



2012

## Youth in Care with Complex Needs



Special Report for the  
Office of the Children's  
Advocate

Prepared by  
Linda Burnside, PhD

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*As youth get older and more difficult to manage, too often child welfare workers are left on their own to try to find and provide the needed services. In spite of doing the best they can, the task is too great and as a result, these youth, who have the highest level of needs among the population of children and youth receiving child welfare services, move from placement to placement, are not provided with the care they require, and are unable to develop their capacity developmentally or educationally.*

*(Office of the Child and Youth Advocate, Alberta, 2002-2003, p. 8)*





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## INTRODUCTION

*Ian, age 16, has been known to child welfare agencies throughout his childhood, related to a series of incidents of physical and sexual abuse perpetrated by his mother's series of partners. His mother has struggled with chronic depression and low self esteem throughout her life; her own childhood was marked by severe abuse and neglect. Ian was referred to child and adolescent mental health services when he was 11 because of behaviour problems at school. By 13, he had entered child welfare care as his mother could no longer manage his behaviour. As adolescence emerged, the effects of years of abuse and inconsistent parenting were evident: Ian was aggressive, disengaged from peers, suspended from school for physically assaulting a teacher, frequently ran away, and was misusing drugs and alcohol. He has been through 10 placements in 4 years, including a specialized treatment facility that was unable to manage his behaviour.*

*Indications of Jasmine's compromised mental health were evident in early childhood. Her parents sought services from mental health services, psychologists, mobile crisis teams, and psychiatrists, with a diagnosis of Psychosis (Not Otherwise Specified) finally being levied when she was 12 years old. The diagnosis, and corresponding prescribed medication, did little to facilitate access to services. Jasmine drifted from foster home to psychiatric ward, from group home to youth correctional facility, from home with her parents to a hospital where she would be placed with adults, although she was only 14 years old. She has not received a consistent educational program for several years.*

*Carol is a 17 year old with a degenerative brain condition. She is developmentally delayed and has an IQ of 40. She is impulsive and her behaviour can be violent and out of control. She has had numerous medical and other assessments and has been hospitalized many times. Carol lived with her parents until age 14 when they could no longer manage the level of care she needed at home. She now resides in a residential facility with up to three staff caring for her at all times. Carol has complex needs and her family expresses frustration in trying to get services from three ministries - Children's Services for 24-hour residential care; Health and Wellness for hospital placements, professional services of neurologists and psychiatrists, and medications; Learning for the provision of special education services.*

None of these children are from Manitoba; their case summaries were gathered from published reports from around the world documenting the challenges in providing services to youth in care with complex needs. But their situations are very consistent with the experiences of children in care in Manitoba who also have complex needs.

Often, youth with particularly challenging circumstances come to the attention of the Office of the Children's Advocate in Manitoba. Because their unique constellation of issues may breach their

right to confidentiality, only brief synopses of specific Manitoba youth are provided here. All names and other identifying information have been altered:

- Abigail, age 16, has a long history of being in care, and an equally long history of mental health struggles. When on medication, she manages fairly well, but most of the time, she refuses to take her medication, sparking a perpetual cycle of aggressive behaviour towards others, placement breakdown, and admission to youth psychiatric care. Once stabilized and back on medication, she is ready for discharge from hospital, but there is no community placement for her.
- Significant developmental delay coupled by diagnosed mental health issues contribute to the challenges in providing care to 14-year-old Brian. His extremely violent behaviour has been a barrier to admission to a range of community treatment facilities. It is agreed that a team of highly skilled staff are required to make a long-term commitment to his care. It is further agreed that such a team does not currently exist.
- Thirteen-year-old Caitlin is at risk due to being sexual exploited, running away from her foster home, substance abuse, and gang involvement. She has been out of control since she was 10, made her first suicide attempt when she was just 11 years old, and has assaulted members of her family, foster family, as well as the family pets.
- Darin was incarcerated at age 16 after being found guilty of murder. Assessed as having attachment disorder, Post Traumatic Stress Disorder as a result of chronic exposure to traumatic events, and depression, there is no forensic treatment facility available to meet his needs.
- Emily, age 17, has been diagnosed with Fetal Alcohol Spectrum Disorder (FASD). She has not been in school for three years after being suspended for aggressive behaviour. In the past two years, she has been through six different foster placements, and is now in an emergency shelter and on a wait list for a group home placement. She is approaching age of majority in a state of instability, with no plan for transition to adulthood in place.
- A permanent ward for most of his life, Farrell, age 15, came into care as a result of parental substance misuse and family violence. Throughout childhood, Farrell behaved in concerning ways: he smeared feces, hoarded food, set fires, talked to himself, and was aggressive towards others. As an adolescent, his behaviours have escalated, but a host of assessments have resulted in no diagnoses to explain his challenging behaviour. As a result, he does not qualify for any specialized programs, and he has been resistant to engaging with his various caregivers, social workers, or support workers over the years.
- Garrett, age 19, is a permanent ward whose care will be extended to age 21. He has many mental health diagnoses and compromised adaptive functioning, including impulsive behaviour, poor social skills, and limited life skills. However, because he does not have an intellectual disability, he does not qualify for many adult support services. He is considered to be vulnerable to exploitation, unemployment, reliance on social assistance, and victimization by others.

These Manitoba youth, and the youth described in the case studies at the beginning of this report, illustrate the challenges facing the child and family services system in providing services and placement supports to youth with complex needs. Frequently, these children are admitted to care as a result of experiences of abuse and neglect or other adverse childhood experiences from which their parents did not protect them. Other children may come into care when their parents are unable to manage their care needs as a result of their challenging needs. Children with complex needs may also still be living with their families, sometimes with the support of a child and family services agency, and other times managing on their own. But no matter where children are residing or who is providing for their care, their complex needs often require the involvement of services from other sectors: mental health, criminal justice, disability services, education and other specializations.

### **Background to the Project**

The Office of the Children's Advocate (OCA) is an independent office of the Manitoba Legislative Assembly. Established in 1992, the OCA's role is to represent the rights, interests and viewpoints of children and youth in Manitoba who are receiving, or should be receiving, services under *The Child and Family Services Act* and *The Adoption Act*.

The challenge faced by child welfare agencies to provide care to children and youth with complex needs is not a new issue that has come to the OCA's attention. For example, in 2004, the OCA's *Review of the Operation of the Winnipeg Child and Family Services Emergency Assessment Placement Department (EAPD) Shelter System* (Mirwaldt, Perron & Thomas, 2004) included commentary on the increasing complexity of needs experienced by children who came into care in Canada. Citing the findings of the first Canadian Incidence Study (MacLaurin, Trocmé, & Fallon, 2003), the 2004 report notes the national trends of the impact of child maltreatment, as well as the impact of distinct behavioural and health issues, on the rate of admission to care:

- Eight per cent of investigations resulted in a child being placed into child welfare care. Placements were not required for 84 per cent of child maltreatment investigations.
- Overall, "placement rates increase with the frequency and duration of the maltreatment, the level of physical harm, the level of emotional harm, and previous reports" of child maltreatment investigations. (p. 39).
- Placement rates are higher for adolescents ages 12 –15 (13 per cent for males and 11 per cent for females) than for younger children. Children ages 0 to 3 (females nine per cent, males eight per cent) are the next likely age group to be placed.
- Children and youth identified as possessing child behavioural or health concerns such as substance abuse related birth defect (28 per cent); self harming behaviour (18 per cent); psychiatric disorders (16 per cent) have higher placement rates.
- Adolescents are rarely removed from their homes for child protection reasons. The decision to remove is more likely if there are identified behavioural issues including criminal involvement (26 per cent), running away (19 per cent) and violence towards other (17 per cent). (Mirwaldt, Perron, & Thomas, 2004, p. 27)

