders found in the literature.

1.4.2 Approaches to Group Care Programming

The theoretical basis for group care and residential programming were initially pioneered as theoretical applications of psychoanalytic theory, systems theory and behaviourism and were used to manage maladaptive behaviour of seriously disturbed children (Konopka, 1954; Maier, 1979; Mayer, 1958; Redl & Wineman, 1951; Schultz, 1951; Trieschman, Whittaker, & Brendtro, 1969). They also provided instructions to caregivers about how to create and maintain a therapeutic milieu to meet the ordinary and special needs of children (Ward, 2004). Basic caretaking tasks such as waking children, putting them to bed, eating together, creating recreation opportunities, teaching positive behaviour, resolving abusive experiences, and coping with emotions are all part of treatment in group care programs. Although some early research on the role of routines and their impact on the child in residential treatment was done (Maier, 1957), these initial theories were never extensively tested in relation to children’s outcomes.

The elements of the therapeutic milieu were outlined by Trieschman, Whittaker & Brendtro (1969) and more recently updated by Burns (2006) who identified five elements of a therapeutic milieu. The physical milieu refers to the space of the group care which needs to be safe, attractive, and inclusive (child/youth friendly). This lends to the creation of an environment that promotes self-esteem, belonging, and healing. The emotional milieu can only be achieved when adults (especially) show concern, and “are interested in and curious about the child’s emotional experiences” (Burns, 2006, p.55). Moreover, how conflict is resolved in the program along with "clearly defined and consistently enforced rules" (Burns, 2006, p.51) are both key elements for the creation of an environment that is emotionally safe; where emotional expression is encouraged and respected. The social milieu is the aspect of the milieu in which children and workers interact for therapeutic benefit. Here, relationships are used as tools for helping the child in learning new and healthy ways of interacting (Burns, 2006). A social milieu reflects the past and present of all people within the milieu, and encourages pro-social interactions. The cultural milieu provides opportunities for youth to learn about each other and discuss
their cultural diversities. Not just an environment that is free from discrimination (Burns, 2006); the cultural milieu is one that promotes cultural competency and safety (Fulcher, 2003; Leigh, 1998). The cultural milieu must maintain a level of acceptance and celebration of culture and diversity. It is therefore vital that staff in group care programs educate and promote awareness around diversity and show genuine interest and curiosity in each person's culture. The ideological milieu refers to the ethics, religious beliefs, and spirituality of both the staff and the clients who reside within the program. It is the way in which the child/youth interprets and perceives his or her world. The ideology of the milieu should allow children and youth the opportunity to speak their mind without fear of punishment and/or rejection.

Along with the design of a therapeutic milieu research has indicated that various group care services contribute to positive outcomes for children and youth. In a systematic review of outcome studies in group care and residential treatment between 1993 and 2003, Hair (2005) found that good outcomes were linked to multimodal, holistic and ecological approaches. Additionally, the MCYS report (Bay Consulting, 2006) outlined desirable characteristics of residential programs based on a review of the literature. The following factors are present in programs in which clients had successful outcomes including both within-treatment improvement and some continuation of gains after discharge.

1. Family and other supports in natural social networks are identified and included in the treatment plan from the initial assessment through to post-discharge services (Bay Consulting, 2006; Curtis et al., 2001; Frensch & Cameron, 2002; Hair, 2005).

2. Quality of life in the discharge placement (especially stability) which includes a positive and supportive environment where there is less stress and more social support in the families. In addition, there is a comprehensive discharge plan implemented (Bay Consulting, 2006; Curtis et al., 2001; Frensch & Cameron, 2002; Hair, 2005).

3. There is a supportive community network; therapeutic and educational opportunities are available for parents as well as for children, and aftercare services are easily available and utilized which include advocacy for school and/or gainful employment (Bay Consulting, 2006; Curtis et al., 2001; Frensch & Cameron, 2002; Hair, 2005).

4. Shorter lengths of stay in group care or RTC (six to nine months for children with less severe psychopathology) and less than 15 months for youth with severe mental health issues (Hair, 2005; K. Hoagwood & Cunningham, 1992).

5. Academic success and educational support before and after discharge (Curtis et al., 2001; Hair, 2005).

6. Successful program completion before discharge, especially for delinquents (Hair, 2005).

7. The residential program philosophy is ecological (embracing multiple social systems). Family and community involvement is maximized to maintain children’s sense of having relationships and support networks while in residence (Bay Consulting, 2006; Hair, 2005).

8. Staff training and supervision is a priority in the facility (Hair, 2005).

9. The therapist-client relationship is valued and nurtured (Hair, 2005; Little, Kohm, & Thompson, 2005).

10. Standardized strengths-based measures are employed to assess each child and family (Bay Consulting, 2006).
11. Early identification and intervention that are flexible and target individuals (rather than “one-size-fits-all”), which includes access to a comprehensive set of formal and informal services (Bay Consulting, 2006).

12. Treatment programs are as minimally restrictive as is clinically acceptable, with youth treated in their community contexts (Bay Consulting, 2006).

13. Exit interviews asking children who have been in care about their experiences (Bay Consulting, 2006).

Researchers have shown that a number of group care services (which consist of one or several of the approaches above) have contributed to positive outcomes for children and youth. A few studies have indicated the various program flaws which have contributed to negative outcomes for children and youth in residential programs. Ridley and McCluskey (2003) for example, showed little evidence of a positive culture within group care that emphasized a healthy lifestyle. In fact, up to a third of youth began smoking, drinking alcohol, or taking drugs while in care. In addition, youth reported being more physically active before entering care. Consistency also appears to be a concern in group care (Barrie & Richardson, 2003; Barter, 2003). A study of violent behaviour within 14 residential programs stated that interventions were inconsistent both within and between homes (Barter, 2003). For instance, although it was routine to intervene in physical violence, which at times included restraints, the urgency in which staff intervened varied. Additionally, staff’s interpretation of guidelines and policies pertaining, but not limited to, the restraint policies was at times inconsistent (Barrie & Richardson, 2003). In addition to the noted inconsistencies Barter (2003) identified key issues and triggers for challenging behaviour on the part of young people which included: staff’s use of inappropriate tone of voice and language, negative body language, children not provided with enough “space” when distressed and not given enough recovery time after an incident (Barrie & Richardson, 2003). In a study of violent behaviour in youth correctional settings in Ontario which gave voice to the perceptions of the youth themselves, Finlay (2005) identified a wide spectrum of violent and abusive behaviours directed largely at peers and occurring largely without the knowledge or intervention on the part of youth correctional workers. The peer subculture included strong unwritten rules that “disavow the role of staff as enforcers of control and institutional security” (p. 43) and create a set of power tactics and social control strategies representative of large institutions. Research that focuses on negative outcomes also identifies the possible barriers to effective service provision such as insufficient finances to meet the costs of some sports, limited resources to hire staff, and insufficient time for programming.

It has also been argued that the interventions used by child and youth care workers in group care programs appear to be “reactive rather than proactive” (Barter, 2003, p.47). Bell et al. (2003) argued that Therapeutic Crisis Intervention along with other strategies used for managing’ behaviour, “do not involve the young person in any real sense of participation” (p.28). In Bell et al.’s (2003) study it was shown that when the staff group concentrated on solving the problematic behaviour “many of the solutions were about control; using sanctions to persuade young people to behave in the wanted way.” (p. 29). Moreover, Day (2000) argued that a lack of training and qualification for CYC practitioners has been responsible for the implementation of unnecessary use of physical restraint, especially when under qualified CYC practitioners are required to work together in teams. There is a need for ongoing training for staff on the proper use of physical restraint and intervention, which would further serve to minimize the risk of injuries to CYC practitioners and children associated with the use of restrictive measures (Day, 2000).

Staff in group care programs have reported that a possible barrier to effective interventions is their lack of confidence and ability to undertake proactive work. Barter (2003) disagreed, stating that the staff group’s skills needed to be “recognised and developed” (p.48). Clearly the success of group care
programming relies on the competence and confidence of CYC practitioners. Given these findings, this is an optimal time to examine how the therapeutic milieu and the day to day interactions of trained CYC practitioners are linked to both child and youth care theory and known EBT.

1.4.3 Evidence on Child and Youth Care Intervention

Research in child and youth care has described the phenomenon of “quality interventions” (Garfat, 1998) and the components of “quality” residential care programs (Anglin, 2002). Most recently, authors have suggested introducing a social pedagogy approach into education and child and youth care practice (Bellefeuille et al., 2008), specifically into residential care. “Social Pedagogy is a system of theory, practice and training that supports the overall development of the whole child...it takes a holistic view of young people” (Bengtsson, Chamberlin, Crimmens, & Stanley, 2008, p.9). Bellefeuille et al. (2008) would argue that it entails “something much deeper than the current system of isolated unconnected professionals...It implies “openness” towards others and a new way of learning and being together” (p. 722). CYC practitioners educated in this system of theory and practice may well employ different strategies and interventions than colleagues educated in different systems (social work, psychology, criminal justice) but hiring practices in group care which fail to specify educational training required for the job makes this difficult to discern.

According to Anglin (2002) skills that are key to CYC practice includes:

1. Listening to and responding with respect.
2. Communicating a framework for understanding.
4. Establishing structure, routine, and expectations.
5. Inspiring commitment.
6. Offering emotional and developmental support.
7. Challenging, thinking, and action.
8. Sharing power and decision making.
9. Respecting personal space and time.
10. Discovering and uncovering potential.
11. Providing resources.

Simply using the skills is insufficient; CYC practitioners must follow a framework when implementing an intervention (Garfat, 1998; Garfat & McElwee, 2004). The intervention process includes the following steps: a) noticing, b) considering alternatives and necessity, c) preparation, d) considering availability of other, e) giving meaning and speculating on the meaning for other, f) checking in, monitoring, and self-presentation, g) connecting, h) the utilization of self, i) noticing and utilizing feedback, j) deciding to intervene, k) positioning, l) choosing an intervention that fits, m) intervening, and n) reflection and preparation (Garfat, 2003; Garfat & McElwee, 2006)

Furthermore, similar to Barter (2003), Daniel (2003) argued that group care staff are skilled, but are lacking the evidence -based component. He suggests a resilience-based approach; stating that a “resilience-led approach may not be markedly different from the kind of activities that residential staff are carrying out already...it is often the kind of work that is ‘squeezed in’ or seen as a luxury. If staff are
armed with the evidence base that the concept of resilience presents, they are in a stronger position to make the case for the time and resources to incorporate such approaches into the heart of their work with young people” (p. 27-28).

A significant part of the daily care provided by CYC practitioners has not been evaluated through randomized controlled trials and single case designs typical of EBT, though it is a replication of the strategies. Some aspects of the work performed by CYC practitioners cannot be traced back to an EBT. These include the use of teachable moments, engaging the youth in a relationship, managing aggressive and non-compliant behaviour (apart from a token economy) and providing rehabilitative social activities. These activities (and others) are the focus of education and training in CYC practice. Such activities are comparable to those described in the literature as “bona fide” treatments. Bona fide treatments are those in which the therapist is trained and specifically educated in a treatment approach, constructs a relationship with the client, and follows a specific approach (Wampold, Minami, Baskin, & Tierney, 2002).

In a meta-analysis of the treatment literature on depression there was no significant difference in outcomes between EBT and bona fide treatments. They were both superior to other therapies. Some bona fide therapies have been included in reviews of EBT (Target & Fonagy, 2005).

It has been clearly established in the literature cited above that there are no EBT that apply to the daily programs delivered by CYC practitioners in residential care. However, bona-fide treatments such as psycho-therapy, narrative therapy, solution-focused therapy and at least five EBT (which will be discussed below) have been deconstructed and adapted to the day-by-day practice of CYC practitioners:

1. PSST or problem solving skills training (Kazdin & Weisz, 1998),
2. Cognitive behavioural therapy (Creighton Youth Services manual, 2003),
3. Behavioural modification (Wong, 1999),
4. Aggression Replacement Training (Goldstein & Glick, 1987) was originally designed for a correctional institution, and
5. Wraparound (Bruns, Burchard, Suter, Leverentz-Brady, & Force, 2004), see Bruns et al. (2004) for a review of compliance to treatment protocols with Wraparound services.

1.4.4 Use of EBT in Group Care: Research

Residential group-care programs are the most intensive and expensive treatments, yet evidence-based knowledge about effective milieu-based interventions is lacking (Weisz, Sandler, Durlak, & Anton, 2005; Whittaker, 2004). The advent of EBP and the attempt to replicate EBT principles in children’s mental health programs has prompted new research in this field. This new research in combination with the government’s oscillating policies on residential care suggests the need for a different approach to EBT in group care (Whittaker, 2004; Whittaker et al., 2006). EBT covers a small percentage of the 100 plus diagnostic categories listed in the DSM-V; “there is little evidence of effective treatments for several disorders including: (a) eating disorders, (b) youth sex offenders, (c) suicidal youth and (d) teenagers with ADHD” (Weisz et al., 2005). Moreover, most treatments are not empirically evaluated, are conducted without control groups, give little information on the range and durability of changes (Knorth, Klomp, Van Den Bergh, & Noom, 2007), and authors tend to be descriptive and do not identify the underlying theory or specify the concepts and components of EBP (Lawson, 1998). This section describes the results of EBT as applied to work with children and youth, identifying the various practices and the positive outcomes demonstrated outside of the group care context which may be useful within group care settings.
Cognitive Behavioural Therapy (CBT)

Based on empirical research Cognitive Behavioural Therapy (CBT), including such treatments as self-instructional training, rationale-emotive behavioural therapy, and problem-solving skills training, is one of the most promising treatments (Thorne, 2007). According to a meta-analysis review that included 830 primary studies and 648 further reports (Dunnachie, 2007) CBT has shown to be effective treatment for the following: phobias, generalized anxiety, obsessive compulsive disorder (OCD), post traumatic stress disorder, depressive disorders, attention-deficit hyperactivity disorder (ADHD), anorexia and bulimia nervosa, and addictions. The most significant factor that contributes to the success of CBT is family involvement (De Seixas Queiroz, Motta, Pinho Madi, Sossai, & Boren, 1981; Friedmann & Silvers, 1977; Howard & Kendall, 1996; Ollendick & King, 1998; Wolpert et al., 2006).

Other factors that are correlated to the effectiveness of CBT include behavioural techniques such as modelling and providing longer courses of CBT (or booster sessions) in cases of non-response to a standard length of treatment (Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999; Kroll, Harrington, Jayson, Fraser, & Gowers, 1996). Also, it has been reported that age can at times contribute to or deter the success of CBT. For example, in regards to phobias CBT it is often more effective in children rather than youth (Dunnachie, 2007). On the other hand, CBT is superior to behaviour therapy in the treatment of Bulimia Nervosa in adolescents, but not for children (Fairburn, 1994; Fairburn et al., 1991; Fairburn, Marcus, & Wilson, 1993). It is important to note that although the effectiveness of CBT had been documented, the extent in which CBT is used in group care was not identified in these findings.

Multi Systemic Therapy (MST)

Multi Systemic Therapy (MST) has been found to be successful in the treatment of substance abusing or substance dependent delinquents (Borduin, 1999) and has shown to be particularly efficient where substance misuse is part of a wider pattern of problems (Szapocznik, Kurtines, & contributors, 1989; Wolpert et al., 2006). MST improves family functioning, reduces delinquency (Torres, 2005), and is the most promising intervention for serious young offenders (Borduin et al., 1995; Wolpert et al., 2006). “A particular strength of MST is the relatively low drop-out rate, which are generally substantial in delinquent populations (Henggeler, Pickrel, Brondino & Crouch, 1996)” (as cited in Dunnachie, 2007, p. 32). MST is effective according to Target & Fonagy (2005), but it also depends on an intact and willing family which means that children and youth in group care may not be able to be engaged in MST programs. MST meets the criteria of EBT according to Burns & Hoagwood (2002) and Target & Fonagy (2005). However, outside the circle of researchers dealing with youth mental health, MST is not highly visible. In a review of 10 separate lists of EB Ts for substance abuse by the seven most prominent research groups in the field, MST appeared on only one list (Miller, Zweben, & Johnson, 2005). A treatment manual has been prepared for MST and the treatment is associated with rigorous protocols for ensuring compliance with the model. Dunnachie (2007) identifies nine essential components to the implementation of MST. MST combines and adapts proven therapeutic techniques including: a) systemic and structural family therapy (e.g. joining, reframing, enactment, b) paradox, (the assignment of specific tasks), c) parent training, d) marital therapy, e) supportive therapy related to interpersonal problems, f) social skills components, g) social perspective training, h) behavioural methods (e.g. contingency contracting, i) cognitive therapy techniques (e.g. self-instructional training), and j) case management with the therapist acting as an advocate to outside agencies.

Wraparound

A large part of why Wraparound is an efficient intervention is that treatments delivered in community programs are more efficient than those delivered in institutional programs (Handwerk, Field, & Friman, 2000). The research evidence in support of Wraparound is based on a retrospective quasi-single case
design without experimental manipulation. Several pre-post outcome studies and two quasi-experimental designs without a comparison group have been conducted (Burns & Hoagwood, 2002). Furthermore, Wraparound has been deconstructed and adapted to treatment foster care (Marsenich, 2002). It has also been mentioned as a “promising guide for beginning the process of reconnecting homeless youth to needed systems of care, although research on its effectiveness with this population is needed (Slesnick et al., 2008). Additionally, Wraparound programs are one of the best known and most widely used in Systems of Care (SOC) programs. SOC programs are currently used in the United States and in some provinces in Canada (e.g. Alberta). SOC clientele are children between the ages of 7 and 16 with severe functional impairments and often multiple diagnoses who come from troubled families with low incomes, histories of mental health problems and involvement with the justice system. According to Sieracki et al. (2007) SOC approaches are comprised of several core elements that are essential to providing effective residential care for children and youth including:

1. Child-centered and family-focused care teams with representatives from multiple service care plans that identify and build goals on family and community strengths through coordinated and integrated services from beginning to end to ensure coherent and consistent care (including both residential and non-residential care when and where appropriate).
2. Involving parents or caregivers as integral members of the care team and equal partners in decision-making.
3. Where possible, involving children and youth in planning for their own care.
4. Ensuring culturally sensitive and community-based care so that children remain as much as possible in normative environments.

Wraparound is not as manualized as MST (Bruns et al., 2004). Bruns has proposed a “Wraparound Index” to assist agencies in monitoring and maintaining the fidelity of its implementation. VanDenBerg & Grealish, (1998) have published a training manual for Wraparound programs, however it is not mentioned in Target & Fonagy’s (2005) recent review of EBTs. Burns & Hoagwood (2002) feature Wraparound on their list of community based treatments for youth with serious emotional and behavioural disorders.

**Life Skills**

Innovative programs that are intensive and include reparation (i.e., programs that target bullying) and education (i.e. programs focused on the attainment of life-skills) look very promising in the treatment of disruptive behaviour disorders, but as yet have been poorly evaluated (Dunnachie, 2007).

Bell et al. (2003) maintained that an essential part of Life Skills training teaches young people how to control their own environment and the relationships within it. They found that “most workers in residential care will have talked about ‘life skills’ training and how necessary it is. So often, however, it is seen in terms of practical skills such as cooking, and is not about learning to be responsible and to manage relationships” (Bell, Fay, Ramsden, & Morgan, 2003, p. 29). This is seen as a part of the reason why young people fail after leaving care. Bell at al.’s study investigated the reasoning why certain life skills were not taught in one particular group care, and found that: staff “often felt uncomfortable to give children and young people responsibility and to allow them to make mistakes because it increased the element of risk...The awareness of risk assessment, child protection and being held responsible when something goes wrong makes it much more comfortable to take the task of dealing with a situation away from the young person and sort it out ourselves or simply say, “You can't do it!” (Bell et al., 2003, p.30).

**Family-Based Treatment**
There are several effective primary prevention models; many are variations of Parent Management Training (PMT). The field of evidence-based parent management training programs is vast, covering various types of clinical issues and client characteristics with some commonalities (behaviourism) and differences. Despite the differences, the results are positive (Kazdin & Weisz, 1998). The findings related to family-based EBT are supported by various authors. Various types of programs and approaches are used, including Incredible Years Parenting Program (IYPP), Brief Strategic Family Therapy, and Behaviour Parent Training.

Incredible Years Parenting Program (IYPP) is the “best-supported” program when treating clients between the ages of 3-8 years old who have been diagnosed with Conduct Disorder (Dunnachie, 2007). For children over 8 years old the program is more effective with the addition of therapy to address specific marital and family concerns, as well as the implementation of cognitive therapy for both the child and family members. However, the IYPP has not been supported for severe Conduct Disordered clients aged 13-17 years old (Dunnachie, 2007).

Brief Strategic Family Therapy (BSFT) has been evaluated for 25 years and has been found effective at treating adolescent drug abuse (Szapocznik, Hervis, & Schwartz, 2003). Studies have shown that BSFT is a promising family-based approach used as both a prevention intervention as well as treatment with African American and Hispanic youth who have behaviour problems and are abusing drugs (Santisteban et al., 2003; Szapocznik & Williams, 2000).

Behaviour Parent Training (BPT) has also shown positive outcomes. A meta-analysis study found short-term effectiveness of BPT to modify child antisocial behaviour at home and school, and to improve parental personal adjustment (Serketich & Dumas, 1996). Additionally, post-treatment assessments indicated significant improvements in comparison with controls, including significant improvements in children’s conduct problems, problem solving, conflict management skills, and parent-child interaction (Webster-Stratton & Hammond, 1997).

**Teaching-Family Model**

There are over 250 programs across Canada and the USA that use the Teaching-Family Model. The literature on outcomes in family-based group care is focused almost entirely on the “Teaching-Family Model” which is listed by many authors as an EBT (U.S. Dept of Health and Human Services, 1999, p. 177). The teaching family model is a derivative of the research at Achievement Place. The components of the Teaching-Family Model are:

1. A token economy system where points are exchanged for privileges.
2. A focus on teaching youth social skills from a standardized skills curriculum.
3. An emphasis on normalization, including having youth involved in the maintenance of the home (e.g., cooking, cleaning, and other chores) and participation in sports, and

Most of the published research is on Achievement Place located in Lawrence, Kansas and Father Flanagan’s Boys Home in Boys Town, Nebraska. “Studies of the effectiveness of this model appear to support modest in-program gains, particularly in the area of educational progress. However, the teaching family model appears to fall short in the long-term maintenance of in-program effects and in the post-treatment reduction of delinquent and criminal behaviour” (Frensch & Cameron, 2002, p. 331). The Teaching-Family Model is based on parented group care, not staffed group care and demonstrates
that it is possible to implement EBT in group care programs, but that consistency of training and implementation is critical to success.