The examination of factors affecting placement specified in the *Canadian Incidence Study* and other literature led the authors to conclude that "the identified factors that contribute to a child coming into care extend beyond those that a child welfare agency can singularly address" (Mirwaldt, Perron, & Thomas, p. 28). However, the evolution of the Emergency Assessment Placement Department (EAPD,

known informally as the shelter system) contributed in part to the tendency for youth with complex needs to be placed in the shelter, according to interviews with Winnipeg Child and Family Services (WCFS) staff:

WCFS staff, from shelter to middle to executive management, have reported to the OCA that foster care and residential care appear to be unwilling to take children they would have taken before there was a shelter system. As pointed out numerous times to the OCA by WCFS staff, the shelter system cannot say "no" to any child or youth needing placement. If a child, particularly a high-needs child, has a safe shelter placement, WCFS report that other systems are slow to create the needed resources for the child. WCFS employees complained to the OCA that historically it was often left to their agency alone to create care alternatives. (Mirwaldt, Perron, & Thomas, 2004, p. 72)

Pertaining to youth with complex needs, the 2004 report recommended that the Department of Family Services enter into discussions with (a) Manitoba Justice to develop emergency care shelters for youth leaving correctional facilities who were unable to return home, and (b) Manitoba Health to develop emergency care services for youth leaving mental health facilities and unable to return home. The report further called for a review of the placement needs for children with high medical needs, mental health issues, and involvement with the criminal justice system, due to the number of children with these characteristics who were placed in shelters.

An update on these recommendations (documented in the Schibler & McEwan-Morris 2009 report *Emergency Placements for Children in Manitoba's Child Welfare System: An Update on the Recommendations made by the Office of the Children's Advocate in the Hotel Review (2000) and the Review of the Operation of the Winnipeg Child and Family Services Emergency Assessment Department (EAPD) Shelter System (2004)*) reported that discussions were under way with Manitoba Justice (although no emergency care facilities had yet been developed) but no discussions had occurred with Manitoba Health to develop placement resources and supports.

In addition to examining systemic issues, much of the OCA's work involves reviewing concerns about the nature of services required by and provided to individual children involved with the child and family services system. Recent concern about the number of cases involving children with complex needs prompted this particular project in March 2011. In particular, staff at the OCA who were involved in these cases noted that youth with complex needs often needed coordinated services across a number of service sectors, services mainly beyond the direct control of the child welfare system. The themes that require specialized intervention include mental health issues, disabilities (including cognitive impairment, significant health concerns, and Fetal Alcohol Spectrum Disorder), behavioural issues, addictions, involvement in the youth criminal justice system, attachment disorder, and unresolved trauma. The interaction between the multitude of issues facing youth and the number of specialized services from different service sectors they require often led to difficulties in arranging services in a timely way; in some instances, services were not available at all. Of further concern, the availability of supportive services had a significant impact on placement stability and placement options.

The OCA undertook this project to gain a better understanding of the scope and nature of the complex needs of youth in care. The terms of reference for this project were:

- To review 12 cases involving youth with complex needs in care of the child and family services system referred to the OCA;

- To identify both the common and diverse themes that contribute to the complexity of needs experienced by some youth in care;
- To prepare a literature review that describes what is already known about these issues, particularly as they contribute to the challenges in providing services to youth with complex needs;
- To examine a sample of children in care through the Child and Family Services System (CFSIS) to describe the characteristics of children in care with complex needs; and
- To develop an overview of the current service needs and gaps for youth with complex needs, based on the results of the OCA case reviews, CFSIS data analysis, review of supplementary reports and documents on services in Manitoba, and interviews of key representatives who provide services to youth with complex needs.

This project was initiated in March 2011 and concluded in December 2011. A list of the individuals who agreed to be interviewed for this project is provided in Appendix 1. Their participation in this project is greatly appreciated.



## DEFINITION OF 'COMPLEX NEEDS'

Across Canada, as well as in many other jurisdictions around the world, attention has turned to the provision of child welfare services to youth with complex needs. The professional literature affirms the anecdotally-reported, case-level experience in child welfare agencies that complex cases are increasing in frequency (Bass, Shields, & Behrman, 2004; Leon, Lawrence, Molina & Toole, 2008). In fact, Thoburn, et al. (2009) assert that children with complex needs are likely to require long term relationships with child and family services agencies, whether or not there is evidence of child maltreatment. But although there is 'common knowledge' about what is meant by 'complex needs', a consistent, comprehensive definition of the term is lacking. Even some studies specifically focusing on children with complex needs acknowledge the limitations of the research given the lack of consensus about the definition of 'complex needs' and the difficulty in obtaining data about the prevalence of its occurrence (Stalker, et al, 2003).

The most common assumption about 'complex needs' is that the term refers to a population of young people experiencing a multitude of issues that cross multiple service sectors (Child Welfare League of America, 2007). A helpful definition that captures this perspective is provided by the CanChild Centre for Childhood Disability Research in Ontario (2004):

Children with complex needs [are] defined as children with multiple health/developmental needs that require multiple services from multiple sectors, in multiple locations. (p. 5)

This definition acknowledges that needs may arise from a number of conditions that affect children's health or development, and asserts that there is value in utilizing a "non-categorical" definition that does not assign responsibility to any single discipline or service sector.

A more comprehensive and specific definition is offered by the Department of Community Services in Australia (Schmied, Brownhill, & Walsh, 2006):

A child or young person who:

- exhibits challenging and/or risk-taking behaviours of such intensity, frequency, and duration that they place themselves or others at serious risk of harm, and/or
- has mental health presentations which impair their ability to participate in an ordinary life and which reduce access to services, activities and experiences, and/or
- has a disability with high level challenging behaviours or complex health issues which are life threatening or require continuous monitoring and intervention. (p. 2)

A similar definition is utilized in Alberta, where three government departments (Alberta Children and Youth Services, Alberta Education and Alberta Health and Wellness) have partnered to collaborate around service delivery issues for children who meet the following definition of 'complex needs':

These children require extraordinary services from more than one ministry and in many cases from various service sectors. Those who require such services include children and youth:

- with multiple impairments, complex mental health issues, and/or severe behavioural needs;
- for whom all currently available resources have been utilized with limited success; and

- who require fiscal and human resources that strain the capacity of any one ministry. (Government of Alberta, 2010)

Severity of issues is one of the criteria that are often cited in defining what is meant by ‘complex needs’. Certainly, there is evidence of more severe mental health disorders in children and adolescents occurring at an earlier age since 1952 (Raphael, Stevens, & Pedersen, 2006) and a fourfold increase in the suicide rate of youth ages 15 – 19 since the 1950s (Breton, Boyer, Bilodeau, Raymond, Joubert, & Nantel, 2002). Another way to look at severity is in relation to children in the general population: For example, “children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally” is a useful definition of severity (Gilbaugh, 2007, p. 2).

Specific family-originating issues are sometimes identified as contributing to the phenomenon of ‘complex needs’ due to their profoundly detrimental effect on children’s functioning, such as parental substance misuse and domestic violence (Faller, 2000; Wharf, 2002) and parental mental health issues (Faller, 2000). Detrimental outcomes from these kinds of life events on children’s functioning, which contribute to the complexity of providing care, include behavioural issues (Burns, et al., 2004) and complex emotional or psychological needs (Higgins, Higgins, Bromfield & Richardson, 2007). Often, it is these behavioural and psychological issues that strain placement resources and other supports, regardless of their origin.

Others focus on the identification of conditions directly affecting children that have previously been under-diagnosed as being key factors in complicating children’s care needs. For example, in recent years, prenatal exposure to alcohol has been recognized as one of the leading causes of developmental disabilities, conditions articulated under the umbrella term Fetal Alcohol Spectrum Disorder (FASD) that affect a high proportion of children in care (Alberta Health and Wellness, 2000; Fuchs, Burnside, Marchenski & Mudry, 2005; Paley & O’Connor, 2009). Conditions such as Attention Deficit Hyperactivity Disorder (Martens, et al., 2004) and Autism Spectrum Disorder (Bryson, Corrigan & Holmes, 2007) are also more frequently diagnosed with the development of clearer diagnostic criteria and emerging insight into their etiology since the 1980s.

The Child Welfare Information Gateway (2006) considers the interaction between children with family problems and “an impaired protective system” that fails to meet their needs, as the dynamic that results in a range of medical, mental, social and developmental problems for children in care. Another perspective is that complexity is in the eye of the beholder, as the skill level of the caregiver and agency case manager affects how ‘difficult’ or ‘complex’ a child’s circumstances are considered to be (Rich, 2009). Some argue that children and youth with complex needs themselves are not necessarily complex: it is the challenge in coordinating all of the services that children need across so many different sectors that creates complexity (Richard & Smallwood, 2011).

New models of service delivery have emerged to serve children with complex needs, such as the Wraparound program models implemented in many jurisdictions in the United States, which develop individualized care plans for youth with complex needs who require services from multiple sectors. These programs define ‘complex needs’ as a condition involving:

...serious emotional, mental health or behavioral needs that cross two or more child-serving systems, has persisted for six months or more, causes some functional impairment at home, school or in the community, and places [youth] at risk of



placement in residential care, juvenile correctional care or psychiatric hospital.  
(Kamradt, 2011, p. 2)

Although many sources do not specify a definition of 'complex needs', as noted above, there is general acceptance that complexity includes a multitude of issues. More than simply an additive effect of multiple risk factors, it is the interaction of risk factors that produces the most harmful effects (McLaughlin, Green, Gruber, Sampson, Zaslavsky & Kessler, 2010; Rutter, 1979). The Child Welfare League of Canada (no date) asserts that this multitude of risk factors must be fully understood in order to make placement decisions in the child's best interests.

Further, "it is clear that no one system or agency has the mandate, resources, or reach to address both the complex and urgent needs of our most vulnerable children and families and the social and economic conditions that exacerbate these needs" (Hornberger, Martin, & Collins, 2006, p. 1). These authors go further, asserting that communication and coordination of services across sectors isn't enough in ensuring that the needs of youth with complex needs are adequately addressed. They argue that it is critical to integrate services, particularly mental health, juvenile justice, child welfare and substance abuse, to "significantly improve quality of care and thereby promote the health and well-being of children, youth and families" (p. 1).

One of the dilemmas stemming from the absence of a standard definition of 'complex needs' is that it becomes impossible to determine how many youth in a given population have 'complex needs'. Often, data that is reported is based on the presence of one particular condition or issue, focusing on that specific client group (Rosengard, Laing, Ridley & Hunter, 2007). Since not all youth with complex needs are involved in the same constellation of services, statistics may only reflect the service sector that is gathering the data, even when efforts are made to document comorbid issues.

One example of an effort to count cases involving complex need is from CONTACT Hamilton, a community agency that serves as an entry point for children and youth with emotional, behavioural, or developmental concerns, where 98 children who met the definition of having "multiple needs that are typically long-term in nature and usually require the involvement of multiple service sectors" (2005, p. 9) were described in a report analyzing the needs of youth with complex needs. This report estimated that 30 out of 1,000 children in care would meet this definition (3%). The Alberta Children and Youth Initiative Partners, a group that developed a policy framework for children with complex needs in 2003, estimated that 10 – 15% of children in care have special needs, with 1% of that group having complex needs that require significant and extraordinary care due to the severity of their impairment.

It becomes apparent that various definitions of 'complex needs' include origins or causes of difficulties for children and youth (including child-based issues such as cognitive disability and family-based issues such as parental mental health issues), the outcomes of those diverse origins (such as behaviour problems), and the need for supports from a wide range of service providers across various disciplines or service sectors (child welfare, mental health, youth corrections, education, etc.). However, the tendency is to view the youth with complex needs with a narrow definitional lens, focusing on the problems presented by the youth rather than seeing the bigger context and the interactional nature of the variables that contribute to 'complexity'.

Rich (2009) is critical of the term 'complex needs' and its associated labels (behaviour problems, attachment disorder, conduct disorder, personality disorder, mental health diagnoses, etc.) due to the stigmatization of youth who are assigned such labels, often with scant evidence to support the

assignment of the label in the first place. Often, the labels are used to make the child “someone else’s problem” (p. 2), as labels tend to exclude children from certain kinds of services rather than facilitate access to services. Labels may also be an expression of the adults’ uncertainty about their own ability to cope with that child, again creating barriers to accessing services. Instead, Rich advocates for better understanding of the central holistic theme experienced by youth with complex needs. She writes:

Children are described as having ‘behavioural difficulties’ or ‘dysfunctional behaviour’. These ideas are not particularly helpful in terms of thinking about why a young person has chosen a particular way of communicating their distress, grief, anger, frustration and fear. Behaviour is rarely dysfunctional. It has a function for the child and that function is usually connected firstly with survival, and secondly with communication. Understanding behaviour and assisting young people to find alternative ways of both surviving in a world they have experienced as difficult and hostile, and communicating the nature of that experience to those around them, is at the root of any successful intervention or ‘treatment’. (p. 1)

Many services assert that the origins of the youth’s difficulties are less important than understanding and responding to the outcomes of those issues – that is, how the youth is functioning. For example, characteristics that meet the criteria for a specialized services program for youth with complex needs in Edmonton include:

- use of drugs and/or alcohol that interfere with daily functioning;
- choices that may jeopardize their safety;
- no healthy adult role model in their personal lives (outside of professional contacts);
- multiple placements;
- conflict with those in authority;
- mental health disorders;
- few people they trust (Smyth & Eaton-Erickson, 2009).

Smyth and Eaton-Erickson (2009) described this population of youth as ‘high-risk’, as their individual characteristics (defiance, running away, and frequent involvement in behaviours that could jeopardize their safety) conflict with system characteristics (high caseloads, tendency toward reactive casework rather than proactive casework, and community distrust in the child welfare system), resulting in youth perpetually exposed to high-risk situations they often cannot control and workers feeling helpless and unable to protect them.

Rich (2009) argues that it makes more sense to focus on the common needs of youth with complex issues, which transcend the origins of issues and the diverse expression of detrimental outcomes. These common needs, shared by all youth with complex needs, call upon all service providers to work collaboratively toward common goals: ensuring that youth with complex needs are provided with a caring environment where they can experience “consistent structure and routine, emotional containment, predictability, and planned effective responses to behaviours and emotions” (p. 3), supported by clinical consultation as well as treatment-based activities.

While a universal definition of ‘complex needs’ is not developed, it is clear that a multitude of issues, involving a multitude of service providers, with a degree of severity in the manifestation of issues, are hallmark characteristics that will inform the analysis in this report.

## YOUTH WITH COMPLEX NEEDS REFERRED TO THE OFFICE OF THE CHILDREN'S ADVOCATE

An overview of twelve cases involving youth with complex needs referred to the Office of the Children's Advocate (OCA) was conducted as part of this report. The cases identified by OCA staff for review arguably included distinctive features, often representing the "worst" or "most challenging" manifestation of particular issues, rendering the cases potentially identifiable because the unique characteristics had brought the case to the attention of a large number of service providers and, on occasion, to the media. It is difficult under such circumstances to guarantee the confidentiality of these youth in summarizing their cases with more detail than that already provided in the introduction to this report for seven of the twelve cases. Conversely, it is difficult to create case composites merging features from the twelve cases, partly due to their small number but also because each case had at least one unique defining characteristic that cannot easily be amalgamated into a composite.