1.4.5 Case Management Practices for Evidence-based Practice

In preparation for drafting residential care standards in Ontario in 1978 a working group defined treatment as an attempt to bring about direct change in persons, through individualized attention, on the basis of a guiding theoretical framework, and a suitably comprehensive and in-depth assessment of the situation (as cited in Anglin, 2002). In short, it suggests that case management, including assessment and outcome measurement is critical. Although it has been 30 years since the issue of standards for residential care was first considered by Anglin with the working group a residential care standard was never formalized in Ontario.

Case planning is an essential aspect to case management and effective practice. The process of case planning includes: alert, assess, and act evaluate (Ricks & Charlesworth, 2003). Alert refers to the situation, problem, crisis, or other factor that draws the attention of someone to the child or youth who then determines that an intervention may be necessary. The assessment component repeated throughout involvement with the child or youth with different foci. In the beginning the child is assessed to determine if the agency can accept the referral. Once the referral is accepted assessment becomes a detailed process of a) clarifying responsibilities, b) building relationships, c) identifying and gathering information, d) sifting, sorting, and interpreting information, e) analyzing information, and f) making recommendations. Finally act, or rather the formulation of a plan to act, involves identifying needs, developing meaningful goals, and monitoring and evaluating the goals (Ricks & Charlesworth, 2003).

Snow and Finlay (1998) suggested that the Ecological Model is an effective model used in case management; stating that when implemented it “will help promote continuity of care, ensure the implementation of an intervention plan, and encourage community and service sectors to organize around meeting the needs of the child. A community-based plan reduces the young person’s isolation and serves as a safeguard” (p.39). Research to date has not indicated whether the Ecological Model has been implemented in case management practices. Farmer & Pollack (2003) emphasized the need for people working with children to have information about the totality of the child’s life experience, a process which includes collection of data from parents/guardians (Field et al., 2004) as well as other members of the child’s ecology, including school, peers, community (Munger, 1998).

Systematic implementation and use of tools for tracking both child and practitioner behaviour is essential in both EBT and case management. One study followed a group care program that cared for children with Autism which adapted seven forms that were designed as a behavioural analysis system. The forms included: (1) Incident Analysis Form, (2) Summary Attachment Form, (3) Issues Identified Form, (4) Monthly Graph, (5) Child Self-Injury Form, (6) Staff Injury Form and (7) Yearly Summary Form (Barrie & Richardson, 2003). The system provided the group care program with a "powerful tool which allows staff to more easily identify specific "key issues" and to highlight inconsistencies in practice and triggers to challenging behaviour" (Barrie & Richardson, 2003, p.17-18). The results of the behavioural analysis were as follows:

1. Inconsistencies in practice were highlighted.
2. Enabled staff to address and resolve problems quickly.
3. Boosted confidence and morale within the staff team.
4. Promoted a more honest and reflective culture within the staff team; encouraging staff to discuss honestly key issues without fear of retribution.
5. Child self injuries reduced.
6. Staff injuries reduced.
7. Identified the cause and triggers to negative behaviour.

The use of systematic tools provides a context for ensuring consistent practice in managing behaviour, while creating regular opportunities to review and update guidelines for working with children (Barrie & Richardson, 2003). Still, the extent to which such tools are used in group care has not been assessed.

A more widely recognized tool in child welfare case management is OnLac. The Ontario Government policy, Bill 210, specifies that CAS social workers must implement OnLac. "OnLac is the Canadian adaptation of the LAC Assessment and Action Record (AAR-C2; Flynn, Ghazal, & Legault, 2006)...overall purpose of OnLAC...is focused on promoting high-quality substitute parenting and positive outcomes" (as cited in Carroll, Vincent, & Flynn, 2007, p. 2). "The Looking after Children (LAC) materials provide a structured basis for information-gathering and a systematic approach for collecting data from different sources" (Daniel, 2003, p.11). It is comprised of two sets of forms: a) main records (essential information, plans and reviews), b) forms concerned with assessment and action, which are then divided into sections covering seven dimensions key to the development of children and youth: health, education, emotional and behavioural development, family and social relationships, identity, social representation, and self-care skills (Scott & Hill, 2003). OnLac provides a structured mechanism with a theoretical orientation toward development that follow the case management process outlined by Ricks and Charlesworth (2003).

Daniel (2003) criticizes the effectiveness of LAC, stating "they [CYC practitioners] lack detailed guidance about what should be done with all the material that is gathered and how to formulate a plan for intervention. The skill, which requires considerable professional judgement, is to make sense of the information and develop a clear plan for intervention, linked with measurable outcomes" (p. 11).

However, Scott and Hill's (2003) study showed that group care staff "saw the Day-to-Day Arrangements record as providing useful structure for clarifying a child's accustomed daily routines in order to assist continuity and identify corresponding tasks for care in fieldwork staff" (p. 20). The usefulness of the LAC forms has been questioned, although it was reported that “the information, planning and review forms were used regularly...this did not apply to the Assessment and Action Records with three-quarters of respondents indicating little or no use” (Scott & Hill, 2003, p. 19). The reasons provided for incomplete use were lack of staff time and the lack of multi-agency co-operation; "responses suggested that many colleagues from other agencies were often unaware of [LAC materials]...and did not expect to take on a role in helping to complete the records" (Scott & Hill, 2003, p. 22). Evidence has shown that the LAC framework is valuable, but serious challenges remain with regards to its use in group care practice (Scott & Hill, 2003, p. 22).

Ultimately, in order for CYC practitioners in management positions to promote EBP within their programs, they must attend to four principles:

1. Being scholarly: reading the current literature and consciously relating their professional opinions to the source (theory or research) (Rettinger, 2006).
2. Evaluating the literature: deciding through a critical process if the literature or ideas from a training seminar meet the standards of good science and are worthy of affecting practice positively (Connor, Miller, Cunningham, & Melloni, 2002).
3. Applying new ideas: taking information about best practice or new knowledge from current research and improving the way service is delivered (Chambless & Hollon, 1998).
4. Sharing the knowledge: disseminating the information learned about best practice to staff and colleagues (Whittaker, 2004).

1.4.6 Pre-service Educational Preparation of CYC Practitioners

The Canadian post-secondary system is internationally recognized for the level of post-secondary education in CYC practice offering a comprehensive system of two year, three year, and four year programs in colleges and universities in every province in both official languages. Ontario has the most extensive pre-service, post-secondary educational preparation for CYC practitioners anywhere. Twenty Colleges of Applied Arts and Technology offer three year Child and Youth Worker diploma programs and Ryerson University offers a 4 year degree in Child and Youth Care. This a very different scenario to the United States which generates much of the research on group care practices.

“The cachet of higher education may be what it takes to gain youth workers the respect and compensation they deserve” (Nichols, 2008). As in many professions, there are job training opportunities that generate certificates, however, Nichols (2008) argued that “a certificate carries far less weight than an associate’s or bachelor’s degree….having a certificate doesn’t protect anyone’s job or help find employment elsewhere” (Nichols, 2008, p. 7). On the other hand, Nichols (2008) also noted that certificate programs can lead to workers acquiring an interest in higher education. “For example, since 2001 the College of Public and Community Service at the University of Massachusetts in Boston (UMass Boston) has offered both a B.A. with a youth-work concentration and a youth-work certificate. Students who get the certificate (earning 18 credits) often go on for bachelor’s degrees” (Nichols, 2008, p. 7). Furthermore, Nichols (2008) noted that the “growth in youth-work classes echoes the changes in early-childhood education that began in the 1980s” (p. 7). Still filling classes is a concern, for example, “since the Charter Oak after-school program’s inception in 2005...more than 140 people have taken the courses. But only seven have graduated with credentials” (p. 7).

A study which reported the qualifications of staff in residential care (referred to as social pedagogues) in England, Germany and Denmark found that nearly all the staff in Denmark held a high level relevant qualification, which included predominantly pedagogy, but also social work and psychology. In Germany residential care workers were almost equally divided between high and medium level qualifications, which are equivalent to an Advanced Level General Certificate of Secondary Education along with a workplace-based award that takes about 18 months to complete. England’s scores were the lowest with only one-fifth holding a high level qualification, while around one-third held a medium, and further third held either no qualifications or none that was relevant to their (Petrie, Boddy, Cameron, Wigfall, & Simon, 2006).

Child and Youth Care curriculum in Ontario is designed to meet the Ontario Vocational Standards for Child and Youth Care Workers (Ontario Ministry of Training, 2002) and is therefore following consistent curriculum. Previous work (Stuart & Carty, 2006) described the Ontario curriculum according to seven domains of practice identified in the literature on child and youth care competencies.

1. Self: Seen as the foundation for professional work and the mediator of knowledge and skills – includes reflective practice, boundaries, the use of self, and self care.
2. Professionalism: Which focuses on standards, competence, professional presentation and identity – includes ethics, life-long professional development, supervision, and diversity.
3. Communication: Defined as the expression of self and professionalism - includes written, verbal and non-verbal, computers, and the professional community.
4. Development: With a focus on normal and abnormal development, developing social competence, recognizing strengths, situating behaviour in its developmental context -
includes developmental theory, patterns of growth and development, learning theory, applying developmental theory to pathology, medication and pharmacology.

5. Systems context: Refers to the systems in which both the child and practitioner are involved — includes environmental conditions, systems theory, ecological perspective, family systems, and legal guidelines and practice.

6. Relationship: The qualities of interpersonal interactions with child and family — includes caring, engagement, use of activities, teamwork and professional as well as therapeutic relationships.

7. Intervention: Include the practitioner’s ability to integrate current knowledge of human development with the skill, expertise, objectivity and self awareness essential for developing, implementing and evaluating effective intervention programs — includes moment to moment interventions, activities of daily living, activity programming, planned interventions, advocacy and group work; observation.

When the curriculum in Ontario post-secondary programs was compared to the competencies identified in the Domains of Practice there was high consistency across the seven domains, although individual education programs had differences in terms of degree and intensity of focus. Differences were also seen between universities and colleges. University programs, for example, showed a greater focus on Professionalism whereas College programs showed a greater focus on Planned Interventions. All programs demonstrated some gaps in what was offered to students when compared to the required competencies. In essence, this means that depending on their program of study, graduates may be more or less prepared to take advantage of the opportunities for training in EBP/Ts offered by the agencies in which they are employed. Overall, however, there is a common orientation to the work that they do. The research also indicated that although there are many CYC practitioners working in mental health organizations, the skills and knowledge conveyed by the educational programs is not well understood amongst program managers supervising CYC practitioners. How child and youth care specific education affects practice or client outcomes remains unclear.

1.4.7 Concluding Remarks

Efforts are being made to change practices in group care programs so that they are clearly evidence-based (McCurdy & McIntyre, 2004; Whittaker, 2000; Whittaker, 2004). The previous absence of evidence in regards to the efficacy of CYC interventions and the discrediting of workers and the profession has at times, led to funding limitations and restrictions on the use of group care (Ainsworth & Hansen, 2005; Whittaker, 2004). A cycle of anti-group home policy and funding cuts has been shown to cause significant harm in other jurisdictions (Ainsworth & Hansen, 2005). There are no scientific grounds for presuming that the lack of evidence is the same as evidence of ineffectiveness (Target & Fonagy, 2005).

We must identify the role that CYC practitioners play in group care programs that are committed to EBP. By identifying the contributions that CYC practitioners make to assessment, planning and outcome evaluation for clients and the specific interventions and strategies that these practitioners implement within the milieu we are then in a position to better assess the efficacy of CYC practice in subsequent studies, thereby providing evidence for or against the efficacy of group care programs. Both the existing EBT literature and the theoretical literature in child and youth care were reviewed in order to define the nature of the expected interventions. We are aware that various treatments, such as MST, combine and adapt proven therapeutic techniques, what is unclear is whether or not CYC practitioners have also adapted certain EBT when working with children, youth and families.
The goal of this project is to identify the extent to which CYC practitioners in residential and group care programs use EBP and intervention strategies which are theoretically linked to EBT and best practices in children’s mental health. The distinction between EBP and EBT is drawn from Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald (2001) who use the term EBT to refer specifically to empirically supported interventions while in children’s mental health services, the term evidence-based practice refers to a body of scientific knowledge about service practices, including referral, assessment, outcome management/assessment, quality improvement practices, and case management.

2 Methodology

This section describes the design of the research including the survey instrument, recruitment, and data collection procedures. The data analysis is described generally and a more detailed discussion of the specific procedures is contained in the appendices.

2.1 Design of the Project

This project used a survey research design to explore the ways in which front-line CYC practitioners understand and use EBT and EBP as well as to describe the scope of practice of CYC practitioners in group care programs. Program managers and front-line CYC practitioners in group care programs were surveyed. A cross-sector statistical analysis was used to identify differences among child welfare (CAS), children’s mental health (CMH), and private operator (PCR) programs. The survey replicated previous work (Barwick et al., 2005) to describe the extent of the uptake of EBP and identify barriers to implementation. Additional questions explored further the understanding of EBT and EBP in group care programs. Responses from the program manager of each group care program were used to dichotomize the answers to questions about readiness for evidence-based practice and capacity to use research-based knowledge (Uptake of EBP) into a categorical variable representing High or Low Uptake of EBP. Differences between High and Low Uptake programs were explored in relation to case management practices and CYC practitioner scope of practice. The survey included questions linked to the theoretical and empirical literature on group care as well as the EBT literature and in order to explore the milieu-based strategies (scope of practice) of CYC practitioners. Survey methodology recommended by Dillman (2000) was used to maximize the survey return rate. Sampling was structured at the program level to maximize the power of the statistical analysis and to generalize the findings to group care programs. The following sections describe the nature of the sampling frame, recruitment methods, data collection and analysis methods as well as identifying the limitations of the study.

2.2 Sample

Instead of using a random sampling technique, the sample was drawn from the full population of licensed residential treatment centers and group homes for children and youth in Ontario. A list of the names of program managers and child and youth care practitioners was not available therefore it was not feasible to randomly sample this workforce. Instead, the sampling frame was based on using each group care program as a single entity and purposefully sampling several practitioners from each home. Our assumption was that the specific interventions used (and their frequency of use) as well as the involvement of CYC practitioners in case management practices, are a function of the individual residence, not the individual worker. In other words, the group home management defines the job or therapeutic tasks of the CYC practitioners working in each group care program. If this is true, then two or three front line staff in any program should provide similar answers to the questions about what interventions are used in the milieu to provide a profile of the nature of programs in the province.
The cluster method anchored to the individual group care program ensures that any potential bias is evenly distributed. The primary differences which existed in the front line practice should be due to forces that operate within the individual home. Factors such as the mix of children served, culture of the home, quality of supervision, program design, quality of staff recruited, financial resources available and organization supports vary by home (Anglin, 2002) not by individual practitioner.

The terms residential treatment centre and group homes, refer to programs within the full continuum of placements for children and youth with special needs. In this survey our interests were in family group care (FGC) with staff support, fully staffed group care (GC), and residential treatment centers (RTC), which we collectively called group care programs. As previously noted these programs are grouped together in the literature and considered to be relatively homogeneous. We were specifically interested in programs that served children with emotional and behavioural disorders placed through child welfare or children’s mental health referrals. Programs serving exclusively young offenders, autistic children, developmentally disabled, medically fragile clients and psychiatric hospital programs were excluded.

The list of group care programs invited to participate in the survey was developed as follows: Agencies providing group care services typically join one of three provincial associations (OARTY, OACAS, and CMHO) who represent a service or employment sector of interest in the study. These three provincial associations supported the project and provided a list of their members, consisting of the agencies and their Executive Directors who operated group care programs. These membership lists covered most of the group care programs in the province of Ontario, however in order to survey the full population of group care programs, the project team obtained a list of provincially licensed group care programs and identified those operators who were NOT members of the three provincial associations. These operators were added to the list of agencies to be contacted. The list of licensed operators included mailing addresses but in only rare instances did it include phone or email contact information. Phone and email contact information was obtained using the provided mailing information and internet search tools (several search procedures were implemented). In many cases there was no evidence that the agency was still operating, or the agency provided only foster care or treatment foster care programs in which case the agency was dropped from the sampling frame.

Confirmation was obtained from each agency to ensure that they operated staffed group care services and to identify broadly the nature of the clients that they serviced. Programs offering group care exclusively for young offenders, autistic children, developmentally disabled, medically fragile clients and psychiatric hospital programs were excluded from the list. Mixed programs were included. Agency Directors or their designate provided a specific list of the group care programs operated by that agency with the name of the program manager. Directors were also asked which provincial association they were associated with and their service sector (PCR, CAS, or CMH) was identified.

Within each program one program manager and two to four full-time CYC practitioners received surveyed. Some program managers supervised multiple programs and in these cases only one completed survey was necessary for the manager. CYC practitioners in each program received surveys and the number distributed was based on the number of full-time staff, 50% were surveyed. We assumed that the program manager responses would characterize all the programs he/she managed, an assumption supported by Anglin (2002). Using the cluster technique minimized any bias as a result of the program manager selecting the front-line sample and simplified the identification of the front-line population.

Our initial estimate of the population of group care programs within each sector identified that we required a return rate of 52% of the programs to generalize the results to the full population of group care programs allowing for a 95% confidence interval and a 5% sampling error. Preliminary estimates of the number of programs and staff represented in each sector were inaccurate. CAS agencies, for
example rarely operate their own group care programs (only 12 of 52 provincial CAS organizations do so) and there were many private operators who did not belong to OARTY identified through the list of licensed group care settings. Table 2-1 Population of Group Care Programs and Return Rate describes the response rate to the survey according to each sector, including agencies/programs recruited and those that responded. In some cases we did not receive both a program manager and a CYC practitioner response, but if one survey was received from the program it was considered to be a program response.

Table 2-1 Population of Group Care Programs and Return Rate

<table>
<thead>
<tr>
<th>Programs Invited</th>
<th>Agencies Invited</th>
<th>Estimated CYC practitioners (programs x 8.4) and actual sample size (surveys mailed)</th>
<th>Return rate -% of programs.</th>
<th>Return rate -% of staff.</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMH Program Manager (PM) surveys N=97 99 programs received CYC survey</td>
<td>48 agencies 115 eligible programs 39 agencies participated 9 Refusals</td>
<td>Estimated population of CYC practitioners=966 Surveys mailed PM N=102 CYC N=415</td>
<td>78 programs returned 79% return rate</td>
<td>188 (45%) CYC returned 55 (54%) PM returned</td>
</tr>
<tr>
<td>CAS 44 programs PM N=32 44 programs received CYC survey</td>
<td>12 agencies 45 eligible programs 11 agencies participated 1 Refusal</td>
<td>Estimated population of CYC practitioners=378 Surveys mailed PM N=32 CYC N=168</td>
<td>33 discrete programs returned 75% return rate</td>
<td>67 (40%) CYC returned 13 (41%) PM returned</td>
</tr>
<tr>
<td>PCR 119 programs PM N=97 119 programs received CYC survey</td>
<td>60 agencies 119 eligible programs 44 agencies participated 26 Refusals</td>
<td>Estimated population of CYC practitioners=999.6 Surveys mailed PM N=97 CYC N=404</td>
<td>67 discrete programs returned 55% return rate</td>
<td>135 (33%) CYC returned 37 (38%) PM returned</td>
</tr>
<tr>
<td>All group care 262 discrete programs</td>
<td>120 agencies invited 94 agencies mailed to 36 refusals</td>
<td>Estimated population of CYC practitioners=2,343.6 Surveys mailed PM N=231 CYC N=987 Total = 1,218</td>
<td>178 programs returned 67% return rate</td>
<td>390 (40%) CYC returned 105 (45%) PM returned</td>
</tr>
</tbody>
</table>

The survey was representative of group care programs NOT group care workers, for the reasons outlined above. An estimate of the number of CYC practitioners working in group care based on the licensing requirements for staffed group care programs is provided for interest. We estimated that there were 8.4 full-time equivalent staff per group care setting (based on five to eight bed licensing requirements) to estimate the population of front-line workers. Table 2-1 Population of Group Care Programs and Return Rate also notes the agency refusals, though we were not always able to identify the number of programs associated with an agency. An agency was considered as a refusal for several different reasons. Some agency directors stated that they did not want the agency to participate due to time, workload issues, or “instability” (very few fell into this category). In other cases the ethical requirements of the agency could not be met within the timelines of the survey (again, very few fell in this category). The largest category of refusals was those agencies where phone or email contact was made but the
Director did not return calls or emails. After three attempts over a three to four week period these agencies were considered refusals. Agencies for whom we could not obtain any contact information were simply dropped from the list of eligible agencies and were not considered a refusal.

2.3 Recruitment

In total, 78% of the eligible agencies were recruited representing 262 group care programs. The recruitment process had several phases. In phase one, the director of the agency was contacted by telephone and/or email by the project manager or the principle investigator. The purpose of the research was reviewed and the director was asked whether he/she consented to the agency participating in the survey. At this point any ethical requirements for the organization were completed and the name(s) and contact information of the program manager(s) for the group care programs were confirmed. Any agencies that refused participation at this point were noted as refusals and no further follow-up occurred.

Each director and the identified program manager received an email or a letter outlining the intent and benefits of the survey participation. A research assistant then contacted the program manager by telephone. The phone call re-confirmed the address of the program care program and discussed the project to answer any questions on the part of the program manager and to encourage distribution and completion of the surveys. Following a package, containing a cover letter, consent forms, program manager survey and two to four front-line CYC practitioner surveys (depending on the size of the operation) were mailed to the program manager. Each survey was in a separate envelope with pre-addressed stamped return envelopes. Following the recommendations of Dillman (2000) each recruitment letter described the importance of the study in relation to the respondents’ work with children in that organization and included a Tim Horton’s gift certificate as an incentive for completion. Two to three follow-up calls to program managers occurred for the duration of the survey to encourage distribution and completion of the surveys. Participants completed the consent form, sealed it in a separate envelope and returned it with their survey where upon the two envelopes were separated once received by the project team.

2.4 Instruments

There were separate surveys for the Program Manager and the CYC practitioner which gathered some common information but were designed to distinguish program and practice differences. The survey was a self-report instrument with a variety of questions about the respondent and his/her involvement in practices in group care. Attention to the aesthetic features of the survey and inclusion of the logos of the collaborating associations served to enhance credibility and increase the response rate.

The program manager survey consisted of two sections: Section one: The Organizational Context and Section two: Case Management Practices. In addition to some basic demographic information on the respondent, section one of the survey included questions on the background of the respondent, the educational background and experience of front line staff in the program, the characteristics of the children in the program and services available. Section one also replicated most sections of a survey on the utilization of new research-based knowledge completed in 2004 with CMH agencies (Barwick et al., 2005). There were four key questions which measured on a 4-point scale the following qualities of the program’s utilization of new knowledge: access to research information, ability to assess the information for scientific merit, ability to adapt the information to practice and then apply it by modifying the practice. Questions replicated from Barwick et al. (2005) provided forced choice responses or used a five point scale from agree strongly (5) to disagree strongly (1).
Section two contained questions which assessed the frequency of best practices in case management. The areas measured included:

1. Screening: How the program screens new admissions.
2. Initial assessment: Including content areas of the assessment and tools used, as well as “who assesses” and how the process of assessment is managed.
3. Case planning: Including details of intervention/treatment models and explicit questions about specific prominent evidence based treatment approaches.
4. Outcome evaluation: Which data flows into outcome evaluation processes.

The CYC practitioner survey had three sections: The first was a shorter version of Section one: The Organizational Context, followed by and identical Section two: Case Management Practices. Section three: Identifying the Interventions of CYC Practitioners detailed the practices and interventions of front line CYC practitioners as linked to theoretical and empirical literature.

Questions in section three were mapped to the literature noted previously and represented three types of information:

1. Questions which identified the implementation of EBP and specific EBT or interventions which are derived from known EBT presented in clinical programs.
2. Questions which identified the best practices within the theoretical writing that formed the basis of the curricula for child and youth care educational programs.
3. Questions about practices that were found to be counter therapeutic or harmful.

Section three questions were randomly presented in the survey but were re-grouped for analysis into clusters representing Elements of the Milieu, Resilience, Attachment, Promoting School Success, Conflict Management, Life Skills, Enhancing Socialization, Community Involvement, Promoting a Positive Identity and Cultural Identification. Section three was randomized to minimize response sets and the potential that questions would be answered with what the participants believed to be a desirable response.

In sections two and three respondents indicated the frequency with which they engaged in certain practices on a four-point scale from frequently (4) to rarely/never (1) for most questions. Space was also provided for the respondent to write in some answers and provide examples of certain practices.

2.5 Data collection

Data collection occurred between November 2007 and May 2008. The research assistant contacted a program manager from each group care program and then mailed a personally addressed package containing a questionnaire for the manager and two to four questionnaires for the CYC practitioners. The program manager was asked to select a team leader to distribute the surveys to the staff in the group care program. In total, 1,218 questionnaires (front line CYC staff and program managers) were distributed. Each respondent provided the project team with a signed informed consent. The survey took approximately one half hour to complete. Respondents were encouraged to complete and return the survey within two weeks of receiving it and follow-up calls offered further encouragement. Program managers were instructed to contact the principle researcher, whose contact information was provided, if there were any questions relating to the project.
2.6 Data Analysis

A detailed outline of the data analysis methodology can be found in the appendices. In this section a brief overview of the approach to the analysis and the specific types of data analysis completed for each goal is presented in a general manner.

Data was entered into an MSAccess database and subsequently exported to SPSS for analysis. Program information, completed by the program manager respondents was associated to the CYC practitioners through the program code identified with each respondents unique ID. This enabled us to create new variables (such as Uptake of EBP, High or Low) which could to be associated with the responses of CYC practitioners on section three, even though they did not respond to questions on the uptake of evidence-based practice in section one.

The Organizational Context (section one) consisted of questions answered by the program managers about their group care programs. The responses of 105 program managers in each of the three service sectors were summarized using frequencies to describe key service factors such as type of program; service area; region served; additional services available to the homes; client profile; placing agencies; education and experience of CYC practitioners for each sector (PCR, CAS, CMH) and for the total group.

Goal One: To identify whether and to what extent CYC practitioners in residential and group care programs use EBP and intervention strategies which are theoretically linked to EBT and best practices in children’s mental health.

Section three of the CYC practitioner survey assessed the frequency of interventions in several different clusters (e.g. Attachment). Section two examined the nature of case management practices as reported by both program managers and CYC’s. Section one determined the level of readiness for EBP in the program. Analysis of the data to address this goal made use of data from all three sections of the survey. Using four items on the implementation of EBP in section one, we determine a collective score for the Uptake of EBP in each program and determined a cut point for High and Low Uptake based on the central tendency of these variables. We designated two groups; those with a High Uptake of EBP and those with a Low Uptake of EBP. Descriptive statistics (mean and standard deviation) were reported for each of the factors from section two of the survey (case management) that were associated with the High Uptake of evidence based practice in those programs in the High Uptake group. Significant differences between the High uptake of EBP and Low uptake of EBP groups were tested. Qualitative data analysis provided detail on the written answers provided in this section. Section three of the survey was analyzed by averaging the items that contributed to each cluster variable and using descriptive statistics (mean and standard deviation) to offer a profile of the frequency of interventions within each cluster and differences between the High and Low Uptake groups were tested.

Goal Two: To determine if there are differences in the uptake of EBP among child welfare, children’s mental health, and private service sector providers of residential and group care services.

Each question in section one on the Utilization of New Knowledge (replicated from Barwick et al., 2005) was analyzed to determine the frequency of each response. The results are described for each sector and for the total of the group care programs. A total of 105 program managers returned the survey and therefore the responses represent 105 program managers some of which supervise more than one program in their agency. Significant differences between the sectors were assessed using non-parametric tests. Based on the knowledge that the CMH sector has been working longer and in a more focused manner on EBT/EBP, we expected a positive change in this sector. The results of the whole group of programs on the utilization of new knowledge are compared to the results of the previous survey (Barwick et al., 2005) in the discussion section.
Goal Three: To identify differences in the educational and experience backgrounds of CYC practitioners among child welfare, children's mental health, and private service sector providers of residential and group care services.

The educational and experience information provided in section one of the surveys was summarized for each service sector. This information was assessed in two ways. Respondents were asked to provide information on their own educational background and years of experience. Different questions assessed whether the respondent had a CYW diploma and the highest level of education that he/she had. In addition program managers were asked to estimate the percentage of program employees within five different categories of years of experience and four different categories of education. The program manager estimates were used to test significant differences between the service sectors for years of experience and CYW specific education. The program manager estimates were compared to the respondent information on education and experience to determine how representative the actual sample was of the group care employees.

Apriori Analysis: Factors Influencing CYC Scope of Practice

When the differences in CYC Scope of Practice between High and Low Uptake programs were tested for significance and only one cluster was found to be significant a more detailed analysis was undertaken using multiple factors to determine the relative influence of three factors: CYW education (having a CYW diploma or not); years of experience; and service sector. All three factors were found to differentially influence some clusters in CYC Scope of Practice (section three).

2.7 Ethical Considerations

Participants were notified with a letter included in their survey package about the steps taken to ensure confidentiality and anonymity of the data. Each survey was accompanied by a consent form to indicate that the respondent had read the information. The research assistant notified the program manager of the process of data collection through a series of phone calls to encourage participation. All surveys and consent forms were returned anonymously and were pre-coded with an indication of the sector and the program for follow-up purposes only to increase the rate of return. To ensure anonymity the participants were provided with a separate envelope to return the consent form. Consents and surveys were immediately separated upon receipt of the returned package and stored separately to avoid any possibility of being linked together. Only numerical identifiers were used in the database. There was an ethical risk to voluntary participation at the agency level since program managers were asked to distribute the CYC practitioner surveys. The research assistant emphasized voluntary participation and anonymity as key principles when discussing the survey with the program manager. This study was approved by the Research Ethics Board at Ryerson University and the Research Ethics Board of any agency that required additional approval.

2.8 Study limitations

There were certain limitations to the overall success of this study. The methodology limits the ability to generalize the results because non-probability sampling techniques were used, however since the sampling frame included the total population of group care programs and the response rate was high, the results should be taken to represent group care programs in the province of Ontario with 95% confidence and a 5% margin of error. The results cannot be generalized to the population of CYC practitioners because they were purposefully selected. The front-line respondents are more experienced and more specifically educated than the general population of staff.

The use of a self-report questionnaire could cause respondents to provide answers they believe are more socially desirable than their actual behaviour. It was not possible to visit programs to observe the
intervention strategies or to check the reliability of the responses. However, the layered recruitment, system of mailing directly to the program managers, requesting independent distribution of the CYC practitioner surveys and multiple samples in each program increase the chances that the responses are accurate representations of what the respondents believe they are doing. Selected items on section two and section three were assessed for the correlation between respondents in the same program and as expected inter-rater correlations are high indicating that respondents are likely reliably reporting similar activities within the same program.

The design of the instrument may have posed some difficulties. There were many questions and some repetition occurred. There was a possibility of a response set because the survey was not constructed with reverse order questions increasing the respondent’s tendency to agree with every question in a series rather than carefully thinking through the answer to each question. The program managers were directed to distribute the surveys via a team leader to avoid the possible bias involved if the program managers were to select the participants, but this may not have occurred in all cases.

The personal contact with agency directors and program managers resulted in a high level of agreement to participate. The recruiters noted that there was a lot of enthusiasm for the survey and participants comments about how important they felt the study was. We were therefore surprised by the (relative to the enthusiasm) low level of response. It is possible that the programs which returned surveys are those which had greater resources to do so and as such may also have greater resources to provide higher quality programming therefore this may be an optimistic profile of the group care sector.
3 Results

This section describes the results of the project. It includes specific results, summarized according to each question or hypotheses as well as new discoveries that were important but not anticipated in the initial questions. An alpha level of .05 was used for all statistical tests. The statistical results are enhanced with descriptive themes generated from textual data. A discussion of the findings anchored in a discussion of the literature and policy follows.

Major Findings

We have reported the findings according to the goals of the project, representing the questions asked. Prior to addressing the goals of the project we will describe the nature of the group care programs who responded and the character of the individual respondents who work in those programs.

3.1.1 Describing the Character of Staffed Group Care in Ontario

3.1.1.1 Program characteristics

The program managers were asked a number of questions to help characterize the service provision and the nature of the children and youth that they served. While in total 172 programs returned the surveys but in many cases a single program manager supervised two or more programs OR the program manager did not return the survey but the CYC practitioners for the program did. In total 105 program managers provided information on the services provided by their agency (representing 67% of the programs surveyed). The following tables provide information that characterizes the programs that participated.

![Primary service area chart]

Figure 3-1 Primary Service Area

The organizations who participated served a relatively even proportion of rural, suburban and urban areas (often dealing with all three areas). Overall, the CAS group care settings (many were from Northern Ontario) and the PCR Programs focused less on urban areas and the CMH programs focused less on rural areas.
Figure 3-2: MCYS Region for Group Care Programs by Sector

Group care settings who responded indicated where their organization was located based on MCYS regions. The regions with the fewest group care programs were in four regions, Hamilton, North East, South East and East. Three of these four regions contain CAS organizations that do not provide their own staffed group care. In addition, neither Central East nor Central West CAS organizations provide staffed group care. In fact, only 12 CAS in the province provide staffed group care of the 53 CAS organizations. CMH organizations were concentrated in South West, Central East, Toronto, and Central West.
Figure 3-3 Referral Sources by Sector

Group care settings often have more than one funding source and therefore more than one source and more than one type of service running in the same facility. The respondents in this held true to this characteristic. All respondents (PM and CYC) were asked what type of service provided. Program managers were asked who they provided placements for. As can be seen in

![Bar Chart - Figure 3-3](chart.png)

Figure 3-3, 94% of all the programs provided placements for CAS referrals, 59% for private placements (parents etc.) and 58% for children’s mental health. Fewer placements were provided for youth justice or community care access centres, but these were still reported as sectors that the group care settings served.
Figure 3-4: Type of Service by Sector
NOTE: More than one choice was possible within the answer as programs provide for multiple types of services. Each sector specialized to a significant degree but all sectors provided all types of services.

Figure 3-5: Group Care Staffing Structure by Sector
Group care programs were asked about their staffing structure. As indicated in Figure 3-5 most of the sample used staffed group care (46.6%) or (staffed) residential treatment (50.4%). In CAS and PCR
sectors the staffing model was more often staffed group care, whereas CMH has more residential treatment centres.

Figure 3-6: Services Available to Programs and/or to Clients

Figure 4-6 explains how treatment might occur in staffed group care, through the use of clinical resources, either attached to the organization or contracted within the community. The figure presents the types of services available to the home and the clients. Differences between the sectors occurred in three areas. Clinical assessment services were provided significantly less often by PCR programs (16.2% did not provide this service) and CAS programs (23.1% did not provide), \( \chi^2 (8, N=105)=24.34, p=.002 \). Clinical counselling for clients was provided significantly less often by CAS programs (15.4% did not provide), \( \chi^2 (8, N=105)=21.82, p=.005 \). Family counselling was provided significantly less often by PCR programs (29.7% did not provide this service) and CAS programs (15.4% did not provide), \( \chi^2 (8, N=105)=25.21, p=.005 \).
Figure 3-7: Evidence-based Treatments by Sector

Respondents were asked to indicate which of the following EBTs are provided by your organization? These treatments are run by the organization but this does not imply that clients in group care access the treatments. As described in Figure 3-7: Evidence-based Treatments by Sector, within the total sample the most frequently reported EBT was Life skills Training (76.2%) followed by Cognitive Behaviour Therapy (CBT) at 69.5%.

There were significant differences in the provision of these two EBT’s across all three sectors, CBT, $\chi^2 (2, N=105)=11.37$, $p=.003$ occurred less frequently in the PCR and the CAS sectors in comparison to the CMH sector and Life Skills Training, $\chi^2 (2, N=105)=7.39$, $p=.025$ occurred less frequently in the CAS sector. Family-focused EBT’s are provided almost exclusively by organizations in the CMH sector.
Program Managers were asked to describe the major presenting problems of the children currently placed in the group care program. The results for the total sample are presented in Figure 3-8. These figures represent the percentage of group care programs who reported having at least one client at the time of the survey with the noted presenting problem. There were some significant differences between sectors. PCR programs had significantly fewer suicidal clients (54.1%) $\chi^2 (2, N=105)=6.64, p=.008$ and dealt less with the psycho-social effects of severe trauma (48.6%), $\chi^2 (2, N=105)=15.09, p=.001$. Both PCR (27%) and CAS (23.1%) programs dealt significantly less often with youth with psychoses than the CMH programs $\chi^2 (2, N=105)=7.86, p=.020$. CAS programs dealt with significantly more medically fragile children and youth (46.2%) $\chi^2 (2, N=105)=11.77, p=.003$.

**3.1.1.2 Respondent Characteristics**

Participants were asked to provide some basic information about their identities age, education, and experience. The following information provides a profile of the respondents, both program managers and CYC practitioners. Differences between program managers and CYC practitioners, or between sectors are noted where they occurred. The respondents were typically less than 40 years of age, 36.8% were in the 20-29 age category and 35.6% were in the 30-39 age category. Sixteen percent were in the 40-49 years category, most of these were in the CAS (16%) and CMH (20%) sectors.

Respondents were asked to record their ethno-cultural background. These responses were then reviewed and categorized using the ethnic diversity categories devised by Statistics Canada for the *Ethnic Diversity Survey* ([http://www.statcan.ca/Daily/English/030929/d030929a.htm](http://www.statcan.ca/Daily/English/030929/d030929a.htm)). In addition, three categories were added (Aboriginal, French Canadian, and Canadian to more closely match the write in responses. **Error! Reference source not found.** presents the results for both the program managers and the CYC practitioners. Respondents were coded more than once for multiple responses.
Table 3-1: Ethnic Cultural Identity

<table>
<thead>
<tr>
<th>Standard ethnic category</th>
<th>CYW Percent</th>
<th>Manager Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian</td>
<td>41.6</td>
<td>23.5</td>
</tr>
<tr>
<td>Canadian</td>
<td>20.2</td>
<td>27.5</td>
</tr>
<tr>
<td>European</td>
<td>9.6</td>
<td>14.7</td>
</tr>
<tr>
<td>British Isles</td>
<td>7.3</td>
<td>10.8</td>
</tr>
<tr>
<td>Other (including WASP and uncodable)</td>
<td>5.5</td>
<td>5.9</td>
</tr>
<tr>
<td>French Canadian</td>
<td>4.5</td>
<td>5.9</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>2.2</td>
<td>4.9</td>
</tr>
<tr>
<td>African</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td>Caribbean</td>
<td>2.2</td>
<td>4.9</td>
</tr>
<tr>
<td>East and Southeast Asian</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Latin, Central and/or South American</td>
<td>1.4</td>
<td></td>
</tr>
<tr>
<td>Arab</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>South Asian</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>West Asian</td>
<td>0.3</td>
<td></td>
</tr>
</tbody>
</table>

Respondents identified primarily with the child and youth care profession (88.1%) and secondarily with social service work (10.1%). social work (8.9%), psychology (5.5%) and corrections (4.3%) were other professions that were identified. This pattern held across the three sectors. We asked more specifically whether respondents had a CYW diploma and 46.4% did. There were significant differences between the sectors (see Goal 3 results). In addition, less than half of those who qualified (i.e. had a CYW diploma) were certified with the professional association (the OACYC), therefore 20.4% of the overall sample were certified as indicated in Table 4-2.

Table 3-2: Respondent Characteristics: Education, Certification, Gender

<table>
<thead>
<tr>
<th>Sector</th>
<th>CYW Diploma</th>
<th>OACYC Certified</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCR</td>
<td>33.5% (n=57)</td>
<td>20.6% (n=35)</td>
<td>74.1%</td>
<td>24.1%</td>
</tr>
<tr>
<td>CAS</td>
<td>41.3% (n=33)</td>
<td>8.8% (n=7)</td>
<td>76.3%</td>
<td>21.3%</td>
</tr>
<tr>
<td>CMH</td>
<td>57.4% (n=140)</td>
<td>24.2% (n=59)</td>
<td>72.5%</td>
<td>25.4%</td>
</tr>
<tr>
<td>Total Sample</td>
<td>46.6% (n=230)</td>
<td>20.4% (n=101)</td>
<td>73.7%</td>
<td>24.3%</td>
</tr>
</tbody>
</table>

Respondents were asked to write in their highest level of education and the discipline or profession of that education, providing an indication of both the level of education overall of the sample and an indication of whether those with CYW diplomas go on and further their education. These responses were categorized as indicated in Figure 3-9.
Figure 3-9: Highest Educational Background of CYC Respondents by Sector

As noted, 24.1% have a BA or MA level of education; 44% have CYC specific education (BA or Diploma), 21.9% have another diploma (usually SSW, DSW or corrections) and 16.6% have not completed post-secondary education though the majority of these have done some course work.

Figure 3-10: Program Managers: Years of Experience by Sector
As indicated in Figure 3-10: Program Managers: Years of Experience by Sector Program Managers and 4-11: CYC Practitioners, the respondents tended to be experienced. Only 14.6% of the full group had less than 2 years experience. Significant differences between the sectors in years of experience were present. The chi-squared tests for program managers cannot be reported since eight cells have less than the minimum expected cell count (total N=101). However, visual inspection indicates that program manager respondents in the CAS sector are more likely to have been recently hired.

Figure 3-11: CYC Practitioners: Years of Experience by Sector

There were also significant differences between the sectors in the experience of respondent CYC practitioners \( X^2 (8, N=384)=23.20, p=.003 \). As can be seen in Error! Reference source not found. the PCR and CAS sector respondents represented have a less experienced work force. 56.5% of CYC practitioners in PCR programs had 5 years experience or less, compared to 43.9% of those in CMH programs and 45.4% of practitioners in CAS program. All sectors had relatively equal numbers of respondents in the 6-10 years of experience category.

3.1.2 Goal 1: Use of EBP by CYC Practitioners

To identify whether and to what extent CYC practitioners in residential and group care programs use EBP and intervention strategies which are theoretically linked to EBT and best practices in children’s mental health.

3.1.2.1 Instrument Development: Factor Analysis

Objective 1: To validate an instrument which identifies and describes the intervention strategies used by CYC practitioners that are: a) linked to EBT, and b) linked to theoretical literature about best practice in residential child and youth care.
Section three of the survey was developed from a literature review of interventions used by CYC practitioners in group care and EBT used with children and youth. The instrument has 98 questions grouped into 16 different clusters describing specific interventions that are mapped to practice literature. Each cluster represents a set of targeted intervention strategies. The vast majority of questions (93) were structured around a frequency scale. The instructions to the respondent were as follows:

*Please describe how often you or someone in your position (CYW) would do this task in the regular execution of their job duties.*

The choices were:

- frequently (4)
- usually (3)
- sometimes (2)
- rarely/never (1)

The plan to validate the instrument included a factor analysis of the 93 Likert scale questions to determine if the individual questions divided into factors that matched the theoretically derived clusters. However, a minimum of 30 respondents for each question in the instrument is required to use the factor analytic method (Pett, Lackey, & Sullivan, 2003). A questionnaire of this size would require at least 8,650 respondents; we have 389 respondents for this section. Therefore, the factor analysis was abandoned and item correlations were examined instead.

The questionnaire has good face validity since each question is an exemplar of the interventions discussed in the literature under each “cluster”. Each cluster variable was computed as the average score of the interventions within that cluster. In order to confirm the face validity of the clusters and their components, we computed correlations for all 93 Likert scale questions and the cluster variables. The three yes/no questions and the two text questions were ignored in computing the average for each cluster. The correlations between individual items and the score of the cluster to which they belonged were examined. We also examined the correlation between items and the scores of other clusters. In general, individual items correlated with the cluster score at 0.5 or higher and were correlated at 0.3 or lower with the scores of other clusters indicating moderate to high correlation of each item with the cluster score. Items that had a low correlation with the score on the cluster were also not significantly correlated with other items in that cluster. The following describes the results of this analysis very generally and indicates how the items were linked to the literature. Statistical details on correlations are available in the appendices.

### 3.1.2.1.1 Elements of the Milieu: Culture

The interventions listed under Milieu: Culture are considered best practice in child and youth care (Burns, 2006). These interventions promote a high level of acceptance and celebration of differences of both culture and other exceptionalities. They are also suggested under the guidelines for standards in residential settings (OCFSA, 2004). The items are highly correlated with the cluster variable. These interventions were reportedly used by CYC practitioners *usually* (M= 3.17) and 10.1% of respondents reported using them less then *sometimes*.

### 3.1.2.1.2 Ethnic Identity

The interventions inquired about under the cluster Ethnic Identity are about how children are connected to their ethnicity and culture. The items are more specific to interventions with the child than those in Elements of the Milieu: Culture. These items are recommended in the guidelines for residential care (OCFSA, 2004). The items are highly correlated with the cluster. These interventions were reportedly used by CYC practitioners *usually* (M= 3.09 ) and 10.3% of respondents reported using them less then *sometimes*. 
3.1.2.1.3 Elements of the Milieu: Ideology

The interventions inquired about under Elements of the Milieu: Ideology are considered best practice in child and youth care (Burns, 2006) and address the value and beliefs of the program, particularly surrounding empowering and advocating for the voices of children and youth. They are suggested under the guidelines for standards in residential settings (OCFSA, 2004). The items are highly correlated with the cluster variable. These interventions were reportedly used by CYC practitioners usually (M = 3.40) and 3.9% of respondents reported using them less then sometimes.