Instead, an overview of thematic findings across the twelve cases is provided. The cases reviewed involved youth ranging in age from 7 to 20 years, with 6 males and 6 females. The identified issues included:

- Mental health concerns
- Physical disabilities
- Developmental disability
- Fetal Alcohol Spectrum Disorder (FASD)
- Criminal justice system involvement
- Behavioural issues
- Sexual exploitation
- Self-harming behaviours
- Harm towards others
- Complex health conditions
- Communication barriers
- Attachment issues

All of the youth experienced a multitude of issues, most frequently involving mental health concerns, developmental delay (or other cognitive disability), behavioural issues, and criminal justice involvement. However, it was clear from these cases that the challenges of providing care were not just related to the multitude of issues: frequently, one issue had a degree of severity that exacerbated the youth's needs and created considerable challenge for the service system to adequately meet the youth's needs for placement and supporting services. For one youth, it was the nature of his criminal behaviour that created difficulties for the child welfare system and the youth justice system in meeting his care needs, resulting in involvement of the adult correctional system. For another youth, it was risky self-harming behaviour associated with a serious mental health condition that was the driver of service needs that remained unmet. Cognitive disability, whether caused by FASD, developmental delay, or other complex health conditions, presented a considerable barrier to placement for several youth, in addition to the other issues they faced.

The most common outcome for youth with complex needs in this sample was placement breakdown and significant difficulty in securing a suitable placement. In fact, lack of placement or inappropriate placement was the most common reason for referral to the OCA for this group of youth. More than 7 youth had spent time in an emergency shelter, often with double staffing in place due to concerns about aggressive behaviour. For three of these youth, the shelter had become their long-term placement, mainly due to the lack of alternative placements in either the foster home system or in the residential care system. Most often cited as major barriers to placement for youth (in foster homes, groups homes, and residential care facilities) were violent or aggressive behaviour issues, suicidal and self-harming behaviours, and cognitive impairment.

The characteristics of the youth were not the only factors that contributed to the complexity of their needs. A number of systems issues were also identified:

- Shelter systems issues
  - Staff not trained to meet the child's needs
  - Not a family-based environment
  - Shelter is unavailable for other placements if beds occupied by youth with complex needs on a long-term basis
- No appropriate placements available
- Child had to access to adult services because appropriate child-based services were not available
- Youth wasn't eligible for an extension of care into adulthood to continue provision of child welfare services
- Youth wasn't eligible for any adult services, although significant needs were still evident at adulthood
- Unable to access services out-of-province and no equivalent service exists in Manitoba
- Difficult working relationship between child welfare system and other service sectors
- Difficult for youth in child welfare system to access services in other systems
- Lack of training for foster parents in meeting the needs of the youth with complex needs
- Child not eligible for any services from any service provider

Further, reviews of the case files maintained by the OCA demonstrated that the interaction between the each youth's unique challenges and the gaps and barriers of the multi-disciplinary service system intensified the complexity of the youths' needs.

In many instances, although the issues experienced by the youth were both multiple and included at least one of significant severity which challenged the child welfare system's ability to meet the child's needs adequately, a "one-off solution" was developed over time that afforded the youth some degree of stability and service supports. Often, the "one-off solution" involved creating an array of services within a shelter that was designated as child-specific: focused on providing care for the long-term for that child alone. While some creative care plans were developed for individual children in shelters, it must be noted that such innovations essentially remove the shelter from availability for other children who are in need of emergency placement. In other cases, arrangements were made for the child to receive services from adult services, which addressed the severity component of one factor of the child's life, but did not necessarily meet all of the other needs that typically fall under children's services (e.g. education).

On one hand, the development of an individualized strategy to provide care for a youth with complex needs is an example of the system's innovation and flexibility, commendable qualities. The Child Welfare Information Gateway (2008) recognizes that "one size does not fit all" and providing a wide range of placement options is necessary to match to the child's unique constellation of needs. However, each of the files reviewed documented the considerable amount of time it took to develop an individualized resource, and usually, this response was a last resort, after efforts to engage other service sectors in responding to the youth's needs were unsuccessful. The bulk of responsibility for responding to the child's wide range of service needs fell mainly on the shoulders of the child welfare system. Reasons for other service sectors' inability to respond to the youths' needs as documented on the OCA files included the youth's violent behaviour (causing staff to fear for their own safety), suicidal behaviour

on the part of the youth, no formal mental health diagnosis, and high-risk behaviours such as sexual exploitation, running away, and setting fires.

A framework is proposed to conceptualize the inter-relationships between issues or conditions experienced by the child (usually multiple conditions), the severity of one or more of those conditions, the eligibility for services that may (or may not) occur as a result of formal diagnoses of various types of conditions, and the set of services that are within child welfare’s control and those that are beyond the CFS system’s direct control (see Table 1). Therefore, it is, as stated by Rutter (1979), the compound interaction of many variables that result in the complexities of meeting the care needs of this population. However, the end result – the identification of appropriate services and placement resources – is not easily achieved. As noted with this sample population of youth with complex needs from the OCA, appropriate placements and service supports tend to be non-existent for the most complex of youth, requiring the creation of individualized placements or the use of adult-level services (which are not necessarily designed to meet the needs of adolescents). However, as noted above, services that need to be developed to meet the needs of an individual youth with complex needs take considerable time, negotiation, and advocacy to establish. One of the goals of this project is to examine the common themes that affect enough children to merit the establishment of a wider range of placement options, which build in the required services that usually fall under the domain of other service sectors. This premise is depicted by the arrow running through the ‘Level of Service’ column, indicating the need to always move towards services that are standardized and regularly available wherever possible, rather than creating placement anew for each unique child with complex needs, an approach that is not time- or cost-effective.

Table 1: Proposed Framework for Complex Needs and Service Response

<u>CONDITION</u>	<u>SEVERITY</u>	<u>ELIGIBILITY</u>	<u>SERVICE SYSTEM</u>	<u>LEVEL OF SERVICE</u>
Mental Health	MILD	CIC	CHILD WELFARE - EPR	STANDARD
Developmental	MODERATE	CRITERIA	- Extension of Care - Foster Homes	SPECIALIZED
Criminal Activity	SEVERE	DIAGNOSIS	- Training	ADAPTED FOR THE INDIVIDUAL
FASD	EXCEPTIONAL	GAP	INTERSECTORAL	CREATED FOR THE INDIVIDUAL
Sexual Exploitation			- Mental Health - Disability Services - Criminal Justice - Education - Health	ADULT SERVICES ONLY
Self Harm				OUT OF PROVINCE SERVICES ONLY
Behaviour Issues				NO SERVICES



## LITERATURE REVIEW

### Introduction

Children and youth become involved with the child welfare system due to a range of risk factors related to child maltreatment (physical abuse, sexual abuse, emotional abuse and neglect), caregiver issues (such as parental substance misuse, poor parenting skills, mental health issues, and domestic violence), and child difficulties (including behaviour problems, disabilities, mental health issues, and parent-teen conflict) (Simmel, 2010). Often, these risk factors are not discrete, isolate variables that only affect child functioning individually, but they occur in combinations that exacerbate their impact. This section of this report reviews what is known about these risk factors, individually and, where possible, in interaction with one another, creating a complexity that challenges child welfare systems and other service sectors in adequately responding. However, it must also be acknowledged that the intensity of risk factors experienced by children is also affected by the capacity of the service system to meet those needs.

Before examining these risk factors, it is also important to acknowledge the cultural context of child welfare services in Canada. It is well documented that Aboriginal children are significantly over-represented in child-in-care populations across the country, especially in the western Canadian provinces (Blackstock, 2007; Blackstock, Prakash, Loxley, & Wien, 2005; Blackstock, Trocmé, & Bennett, 2004; Canadian Council of Child and Youth Advocates, 2011). As it pertains to children with complex needs, there is evidence to support that Aboriginal children come into care more frequently partly as a result of the presence of multiple risk factors such as poverty, oppression, compromised parenting abilities as a result of the impact of the residential school system, and other social, economic and cultural variables (Fluke, Chabot, Fallon, MacLaurin, & Blackstock, 2010). The data from the 2003 Canadian Incidence Study was examined by Trocmé et al. (2005) for differences between maltreatment rates of Aboriginal and non-Aboriginal children, finding that over half of all investigations involving Aboriginal children were substantiated, compared to 47% for non-Aboriginal children. Substantiated maltreatment resulted in an admission to care for 16% of Aboriginal children, compared to 7% of non-Aboriginal children, with a further 13% of Aboriginal children, compared to 4% of non-Aboriginal children, placed in informal kinship care. In summarizing these findings, the authors note:

The significant overrepresentation of First Nations children in substantiated child investigations and referrals to child welfare placement can clearly be related to the high level of caregiver, household, and community risk factors. The finding that neglect is the primary type of child maltreatment experienced by First Nations children calls for a reorientation of child welfare research, policy and practice to develop culturally sensitive and effective responses. Effecting change also calls for a much greater emphasis by child protection authorities on the structural factors contributing to child maltreatment amongst First Nations children such as poverty, poor housing and parental substance misuse. (Trocmé, et al., 2005, p. 72)

However, in looking at the characteristics of children who had been the subject of a substantiated maltreatment investigation, Blackstock and Trocmé (2005) found no difference between Aboriginal and non-Aboriginal children. That is, the occurrence of depression, self-harming behaviour, violence towards others, substance abuse, school disruption, or criminal justice involvement – all considered to be deleterious outcomes of maltreatment – were similar across different ethnic groups.

Another contextual variable to consider is adolescence itself. Adolescence is viewed as a time of physical growth and developmental change, marked by the formation of personal identity, the deepening of peer relationships, and the achievement of independence and autonomy (Christie & Viner, 2005). Some aspects of adolescent development are particularly challenging for many youth. Early adolescence is characterized by concrete thinking, difficulty in planning for the future, and feelings of being misunderstood. In middle adolescence, youth can be self-absorbed and experiment with risk-taking behaviours. The capacity for abstract thinking is more developed by late adolescence, when youth are able to be more future-oriented and their sense of self is more stable. However, late adolescence is considered to be ages 18 – 21 (Christie & Viner, 2005), when the majority of youth have reached age of majority and already been discharged from child welfare care. Adolescence is also a stage when serious problems can emerge: mental health issues, drug and alcohol use, running away behaviour, sexual offending, and criminal activity (Biehal, 2005).

Youth in care may face additional challenges in their development, such as adopting a negative self-identity as a result of the stigmatization of being a child in care (Kools, 1997). Often, the years where identity formation occurs are disrupted for youth in care by placement breakdowns, negative sanctions for misbehaviour, and the influence of negative peer groups. Children in foster care also are vulnerable because of the impact of coming into care itself: the emotional consequences of being removed from parents, disrupted attachment, and the effects of maltreatment by parents (Bruskas, 2008).

The Child Welfare League of America (no date) reports alarming rates of problems facing children in care in the United States. At least 30% of children in care have physical health problems resulting in health care demands and more frequent medical appointments, including hospitalizations. Mental health problems are estimated to affect between 30 and 85 percent of children in out-of-home care, about four times the rate of mental health concerns of children in the general population. Developmental disabilities are identified for about 20% of children in care, and while the actual prevalence of FASD as a specific disability is not clear, the Child Welfare League of America notes that between 14 and 18 percent of all pregnancies involve prenatal substance exposure.

Similar trends have been found in Canada's child-in-care population (Farris-Manning & Zandstra, 2003). Emotional and behavioural problems are more common today than in the past two decades, affecting up to 80% of children in care. More than 60% of children in care are estimated to have a disability of some kind (Canadian Association of Community Living, 2003), including a high prevalence of children in care diagnosed with FASD (11%) in Manitoba (Fuchs, Burnside, Marchenski, & Mudry, 2005). The *Canadian Incidence Study* (Trocmé et al., 2010) found that the most common child functioning issues reported for children who had been abused were academic difficulties (23%), depression/anxiety/withdrawal (19%), aggression (15%), attachment issues (14%), ADD or ADHD (11%), and intellectual or developmental disabilities (11%).

Additionally, child welfare agencies are pressed to provide care services to a growing number of children. Using federal, provincial, and territorial published statistics, Mulcahy and Trocmé (2010) examined the number of children in care and reported a steady increase in the number of children in care in Canada from 1992 to 2007. The increase in the overall number of children in care in Canada is attributed to several key factors (Farris-Manning & Zandstra, 2003):

- an increase in reports of neglect and exposure to domestic violence;
- a shift to a more interventionist approach to practice;



- a reduction in the social, health and educational services available to support families;
- stream-lined investigation and risk assessment procedures, resulting in more cases being deemed “high risk”; and
- the majority of investigations involving families with previous child welfare contact.

Changes within the child welfare system have also contributed to challenges in meeting the needs of children in care, which compromise the provision of services to youth with complex needs. A survey of child protection workers conducted by the Canadian Association of Social Workers (Herbert, 2002) identified poor worker morale, high caseloads, worker turnover, and a shortage of qualified workers as major themes of concern affecting service delivery. Nationally, jurisdictions struggle with a lack of appropriate placement options for children and youth – foster homes, residential care, and especially treatment-oriented placements – which leaves children in care without the resources they need in a timely manner (Farris-Manning & Zandstra, 2003). The shortage of qualified caregivers is associated with a lack of training and inadequate compensation for providing care to youth with complex needs (Chamberlain, Moreland & Reid, 1992). Further, with diminishing placement resources, increasing numbers of children in care, and high staff turnover, child welfare agencies were forced to restrict placement to those children and youth most in need of protection, leaving some struggling families to fare on their own:

This reduction in service to families who are struggling, but whose children do not meet the risk assessment criteria, occurred at a time when, throughout Canada, the system of social supports, community agencies, and local programs were also decreasing. This has created a challenging environment through which child protection service providers must navigate, as they strive to effectively serve the children in their care. (Farris-Manning & Zandstra, 2003, p. 6)

In response to these struggling families who are not at high risk but, without timely intervention, may experience a deterioration in functioning that could create risk to children, many jurisdictions in Canada have created “differential response” service paths (Trocmé, Knott, & Knoke, 2003). Less urgent referrals to child welfare agencies are streamed to assessment or brief intervention service streams, to respond more proactively to family issues and prevent the escalation of child protection issues. It is not clear if youth currently characterized as having complex needs came from families where the risks were already high when child welfare became involved or whether some may have involved families who were redirected to differential response services prior to admission to care.

### **Child Abuse and Neglect**

Although a growing number of complex behavioural and emotional issues experienced by adolescents are brought to the attention of child welfare agencies, child abuse and neglect remain major themes of investigation and intervention and often precede the manifestation of more complex symptoms. Child maltreatment has traditionally included physical abuse, sexual abuse, emotional abuse and neglect, with exposure to domestic violence subsumed within the category of emotional abuse. In recent years, however, the distinct impact of family violence has been increasingly recognized and it is now considered to be a separate type of maltreatment (Jack, Munn, Cheng, & MacMillan, 2006).