3.1.2.1.4 Elements of the Milieu: Physical

The interventions inquired about under Elements of the Milieu: Physical are considered best practice in child and youth care (Burns, 2006) and these items assess how the physical environment is kept safe and designed to be comfortable and inviting for children and youth. Items are also reflective of the guidelines for standards in residential settings (OCFSA, 2004). The items are highly correlated with the cluster variable. These interventions were reportedly used by CYC practitioners usually (M = 3.42) and 0.3% of respondents reported using them less then sometimes. Elements of the Milieu: Physical is the only cluster that was significantly different among programs with a High Uptake of EBP.

3.1.2.1.5 Iatrogenic

The interventions inquired about under the cluster Iatrogenic are designed to prevent the unintended bad outcomes, sometimes referred to as deviancy training (i.e. a iatrogenic effect) (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Little et al., 2005). The items are moderately correlated with the cluster variable. These interventions were reportedly used by CYC practitioners more than sometimes but less than usually (M = 2.74) and 15% of respondents reported using them less then sometimes.

3.1.2.1.6 Attachment

The interventions inquired about under the cluster Attachment inquired about activities undertaken to promote relationships, develop the therapeutic alliance (Ackerman & Hilsenroth, 2003; Anglin, 2002; VanderVen, 2004) and dealt with how the workers deal with conflict and bullying to promote emotional safety and attachment (Burns, 2006). The items are moderately to highly correlated with the cluster variable. These interventions were reportedly used by CYC practitioners more than usually but less than frequently (M = 3.48) and 1.3% of respondents reported using them less then sometimes.

3.1.2.1.7 Resilience

Interventions classified under the Resilience cluster focus on relationship development (Anglin, 2002; Burns, 2006; Garfat, 1998). Some items are also recommended in the guidelines for residential care (OCFSA, 2004). Having a supportive adult relationship is a key factor in resilient children and youth (Masten, 2004). The items are moderately correlated with the cluster. These interventions were reportedly by CYC practitioners usually (M = 3.37) and only 0.3% of respondents reported using them less then sometimes.

3.1.2.1.8 Trauma

Interventions classified under the Trauma cluster describe helping children deal with historical traumatic events (Anglin, 2002; Farmer & Pollack, 2003) and with the separation trauma that is associated with being placed into care (Burns, 2006; Garfat, 1998). Some of these interventions may be components of evidence based treatments for trauma (Kazdin & Weisz, 1998). Some items are recommended in the guidelines for residential care (OCFSA, 2004). The items are moderately correlated with the cluster.
These interventions were reportedly used by CYC practitioners usually (M= 3.30) and 1.6% of respondents reported using them less then sometimes.

3.1.2.1.9 Positive Identity

Interventions classified under the Positive Identity cluster are related to helping children develop self-concept and create their own personal identity (Anglin, 2002) including exploring sexual identity (Farmer & Pollack, 2003) The items are moderately correlated with the cluster. These interventions were reportedly used by CYC practitioners usually (M= 3.0) but 12.4% of respondents reported using them less then sometimes.

3.1.2.1.10 Conflict Management

The interventions inquired about under the cluster Conflict Management inquired about activities are components of evidence based interventions used in a day treatment clinical setting (Field et al., 2004; Kazdin & Weisz, 1998) and on principles of positive peer culture (Vollmer, 2005). The items are moderately to highly correlated with the cluster variable and the correlations ranged from .410 to .766, a much wider range than most clusters. These interventions were reportedly used by CYC practitioners usually (M= 2.92) and 3.6% of respondents reported using them less then sometimes.

3.1.2.1.11 Socialization

Interventions classified under the Socialization cluster identify the importance of peer relationships and social events in children’s lives as they are incorporated into group care (Burns, 2006). Many items are recommended in the guidelines for residential care (OCFSA, 2004). The items are moderately to highly correlated with the cluster. These interventions were reportedly used by CYC practitioners usually (M= 3.09) and 9% of respondents reported using them less then sometimes.

3.1.2.1.12 Leisure

Interventions classified under the Leisure cluster are related to helping children learn to play, engage in recreational activities and enjoy themselves which are critical developmental tasks (Trieschman et al., 1969; VanderVen, 2004). Recreational therapy as a service is commonly provided by residential treatment programs but its specific role in outcomes is unknown (Libby, Coen, Price, Silverman, & Orton, 2005). The items are moderately and unevenly correlated with the cluster. These interventions were reportedly used by CYC practitioners less than usually (M= 2.85 ) and 3.1% of respondents reported using them less then sometimes.

3.1.2.1.13 School Success

Interventions classified under the School Success cluster relate to the importance of school success in later life and the extent to which schooling is provided inside most residential treatment centres. These interventions are identified in pre-post designs as related to good outcomes (Libby et al., 2005). Many items are recommended in the guidelines for residential care (OCFSA, 2004). The items are moderately to highly correlated with the cluster. These interventions were reported by CYC practitioners more than sometimes but less than usually (M= 2.83) and 15% of respondents reported using them less then sometimes.

3.1.2.1.14 Aftercare

Interventions classified under the Aftercare cluster have been found to be related to positive outcomes in pre-post designs (Frensch & Cameron, 2002; McCurdy & McIntyre, 2004). Aftercare interventions are the least frequently reported by CYC practitioners (M= 2.44) and 41.2% of respondents used them less
than 2 (*sometimes*). Each question within the aftercare cluster was highly correlated with the composite score.

### 3.1.2.15 Independence

The interventions inquired about under the cluster Independence describe interventions that prepare youth for independent living including cooking and life skills programs. Some items are also recommended in the guidelines for residential care (OCFSA, 2004). The items are highly correlated with the cluster. These interventions were reportedly used by CYC practitioners less than usually (*M* = 2.37) and 31.8% of respondents reported using them less than *sometimes*.

### 3.1.2.16 Vocational Skills

Interventions classified under the Vocational Skills are associated with helping youth develop employment skills an important focus of adolescent development. Some items are recommended in the guidelines for residential care (OCFSA, 2004). Two of the items are highly correlated with the cluster variable, indicating that most of the variance in the cluster is explained by these two items. One of the interventions is moderately correlated with the cluster variable. These interventions were reportedly used by CYC practitioners more than *sometimes* but less than usually (*M* = 2.63) and 30.9% of respondents reported using them less then *sometimes*.

#### 3.1.2.2 Case Management Practice in High Uptake EBP

Objective #2: To identify the differences in the use of EBP for client case management among providers of group care services. Our hypothesis is that group care settings with High Uptake of EBP will report a higher score in case management practices associated with EBP than those with low uptake of EBP.

Case management practices assessed by the survey described four areas of evidence-based practice related to case management. These four areas were screening, assessment following placement, case planning, and outcome evaluation. The questions identified both the processes that were followed and the types of tools, assessments and interventions used in plans of care. Group care programs were divided into two groups based on the program manager responses to four questions about how well the program was able to *access*, *assess*, *adapt*, and *apply* research based knowledge. The programs above the mean were considered to have a *High Uptake* of EBP and those below the mean a *Low Uptake* of EBP.

#### 3.1.2.2.1 The Process of Case Management

There were many significant differences in the process of case management between the group of programs with a High Uptake of EBP and the group of programs with a Low Uptake of EBP as outlined in Table 3-3. There were no significant differences in 3 items that were part of the assessment process following placement. Regardless of whether a program had a high or low uptake of EBP, respondents prepared a written assessment of the child's needs, used logs as a primary source for that assessment, and interviewed the child in a one to one situation to complete the assessment. In Low Uptake programs the CYC practitioner was significantly less likely to be involved in the interview of the child; however there was no difference in whether or not someone completed the interview. Table 3-3 presents the areas of case management process where there were significant differences between the High Uptake and Low Uptake groups. Since both the CYC practitioners and the program managers answered these questions, with reference to their own involvement in case management the analysis was completed on the full group (all respondents) and then separately on program managers and CYC practitioners. In some cases a significant difference in either the program manager or the CYC responses
affected the total group score and therefore, if appropriate, there is a notation if there was a specific difference in responsibility between the CYC practitioner and the program manager.

Table 3-3: The Process of Case Management: Independent Samples Test: Program Managers and CYC Practitioners

<table>
<thead>
<tr>
<th>Full Group PM and CYW: Total N approximately 337 people, 105 programs</th>
<th>T score</th>
<th>Sig. (2-tailed)</th>
<th>Mean Difference</th>
<th>N High Uptake Group</th>
<th>Mean High Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency has written screening criteria*</td>
<td>-2.712</td>
<td>.007</td>
<td>-.276</td>
<td>184</td>
<td>3.54</td>
</tr>
<tr>
<td>Agency specifies type of info required to a referring source.</td>
<td>-4.095</td>
<td>.000</td>
<td>-.387</td>
<td>176</td>
<td>3.52</td>
</tr>
<tr>
<td>CYW’s have a role in screening</td>
<td>-4.077</td>
<td>.000</td>
<td>-.466</td>
<td>186</td>
<td>2.19</td>
</tr>
<tr>
<td>CYW’s read the full referral info prior to placement*</td>
<td>-2.348</td>
<td>.019</td>
<td>-.274</td>
<td>186</td>
<td>2.85</td>
</tr>
<tr>
<td>Assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YOU provide verbal input to the child’s assessment-prepared by someone else.</td>
<td>-3.350</td>
<td>.001</td>
<td>-.348</td>
<td>185</td>
<td>3.21</td>
</tr>
<tr>
<td>YOU interview to gather information.</td>
<td>-2.779</td>
<td>.006</td>
<td>-.364</td>
<td>185</td>
<td>2.82</td>
</tr>
<tr>
<td>You gather information informally-phone or direct contact*</td>
<td>-2.739</td>
<td>.006</td>
<td>-.307</td>
<td>187</td>
<td>3.08</td>
</tr>
<tr>
<td>Parents are interviewed by someone in program during assessment.</td>
<td>-3.153</td>
<td>.002</td>
<td>-.396</td>
<td>186</td>
<td>2.94</td>
</tr>
<tr>
<td>Case Planning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YOU participate in treatment planning**</td>
<td>-3.185</td>
<td>.002</td>
<td>-.269</td>
<td>187</td>
<td>3.71</td>
</tr>
<tr>
<td>YOU are directed at a planning conference for a specific intervention**</td>
<td>-3.172</td>
<td>.002</td>
<td>-.317</td>
<td>187</td>
<td>3.43</td>
</tr>
<tr>
<td>You have a lead role in preparing the POC.</td>
<td>-2.33</td>
<td>.02</td>
<td>-.306</td>
<td>183</td>
<td>3.13</td>
</tr>
<tr>
<td>POC interventions are followed through on in actual practice*</td>
<td>-1.60</td>
<td>.105</td>
<td>-.121</td>
<td>173</td>
<td>3.58</td>
</tr>
<tr>
<td>Outcome evaluation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You collect data regularly to evaluate child’s progress*</td>
<td>-2.31</td>
<td>.022</td>
<td>-.252</td>
<td>178</td>
<td>3.46</td>
</tr>
</tbody>
</table>

*Difference significant ONLY for PM’s and overall group

**Difference significant ONLY for CYW’s and overall group
3.1.2.2 Tools and Interventions for Case Planning

Participants were asked what areas of information the assessment of the child gathered information on. They were also asked what interventions or treatment models they incorporated in their plans of care. Finally they were asked what areas they collected outcome data on.

Respondents indicated that there were a variety of people who performed the assessments in addition to themselves. 0.3% of program managers reported that someone else performed the assessments and 69.5% of CYC practitioners reported this. Written in responses indicated that multiple assessments were completed and that the approach to assessing the needs of children and youth was team based and included other mental health professionals, social workers, or CYC practitioners.

Table 3-4 presents the areas of assessment that CYC practitioners and program managers gather information on. Where there were significant differences between programs with a High vs. a Low Uptake of EBP the item is highlighted. Most areas were reportedly assessed usually (3) to frequently (4).

Table 3-4: Assessment Information: Test of Significant Differences between High Uptake and Low Uptake EBP Programs

<table>
<thead>
<tr>
<th>Full Group PM and CYW: Total N approximately 337 people, 105 programs</th>
<th>T score</th>
<th>Sig. (2-tailed)</th>
<th>Mean Difference</th>
<th>N High Uptake Group</th>
<th>Mean High Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>The program assessment you complete gathers information on....</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Needs and organic brain damage</td>
<td>-.663</td>
<td>.508</td>
<td>-.097</td>
<td>161</td>
<td>2.45</td>
</tr>
<tr>
<td>Language</td>
<td>-3.977</td>
<td>.000</td>
<td>-.504</td>
<td>163</td>
<td>3.09</td>
</tr>
<tr>
<td>Ability to communicate needs</td>
<td>-3.110</td>
<td>.002</td>
<td>-.331</td>
<td>163</td>
<td>3.39</td>
</tr>
<tr>
<td>Ability to communicate feelings</td>
<td>-3.277</td>
<td>.001</td>
<td>-.309</td>
<td>163</td>
<td>3.58</td>
</tr>
<tr>
<td>Strengths and Accomplishments</td>
<td>-2.194</td>
<td>.029</td>
<td>-.172</td>
<td>163</td>
<td>3.72</td>
</tr>
<tr>
<td>Self destructive behaviour</td>
<td>-2.339</td>
<td>.020</td>
<td>-.192</td>
<td>163</td>
<td>3.70</td>
</tr>
<tr>
<td>Aggressive behaviour</td>
<td>-1.956</td>
<td>.051</td>
<td>-.150</td>
<td>163</td>
<td>3.74</td>
</tr>
<tr>
<td>Academic performance</td>
<td>-2.116</td>
<td>.035</td>
<td>-.215</td>
<td>163</td>
<td>3.55</td>
</tr>
<tr>
<td>School functioning (behaviour)</td>
<td>-1.790</td>
<td>.075</td>
<td>-.184</td>
<td>163</td>
<td>3.52</td>
</tr>
<tr>
<td>Educational needs</td>
<td>-1.696</td>
<td>.091</td>
<td>-.178</td>
<td>162</td>
<td>3.48</td>
</tr>
<tr>
<td>Peer relationships</td>
<td>-2.187</td>
<td>.030</td>
<td>-.184</td>
<td>163</td>
<td>3.69</td>
</tr>
<tr>
<td>Relationship with you</td>
<td>-1.916</td>
<td>.056</td>
<td>-.213</td>
<td>163</td>
<td>3.44</td>
</tr>
<tr>
<td>Cultural identity</td>
<td>-.837</td>
<td>.403</td>
<td>-.091</td>
<td>162</td>
<td>3.34</td>
</tr>
</tbody>
</table>
**Full Group** PM and CYW:
Total N approximately 337 people, 105 programs

<table>
<thead>
<tr>
<th></th>
<th>T score</th>
<th>Sig. (2-tailed)</th>
<th>Mean Difference</th>
<th>N High Uptake Group</th>
<th>Mean High Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community involvement</td>
<td>-1.195</td>
<td>.233</td>
<td>-.128</td>
<td>163</td>
<td>3.42</td>
</tr>
<tr>
<td><strong>Religious identity</strong></td>
<td>-2.392</td>
<td><strong>.017</strong></td>
<td>-.275</td>
<td>162</td>
<td>3.36</td>
</tr>
<tr>
<td>Family experience</td>
<td>-1.423</td>
<td>.156</td>
<td>-.157</td>
<td>163</td>
<td>3.40</td>
</tr>
<tr>
<td>Family relationships</td>
<td>-1.357</td>
<td>.176</td>
<td>-.144</td>
<td>162</td>
<td>3.42</td>
</tr>
<tr>
<td>Recreation</td>
<td>-1.265</td>
<td>.207</td>
<td>-.118</td>
<td>163</td>
<td>3.53</td>
</tr>
<tr>
<td>Personal hygiene</td>
<td>-.803</td>
<td>.423</td>
<td>-.071</td>
<td>163</td>
<td>3.60</td>
</tr>
<tr>
<td>Nutrition</td>
<td>.336</td>
<td>.737</td>
<td>.037</td>
<td>163</td>
<td>3.35</td>
</tr>
<tr>
<td>Social skills</td>
<td>-1.655</td>
<td>.099</td>
<td>-.135</td>
<td>163</td>
<td>3.67</td>
</tr>
</tbody>
</table>

**NOTE:** In most cases of significant difference equal variances between the groups could not be assumed for this particular set of tests.

Interventions can be “prescribed” or incorporated into Plans of Care (POC) and systemically applied by the CYC practitioners or clinical counsellors associated with the program. Respondents were asked to identify how frequently they incorporate certain types of interventions on the plan of care and to indicate what specific model or approach they used. The results are presented here, noting significant differences between High Uptake of EBP programs and Low Uptake of EBP programs. Results were analyzed separately for program managers and CYC practitioners as well as for all respondents together. The results reported here are for the total group of respondents (see Table 3-5: Types of interventions included in case plans: Test of Significant Differences between High Uptake and Low Uptake EBP Programs) but if significant differences were influenced by either program manager or CYC respondents this is noted. The analysis of qualitative response is presented here along with the quantitative differences to give a clear idea of the types of models and approaches most commonly reported.

There were four interventions which indicated NO significant difference between High or Low Uptake programs. On a scale of 1 (rarely/never) to 4 (frequently) the following interventions were not significantly different between groups. Wrap around (M=1.70;1.61), use of restraints (M=2.08;2.09), use of de-escalation techniques (M=3.69,3.60) and Applied Behaviour Analysis (M=2.28;2.09), showed no difference between groups.

Less than 24% (23.5%) of those surveyed provided a written response detailing the techniques used in wraparound services. Just under 9% (8.9%) of those who provided an answer indicated their lack of understanding of Wraparound services (unsure/unknown, PMAB/UMAB, “I don’t know what that is.”, “Maybe we call it something else, what is wraparound? Is it a restraint technique?”). One program manager stated: “Ability to connect with wraparound programs has been very difficult”. CYC practitioners who provided additional information reported that they are often involved in the provision
of wraparound services as members of a multi-disciplinary team. Many responses indicate the involvement of clinicians, case managers, and transitional workers.

The intervention most frequently recorded on the POC by the High Uptake of EBP group was Behavioural Interventions** (M=3.65; t(171)=-2.307, p=.022, d=-.206). CYC practitioners and program managers are highly involved and varied in their behavioural programs and interventions. Eighty-eight percent of respondents provided write-in answers pertaining to this question. Treatment models that CYC practitioners reported using to manage behaviour included Non-Violent Crisis Intervention (NVCI), Therapeutic Crisis Intervention (TCI), Understanding and Managing Aggressive Behaviour (UMAB), Preventing and Managing Aggressive Behaviour (PMAB), Hurdle Help, and 1-2-3 Magic.

The second most frequently intervention recorded on the POC by the High Uptake of EBP group was Life Skills Training (M=3.41; t(177)=-3.242, p=.001, d=-.344). CYC practitioners reported using formal and informal ways of teaching and measuring life skills. In formal monitoring and measurement, the following models or tools were reported as being used to evaluate the clients’ independence: the client’s Plan of Care, Individual Program Plans (IPP), Independent Living Skills assessments (ILS), Child and Adolescent Functional Assessment Scale (CAFAS), Ontario Looking After Children (ONLAC) and OARTY’s vision were all part of measurement techniques. Some tools are used in tandem with measuring social skills including the 4th R, RAP and Casey Life Skills. Some agencies reported developing their own curriculum to teach and measure life skills.

The third most frequently intervention recorded on the POC by the High Uptake of EBP group was Individual Sessions (M=3.25; t(174)=-1.936, p=.054, d=-.227). In individual treatment sessions with their clients, CYC practitioners reported that they utilized varied types of therapeutic approaches, the majority with a psycho-therapeutic focus. Cognitive Behavioural Therapy (CBT) is most widely reported as a treatment model for individual sessions on the Plan of Care. CYC practitioners reported using tools from CBT on the floor as well as supporting another clinician’s work with the client by using the CBT model. Other reported treatments included Relationship Oriented Psychotherapy, Solution Focused Brief Therapy, Reality Therapy, Narrative Therapy and Strengths-Based Therapies. Stop Now and Plan (SNAP), Coping Cat, and COPE are also used. Art and Play Therapies were also reported although it is unclear whether the therapy is implemented by the CYC practitioner or by a trained clinician.

The fourth most frequently intervention recorded on the POC by the High Uptake of EBP group was Social Skills Training, (M=2.97; t(174)=3.016, p=.003, d=-.39). This was the largest difference between the two groups. CYC practitioners reported using formal and informal techniques to teach and measure their clients’ social skills. Reported formal systems used to teach social skills include Goldstein’s Skill Streaming, the 4th R Initiative, Social Stories developed by Carol Gray, Casey’s Life Skills, Volcano in My Tummy, YWCA format, Virtues training, and the Raising Academic Performance (RAP) Program. Some agencies reported creating their own curriculum for teaching and measuring social skills. Tools used include books, worksheets and manuals.

Group Treatment sessions** were recorded on the POC by the High Uptake of EBP group with less frequency, but still significantly more often than the Low Uptake group, M(High)=2.98; t(173)=2.51, p=.013, d=-.324). Specific therapeutic models reported for group treatment include Cognitive Behavioural Therapy (CBT) and Aggression Replacement Therapy. The SNAP model that was reported in individual treatments was at times applied to group treatments. Expressive art therapies and peer-led group sessions are examples of ways that CYC practitioners actively engage clients in treatment.

Applying attachment theory to build secure relationships * was an intervention recorded on the POC by the High Uptake of EBP group with less frequency, but still significantly more often than the Low Uptake group M(High)=2.44; t(170)=2.715, p=.007, d=-.348). This was also a large difference between the two
groups. CYC practitioners demonstrated limited understanding of Attachment theory; less than 35% of those surveyed provided a write-in answer for this question. Some practitioners indicated that the application of attachment theory happens only in individual therapy sessions with clinicians, social workers or therapists. The responses that supported the use of attachment theory by CYC practitioners to build relationships with their clients were few, but content rich. One treatment model was mentioned: Modified Interactive Guidance (MIG). Other reported techniques used to improve the attachment relationship were less formal.

Trauma treatment ** was an intervention recorded on the POC by the High Uptake of EBP group M(High)=2.07; with less frequency, but still significantly more often than the Low Uptake group. t(166)=-2.554, p=.011, d=-.312. CYC practitioners reported that clients are most often referred to clinicians, psychologists, psychiatrists or other types of professionals (whether within or outside the agency) for trauma specific treatment. Therapies used for the treatment of trauma (as reported by CYC practitioners) include Cognitive Behavioural Therapy (CBT), Narrative therapy, Art Therapy, Play Therapy, Eye Movement Desensitization and Reprocessing (EMDR) and the holistic approach called Emotional Freedom Training (EFT).