The Canadian Incidence Study (CIS) has endeavoured over the past 15 years to examine the national incidence of reported child maltreatment investigated by child welfare agencies, as well as the characteristics of children and family who are the subject of these investigations. The most recent wave

of the study (2008) found that 20% of substantiated investigations involved physical abuse as the primary form of maltreatment, 3% involved sexual abuse as the primary form, and 9% involved emotional abuse as the main type of abuse (Trocmé, et al., 2010). While investigations involved only one type of maltreatment in 82% of substantiated cases, both physical abuse and emotional abuse were sometimes associated with family violence while sexual abuse was rarely found in combination with other forms of maltreatment. Neglect was the primary category of maltreatment in 34% of substantiated cases of the 2008 CIS study. However, it is recognized that “only a small percentage of children who are maltreated – the ‘tip of the iceberg’ – ever become known to health and social service agencies” (Jack, Munn, Cheng, & MacMillan, 2006, p. 3).

Child maltreatment has been associated with a wide range of deleterious outcomes for children and adolescents, symptoms which often vary with age: attachment problems, dependency, hyperactivity, sexually inappropriate behaviours, withdrawn behaviour (preschool children); acting out, anger, anxiety, conduct disorders, poor school performance, psychosomatic symptoms, sleep disturbances (school-age children); and substance misuse, delinquency, major depressive disorder, eating disorders, gang involvement, aggression and violence, running away behaviour, and suicidal ideation (adolescents), as summarized by Gushurst (2003). Behavioural issues, typically the result of conditions of untreated anxiety and depression that grow more pronounced over time, are especially common in adolescence (Thompson & Tabone, 2010), and often increase the risk of admission to care and placement breakdown (Chamberlain, Price, Reid, Landsverk, Fisher, & Stoolmiller, 2006; Hurlburt, Chamberlain, DeGarmo, Zhang, & Price, 2010).

Different types of maltreatment may lead to different harmful outcomes. Physical abuse has been associated with later violent behaviours (Briere & Runtz, 1990), depression and suicidal ideation (Silverman, Reinherz & Giaconia, 1996), and mental health problems (Malinosky-Rummell & Hansen, 1993). Numerous studies have found that childhood sexual abuse is associated with increased rates of mental health disorders (Putnam, 2003). Of particular concern is the research that has demonstrated a relationship between child maltreatment and risk of suicide. Childhood sexual abuse has frequently been associated with suicidal behaviour (Joiner, Sachs-Ericsson, Wingate, Brown, Anetis, & Selby, 2007; Plunkett, O’Toole, Swanston, Oates, Shrimpton, & Parkinson, 2001; Thakkar, Gutierrez, Kuczen, & McCanne, 2000; Ystgaard, Hestetun, Loeb, & Mehlum, 2004), but recent studies have also found an independent link between physical abuse and suicidality (Mironova et al., 2011; Salzinger, Rosario, Feldman, & Ng-Mak, 2007). Both childhood physical and sexual abuse has been associated with further victimization in adolescence, as well as risky sexual behaviour, such as failure to use a condom, having sex while under the influence of substances, and having sex with a stranger rather than a regular dating partner (Messman-Moore, Walsh, & DeLillo, 2010). Physical abuse has also been linked with an increased likelihood of pregnancy during adolescence (Adams & East, 1999), and both physical and sexual abuse are associated with substance misuse in adolescence (Simpson & Miller, 2002). Neglected children tend to face cognitive problems and may have more emotional problems than children who have been physically abused (Hildyard & Wolfe, 2002). However, Ney, Fung and Wickett (1994) found that children were often subjected to more than one type of abuse, making it difficult to identify the origin of the detrimental effects on functioning. In their examination of combinations of maltreatment types, they found that the co-occurrence of physical abuse, neglect, and verbal abuse to be particularly detrimental to children. The Canadian Incidence Study (Trocmé, et al., 2010) reported that 18% of all substantiated abuse investigations involved more than one type of maltreatment.

The 2008 Canadian Incidence Study (Trocmé, et al., 2010) found that 26% of children who had been physically abused were emotionally harmed, with half experiencing symptoms severe enough to

require treatment. Emotional harm was identified in 47% of the children who had been sexually abused, with most of these children also experiencing severe emotional symptoms requiring treatment. A range of child functioning issues were identified by investigating workers as evidence of emotional harm, with almost half of all substantiated investigations noting at least one child functioning concern, including depression/anxiety (19%), aggression (15%), attachment issues (14%) and cognitive or developmental disabilities (11%).

Additional analysis on the relationship between child functioning characteristics and decisions to admit children to care are not yet reported for the 2008 CIS data, but are available for the 2003 CIS (Trocmé, et al., 2005). Children who had two or more functioning concerns were more likely to be placed in care than children who had fewer or no functioning issues. Issues that were more likely to lead to placement were behavioural/emotional issues, depression/anxiety, irregular school attendance, and negative peer influences.

DuRoss, Fallon and Black (2010) used the 2003 CIS data to examine the relationship between substantiated maltreatment, child functioning characteristics, and placement in specialized environments, as upon admission to care, 1% of all children with substantiated maltreatment had been placed in group homes and an additional 1% had been placed in residential care. They found that at least one behavioural issue (negative peer influences, irregular school attendance, running away, and violence towards others) was identified for 81% of children of substantiated investigations placed in a group home or residential facility. Emotional issues such as depression, anxiety, and self-harming behaviour were identified in about 40% of substantiated investigations. The most common type of investigation leading to placement in group or residential care was neglect. The primary caregiver of children in these cases was identified as lacking social supports, victimized by domestic violence, experiencing mental health issues, struggling with alcohol abuse, and having a history of maltreatment as a child. The authors noted that 17% of the investigations that were unsubstantiated also resulted in the placement of children in group homes or residential care facilities:

Our findings also suggest significant discord within the home, as indicated by the high number of caregiver risk factors present in maltreatment investigations leading to group home or residential/secure placement...Taken together with the functioning concerns noted for children (primarily behavioural issues), a picture emerges that suggests these caregivers may not be well-equipped to handle the behavioural or emotional needs of their children. (DuRoss, Fallon & Black, 2010, p. 70)

The impact of childhood maltreatment extends into adult functioning. Numerous studies have identified a wide range of issues experienced by adults who had been abused as children, including mental health disorders, anxiety, substance abuse, depression, low self esteem, and aggressive behaviour (Bagley & Ramsay, 1986; Briere & Runtz, 1988; Malinosky-Rummell & Hanson, 1993), as well as intimate partner violence (Gómez, 2011). While the long-term impact of childhood maltreatment is well established, the findings have been more consistent pertaining to the deleterious impact of childhood sexual abuse on long-term functioning (Fergusson, Boden, & Horwood, 2008). Childhood physical abuse does have an impact on adult functioning, but Fergusson and Lynskey (1997) found that the context within which the physical abuse occurred had a mediating effect, with children whose families also struggled with parental substance misuse, parental conflict, family violence, poverty or financial difficulties, and stressful life events having more pronounced difficulties than children who did not experience the same family stressors. Fergusson, Boden, and Horwood (2008) found that childhood sexual abuse accounted for 13% of the mental health issues experienced by a cohort of young adults

who had been abused in childhood, while childhood physical abuse accounted for 5% of their mental health issues. Research has also demonstrated that indicators of impaired functioning as a result of childhood maltreatment are evident in adolescence and continue to escalate into adulthood without intervention (Silverman, Reinherz, & Giaconia, 1996).

Studies have also found that childhood abuse has an inter-generational effect, with adults who had been abused as children being more likely to be abusive parents themselves (Kim, Pears, Fisher & Connelly, 2010; Milner, et al., 2010). This phenomenon is attributed to the relationship between child abuse and neglect and an increased risk of trauma symptoms in adulthood, including depression and alcohol misuse (Widom, DuMont & Czaja, 2007). Evidence also exists to suggest that individuals who had been abused as children may have a reduced risk of abusing their own children when provided with opportunities to work through these traumatic experiences in childhood (Milner, et al., 2010).