While Parent Support or skills training** was recorded on the POC “sometimes” by the High Uptake of EBP group (M=2.08); it was still significantly more often than the Low Uptake group (M=1.79); t(154)=-2.13, p=.034, d=-.29). Parents of children in group care settings are supported in a variety of ways. Models such as the Triple P - Positive Parenting Program and the Community Parent Education Program are the commonly reported treatment models used by CYC practitioners and program managers. Often, the CYC practitioner reported that these forms of support are provided by professionals other than him or herself. Clinical social workers, Child and Family Clinicians, workers from the Centre for Individual and Family Therapy (CIFT), and Children’s Aid Service workers are reportedly providing formal parental supports.

Formal treatment sessions with the family ** were recorded on the POC less than “sometimes” by the High Uptake of EBP group (M=1.88); it was still significantly more often than the Low Uptake group (M=1.58); t(176)=-2.412, p=.016, d=-.298). Written responses show that family treatments are delivered by clinicians (social workers, family therapists, CIFT workers). Treatment models used, as reported by program managers and CYC practitioners, include Cognitive Behavioural Therapy (CBT), Multisystemic Therapy (MST) and the Triple P – Positive Parenting Program. Family treatments include Plan of Care meetings and reviews with the family in attendance.

Table 3-5: Types of interventions included in case plans: Test of Significant Differences between High Uptake and Low Uptake EBP Programs

<table>
<thead>
<tr>
<th>Full Group</th>
<th>PM and CYW: Total N approximately 337 people, 105 programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>You and/or the other CYW’s in the program incorporate these interventions or treatment models in your plans of care...</td>
<td>T Score</td>
</tr>
<tr>
<td>Behavioural Treatment**</td>
<td>-2.307</td>
</tr>
</tbody>
</table>
### Outcome Evaluation

Respondents were asked how data on outcomes was collected and what type of information was collected. There were no significant differences between the groups in their use of logs for outcome data, 90% of both groups used logs. Similarly 78% of both groups collected data using social skills checklists and 87% collected data on the child's strengths and assets to assess outcomes. There was a significant difference in the use of behaviour observation checklists. In the High Uptake group 56.9% reported using behaviour observation checklists and in the Low Uptake group 39.1% did (Pearson chi-squared=3.24; df=1; sig. =.054). Similarly, in the High Uptake group 65.5% reported using self-report instruments and in the Low Uptake group only 39.1% did (Pearson chi-squared=7.18; df=1; sig. =.006). While the use of a structured method to assess functional abilities of the child was not significantly different it was approaching significance, 60% of the High Uptake group reported using a structured method and in 46% of the Low Uptake group did.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Z</th>
<th>p</th>
<th>r</th>
<th>n</th>
<th>d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life Skills Training</td>
<td>-3.242</td>
<td>.001</td>
<td>-.344</td>
<td>177</td>
<td>3.41</td>
</tr>
<tr>
<td>Individual Sessions</td>
<td>-1.936</td>
<td>.054</td>
<td>-.227</td>
<td>174</td>
<td>3.25</td>
</tr>
<tr>
<td>Group Treatment **</td>
<td>-2.508</td>
<td>.013</td>
<td>-.324</td>
<td>173</td>
<td>2.98</td>
</tr>
<tr>
<td>Social Skills Training</td>
<td>-3.016</td>
<td>.003</td>
<td>-.390</td>
<td>174</td>
<td>2.97</td>
</tr>
<tr>
<td>Attachment*</td>
<td>-2.715</td>
<td>.007</td>
<td>-.348</td>
<td>170</td>
<td>2.44</td>
</tr>
<tr>
<td>Parent Support or Skills</td>
<td>-2.368</td>
<td>.018</td>
<td>-.300</td>
<td>178</td>
<td>2.08</td>
</tr>
<tr>
<td>Family Training **</td>
<td>-2.554</td>
<td>.011</td>
<td>-.312</td>
<td>166</td>
<td>2.07</td>
</tr>
<tr>
<td>Trauma**</td>
<td>-2.368</td>
<td>.016</td>
<td>-.298</td>
<td>176</td>
<td>1.88</td>
</tr>
<tr>
<td>Formal Treatment with Family**</td>
<td>-1.135</td>
<td>.257</td>
<td>-.091</td>
<td>173</td>
<td>3.69</td>
</tr>
<tr>
<td>Applied Behavioural Analysis</td>
<td>-1.363</td>
<td>.174</td>
<td>-.185</td>
<td>158</td>
<td>2.28</td>
</tr>
<tr>
<td>De-escalation</td>
<td>-.671</td>
<td>.503</td>
<td>-.082</td>
<td>151</td>
<td>1.70</td>
</tr>
<tr>
<td>Restraints</td>
<td>.048</td>
<td>.962</td>
<td>.006</td>
<td>177</td>
<td>2.08</td>
</tr>
</tbody>
</table>

* Difference significant ONLY for PM’s and overall group

** Difference significant ONLY for CYW’s and overall group
3.1.2.3 CYC Scope of Practice in High Uptake EBP

Objective #3: To describe the scope of practice of CYC practitioners in the therapeutic milieu and identify the nature of the activities and the role of CYC practitioners among group care services with a High Uptake of EBP. Our hypothesis is that group care settings with High Uptake of EBP will report a higher overall frequency of CYC intervention strategies and that there will be clusters of strategies that represent interventions linked to the literature on EBT and best practice.

The hypothesis that the overall reported frequency of CYC interventions would be higher among organizations with a High Uptake of EBP was not supported. As indicated in Table 3-6 there was no difference among the High Uptake vs. Low Uptake group care settings in the overall frequency of CYC interventions (x=3.0 for both groups). There was one cluster of items where there was a significant difference between Low and High Uptake groups. The High Uptake group of programs had a significantly higher mean frequency of interventions related to the physical milieu (x=3.40, t=-2.698, sig. less than .01).

Table 3-6: Differences in CYC Scope of Practice between Programs with a High Uptake vs Low Uptake of EBP

<table>
<thead>
<tr>
<th>Elements of the physical milieu</th>
<th>N=241 CYC Practitioners</th>
<th>t-score</th>
<th>Sig. (2-tailed)</th>
<th>N High Uptake</th>
<th>Mean High Uptake</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>125</td>
<td>3.49</td>
</tr>
</tbody>
</table>

A more detailed examination of these differences indicated that High Uptake programs more frequently paid attention to safety ensuring clear boundaries for supervision, efficient traffic flow and good lighting. Factors such as use of children’s art work and appropriate music were not significantly different.

3.1.2.3.1 Factors influencing CYC Scope of Practice in Group Care

Additional analysis was undertaken to determine if other factors influenced the scope of practice for CYC practitioners. Based on the findings that service sectors had significantly different levels of education and experience of practitioners as well as differences in the Uptake of EBP, we decided to examine the effects of three factors: Sector, CYW education, and Years of Experience on clusters of CYC interventions. Our hypothesis was that there would be NO difference in the clusters of interventions based on the combination of the three independent variables. A MANOVA was conducted with all three independent factors to test the idea or model that these three factors combined to influence the results on section three. Sector included three groups, Child Welfare (CAS), Children’s Mental Health (CMH) and Private Children’s Residences (PCR). CYW Education included two groups, those that had a CYW and those that did not. Years of Experience included 5 groups, as selected by the respondents, 0-2 years of experience, 3-5 years of experience, 6-10 years of experience 11-15 years of experience and 16 or more years of experience. The dependent variables were the mean scores on the cluster variables in section three of the survey which measured frequency of certain types of interventions as reported by 348 CYC practitioners. The results of the MANOVA indicated that all three factors significantly influenced some of the variance in the clustered interventions and that there was significant interaction between the factors. Table 3-7 reports the F scores and significance level for each factor and the interactions of the factors. The funding sector accounted for the greatest variance in the reported frequency on the clusters of CYC interventions, followed by CYW specific education and years of experience. All three factors combined did not significantly influence the variance however in pairs they did have an influence. For
example, the sector and having a CYW education combined together to influence 9% of the overall variance in the cluster scores.

Table 3-7: MANOVA Interaction Effects

<table>
<thead>
<tr>
<th>Multivariate Tests(c)</th>
<th>F</th>
<th>Hypothesis df</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>1341.889(a)</td>
<td>16</td>
<td>.000</td>
</tr>
<tr>
<td>Sector</td>
<td>4.020378</td>
<td>32</td>
<td>.000</td>
</tr>
<tr>
<td>Experience</td>
<td>1.498011</td>
<td>64</td>
<td>.008</td>
</tr>
<tr>
<td>CYW</td>
<td>2.034(a)</td>
<td>16</td>
<td>.011</td>
</tr>
<tr>
<td>sector * experience</td>
<td>1.315848</td>
<td>128</td>
<td>.012</td>
</tr>
<tr>
<td>sector * CYW</td>
<td>2.057728</td>
<td>32</td>
<td>.001</td>
</tr>
<tr>
<td>experience * CYW</td>
<td>1.466721</td>
<td>64</td>
<td>.011</td>
</tr>
<tr>
<td>sector * experience * CYW</td>
<td>1.065737</td>
<td>96</td>
<td>.316</td>
</tr>
</tbody>
</table>

A more specific examination of the clusters of items in section three was undertaken to investigate the differential effect on the clusters of interventions. An ANOVA was performed to examine the effect of having a CYW diploma and the effect of the employment sector. Having a CYW diploma made a significant difference in the reported frequency of interventions in the following clusters: Aftercare, Ideology elements of the Milieu, Attachment, Resilience, School Success, Trauma, and the Overall frequency of Interventions. Table 3-8: ANOVA: CYW Diploma effect on CYC Scope of Practice summarizes the results of the ANOVA for these clusters of intervention. As indicated in the overall model determined by the MANOVA having a CYW education may also be moderated by Years of experience and Employment Sector for some of these variables.

Table 3-8: ANOVA: CYW Diploma effect on CYC Scope of Practice

<table>
<thead>
<tr>
<th>Scope of Practice: Intervention clusters</th>
<th>df</th>
<th>F</th>
<th>Sig.</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aftercare</td>
<td>1</td>
<td>6.717</td>
<td>0.010</td>
<td>203</td>
<td>2.33</td>
</tr>
<tr>
<td></td>
<td>386</td>
<td>CYW Diploma</td>
<td>185</td>
<td>2.55</td>
<td></td>
</tr>
<tr>
<td></td>
<td>387</td>
<td>Total</td>
<td>388</td>
<td>2.44</td>
<td></td>
</tr>
<tr>
<td>Ideology elements of the milieu</td>
<td>1</td>
<td>5.599</td>
<td>0.018</td>
<td>195</td>
<td>3.33</td>
</tr>
<tr>
<td></td>
<td>376</td>
<td>CYW Diploma</td>
<td>183</td>
<td>3.46</td>
<td></td>
</tr>
<tr>
<td></td>
<td>377</td>
<td>Total</td>
<td>378</td>
<td>3.39</td>
<td></td>
</tr>
<tr>
<td>Attachment</td>
<td>1</td>
<td>9.706</td>
<td>0.002</td>
<td>203</td>
<td>3.41</td>
</tr>
<tr>
<td></td>
<td>386</td>
<td>CYW Diploma</td>
<td>185</td>
<td>3.54</td>
<td></td>
</tr>
<tr>
<td></td>
<td>387</td>
<td>Total</td>
<td>388</td>
<td>3.47</td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>1</td>
<td>8.758</td>
<td>0.003</td>
<td>201</td>
<td>3.32</td>
</tr>
<tr>
<td></td>
<td>384</td>
<td>CYW Diploma</td>
<td>185</td>
<td>3.42</td>
<td></td>
</tr>
<tr>
<td></td>
<td>385</td>
<td>Total</td>
<td>386</td>
<td>3.37</td>
<td></td>
</tr>
<tr>
<td>School success</td>
<td>1</td>
<td>9.697</td>
<td>0.002</td>
<td>202</td>
<td>2.73</td>
</tr>
<tr>
<td></td>
<td>385</td>
<td>CYW Diploma</td>
<td>185</td>
<td>2.93</td>
<td></td>
</tr>
<tr>
<td></td>
<td>386</td>
<td>Total</td>
<td>387</td>
<td>2.82</td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td>1</td>
<td>9.334</td>
<td>0.002</td>
<td>202</td>
<td>3.23</td>
</tr>
</tbody>
</table>
The employment sector one worked in made a significant difference in the reported frequency of interventions in the following clusters: Cultural and Ideology elements of the Milieu, Ethnic Identity, Positive Identity, Resilience, and Trauma. Table 3-8: ANOVA: CYW Diploma effect on CYC Scope of Practices summarizes the results of the ANOVA for these clusters of intervention. As indicated in the overall model determined by the MANOVA the effect of the employment sector may also be moderated by Years of Experience and a CYW Diploma for some of these variables.

Table 3-9: ANOVA: Employment Sector effect on CYC Scope of Practice

<table>
<thead>
<tr>
<th>Scope of Practice: Intervention clusters</th>
<th>df</th>
<th>F</th>
<th>Sig.</th>
<th>Education</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>385</td>
<td></td>
<td></td>
<td>PCR</td>
<td>185</td>
<td>3.37</td>
</tr>
<tr>
<td></td>
<td>386</td>
<td></td>
<td></td>
<td>Total</td>
<td>387</td>
<td>3.29</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>4.921</td>
<td>0.027</td>
<td>No Diploma</td>
<td>203</td>
<td>2.91</td>
</tr>
<tr>
<td></td>
<td>386</td>
<td></td>
<td></td>
<td>CYW Diploma</td>
<td>185</td>
<td>3.00</td>
</tr>
<tr>
<td></td>
<td>387</td>
<td></td>
<td></td>
<td>Total</td>
<td>388</td>
<td>2.96</td>
</tr>
</tbody>
</table>

| Cultural Elements of the Milieu        | 2  | 3.297| 0.038| PCR       | 129| 3.1627907  |
|                                        | 378|     |      | CAS       | 67 | 3.3694030  |
|                                        | 380|     |      | CMH       | 185| 3.1121622  |
|                                        |    |     |      | Total     | 381| 3.1745407  |
| Ideological Elements of the Milieu     | 2  | 4.934| 0.008| PCR       | 129| 3.2764858  |
|                                        | 375|     |      | CAS       | 65 | 3.5076923  |
|                                        | 377|     |      | CMH       | 184| 3.4438406  |
|                                        |    |     |      | Total     | 378| 3.3977072  |
| Ethnic Identity                        | 2  | 5.247| 0.006| PCR       | 132| 2.9722222  |
|                                        | 385|     |      | CAS       | 67 | 3.3059701  |
|                                        | 387|     |      | CMH       | 189| 3.0961199  |
|                                        |    |     |      | Total     | 388| 3.0902062  |
| Positive Identity                      | 2  | 10.737| 0.000| PCR      | 132| 3.1691919  |
|                                        | 385|     |      | CAS       | 67 | 3.1019900  |
|                                        | 387|     |      | CMH       | 189| 2.8421517  |
|                                        |    |     |      | Total     | 388| 2.9982818  |
| Resilience                             | 2  | 3.224| 0.041| PCR       | 131| 3.3190493  |
|                                        | 383|     |      | CAS       | 67 | 3.4330167  |
|                                        | 385|     |      | CMH       | 188| 3.3874785  |
|                                        |    |     |      | Total     | 386| 3.3721594  |
| Trauma                                 | 2  | 3.757| 0.024| PCR       | 131| 3.2201654  |
|                                        | 384|     |      | CAS       | 67 | 3.2851812  |
|                                        | 386|     |      | CMH       | 189| 3.3593285  |
|                                        |    |     |      | Total     | 387| 3.2993848  |
3.1.3  **Goal # 2: Sector Analysis of the Uptake of Evidence Based Practice:**

The second goal of the project is: To determine if there are differences in the uptake of EBP among child welfare, children's mental health, and private service sector providers of group care services. This goal is associated with the following hypothesis:

There will be significantly more High Uptake group care programs among children’s mental health (CMH) than either child welfare (CAS), or private sector providers (PCR).

The Uptake of EBP was assessed using questions drawn from Barwick et al. (2005) who surveyed members of CMHO in 2004. This survey focused on group care programs only and surveyed all group care programs in the province. Among the respondents to the current survey there was a significant difference between sectors regarding the Uptake of EBP. Further to this, the specific area where uptake was being affected could be determined by examining the subscales.

For the purposes of comparison to earlier results (see the Discussion) the results of the four questions which inquired about readiness for using research-based knowledge are presented in two different ways. The mean score for each sector was computed for each question and a “summed” score to assess overall uptake of EBP was computed. Sector scores and the overall group score were computed and an ANOVA identified differences between the sectors. T-tests indicated that in all cases the CAS sector was significantly different from the PCR and the CMH sectors.

Table 3-10 indicates that overall the computed score on Uptake of EBP was significantly different between the three sectors, F(2,103)=4.798, p=.010. While the respondents reported no difference in their ability to Access or to Adapt information on EBP, there were significant differences in their ability to Assess (F(2,103)=3.351, p=.039) and Apply (F(2,103)=5.934, p=.004) the information.

**Table 3-10: ANOVA on Mean scores for differences in uptake of EBP between sectors**

<table>
<thead>
<tr>
<th></th>
<th>df</th>
<th>F</th>
<th>Sig.</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACCESS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2.305</td>
<td>.105</td>
<td>PCR</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>100</td>
<td>CAS</td>
<td>13</td>
<td>2.15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>102</td>
<td>CMH</td>
<td>53</td>
<td>2.74</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>103</td>
<td>2.62</td>
<td></td>
</tr>
<tr>
<td>ASSESS</td>
<td>2</td>
<td>3.351</td>
<td>.039</td>
<td>PCR</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>100</td>
<td>CAS</td>
<td>13</td>
<td>2.00</td>
<td></td>
</tr>
<tr>
<td></td>
<td>102</td>
<td>CMH</td>
<td>54</td>
<td>2.67</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>103</td>
<td>2.51</td>
<td></td>
</tr>
<tr>
<td>ADAPT</td>
<td>2</td>
<td>2.559</td>
<td>.082</td>
<td>PCR</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>100</td>
<td>CAS</td>
<td>13</td>
<td>2.15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>102</td>
<td>CMH</td>
<td>54</td>
<td>2.65</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>103</td>
<td>2.61</td>
<td></td>
</tr>
<tr>
<td>APPLY</td>
<td>2</td>
<td>5.934</td>
<td>.004</td>
<td>PCR</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>100</td>
<td>CAS</td>
<td>13</td>
<td>1.85</td>
<td></td>
</tr>
<tr>
<td></td>
<td>102</td>
<td>CMH</td>
<td>54</td>
<td>2.59</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>103</td>
<td>2.47</td>
<td></td>
</tr>
<tr>
<td>UPTAKE</td>
<td>2</td>
<td>4.798</td>
<td>.010</td>
<td>PCR</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>101</td>
<td>CAS</td>
<td>13</td>
<td>8.15</td>
<td></td>
</tr>
</tbody>
</table>
Figure 3-12: Capacity to ACCESS research-based knowledge by Sector to Figure 3-15: Capacity to APPLY research-based knowledge by Sector describe the frequency of responses on a continuum from *not well* (1) to *very well* (4) for each sector for the four questions about organizational use of research-based knowledge. These results can be directly compared to the results of Barwick et al. (2005) (see Discussion and Recommendations). Chi-squared tests demonstrated similar areas of significance.

Almost one half of respondents (49%) indicated that their program was able to Access only *somewhat well or not well* research-based knowledge.
Figure 3-13: Capacity to ASSESS research-based knowledge by Sector

Almost one half of all respondents (49.6%) indicated that their program was able to Assess research-based knowledge only *somewhat well or not well*. The CAS group care programs, while not significantly different using chi-squared tests of significance ($\chi^2(6,103)=11.066, p=.086$) reported that 76.9% were able to Assess research-based knowledge only *somewhat well or not well* in contrast to CMH (44.5%) and PCR (42%).

Figure 3-14: Capacity to ADAPT research-based knowledge by Sector

Almost one half of all respondents (47.5%) indicated that their program was able to Adapt research-based knowledge only *somewhat well or not well*. 
Figure 3-15: Capacity to APPLY research-based knowledge by Sector

Over one half of all respondents (54.4%) indicated that their program was able to Apply research-based knowledge only somewhat well or not well. The CAS group care programs were significantly less able to Apply research-based knowledge than not well. The CAS group care programs were significantly less able to Apply research-based knowledge than not well. The CAS group care programs were significantly less able to Apply research-based knowledge than not well. The CAS group care programs were significantly less able to Apply research-based knowledge than not well. The CAS group care programs were significantly less able to Apply research-based knowledge than not well.

3.1.3.1 Factors Supporting Utilization of New Knowledge

In addition to the program manager reporting about the program’s uptake of new knowledge in children’s mental health, the survey examined several factors that affect the uptake. These questions are repeated from the original survey of CMHO by Barwick et al. (2005).

Almost one half of respondents (49%) indicated that their program was able to Access only somewhat well or not well. As indicated in Figure 3-16: Barriers to Assessing Research sufficient time, staff and money are the major barriers to greater access to research-based knowledge.
As noted in Figure 3-17 the number one source of research based information is conferences and forums and this followed by newsletters, organizations and journals. About one-third of respondents report the ability to access to both on-site and off-site research. The respondents also emphasized access to the internet, training sessions hosted by provincial associations and knowledge transfer from supervisors and consultants.
The ability to assess research information varied significantly by sector as noted previously. Therefore, the follow up questions were analyzed by sector as well to determine reasons for this difference. The PCR group care programs reported seeking consultation or a second opinion significantly less often (35.1% of the time in comparison to the CAS programs (69.2%) and the CMH programs (56.4%) $X^2(2, 105)=6.075. p=.048$.

While there were no significant differences between sectors in the program’s ability to Adapt the research information so that it is able to be implemented for group care, the follow up questions were
analyzed by sector and there were significant differences in the nature of the obstacles to adaptation which are presented in Figure 3-19.

CAS programs were hampered by lack of brief reports significantly more frequently ($\chi^2(2, 105)=7.388$, $p=.025$) and were also more often unsure how to modify research information ($\chi^2(2, 105)=8.628$, $p=.013$). PCR programs more often reported that there were no obstacles ($\chi^2(2, 105)=10.587$, $p=.005$) and CAS programs never reported no obstacles. The CAS and to a lesser extent the CMH respondents felt hampered by the lack of brief reports. Close to one half of respondents from the PCR sector (43.2%) felt that there were no obstacles to modifying the research information; whereas no-one from the CAS sector felt that there no obstacles and only one fifth of the CMH sector (21.8%) felt that there were no obstacles to modifying or adapting the research information.