Finally, research is emerging that points to the long-term economic costs of child abuse on the health care system. Women who reported childhood abuse and neglect had higher annual health care costs than women who did not report childhood maltreatment, especially for those who experienced sexual abuse (Walker, et al., 1999). A diagnosis of breast cancer was found to trigger prior trauma experiences in women who had experienced emotional, physical, or sexual abuse in childhood, which exacerbated cancer treatment and recovery (Goldsmith et al., 2010). Physical abuse has been correlated with pain in adulthood, such as chronic headaches (Scott, et al, 2011). Multiple childhood trauma experiences, such as physical, sexual and emotional abuse and witnessing family violence, have also been associated with an increased risk of heart disease, cancer, and diseases of the nervous system, respiratory system and digestive system (Brown, et al., 2009). In one Canadian study, childhood physical abuse was associated with a 45% increase in the likelihood of adult heart disease, independent of other risk factors known to contribute to heart disease (Fuller-Thomson, Brennenstuhl, & Frank, 2010). In this holistic view of well-being, the mental health disorders that stem from childhood abuse are seen to affect adult physical health through behavioural, social, cognitive and emotional pathways (Kendall-Tackett, 2002; Maté, 2004).

### **Family Issues**

As noted by Fergusson and Lynskey (1997) and Wekerle (2011), child maltreatment that occurs within the context of other family issues tends to intensify the negative effects of maltreatment on children's functioning. Family factors associated with an increased risk of child physical abuse included a family history of alcohol or drug abuse, parental conflict (arguments), family violence, poverty or financial difficulties, and stressful family events (Kimberley, 2010). The Canadian Incidence Study (Trocmé, et al., 2010) found that parents in substantiated child abuse investigations abused alcohol (21%) or drugs (17%), had mental health issues (27%), had few social supports (39%), and experienced family violence (46%). Only 22% of caregivers did not have any risk factors for child maltreatment. When examining differences between Aboriginal and non-Aboriginal families in the 2003 CIS data, Trocmé et al. (2005) noted that Aboriginal families with substantiated maltreatment were more likely to live in public housing or rented accommodations, and were more likely to live in environments that were crowded or unsafe.

The relationship between family violence and child abuse has been well documented (Appel & Holden, 1998; Goddard & Hiller, 1993; Hartley, 2004), but exposure to intimate partner violence is harmful to children even in the absence of child physical or sexual abuse. Symptoms such as depression, post-traumatic stress disorder, anxiety, school difficulties, and aggressive behaviour have been

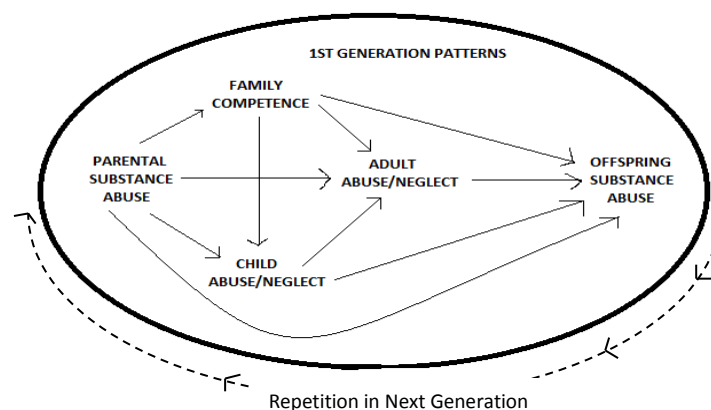
identified as common outcomes in children who have witnessed violence between adults in the home (Bedi & Goddard, 2007; Graham-Bermann & Levendosky, 1998; Holt, Buckley, & Whelan, 2008; McCloskey & Walker, 2000). The effects of family violence also extend into adulthood. Repeatedly witnessing family violence in childhood has a unique contributory role to the onset of depressive symptoms in young adults (Russell, Springer & Greenfield, 2010). Goddard and Bedi (2010) argue that exposure to sustained intimate partner violence against a primary caregiver has such profound emotional impacts that it should be considered as an independent form of child abuse.

The Canadian Incidence Study (Trocmé, et al., 2010) found that 34% of substantiated maltreatment investigations involved children being exposed to intimate partner violence. Evidence of emotional harm was documented at the time of the investigation for 26% of children. However, Black, Trocmé, Fallon, and MacLaurin (2008) found in their examination of the 2003 CIS data that how child welfare agencies respond to the identification of exposure to intimate partner violence depends on whether it occurs in isolation or with another form of child maltreatment. Investigations involving family violence alone had the lowest rate of ongoing child welfare involvement after investigation, choosing to close the case in 64% of investigations. The authors remark:

The Canadian child welfare system is substantiating exposure to domestic violence but is concluding that these families do not require child welfare services. (Black, Trocmé, Fallon & MacLaurin, 2008, p. 403)

Due to the strong relationships between family functioning and child maltreatment, Sheridan (1995) proposes an intergenerational model that helps to explain the perpetuation of issues from generation to generation. Citing the considerable body of literature on the impact of substance abuse on functioning, Sheridan postulates that parental substance abuse has a direct impact on the occurrence of child abuse/neglect, and an indirect effect on family competence by compromising adult functioning when the parent is under the influence of substances. Parental substance abuse also has a direct influence on adult abuse/neglect (the occurrence of intimate partner violence). All four factors (parental substance misuse, child abuse/neglect, family competence, and adult abuse/neglect) also influence the substance abuse of the adolescents in the family, who often continue with substance misuse into adulthood, setting the stage for the pattern to repeat in the next generation. The intergenerational model is reproduced in Figure 1 (Sheridan, 1995, p. 527):

Figure 1: Proposed model of intergenerational substance abuse, family functioning, and abuse/neglect



## **Maladaptive Parenting**

In addition to the harmful effects of child maltreatment and family functioning issues, maladaptive parenting has also been associated with an increased risk for mental health issues in children, interpersonal difficulties, and suicide attempts in late adolescence. Wolfe and Mclsaac (2011) characterize maladaptive parenting as including emotionally abusive behaviours such as continuous criticism, denigration, repeated blaming, threats, and terrorizing by children's caregivers. They distinguish between poor parenting styles, such as overly permissive or authoritarian approaches to parenting, which also have detrimental effects on children and adolescents but generally do not result in the emotional maltreatment of children. Factors that distinguish maladaptive parenting from poor parenting are:

- 1) The chronic, severe and escalating pattern of emotionally abusive and neglectful parental behaviour toward the child.
- 2) The pattern of chronic and severe parenting methods is associated with a proportionate increase in the likelihood of psychological harm or developmental disruptions, presumably because the child is exposed to ongoing stress that interferes with his or her ability to establish emotion regulation. (Wolfe & Mclsaac, 2011, p. 806)

Johnson, Cohen, Gould, Kasen, Brown and Brook (2002) found that maladaptive parenting contributed to children having more interpersonal difficulties, diminished social skills, and trouble maintaining healthy relationships with peers and adults. Without these skills, youth may become emotionally isolated, contributing to a sense of despair, hopelessness and greater risk of suicide. Research has also indicated that maladaptive parenting can lead to an increased likelihood of psychiatric disorders in youth (Johnson, Cohen, Kasen, Smalles, & Brook, 2001). Interestingly, children whose parents had psychiatric conditions but no history of maladaptive parenting were not at increased risk for psychiatric conditions.