![Barriers to applying the research information](image)

**Figure 3-20: Barriers to Applying Research Information**

As illustrated in Figure 3-20 above, there are a variety of barriers to applying the research and there were some significant differences between the sectors regarding these barriers which help to identify what the difficulties are for the CAS sector. The programs were asked to assess the statement: *organizational change is difficult to accomplish*. This statement rings true for 30% of the PCR programs, 62% of the CAS programs and 53% in the CMH programs ($\chi^2(2, 103)=6.211$, $p=.045$). There are also significant differences by sector regarding the barrier: *not enough information available to enable implementation*. This statement is supported to the least extent by managers in the CMH sector (15%), followed by the PCR (22%) and by the CAS sector (46%) ($\chi^2(2, 103)=6.358$, $p=.042$). Other barriers noted by program managers included: (a) most of the research related to the work of social workers not CYWs, (b) few evidence based programs for Child and Youth work as well as, from many respondents, time, money and resources.

There are no sector differences related to the extent to which programs are supported by research evidence. The overall average is 2.91, close to the phrase *pretty much* on a five point scale. There are no sector differences related to the staff’s ability to use resources on the internet. The overall average is 3.48, on a four point scale ending with *very likely*.
More than one quarter of respondents (27.8%) have membership access to a university or college library; 80% of organizations are affiliated with a college or university; and 39% of program managers are pursuing continuing education. The vast majority of agencies are connected to the web (93%) and 82% of managers have access on their desk; an additional 10.5% have shared access to the web and about 5% as noted above have no access.

There were significant differences by sector regarding the how much assistance is needed with various aspects of the EBP process related to gathering program outcomes. The Program Managers were asked on a 5 point scale from disagree strongly (1) to agree strongly (5) to identify areas they needed help with. The CAS sector consistently reported higher needs for assistance in the areas outlined in Table 3-11.

Table 3-11: "Your program needs assistance with..."

<table>
<thead>
<tr>
<th>Sector</th>
<th>N</th>
<th>Mean</th>
<th>t-score</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>assessing client needs</td>
<td>PCR</td>
<td>36</td>
<td>2.06</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAS</td>
<td>13</td>
<td>3.23</td>
<td>2.558</td>
</tr>
<tr>
<td></td>
<td>CMHO</td>
<td>55</td>
<td>2.29</td>
<td></td>
</tr>
<tr>
<td>matching needs with services</td>
<td>PCR</td>
<td>37</td>
<td>2.46</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAS</td>
<td>13</td>
<td>3.85</td>
<td>3.700</td>
</tr>
<tr>
<td></td>
<td>CMHO</td>
<td>55</td>
<td>2.67</td>
<td></td>
</tr>
<tr>
<td>increasing program participation by client</td>
<td>PCR</td>
<td>36</td>
<td>2.58</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAS</td>
<td>13</td>
<td>3.54</td>
<td>2.223</td>
</tr>
<tr>
<td></td>
<td>CMHO</td>
<td>55</td>
<td>2.71</td>
<td></td>
</tr>
<tr>
<td>measuring client performance</td>
<td>PCR</td>
<td>36</td>
<td>2.81</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAS</td>
<td>13</td>
<td>4.15</td>
<td>3.374</td>
</tr>
<tr>
<td></td>
<td>CMHO</td>
<td>55</td>
<td>3.15</td>
<td></td>
</tr>
<tr>
<td>raising overall quality of service</td>
<td>PCR</td>
<td>36</td>
<td>2.44</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAS</td>
<td>13</td>
<td>3.54</td>
<td>2.217</td>
</tr>
<tr>
<td></td>
<td>CMHO</td>
<td>55</td>
<td>2.95</td>
<td></td>
</tr>
<tr>
<td>using client assessments to guide clinical and program decisions</td>
<td>PCR</td>
<td>36</td>
<td>2.58</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAS</td>
<td>13</td>
<td>3.77</td>
<td>2.717</td>
</tr>
<tr>
<td></td>
<td>CMHO</td>
<td>55</td>
<td>2.84</td>
<td></td>
</tr>
<tr>
<td>using client assessments to document program effectiveness</td>
<td>PCR</td>
<td>36</td>
<td>2.72</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAS</td>
<td>13</td>
<td>3.85</td>
<td>no diff</td>
</tr>
<tr>
<td></td>
<td>CMHO</td>
<td>55</td>
<td>3.20</td>
<td></td>
</tr>
</tbody>
</table>

Table 3-12: Training needs to assist with aspects of EBP

<table>
<thead>
<tr>
<th>You need training in:</th>
<th>N</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>assessing client problems and needs</td>
<td>104</td>
<td>2.404</td>
</tr>
<tr>
<td>increasing client participation in treatment</td>
<td>104</td>
<td>2.885</td>
</tr>
<tr>
<td>monitoring client progress</td>
<td>102</td>
<td>2.745</td>
</tr>
<tr>
<td>Activity</td>
<td>N</td>
<td>Minimum</td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td>----</td>
<td>---------</td>
</tr>
<tr>
<td>using computerized client assessments</td>
<td>104</td>
<td>3.240</td>
</tr>
<tr>
<td>Conducting research</td>
<td>104</td>
<td>3.548</td>
</tr>
</tbody>
</table>

As illustrated in Table 3-12 respondents were asked on a five point scale from disagree strongly (1) to agree strongly (5) whether they needed training to assist them with aspects of EBP. There were no different by sector in this area and with the exception of assistance for conducting research program managers were neutral or disagreed that they needed training in these areas. The highest area of need of was Conducting research; this was close to agree; other answers disagreed with the assertion or were neutral.

Table 3-13: Critical organizational issues affecting the uptake of EBP

<table>
<thead>
<tr>
<th>Statement</th>
<th>N</th>
<th>Minimum</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>You are willing to try new ideas even if some staff members are reluctant</td>
<td>105</td>
<td>2</td>
<td>4.362</td>
</tr>
<tr>
<td>This program operates with clear goals and objectives</td>
<td>105</td>
<td>2</td>
<td>4.057</td>
</tr>
<tr>
<td>This organization holds regular in-service training</td>
<td>103</td>
<td>2</td>
<td>3.951</td>
</tr>
<tr>
<td>You are encouraged here to try new and different techniques</td>
<td>103</td>
<td>2</td>
<td>3.922</td>
</tr>
<tr>
<td>You usually accomplish whatever you set your mind on</td>
<td>104</td>
<td>2</td>
<td>3.856</td>
</tr>
<tr>
<td>You learned new skills or techniques at a professional conference in the past year</td>
<td>104</td>
<td>1</td>
<td>3.779</td>
</tr>
<tr>
<td>Communication with other organizations that have similar interests would help</td>
<td>102</td>
<td>1</td>
<td>3.775</td>
</tr>
<tr>
<td>You learned new clinical skills or techniques from manuals or other self-education materials in the past year</td>
<td>104</td>
<td>1</td>
<td>3.721</td>
</tr>
<tr>
<td>You have staff meetings weekly</td>
<td>105</td>
<td>1</td>
<td>3.705</td>
</tr>
<tr>
<td>Clinical staff here are well-trained</td>
<td>101</td>
<td>1</td>
<td>3.693</td>
</tr>
<tr>
<td>You used the Internet to get work-related information</td>
<td>104</td>
<td>1</td>
<td>3.673</td>
</tr>
<tr>
<td>Staff members often show signs of stress and strain</td>
<td>105</td>
<td>1</td>
<td>3.629</td>
</tr>
<tr>
<td>Mutual trust and cooperation among staff in this organization are strong</td>
<td>104</td>
<td>2</td>
<td>3.625</td>
</tr>
<tr>
<td>Clinicians here often try out different techniques to improve their effectiveness</td>
<td>102</td>
<td>1</td>
<td>3.598</td>
</tr>
<tr>
<td>The formal and informal communication channels here work very well</td>
<td>103</td>
<td>2</td>
<td>3.583</td>
</tr>
<tr>
<td>You have easy access to specialized consultations/treatments for clients when needed</td>
<td>104</td>
<td>1</td>
<td>3.548</td>
</tr>
<tr>
<td>It is easy to change procedures here to meet new conditions</td>
<td>105</td>
<td>1</td>
<td>3.219</td>
</tr>
<tr>
<td>You are under too many pressures to do your job effectively</td>
<td>104</td>
<td>1</td>
<td>3.019</td>
</tr>
<tr>
<td>Frequent staff turnover is a problem for this organization</td>
<td>104</td>
<td>1</td>
<td>3.000</td>
</tr>
<tr>
<td>The heavy workload here reduces program effectiveness</td>
<td>104</td>
<td>1</td>
<td>2.971</td>
</tr>
<tr>
<td>There are enough clinicians here to meet current client needs</td>
<td>105</td>
<td>1</td>
<td>2.933</td>
</tr>
<tr>
<td>Policies here limit staff access to the Internet and use of e-mail</td>
<td>104</td>
<td>1</td>
<td>2.904</td>
</tr>
<tr>
<td>The workload and pressures at your organization keep motivation for new training low</td>
<td>104</td>
<td>1</td>
<td>2.827</td>
</tr>
<tr>
<td>You regularly read professional journal articles or books on</td>
<td>104</td>
<td>1</td>
<td>2.750</td>
</tr>
</tbody>
</table>
How strongly do you agree or disagree with each of the following statements?

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Minimum</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The respondent was asked to rate their agreement with a set of statements about that can affect the uptake of EBP on a five point scale from strongly disagree (1), disagree (2), (3), agree (4) and strongly agree (5). There were few differences between sectors and as noted in

Table 3-13 for many items there was high mean and no respondents strongly disagreed (the minimum is 2 or above). Items that had a negative valance (eg. Disagreeing put the organization in a positive light) are highlighted in green and often had a lower mean score, indicating disagreement. Only two organizational pressures showed statistically significant differences between funding sectors and these were: (a) access to specialized consultation/treatments for clients when needed and (b) frequent staff turnover is a problem. The PCR programs (M=3.38) and the CAS programs (M=2.54) are significantly different in their disagreement with the statement: you have easy access to specialized treatment/consultation for your clients when needed. t(n=37,13,54)=2.158, p=.036. PCR programs are also significantly different from the CMH programs (M=3.91) t(n=91)=2.258, p=.026. As well, CAS and CMH programs are significantly different t(n=67)=-4.34, p=.000. Conversely, the PCR programs (M=3.49) was significantly more likely than CMH programs (M=2.70) to agree with the statement: Frequent staff turnover is a problem; t(n=91)=2.65, p=.01 though there were no significant differences between CAS (M=2.85) and PCR or CAS and CMH. In other organizational stressors the funding sectors are not statistically different and overall program managers assessed their organizations in a neutral or positive manner.

3.1.4 Goal 3: Sector Analysis of Group Care Employees

The third goal of the project is to identify the differences in the educational and experience backgrounds of CYC practitioners among child welfare, children’s mental health, and private service sector providers of group care services. This goal is associated with the following hypotheses:

3.1.4.1 Education of CYWs: Sector Analysis

Hypothesis: Group care programs in the PCR sector will report significantly fewer CYC practitioners with specific CYW education compared to programs who receive transfer payment funds in the CMH and CAS sectors.

Information to assess this hypothesis was collected in two ways. Each program manager was asked to estimate the percentage of employees in the program who had a CYW diploma. In addition, each respondent was asked to identify whether they had a CYW diploma (or alternative educational experience). The program manager estimate is thought to provide a more accurate estimate since the selection of respondents who were in CYC practitioner roles was not random. There were significant differences between the sectors in the predicted direction. As described in Table 3-14 The PCR sector had an estimated mean of 35.22% of their group care workers with CYW diplomas. CAS programs estimated 63% and CMH programs estimated 57.24%. A t-test for significant differences between sectors indicated that the CAS and CMH groups were NOT significantly different but that the PCR programs were significantly different from both the CAS (t (n=13)=-2.4, p=.002) and CMH (t (n=55)=-3.2, p=.019) programs.

Table 3-14: Estimated % of CYW diploma (by Program Manager)
3.1.4.2  Experience of CYWs: Sector Analysis

Hypothesis: Group care programs in the PCR sector will report significantly fewer overall years of experience compared to programs who receive transfer payment funds in the CMH and CAS sectors.

Similar to the previous section which reports the differences in educational background (specifically CYW diplomas) of the child and youth practitioners in each sector, Program managers were asked to estimate the years of experience of the staff working for them. There were significant differences in several areas related to the years of experience of the practitioners. As can be seen from Table 3-15, in the PCR sector, program managers estimated that 37.5% of their staff had only 0-2 years experience and 14.8% had 6-10 years of experience, a significant difference from the CMH sector where only 20% had less than 2 years experience and 26.8% had 6-10 years of experience. Similarly in the CAS sector, in comparison to CMH, 38% had less than 2 years experience. According to program manager estimates, the CAS sector has significantly fewer people with 3-5 years experience (15.8%) than either the PCR (32.3%) or the CMH (30.9%) sector.

Overall the majority of employees, according to program manager estimates in the PCR section have 0-2 years experience (37.5 %) or 3-5 years experience (32.3%). In the CAS sector, the majority have 0-2 years of experience (38.2%) OR have 6-10 years of experience (19.4%). In the CMH sector, the majority have 3-5 years experience (30.9%) or 6-10 years experience (26.8%).

Table 3-15: Significant differences in Experience: Program manager estimates

<table>
<thead>
<tr>
<th></th>
<th>t</th>
<th>Sig. (2-tailed)</th>
<th>Mean Diff</th>
<th>Sector</th>
<th>n</th>
<th>mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCR to CMH</td>
<td>2.853</td>
<td>.006</td>
<td>16.596</td>
<td>PCR</td>
<td>37</td>
<td>37.54</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CMH</td>
<td>54</td>
<td>20.94</td>
</tr>
<tr>
<td>6-10 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCR to CMH</td>
<td>-2.703</td>
<td>.008</td>
<td>-12.016</td>
<td>PCR</td>
<td>37</td>
<td>14.78</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CMH</td>
<td>55</td>
<td>26.80</td>
</tr>
<tr>
<td>3-5 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCR to CAS</td>
<td>2.462</td>
<td>.019</td>
<td>16.451</td>
<td>PCR</td>
<td>37</td>
<td>32.30</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CAS</td>
<td>13</td>
<td>15.85</td>
</tr>
<tr>
<td>0-2 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAS to CMH</td>
<td>-2.201</td>
<td>.031</td>
<td>-17.286</td>
<td>CMH</td>
<td>54</td>
<td>20.94</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CAS</td>
<td>13</td>
<td>38.23</td>
</tr>
<tr>
<td>3-5 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAS to CMH</td>
<td>2.164</td>
<td>.034</td>
<td>15.117</td>
<td>CMH</td>
<td>54</td>
<td>30.96</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CAS</td>
<td>13</td>
<td>15.85</td>
</tr>
</tbody>
</table>
Table 3-16: Program manager estimates of Years of Experience

<table>
<thead>
<tr>
<th></th>
<th>0-2 years</th>
<th>3-5 years</th>
<th>6-10 years</th>
<th>11-15 years</th>
<th>16+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCR</td>
<td>37.54%</td>
<td>32.30%</td>
<td>14.78%</td>
<td>6.06%</td>
<td>7.83%</td>
</tr>
<tr>
<td>CAS</td>
<td>38.23%</td>
<td>15.85%</td>
<td>19.54%</td>
<td>8.54%</td>
<td>5.38%</td>
</tr>
<tr>
<td>CMH</td>
<td>20.94%</td>
<td>30.96%</td>
<td>26.80%</td>
<td>7.91%</td>
<td>9.23%</td>
</tr>
<tr>
<td>Total</td>
<td>20.01%</td>
<td>29.55%</td>
<td>21.67%</td>
<td>7.33%</td>
<td>8.24%</td>
</tr>
</tbody>
</table>

4 Discussion and Recommendations

The purpose of this project was to understand the factors (systemic, organizational, and human) affecting the use of EBP and EBT in group care programs in the province of Ontario and to document the strategies and interventions used by CYC practitioners in the milieu which are linked to EBT and theoretical models of intervention. Overall the results of the survey indicate that interventions that are used by CYC practitioners are theoretically linked to EBTs that have demonstrated positive outcomes for children, youth and families, though the procedures to classify them as EBT’s are not followed. An understanding of EBP and EBT has permeated into residential group care programs. The results also indicate that there is differential knowledge and implementation of EBP within the various sectors that provide residential services for children and youth. Implementation of EBP was affected by organizational and individual factors, such as funding, access to information, and educational preparation of front-line workers. More research to demonstrate the link between group care models, CYC practitioner interventions and client outcomes would develop EBT models in group care that could be replicated. More research on the factors supporting implementation and replication is essential for group care to have demonstrated success. In this section the findings are discussed in relation to previous literature and recommendations are made to support further implementation of EBP in the residential and group care providers. Recommendations for further research are provided.

There were five anticipated outcomes for the project and the following discussion also addresses these outcomes. Recommendations related to each outcome are summarized in each section:

1. A survey on the uptake of evidence based practices in group care including case management practices and interventions by CYC practitioners.

2. A description of the evidence-base that CYC practitioner interventions are drawn from.

3. A profile of the uptake of EBP, barriers to the uptake of EBP, and the nature of case management and CYC practitioners interventions used in three different sectors providing residential treatment and group care in Ontario. This is new information for the child welfare and private sector and provides an update on the uptake of EBP in the children’s mental health sector for comparison to the 2005 results.

4. A profile of the nature of education and experience among CYC practitioners in three different sectors providing residential treatment and group care in Ontario.

5. A profile of the nature of case management practices amongst group care settings with a high uptake of evidence-based practices.
4.1 Message #1: CYC Practitioner’s Scope of Practice has a knowledge base which needs to be developed into a documented EBT through additional research related to client outcomes.

The scope of practice of CYC practitioners in the therapeutic milieu was assessed in section three of the survey completed only by front-line practitioners. The hypothesis that group care settings with High Uptake of EBP would report a higher overall use of CYC intervention strategies that are theoretically and empirically based was NOT supported.

These results, while initially surprising, indicate that readiness to seek and apply a research knowledge base on treatments for children and youth has very little to do with the reported frequency of specific child and youth care interventions. Further investigation of the survey results indicated that three factors; employment sector; years of experience; and having a CYC specific education influenced strongly certain clusters of interventions. The literature review on group care programs indicated that there is no research that investigates how practitioner interventions influence the outcomes of children and youth and no evidence-based treatments with demonstrated effectiveness implemented inside a staffed group care setting, though the Teaching Family Model (Fixsen & Blase, 2002) has some relevance. CYC Practitioners will follow a knowledge base when that knowledge, research and theory is provided to them. If they have a CYC specific education they follow and implement the interventions that they have been taught, regardless of where they work. When they work for a program that follows the knowledge base of EBP and best practices in case management, they implement those practices.

Recommendation: Further research should be undertaken with group care programs with a High Uptake of EBP who have CYC trained practitioners to document client outcomes as they are related to CYC interventions. {XE "Recommendation": Further research should be undertaken with group care programs with a High Uptake of EBP who have CYC trained practitioners to document client outcomes as they are related to CYC interventions. ”}

4.1.1 Objective 1: To validate an instrument which identifies and describes the intervention strategies used by CYC practitioners that are: a) linked to EBT, and b) linked to theoretical literature about best practice in residential child and youth care.

This project was successful in piloting an instrument which measures the frequency of child and youth care intervention strategies that are directly related to the intervention protocols used in several different EBTs as well as strategies that are linked to theoretical models from child and youth care literature. It also demonstrated our ability to measure the use of specific case management practices (EBP) demonstrated to be effective in enhancing children’s outcomes. The instrument (section three) clustered questions into groups of intervention strategies related to attachment, milieu therapy, school success, conflict management, etc. Individual items were shown to be highly correlated with the summed score in each subsection. Exploratory analysis to understand what was influencing the scope of practice assessed in section three indicated that the employment sector (PCR, CAS, CMH); the years of experience, and the type of education (specifically having a CYW diploma) affected the nature of the interventions that were undertaken, both independently and collectively. The combined effects of these factors on scope of practice means that having a CYW does not just increase intervention scores adding to increased scores produced by working in a specific sector or having more years of experience. In addition to those "main effects", it appears that certain sectors affect the way a person with a CYW uses the interventions he/she is trained in. So for example, a professional CYW from the Child Welfare sector may be more able to "modify their practice" to align with the "child welfare perspective" than a non-trained CYW.
Recommendation: A more detailed analysis of the section three responses could uncover those specific aspects of the clusters of interventions that are influenced by organizations and developed with additional years of experience. If indeed certain interventions have a greater likelihood of influencing children’s outcomes and they are mediated by organizational factors or by education and experience, such an understanding could guide organizational hiring practices.  

One might expect that the items contributing to the clusters of interventions influenced by CYW specific education are more clearly mapped to the theoretical interventions in the child and youth care knowledge base. In fact, this is true. Recent work by Burns (2006) drew on the child and youth care literature on residential care and the development of the therapeutic milieu to identify checklists of the elements of a therapeutic milieu and items in the Elements of the Milieu clusters (Cultural and Ideological) were drawn from that work as well as the Systems of Care approach (Whittaker, 2006) which advocates for addressing the individuality of children, youth and families and attending to their cultural identity.

The items in the cluster on Trauma considered that “To move on, pain must be owned, named, and understood in its developmental context, and put within a story that can lead to a desired future-workers can help with this.” (Anglin, 2002, p. 111). The items were developed from an examination of the child and youth care knowledge base and reflected the attention paid to separation from family in group care (Farmer & Pollack, 2003) and to processing underlying feelings related to past events rather than strictly managing behaviour (Ward, 2004).

The items in the cluster labelled Resilience focus on the idea that relationships and supportive adults in the child’s life are critical to positive developmental outcomes (Masten, 2004) and the child and youth care research base was examined to indentify HOW relationships were promoted in group care programs (Anglin, 2002; Burns, 2006; Field et al., 2004; Garfat, 1998; Kelley, 2003; Ward, 2004)

The items in the cluster labelled Attachment focused on the use of relationships, intervention in conflict and bullying, and helping children deal with the stigma of being in care. This set of interventions is likely an example of something learned in the CYW diploma programs in the province and then modified by the employment sector that a graduate is placed in.

Finally the items in the cluster labelled School Success required staff to be more involved with the school and with parents in guiding children in the school. These are items that involve relationships with children, their parents, and the school personnel.

In section two of the survey CYC practitioners indicated that Behavioural Interventions were the most frequently prescribed on the plan of care and wrote in many examples of milieu specific interventions related to behaviourism, combining these with the relational approach to practice and the development of social skills in context. These items are not addressed in section three and consideration should be given to including some more behavioural interventions typical of CBT or other EBT drawn from behaviourism if the instrument is used to relate client outcomes to CYC interventions.
Recommendation: The instrument has the potential to be used to bring consistency to the adaptation of EBT strategies in the group care sector (similar to the design of Wraparound, Multi-systemic Therapy, and Teaching Family Model). Further work is needed to refine the instrument and to develop a mechanism for assessing the outcomes of children and youth consistently across programs that are using these group care models. The instrument has the potential to be used to bring consistency to the adaptation of EBT strategies in the group care sector (similar to the design of Wraparound, Multi-systemic Therapy, and Teaching Family Model). Further work is needed to refine the instrument and to develop a mechanism for assessing the outcomes of children and youth consistently across programs that are using these group care models.

4.2 Message #2: EBP is used by CYC Practitioners in Group Care and EBT strategies are in evidence

The use of EBP and EBT by CYC practitioners in group care settings was assessed in a number of different ways through the survey. It was clear that program managers and front-line CYC practitioners are familiar with the terminology of evidence-based practice and evidence-based treatment in all sectors. There is also strong evidence that the case management practices which are related to EBP and have been demonstrated to be critical for positive outcomes for children and youth involved in mental health and child welfare services (Burchard, Burns, & Burchard, 2002; Evans & Armstrong, 2002; Pantin, Flynn, & Runnels, 2006) are present in programs with a High Uptake of EBP. (This finding is discussed in the next section.) What is less clear is the relationship between case management and the prescription of specific treatments (EBT) known to have good outcomes. The models, techniques and strategies that respondents described in response to questions about specific EBT prescribed on the plan of care were drawn from the child and youth care knowledge base NOT the EBT knowledge base.

4.2.1 Case management Interventions and the Relationship to Evidence-Based Treatment

As discussed in the previous section there was limited relationship between a programs readiness to undertake EBP and the actual front-line interventions undertaken with children in the program as reported in section three of the survey. The literature review noted that criticisms of LAC (Daniel, 2003) included it's failure to provide guidance on how to formulate a plan of intervention from the assessment material gathered and link the plan to measurable outcomes. This survey shows that programs with a High Uptake of EBP reportedly engage in more detailed assessments, write up the plan of care and were more likely to report gathering outcome data.

Program managers and practitioners were asked to identify the types of interventions of treatment models incorporated into plans of care. Since we were interested both in EBT models and typical CYC practice models a specific list of 13 categories include some specific EBT (Intensive Behavioural Intervention, Wraparound) as well as more general categories such as group treatment sessions. Respondents indicated how frequently each category was incorporated on the plan of care. Each category included a box to write in the specific model or approach used and examples were listed which included both specific EBT and typical child and youth care interventions.

EBT programs such as Intensive Behavioural Intervention and Wraparound were unfamiliar to the participants. Family Treatments and Parent Support programs such as Triple P Parenting, Brief Strategic Family therapy, and the Incredible Years were more commonly used in the CMH sector and were not as frequently reported as planned interventions recorded on the plan of care.

The types of interventions recorded on plans of care varied. Family treatment (M= 1.88;1.58); Parent Support (M= 2.08,1.78); Attachment theory interventions(M= 2.44,2.09); and Trauma Treatment (M=...
2.07,1.76) were reportedly used only sometimes in comparison to the usually planned use of Individual Sessions (M= 3.25,3.02); Group Treatment (M=2.98,2.65); Behaviour Programs (M=3.65,3.44); Social Skills (M=2.97,2.58) and Life Skills(M=3.41,3.07) programs.

Prescribed most frequently were Behavioural Interventions. In response to the request to identify the models they used CYC practitioners reported a wide range of techniques that fit with Cognitive Behavioural Treatment approaches (the second most common EBT delivered by the participating agencies across all employment sectors) and strict Behaviourism. Reported techniques such as de-escalation, redirection (or directive statements), prompting (or cues), boundaries, proximity control, planned ignoring, removal of triggers or audience, time and space, and reinforcement are “in the moment” behavioural management tools discussed in the CYC literature and drawn from behaviourism. CYC practitioners also reported using social reinforcement in guiding their clients’ behaviour including positive attention such as praise and caring gestures, rewards for good behaviour. Consequences such as: time out, time in, grounding, natural consequences, and loss of privilege are accompanied by active listening and relating to the client. Such conversations include reviewing choices, options and alternatives, the use of “when-then” statements, and humour. CYC Practitioners are combining the relationship-based interventions with CBT techniques. Formal models that were reported referenced the crisis intervention and aggression management training that is approved and required by MCYS. Clearly these training programs and the requirement that all group care programs provide training in specific management techniques (MCYS implemented in 2004) have had an effect, as there is no significant difference in the prescription of de-escalation techniques (which was done frequently) or restraints (rarely done) across the sectors.

Recommendation: The examples provided by respondents should be developed into questions to add to section three of the instrument to capture the nature of these interventions. {XE "Recommendation": The examples provided by respondents should be developed into questions to add to section three of the instrument to capture the nature of these interventions."}

The prescription of Life Skills on the case plan was closely linked to the use of MCYS recommended materials for outcome assessment such as ONLAC and CAFAS. These instruments were identified as part of the assessment battery used for Life skills assessment, along with OARTY’s Vision assessment. Skill acquisition is followed with daily, weekly or monthly tracking sheets and charts, and by observational monitoring. While there are specific curriculums, many agencies have developed their own curriculums and CYC practitioners work with clients specifically on: laundry, ironing, nutrition and cooking, shopping (clothes, food), budgeting, banking, household maintenance and cleaning, personal hygiene, booking appointments, and managing public transportation. These skills are developed in group sessions, workbooks and experiential learning activities. Recreational activities such as camping, community outings and volunteering are mentioned. Social skills was often viewed as similar to, or a sub-component of life skills with a stronger focus on the informal interactions that the client has with the worker and with his or her peers. Engaging clients in experiential learning and using teachable moments to further development includes cueing, role play, and discussions. Discussions occur in planned (group sessions, for example) or ad-hoc (one-to-one in the community) settings. CYC practitioners also reported using role modelling as a teaching tool for social skills.
Recommendation: It would be useful to determine which group care programs have specific planned curriculums for life skills or social skills, how these are integrated with daily living interventions (for transfer of training) and to assess specifically the outcomes of these curriculums using pre-and post existing measures such as ONLAC or built in plan of care assessments to determine the impact and the essential ingredients. These would then meet the criteria of EBT in group care programs and could be part of a “multi-point” approach similar to MST. \{XE “Recommendation”\} It would be useful to determine which group care programs have specific planned curriculums for life skills or social skills, how these are integrated with daily living interventions (for transfer of training) and to assess specifically the outcomes of these curriculums using pre-and post existing measures such as ONLAC or built in plan of care assessments to determine the impact and the essential ingredients. These would then meet the criteria of EBT in group care programs and could be part of a “multi-point” approach similar to MST. \}

It is clear that CYC practitioners engage in Individual Sessions with clients AND that they support other clinicians in specific treatment models such as CBT and COPE. They are familiar with the EBT’s that program managers reported were available in their agencies as well as other psycho-therapeutic approaches but do not necessarily identify how these models are used in their practice. Individual treatment reportedly also includes informal sessions between the worker and the client. Such sessions provide time and opportunity to do work with respect to the client’s determined needs and may include such areas as relationship building, social skills, communication skills, anger management and aggression, and conflict resolution.

Group sessions also have both a formal and informal component. Much of the content reportedly covered in group treatment sessions centers on helping the client develop better ability to express him or herself. Topics reported included such things as understanding and processing feelings, respectful communication, anger management and conflict resolution. Group sessions also include discussions surrounding moral reasoning, dating and sexual health, life skills and social skills development, and positive peer culture. Some CYC practitioners report using group sessions to lead resident meetings or to discuss issues pertinent to all involved. CYC practitioners demonstrated that they were using specific curriculum in group sessions and many of these were recognized programs for group therapy, social skills training and life skills training such as Casey Life Skills which do not necessarily meet the EBT criteria. Less rigorous curriculum also used in formal group sessions centered on helping the client develop better ability to express him or herself. Group sessions also include discussions surrounding moral reasoning, dating and sexual health. Some CYC practitioners report using group sessions to lead resident meetings or to discuss issues pertinent to all involved.

Recommendation: Observing more specifically what techniques are being implemented in both individual and group sessions using strategies from Narrative Therapy, Solution Focused Therapy, SNAP, and COPE etc. would more clearly define how these approaches are being modified (if at all) and the effect on client outcomes.\{XE “Recommendation”\} Observing more specifically what techniques are being implemented in both individual and group sessions using strategies from Narrative Therapy, Solution Focused Therapy, SNAP, and COPE etc. would more clearly define how these approaches are being modified (if at all) and the effect on client outcomes.”

Planned interventions such as family involvement and dealing with attachment or trauma issues are referred to other professionals who see the child or youth outside of the residence. Family therapists and social workers used EBT’s such as Multi-Systemic Therapy (MST), Triple P parenting, Community Parenting Education (COPE). Informal support for related issues and informal support to parents was also reported by CYC practitioners but NOT at the direction of the therapist, nor with any apparent direction or communication directly with the therapists. Clearly there was a differentiation of roles
between CYC practitioners in group care and therapists who provided services to those children and youth placed in group care, with limited discussion between them. CYC practitioners however were still working within the milieu in the areas of parent support and attachment, as indicated by their reported use of informal interventions such as phone and in-person support especially during home-visits. Workers reported they often go through a debrief session with parents after family visits, where the CYC is able to offer insight, advice and continued support.

Recommendation: Whittaker (2004) strongly recommended the co-location of family and residential programs to bring these aspects together and given the informal work that CYC practitioners are already doing with families, such a co-location could likely offer great benefits to group care programs and enhance the communication between family therapists and CYC practitioners working with the children and youth.

Use of attachment therapy and trauma therapy was reported as occurring with psychologists and psychiatrists in individual sessions outside the home. This is not to say that CYC practitioners do not engage in furthering the attachment relationship. They reported creating an environment of security, consistency and predictability with routines and boundaries. They mention using themselves as a model for healthy relationships and interactions, and they showed commitment to the client by providing unconditional support. Workers report continually working on developing their client relationships through activities that build trust and develop communication skills. One-to-one activities (such as cooking, walks and community outings) provide opportunity to further the attachment between the client and the worker. These are all aspects that are inquired about in section three and seem to be a regular and frequent part of intervention in group care programs.

In contrast to the literature which indicates that EBT is not implemented within group care settings, practitioners and program managers in high uptake EBP programs seem to believe that they are implementing specific treatment models and EBT. The focus is on group-based life skills training and social skills training as well as individual sessions and the use of CBT within the milieu. Family involvement, family counselling, and parent support, all indicated as essential contributors to successful outcomes in group care are used but are less directly linked to the group care setting.

4.3 Message #3: Case Management Practice is slightly different in programs that are ready to apply research based knowledge

In order to assess how group care programs who are more prepared to use research and new knowledge to guide the implementation of their program (High Uptake EBP) might differ from those that are less ready to make use of research, the programs were divided into two groups based on a calculated Uptake of EBP score. Those in the High Uptake group were above the mean and those in the Low Uptake group were below the mean of the entire sample.

Group care settings reported on the frequency with which a variety of case management activities were engaged in (a 4 point scale) and overall, regardless of whether the program had a high or low uptake score, case management activities were engaged in frequently (3) or better. Section two of the instrument assessed the actions of CYC practitioners and program managers in completing case management activities and distinguished those activities practiced by programs with a high readiness for EBP.
While there were some differences between the sectors in regards to the uptake of EBP (discussed in 5.4) there were programs with High Uptake in all three sectors and in fact some agencies had programs in both the High Uptake and Low Uptake groups. Given the similarities overall in the clientele, services, referral mechanisms and staffing across all three employment sectors (see 5.4) there are strong commonalities between group care programs with a High Uptake of EBP, regardless of the sector they are in. The hypothesis that group care settings with High Uptake of EBP would report a higher score in case management practices associated with EBP than those with Low Uptake of EBP was supported.

Evans & Armstrong (2002) demonstrated that Intensive Case Management (ICM) was effective to enhance outcomes for children and youth by reducing symptoms and improving social adaptation. Effective ICM requires case managers provide culturally sensitive service and supports in an educational manner that empowers the clients. Creative and novel service implementation, especially in relation to informal supports, is important. Informal supports are the services and resources that the child and his or her family will utilize after the termination of service provision. Essentially, the case manager provides effective ICM when children and their families are able to self-advocate, and to access support and services on their own in their community. ICM requires ongoing client assessment, progress monitoring and evaluation of goals, interventions and outcomes. High-quality supervision to ensure the availability of support and resources when they are requested by the case manager(s) is a supporting factor for high quality case management. Flexible funding to suit the specific needs of children and their families also contributes to the success of ICM (Evans & Armstrong, 2002) our phases to case management were identified in section two of the survey; screening, assessment, case planning, implementation, and outcome evaluation. All group care programs engage in these phases and undertake case management; however certain aspects are reported at a significantly higher frequency by programs with a High Uptake of EBP.

Based on the results of this survey a group care program with a High Uptake of EBP would more frequently have written criteria for screening, request specific information from the referral source and provide a full referral package to the staff in the program, including the CYC practitioners. Although the CYC Practitioner’s indicate that they are not able to read the full the referral package any more often than those in Low Uptake programs, perhaps indicating an equal lack of time to attend to this task.

During the assessment phase, after the child or youth is placed in group care there are no differences in the preparation of a written assessment by group care staff and most often this assessment is based on daily logs. These aspects of case management have been built into staffed group care programs for many years. Key aspects of the assessment phase that are different in High Uptake programs evidenced a more collaborative and multi-professional approach. Specifically, assessment interviews with children and youth are reportedly done more frequently by group care staff, who report more frequent input into the assessments done by others in High Uptake programs. There is significantly more involvement of parents during the assessment phase. High Uptake programs assess children on a broader range of factors, particularly communication, strengths and accomplishments, destructive behaviour, academic performance, and religious identity. They appear to be more concerned with the unique aspects of the child as an individual as well as his/her relationships with others and social and recreational skill set.

In High Uptake EBP group care settings CYC practitioners and program managers report significantly more involvement in developing and implementing the plan of care (POC). They more usually attend the conference, develop the POC and are directed to implement the interventions. The types of interventions recorded on POC’s in high uptake settings also vary. High uptake group care settings are more likely to report the use of individual sessions; group treatment; social skills training; life skills training; behavioural treatment programs; family treatment; and parent support; use of attachment theory; and trauma treatment on the plan of care.
Finally, High Uptake EBP programs were more likely to collect data on a regular basis in order to evaluate outcomes. They specifically used instrumentation such as behaviour observation checklists or self-report instruments to assess outcomes more frequently than Low Uptake programs.

The results confirm that the programs ability to access and apply research based knowledge has had an influence on practice. There is more information available to group care programs on the nature of case management and the relationship to client outcomes (than there is on EBT in group care) and those programs that are committed to EBP appear to have enhanced their case management practice.

This instrument has the potential to guide programs and workers into appropriate case management activities to enhance the potential for good client outcomes and for collecting data that will reflect changes in the wide variety of developmental issues and behaviours present in their clients. In some items there was no difference between programs with a High Uptake of EBP and those with a Low Uptake of EBP, however those items should still be retained as they are relevant to client outcomes in all programs (eg. Logs; assessment protocols) and are reportedly used frequently.

**Recommendation:** Refine the instrument to identify both common and different elements of case management and then use the survey with the selected High Uptake of EBP programs and collect children’s outcomes to identify which items are good practice and which reflect a more intensive case management process and therefore contribute to enhanced outcomes. High Uptake EBP programs already have the capacity to undertake this type of assessment and data collection and the relative contributions of the particular case management factors can therefore be determined.

**4.4 Message #4: Cross Sector analysis indicates there are more similarities than differences, particularly in the organizational characteristics related to the Uptake of Evidence Based Practice**

**4.4.1 Sector Differences in Readiness for EBP and EBT and Comparison to Previous Readiness in Children’s Mental Health**

The hypothesis that there would be significantly higher Uptake of EBP among group care programs that are part of the CMH sector over programs that are part of the PCR and the CAS sectors was only partially supported. There are differences in the uptake of EBP among child welfare, children’s mental health, and private sector providers of group care services but these differences are focused on the CAS sector which had a significantly lower Uptake of EBP.

Differences between the sectors lay in the capacity of the program to Assess whether research was relevant, reliable and of high quality as well as the ability to Apply research information by implementing and adopting it. PCR and CMH group care programs stated that on average they were able to Access, Assess, Adapt, and Apply research information somewhat well to well where as CAS programs felt less than somewhat well able to Assess and Apply research, though they had equal Access to it and reported an equal ability to Adapt it.

These questions were replicated from Knowledge *Transfer & Implementation of Evidence-Based Practice in Children’s Mental Health*, Barwick et al., (2005). The readiness for EBP in group care programs was higher overall than the readiness in the Children’s Mental Health Sector reported in 2005. In this
discussion the responses of clinical directors (Barwick et al., 2005) are compared to the responses on the current survey of group care programs (See Figure 4-1: ACCESS Research Information Compared to 2004 to Figure 4-6: APPLY Research Information compared to 2004).

Given the focus by CMHO on EBP and EBT over the last three years the increase in readiness for EBP should be expected in the CMH sector. The PCR sector appears to have been influenced through the CMHO focus on educating and supporting their membership in implementing research-based programming. Since many PCR agencies state that they provide children’s mental health services they would of course try to adjust the orientation of the programs. We also expected that the CAS sector would follow in this direction, since CMHO and OACAS have held joint conferences for the last three years. The effects though have been differential.

![Figure 4-1: ACCESS Research Information Compared to 2004](image)

Almost one half of respondents (49%) indicated that their program was able to access only somewhat well or not well. This was similar to earlier findings (Barwick et al., 2005). The barriers to accessing research-related knowledge have changed little since 2005 and do not differ across the sectors. Group care programs reported that they have limited time to find information and limited resources, specifically staff and money to be able to access research. Their primary source of information is conferences. Group care program managers reported an increase in access to both on-site and off-site research since 2005, indicating that they see their organizations engaging in research and participating in off-site research projects. Clearly the trend toward EBP and EBT is influencing the work that agencies do, including those in group care programs, though as yet there is still little published research on the efficacy of group care.
There are few differences reported in the group care sector overall compared to three years earlier in the CMH sector as illustrated in Figure 4-3: ASSESS Research Information compared to 2004. The CAS sector reports being less able to Assess the quality of research-based knowledge than the other two.
sectors. Respondents indicated that research is primarily assessed through the credibility of the organization, individual or source of the information and this has changed little from 2005. CAS programs make significantly more use of outside consultation even though they report that it is more difficult to access outside consultation.

Figure 4-4: ADAPT Research Information compared to 2004

As illustrated in Figure 4-4: ADAPT Research Information compared to 2004 there were few reported differences in how prepared agencies are to Adapt research-based knowledge compared to three years earlier (Barwick et al., 2005) and there were no significant differences between the sectors.

Figure 4-5: Obstacles to Adapting Research Compared to 2004
There were a variety of reported reasons for difficulties with adapting research information (Figure 4-5: Obstacles to Adapting Research Compared to 2004). PCR programs reported 43.5% of the time that there were no obstacles to adapting research information. Since group care program managers disagreed with statements asking about whether they needed assistance with measuring program effectiveness through documenting client outcomes, and overall the group care programs agreed that they were willing to try new ideas and that programs had clear goals and objectives it seems that both the initiative and organizational structures are in place to adapt and change in response to new research. However, while the capacity to adapt research is reported to be there, applying research is reportedly more difficult.

![Figure 4-6: APPLY Research Information compared to 2004](image)

There were significant differences in the capacity of the CAS group care programs to Apply research-based knowledge. There were few differences between this survey and the survey of CMHO agencies in 2005, only 7.7% of the CAS group care programs reported being able to Apply research well or very well, compared to 51.9% of the CMH programs and 50% of the PCR programs.

The barriers to applying the information were similar to those reported earlier. Programs were not always sure how to link research with practice and there was limited access to information to enable implementation. This finding was a little surprising given that there were not many obstacles to adapting the information. There are significant differences by employment sector regarding the barrier: organizational change is difficult to accomplish which may explain the difference between adapting and applying research-based knowledge. This statement was perceived to be true for 30% of the PCR sector, 62% of the CAS sector and 53% of the CMH sector. The CMH responses are no different than the results in the earlier survey. The PCR sector, where agencies are typically smaller and more entrepreneurial with fewer restrictions based on the contract process (Bay Consulting, 2006), reported significantly less difficulty with organizational change.

Somewhat different from the previous survey, group care programs reported that a barrier to change was the lack of staff with research knowledge, indicating that training and support to understand
research might be of use for group care employees. Further examination of the differences in the CAS sector found that CAS program managers reported feeling more strongly than either of the other two sectors that they need assistance with assessing client needs and outcomes and using this information to evaluate service effectiveness for individual clients as well as the program overall.

The sectors differed little in the nature of organizational factors that affect the uptake of EBP though the PCR sector and the CAS sector were significantly more likely to disagree with the statement: you have easy access to specialized treatment/consultation for your clients when needed. Conversely, the PCR sector is significantly more likely than either the CAS or the CMH sector to agree with the statement: significant staff turnover is a problem and responses to the survey indicate that the PCR sector reported significantly more workers with less experience (0-2 years). Overall group care programs agreed that the staff showed signs of stress and strain, but also agreed that there was sufficient training and that they met on a regular basis. The program managers were generally positive about organizational factors. Compared to the results reported by Barwick et al. (2005), the proportion of staff with no research or statistical knowledge has increased considerably, perhaps indicative of the specific population surveyed and their interest and readiness to consider the research base.

There are significant differences by funding sector over the barrier: not enough information available to enable implementation. This statement was supported to the least extent by managers in the CMH sector (15%), followed by the PCR (22%) and by the CAS sector (46%). Other barriers recorded included: (a) most of the research related to the work of social workers not CYWs, (b) few evidence based programs for Child and Youth work and from many respondents, time, money and resources. These comments lend support to the previous discussion about the need to engage with group care programs to assist them in researching and publishing to create an evidence-base of effective treatment relevant to group care programming. There may be a split in the PCR sector’s ability to adapt and apply EBP/EBT in group care settings and agencies. PCR sector programs report an enhanced openness to organizational change and with support could quickly develop additional capacity for applying research-based knowledge.

Recommendation: Given the MCYS direction toward EBP/EBT and the results of this survey among group care programs, CAS sector programs need significant support to implement EBP but are aware of the issues and concerns that need to be addressed. OACAS, OARTY and MCYS should work together to identify those agencies that need extra support and to provide training and additional support for research.

4.4.2 Staffed Group Care in the Province of Ontario: Characteristics and Sector Differences

A discussion of the nature of staffed group care in the Province of Ontario will be undertaken, adding to the results of a recent review of residential care services (Bay Consulting, 2006) undertaken by MCYS. This survey asked questions not considered in the MCYS review and provides an important perspective on staffed group care programs.

The care of children and youth requiring out of home placement occurs in both parented and staffed settings. These programs deal primarily with the more difficult to serve children with mental health needs. This survey focused on staffed settings which, according to Bay Consulting, make up approximately 25% of the bed spaces available for children and youth in the province and include child
welfare, children’s mental health, youth justice, and developmentally delayed services. This survey did not include staffed group care for the last two areas therefore covering 19% of the bed spaces available for out of home care and focusing on children and youth with mental health needs who are placed in staffed group care through child welfare and children’s mental health systems.

There was no explicit intent in this research project to assess differences in the employment sectors that provide staffed group care beyond examining differences in education and experience of the CYC practitioners. However, the questions asked have indicated that there are more similarities in the sectors than there are differences. While the residential services review (Bay Consulting) describes a number of systemic variations (cost of care, mechanisms of varied accountability, staff training requirements) it does not describe the nature of the services associated with group care except in a very general manner, nor does it describe the nature of programs, case management, or human resources associated, all of which were addressed in this project. The results of this survey provide us with an enhanced description of the 19% of out of home care beds (estimated at 4400 beds) that are in group care programs operated to meet children’s mental health and child welfare service needs in the province. Our results are not representative of the staffed programs for youth justice and the developmental services sectors which were also addressed in earlier the residential services review.

Overall each agency runs an average of 2.7 staffed group care programs, varying a little by sector. CAS agencies run an average of 4 programs in the 12 agencies that provide their own services. CMH agencies (N= 48) run an average of 2.5 programs and PCR agencies (N= 60) run an average of 2.7 programs. There appear to be about the same number of agencies running programs with “per diem” funding as are receiving transfer payments and this survey revealed that they report very little difference in type of clientele, services offered, nature of treatment interventions OR readiness for EBP (as explored in the previous section).

There are some regional variations regarding the types of out of home care provided. The North East region uses very little staffed group care, and the East, South-East and Hamilton regions also appear to favour foster care placements. CAS agencies are more likely to provide staffed group care in rural and suburban regions and CMH agencies tend to provide care in suburban and urban regions. PCR agencies are predominatly located in 4 regions; Toronto, Southeast, East, and Hamilton. While CMH programs are located in South-West, Central East, Toronto, and Central West. CAS group care programs dominate in the North and in Toronto. Taken together with the results of the residential service review (Bay Consulting, 2006) which indicates that most of the overall bed spaces are child welfare beds (primarily in foster care), and the highest number of beds are in North, South-west, Hamilton, and Central East this raises some questions about how mental health vs. child welfare needs are determined and how regions makes decisions about types of service provision and funding models. At a macro level the system of child and youth services has regional differences which may be the result of the historical evolution of service delivery and the involvement of MCYS in guiding service development, rather than the specific needs of children and youth in the region, since there are very few differences between these sectors in the types of clients they are serving.

Client characteristics across the sectors were very similar. Children and youth are most often classified as having behavioural and emotional problems. Clients are also equally as likely across the sectors to have cognitive impairments. PCR programs are less likely to service clients with suicidal behaviours (54% do) or those with effects of serve or prolonged trauma (48%) as these clients are more likely to be placed with group care settings in CAS or CMH. Over 50 to 70% of the programs across all sectors service children and youth with FAS/FAE, fire setting, sexual offenders, and dual diagnosis. Children and youth with psychosis are most likely to be served in the CMH sector if placed in group care settings.
According to program managers the sectors have some differentiation but do not provide discretely differently types of services, nor do they differ in the sources from which they receive referrals for group care placements. PCR’s are most likely to provide long term placements (58.2%) but also provide child welfare, crisis, and children’s mental health services and some youth justice services. All PCR’s take CAS referrals and their next largest referral source is private, followed by children’s mental health. CAS agencies on the other hand provide child welfare and crisis beds most often but also provide long term and mental health services. Their primary referral source is their CAS system. The primary referral source for CMH programs is also the CAS (92.7% of programs take CAS referrals), followed closely by children’s mental health (regional placements committees likely) and private placements. CMH programs provide primarily children’s mental health services (70.1%) but also provide long term (44%), child welfare (32%) and crisis services. The differences across the sectors are in emphasis and may well be affected by the regional and community variations in how business is done but all three sectors provide similar services and have the same referral sources.

The residential services review (Bay Consulting, 2006) could not investigate in detail the types of services provided to children in out of home care. In this survey program managers were asked to describe the types of services that their agency provided. The results again indicated very few differences between the sectors. Group care programs and the agencies that run them provide specialized education (section 20 classrooms) (over 80%), crisis back-up, support and consultation for staff, case managers, mandatory staff training, psychological and psychiatric services. The latter two services are contracted out in 30-40% of the agencies. The differences in service provision occurred in the areas of clinical counselling, assessment, and family counselling services. CMH agencies provide these services but CAS and PCR agencies are less likely to provide clinical assessment services (though over 77% of these agencies DO provide these services). CAS agencies are less likely to provide clinical counselling (though again over 85% do) and PCR agencies are less likely to provide family counselling (though over 70% do). These services are likely to be contracted out, 20% or more of the time.

In spite of the similarities in types of clients served, general services provided, referral sources etc. there are significant differences in the use of treatment interventions which have been systematically researched (EBT) by agencies operating staffed group care programs. This type of out of home care can be characterized as using Life Skills Training (76.2%) and CBT (69.5%) across all the sectors. CAS programs rarely reported the use of anything other than CBT or Life Skills Training. Agencies providing group care programs through the CMH sector were significantly different in their use of specific EBT. Family focused EBT’s and COPE are provided almost exclusively by CMH programs, although PCR programs do use Behavioural Parent Training. PCR programs also report using MST, Narrative Therapy, SNAP and Wraparound, though not as frequently as CMH programs.

A profile of group care programs in Ontario emerges which indicates similarities such as:

1. Children and youth in all group care programs are most likely to have been referred by a CAS and will have access to agency-based services for specialized classroom support (Section 20 classrooms), case management services, clinical counselling, psychological or psychiatric assessment.

2. Staff in all group care programs will likely have access to crisis support, mandatory staff training, relief staff and will be involved in providing CBT and Life Skills Training, probably from a recognized EBT system.

3. Children and youth in all group care programs are most likely to have emotional or behavioural disorders or cognitive impairments.

And differences such as:
4. Children and youth in need of out of home care in Hamilton, North East, South East and East regions are least likely to be in staffed group care and if they are it is probably run by an PCR agency.

5. Children and youth in long term care are most likely to be in PCR group care program and if a child or youth needs a Crisis placement he/she most likely is in a CAS group care program.

6. Children and youth who are suicidal or are in need of treatment for traumatic events are most likely to be in a CAS or CMH group care program.

7. Family support and counselling is more likely operated from CMH agencies but these services are probably accessed by PCR and CAS group care programs. It is unclear how much family involvement there is in group care programs (formal or informal) since neither Family Treatment nor Parent Support programs are reported as frequently on the plan of care interventions.

The survey has begun to identify some of the organizational factors and human resource factors that support staffed group care to implement EBP and EBT. There are more similarities than there are differences between the employment sectors regarding the delivery of child welfare and children’s mental health services, indicating a good climate for implementing EBT in staffed group care, however there is a need for more information on the agency support factors and the support available through the regional MCYS system. In addition, there is limited information about how parented care operates and how it is different from staffed care and therefore almost 80% of the programs operating out of home care and the children and youth that they service are not represented by the information uncovered in this survey.
Recommendation: The survey should be repeated with parented group care, treatment foster care, and young offender facilities, with a more supportive methodology (eg. phone survey) to determine differences in support, interventions, case management, and types of clientele as well as examining how families are involved in the lives of children that are placed in out of home care in order to maximize the potential for successful outcomes following return home. \( \text{XE "Recommendation\: The survey should be repeated with parented group care, treatment foster care, and young offender facilities, with a more supportive methodology (eg. phone survey) to determine differences in support, interventions, case management, and types of clientele as well as examining how families are involved in the lives of children that are placed in out of home care in order to maximize the potential for successful outcomes following return home"} \)

Recommendation: More specific investigation of how staffed group care programs incorporate family focused EBT’s and how they make use of informal family contact is warranted, given that they do not “prescribe” them on the plan of care, there is a significant difference between the sectors in their reported provision of family counselling and that family involvement is highly recommended in the literature as one of the factors influencing successful outcomes. \( \text{XE "Recommendation\: More specific investigation of how staffed group care programs incorporate family focused EBT’s and how they make use of informal family contact is warranted, given that they do not "prescribe" them on the plan of care, there is a significant difference between the sectors in their reported provision of family counselling and that family involvement is highly recommended in the literature as one of the factors influencing successful outcomes."} \)

4.5 Message #5: Sector Analysis of Group Care Employee’s Education and Experience: There are some differences in human resources.

The third goal of the project was to identify differences in the educational and experience backgrounds of CYC practitioners among child welfare, children’s mental health, and private service sector providers of group care services.

The hypothesis that private operators would report significantly fewer CYC educated employees was supported. PCR program managers reported that they had significantly fewer child and youth practitioners with a CYW diploma (35%) than the CAS sector (63%) and the CMH sector (57%). Survey respondents in the CAS sector were not typical of the program manager’s perception. Since the sample was selective and managers were asked to choose participants who could respond easily to the survey questions it is possible that respondents were chosen for their expertise and/or experience in child and youth care practice, or that respondents who have this expertise were more likely to volunteer. With either explanation, it is clear that there is value placed on a unique set of expertise that is developed in CYW diploma programs in Ontario. Table 5-1 (below) compares estimates with respondent characteristics.

| Table 4-1: Respondents with a CYW Diploma |
|-------------------------------|---------------------|----------------------|
| N=494 total                   | Yes, I have a CYW Diploma | Mean estimate of Program Manager |
| PCR                           | 33.5% (n=57)         | 35.22 %               |
| CAS                           | 41.3% (n=33)         | 33.00 %               |
| CMH                           | 57.4% (n=140)        | 57.24 %               |
| Total Sample                  | 46.6% (n=230)        | 50.19 %               |
Similarly, the hypothesis that private operators would report employees with less experience than the other two sectors was also supported. According to program manager estimates the majority of employees in the PCR sector have less than 5 years experience (69.8 %), while in the CAS sector 54% have less than 5 years of experience and most of these (38.2%) have less than 2 years experience. In the CMH sector, 52% have less than 5 years experience with only 21% with less than two years. Recent turnover in the programs in the CAS sector may have increased the number of new inexperienced employees but overall it seems that the CAS and CMH sector attract CYC practitioners with specific education in child and youth care and retain them for longer periods of time. This has some implications for the quality of practice overall in the sectors since the use of interventions reported by CYC practitioners is affected by a combination of employment sector, education, and years of experience. It is possible that the ability of the PCR sector to attract qualified employees and retain them relates to the differential wages in the sector though there are likely other factors such as location, benefits, opportunity for advancement etc.. The average annual base income of the staff caring for children in the PCR sector is $28,730 to an average maximum of $35,429 (OARTY, 2008). By contrast the salary range currently for CAS CYC practitioners is $41,800 to $53,383 (personal communication, Gail Vandermeulen, July 2008).

**Recommendation:** Factors such as education and experience of group care staff should be assessed and considered in program’s ability to implement EBP and EBT. Additional support to programs in the PCR and CAS sectors maybe required.

### 4.6 Conclusion and Summary of Recommendations

The purpose of this project was to understand the factors (systemic, organizational, and human) affecting the use of EBP and EBT in group care settings in the province of Ontario and to document the strategies and interventions that CYC practitioners use in the milieu which are supported by EBT and theoretical models of intervention. Both aspects of this purpose have been partially accomplished. The instrument developed has good face validity and appears to be differentially affected by several variables such as CYC education, years of experience, and employment sector. It needs refinement, but has the potential to provide a tool for assessing both case management practice and the interventions used in group care programs and identifying which ones are most clearly connected with client outcomes.

We have a beginning understanding of the factors affecting the use of EBP and EBT in group care programs. It is clear that the MCYS policy and encouragement of the use of EBT for service provision in the children’s mental health sector has influenced both the CMH agencies receiving transfer payments to deliver group care services and the agencies receiving per diem funding, generally known as the *private operators* but more appropriately termed *Private Children’s Residences (PCR)*. It is also clear that being a PCR vs. a CMH centre does not affect the programs ability to ACCESS, ASSESS, ADAPT, or APPLY evidence-based practices in group care. Programs that are already engaged in EBP are poised to be able to help us describe and further identify clusters of milieu-based interventions which can be demonstrated to affect the outcomes of children and youth in group care AND to be replicated in other programs to enhance the quality of care and service overall.

Organizational factors such as the ability to seek consultation, ability to identify and implement appropriate modifications to research-based knowledge, and the capacity of organizations to engage in change vary across the employment sectors. The education and experience levels of both program managers and CYC practitioners also varied across the employment sectors making system wide
implementation of an EBP/EBT policy difficult without addressing these inequities and providing support to programs. It is essential that group care programs develop an understanding of the implications of a research-based approach to group care and the requirements of implementing the organizational change necessary to systematize procedures; collect assessment data as youth enter and exit programs that is related to interventions; AND maintain a system of care that remains individualized. Whittaker (2006) speaks eloquently to these challenges within a single agency, and the largest province in Canada has adopted a vision of for all children’s mental health services which is evidence-based and accountable (Government of Ontario, 2005) This demands additional supports for research and outcome measurement.

Summary of Recommendations

Recommendation: A more detailed analysis of the section three responses could uncover those specific aspects of the clusters of interventions that are influenced by organizations and developed with additional years of experience. If indeed certain interventions have a greater likelihood of influencing children’s outcomes and they are mediated by organizational factors or by education and experience, such an understanding could guide organizational hiring practices., 2

Recommendation: Factors such as education and experience of group care staff should be assessed and considered in program’s ability to implement EBP and EBT. Additional support to programs in the PCR and CAS sectors maybe required, 19

Recommendation: Further research should be undertaken with group care programs with a High Uptake of EBP who have CYC trained practitioners to document client outcomes as they are related to CYC interventions., 2

Recommendation: Given the MCYS direction toward EBP/EBT and the results of this survey among group care programs, CAS sector programs need significant support to implement EBP but are aware of the issues and concerns that need to be addressed. OACAS, OARTY and MCYS should work together to identify those agencies that need extra support and to provide training and additional support for research., 14

Recommendation: It would be useful to determine which group care programs have specific planned curriculums for life skills or social skills, how these are integrated with daily living interventions (for transfer of training) and to assess specifically the outcomes of these curriculums using pre-and post existing measures such as ONLAC or built in plan of care assessments to determine the impact and the essential ingredients. These would then meet the criteria of EBT in group care programs and could be part of a “multi-point” approach similar to MST., 6

Recommendation: More specific investigation of how staffed group care programs incorporate family focused EBT’s and how they make use of informal family contact is warranted, given that they do not “prescribe” them on the plan of care, there is a significant difference between the sectors in their reported provision of family counselling and that family involvement is highly recommended in the literature as one of the factors influencing successful outcomes., 18

Recommendation: Observing more specifically what techniques are being implemented in both individual and group sessions using strategies from Narrative Therapy, Solution Focused Therapy, SNAP, and COPE etc. would more clearly define how these approaches are being modified (if at all) and the effect on client outcomes., 6

Recommendation: Refine the instrument to identify both common and different elements of case management and then use the survey with the selected High Uptake of EBP programs and collect children’s outcomes to identify which items are good practice and which reflect a more intensive case
management process and therefore contribute to enhanced outcomes. High Uptake EBP programs already have the capacity to undertake this type of assessment and data collection and the relative contributions of the particular case management factors can therefore be determined., 9

Recommendation: The examples provided by respondents should be developed into questions to add to section three of the instrument to capture the nature of these interventions., 5

Recommendation: The instrument has the potential to be used to bring consistency to the adaptation of EBT strategies in the group care sector (similar to the design of Wraparound, Multi-systemic Therapy, and Teaching Family Model). Further work is needed to refine the instrument and to develop a mechanism for assessing the outcomes of children and youth consistently across programs that are using these group care models, 4

Recommendation: The survey should be repeated with parented group care, treatment foster care, and young offender facilities, with a more supportive methodology (eg. phone survey) to determine differences in support, interventions, case management, and types of clientele as well as examining how families are involved in the lives of children that are placed in out of home care in order to maximize the potential for successful outcomes following return home, 18

Recommendation: Whittaker (2004) strongly recommended the co-location of family and residential programs to bring these aspects together and given the informal work that CYC practitioners are already doing with families, such a co-location could likely offer great benefits to group care programs and enhance the communication between family therapists and CYC practitioners working with the children and youth., 7
5 Knowledge Exchange and Advancement of Field

This section describes the dissemination activities that have already been undertaken and additional ones that are planned. It briefly reviews how the research fits in the broader context of the conversation in Ontario and across Canada about the contribution of CYC practitioners in the field of residential care for children and youth with mental health difficulties.

This final report is distributed to the Executive Directors of all the agencies that participated in the project (262). Additional copies will be available for the program managers (105) that returned their survey. Staffed group care in the province of Ontario is undergoing significant examination. MCYS undertook the Residential Services Review in 2005, released in 2006. The Residential Services Vision was released in January 2007, just prior to the beginning of this project. It is hoped that the results of this survey add to the information already obtained and enhance the credibility of the staffed care resources available to children and youth in the province.

This survey represents the initial collection of information and the development of tools which will lead to additional research that will demonstrate the efficacy of milieu-based interventions in a manner that is not currently evident in the literature. It is hoped that participating group care programs from this survey will be interested in undertaking additional research to collect the evidence they need to demonstrate the efficacy of their programs.

Publications are planned for leading journals in residential care and child and youth care practice which will further disseminate the results and three conference presentations will disseminate the information provincially (Children’s Mental Health Ontario Conference, November 2008); nationally (Child and Youth Care conference, October 2008) and internationally (Child and Youth Care conference, May 2009). A presentation will be made to the OARTY general membership meeting in October 2008 and further stakeholder presentations will be arranged as requested.

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Glossary

**Best-Supported (‘Well-Established’) Interventions:** Best-Supported Interventions require: a) At least 2 scientifically defensible group-design studies conducted by different investigative teams b) Or more than 9 single-case designs, treatment manuals and strong experimental designs (NIMH, 2001).

**Child and Youth Care (CYC) Practitioner:** Also referred to as Child Care Worker, Child and Youth Worker, Child and Youth Care Worker, Youth Worker. Professional Child and Youth Care practice focuses on the infant, child and adolescent, both normal and with special needs, within the context of the family, the community and the life span. The developmental-ecological perspective emphasizes the interaction between persons and the physical and social environments, including cultural and political settings. ([www.cyc-net.org](http://www.cyc-net.org)) The practice of Child and Youth Counselling is: "The assessment of maladaptive behaviour patterns and social-emotional functioning in children, adolescents, and young adults and the prevention and treatment of conditions in the individual, family, and community, in order to develop, maintain, and promote emotional, social, behavioural, and interpersonal wellbeing within the context of daily living." © Adopted March 2004 Ontario Association of Child and Youth Counsellors ([www.oacyc.org](http://www.oacyc.org))

**Children’s Aid Society (CAS):** CAS is a child welfare organization which provides adoption, foster and residential care, health, and education services to children, youth and families. CAS also provides assessments, crisis intervention, counselling and services to prevent child abuse and neglect as well as to assist vulnerable communities to help care for and support their children and youth. In Ontario there are 53 CAS organizations who receive transfer payment funding from the Ministry for Children and Youth Services (MCYS).

**Children’s Mental Health Agency (CMH):** CMH agencies are contracted directly with MCYS to provide children’s mental health programs, residential and non-residential. They are typically non-profit organizations with a volunteer board and receive transfer payment funding for their services.

**Cognitive Behavioural Therapy (CBT):** CBT is a psychotherapy based on cognitions, assumptions, beliefs, and behaviors, with the aim of influencing negative emotions by identifying dysfunctional and/or inaccurate perceptions in an effort to reject the distorted cognitions and to replace them with more realistic and self-helping alternatives. CBT includes the following approaches: behaviour modification, Cognitive Therapy (CT), and Rational Emotive Behaviour Therapy (REBT). The individual therapeutic techniques differ according to the particular kind of client or issue, but generally include: keeping a diary of significant events and associated feelings/thoughts/behaviors; questioning and testing cognitions, assumptions, evaluations and beliefs; progressively gradually facing activities which may have been avoided; trying out different ways of behaving and reacting; and using distraction and relaxation techniques.

**Evidence-Based Practice (EBP):** EBP refers to a set of practices that such as outcome assessment, case management, and program evaluation which incorporate the explicit use of current evidence on effective interventions in the care and treatment of clients and are designed to develop further the evidence for effective interventions. (Barwick, et. al, 2005).

**Evidence-Based Treatment (EBT):** EBT is much more narrowly defined than evidence-based practice. Evidence-based treatment includes a set of interventions that meet the conditions for scientific rigour defined in the manner of best supported interventions or promising interventions.

**Intensive Case Management (ICM):** The functions of ICM are assessment, service planning, service implementation, service coordination, monitoring & evaluation and advocacy. The goal of ICM is to
compose, coordinate and maintain a range of services and resources to meet the needs of individuals over a period of time (Evans & Armstrong, 2002)

**Multi-systemic Therapy (MST):** MST is a form of family therapy with specific content of the intervention (marital or family therapy, parent training, behavioural and cognitive approaches, supportive therapy and case management) combined to fit the clinical picture.

**Per Diem Funding** is a funding mechanism by which an agency is paid a daily rate for each day that a bed in a group care program is occupied by a client. Per diem rates vary.

**Private Children’s Residence (PCR):** PCR refers to an agency operated as a profit or not for profit organization receiving per diem funding for bed spaces. PCR is often referred to as Outside Paid Resources (OPR) or Outside Paid Institutions (OPI).

**Promising (‘Probably Efficacious’) Interventions:** Promising Interventions require: a) At least two studies demonstrating the intervention to be more effective than no treatment b) A control group, or several single-case studies demonstrating their impact, in addition to manuals that prescribe the intervention (NIMH, 2001).

**Therapeutic Crisis Intervention (TCI):** The purpose of TCI is to provide a crisis prevention and intervention model for residential child care facilities which will assist an organization in: preventing crises from occurring, de-escalating potential crises, effectively managing acute crisis phases, reducing potential and actual injury to children and staff, learning constructive ways to handle stressful situations, developing a learning circle within the organization. ([http://safeguards-training.net/Courses/Detail.aspx?id=10](http://safeguards-training.net/Courses/Detail.aspx?id=10))

**Wraparound:** Wraparound is a “definable planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes” (Bruns et al., 2004), p. 69). The approach engages families as decision makers in a strength-based, ecological team approach emphasizing the strengths in the family, school, and community.

### 10 Appendix A: Instruments

Available separately

### 11 Appendix B: Details of Data Analysis

Available separately