## **Emotional Abuse**

There is increasing recognition of the central importance of the psychological domain to children's well-being and functioning. While the entwined relationship between physical/sexual abuse and emotional abuse has been well known since the 1970s, there have been significant barriers that have prevented the child welfare field from adequately responding to this form of maltreatment: lack of operational definitions, reliance on the expertise of psychiatrists and psychologists to assess the occurrence and impact of emotional abuse, and distrust of the child welfare system to distinguish between poor and seriously harmful parenting (Hart & Glaser, 2011). The Manitoba *Child and Family Services Act's* definition of emotional abuse is an example of these constraints, with its emphasis on confirming the permanent nature of emotional disability in order to substantiate emotional abuse:

### ***Definitions***

1(1) *In this Act*

**"abuse"** means an act or omission by any person where the act or omission results in

(a) physical injury to the child,

(b) emotional disability of a permanent nature in the child or is likely to result in such a disability, or

(c) sexual exploitation of the child with or without the child's consent.

Hart and Glaser (2011) assert that until child welfare is considered to be a public health imperative, that is, a community responsibility with a strong incentive for determining the causes of violence and child maltreatment, the child welfare system will continue to be relegated to its 'rescuing' role, intervening only after children have already been maltreated.

Slep, Heyman and Snarr (2011) have built on the current literature and considerable field testing and developed detailed operational criteria for the identification of child emotional maltreatment. Consisting of first confirming that the verbal/symbolic act was non-accidental (Criterion A) and then that the child experienced significant impact (Criterion B), the framework offers a useful construct for child welfare practitioners (adapted in Table 2 from Slep, Heyman, & Snarr, 2011, p. 793).

Table 2: Child Emotional Abuse Criteria

Criterion A – Non-Accidental Act	Criterion B – Significant Emotional Impact
<p>Non-accidental verbal or symbolic act or acts (excluding physical and sexual abusive acts) such as those listed below. <i>Acts not listed but of similar severity are also eligible.</i></p> <ul style="list-style-type: none"> <li>• Berating, disparaging, degrading, scapegoating, or humiliating child (or other similar behavior)</li> <li>• Threatening child (including, but not limited to, indicating/implying future physical harm, abandonment, sexual assault)</li> <li>• Harming/abandoning – or indicating that alleged abuser will harm/abandon – people/things that child cares about, such as pets, property, loved ones</li> <li>• Confining child (a means of punishment involving restriction of movement, as by tying a child's arms or legs together or binding a child to a chair, bed, or other object, or confining a child to an enclosed area [such as a closet])</li> <li>• Coercing the child to inflict pain on him/herself (including, but not limited to, ordering child to kneel on split peas/rice for long periods or ordering child to ingest highly spiced food)</li> <li>• Disciplining child (through physical or non-physical means) excessively (i.e. extremely high frequency or duration, though not meeting physical abuse criteria)</li> </ul>	<p>Significant impact on the child involving any of the following:</p> <ol style="list-style-type: none"> <li>1. Psychological harm, including either               <ol style="list-style-type: none"> <li>a) More than inconsequential fear reaction</li> <li>b) Significant psychological distress (Major Depressive Disorder, Post-Traumatic Stress Disorder, Acute Stress Disorder, or other psychiatric disorders, at or near diagnostic thresholds) related to the act(s)</li> </ol> </li> <li>2. Reasonable potential for psychological harm               <ol style="list-style-type: none"> <li>a) The act (or pattern of acts) creates reasonable potential for the development of a psychiatric disorder (at or near diagnostic thresholds) related to, or exacerbated by, the act(s). The child's level of functioning and the risk and resilience factors present should be considered.</li> <li>b) The act (or pattern of acts) carries a reasonable potential for significant disruption of the child's physical, psychological, cognitive, or social development.</li> </ol> </li> <li>3. Stress-related somatic symptoms (related to or exacerbated by the acts) that significantly interfere with normal functioning.</li> </ol>

Trocmé, Fallon, MacLaurin, Chamberland, Chabot, and Esposito (2011) examined emotional maltreatment in the 2008 Canadian Incidence Study data in detail. They reported that a large proportion of substantiated emotional maltreatment investigations were opened by child welfare agencies for ongoing services, which often resulted in the child's admission to care. They argue that

“concerns that emotional maltreatment may be too difficult to document and substantiate in a child protection context are not supported by these findings” (p. 838).

Further analysis of the 2008 CIS data by Chamberland, Fallon, Black and Trocmé (2011) noted that emotional maltreatment is a leading form of substantiated maltreatment in Canada at 29% of all substantiated investigations, both as a single form of maltreatment and in conjunction with other forms of maltreatment. However, despite the recognition of emotional maltreatment documented in the 2008 CIS, the authors state that there are still considerable challenges to address in strengthening the response of the child welfare system to reports of emotional maltreatment. These challenges include the tendency of child welfare investigations to focus on incident or crisis over assessing the relational or social context of the family, the lack of objective measures to establish occurrence of emotional maltreatment, and the difficulty in establishing a causal link between parental conduct and the emotional impact on children.

## **Trauma**

Traumatic events can be singular or chronic, interpersonal or non-interpersonal (such as natural disasters or accidents) with interpersonal traumas – especially those perpetuated by family members – the most common cause of Post Traumatic Stress Disorder (PTSD) in children and adolescents (De Bellis & Van Dillen, 2005). Child maltreatment is considered to be an example of trauma, defined as “a perceived threat to one’s own or another’s life or physical integrity, and intense fear, helplessness or horror” (Black & Tufnell, 2006, p. 466). Although short-term symptoms are expected after experiencing a traumatic event, exposure to chronic trauma can result in physical alterations to the sympathetic nervous system that responds when an individual is threatened or under stress – known as the ‘fight-or-flight response’ – alterations which increase the risk of depression, aggression, and hostile behaviour as they compromise the child’s capacity for emotional and behavioural regulation (De Bellis & Van Dillen, 2005; Milot, Éthier, St-Laurent, & Provost, 2010; Perry, 1994; Twardosz & Lutzker, 2010). These brain alterations may become the organizing framework for the child’s experiences (Perry & Pollard, 1998). Other studies note that trauma can result in both internalized behaviours (such as self-harm, depression, withdrawn behaviour) and externalized behaviours (such as aggression, defiance, behaviour problems) (for example, Wolfe, Sas, & Werkerle, 1994). Children are considered to be more at risk psychologically to the effects of traumatic experiences than adults (Black & Tufnell, 2006).

There is some suggestion that potentially traumatic events (such as accidents, natural disasters, physical violence, physical abuse, death of a loved one, etc.) are more common in the general population than generally recognized because the majority of these events don’t result in PTSD symptoms except after multiple traumas or a history of anxiety (Copeland, Keeler, Angold, & Costello, 2007). In their study of 1420 children who experienced a traumatic event before age 16, 13.4% developed PTSD symptoms. Other studies have also suggested that factors that increase the likelihood of PTSD are experiencing multiple traumatic events, emerging adolescence, and having a history of childhood physical or childhood sexual abuse (Macdonald, Danielson, Resnick, Saunders, & Kilpatrick, 2010). The experience of childhood maltreatment may be a unique contributor to trauma symptoms, as parents are the source of distress and yet are also supposed to be the child’s source of comfort (Milot, Éthier, St.-Laurent, & Provost, 2010). This “irresolvable paradox” may lead to attachment disorders, stress reactions, emotional dysregulation, and problems in behavioural regulation (Milot, et al., 2010), and has been termed “complex trauma” to denote the developmental consequences associated with chronic interpersonal trauma. De Bellis and Van Dillen (2005) assert that even neglect can be perceived by the child to be traumatic.



Despite their increased psychological vulnerability to trauma effects and PTSD, the majority of children who experience a traumatic life event recover in the environment of a safe and secure relationship with consistent caregivers (Black & Tufnell, 2006). However, as noted above, children who have been maltreated may not have supportive relationships available to them to foster their recovery from trauma, especially those children whose parents are the source of their traumatic experiences. In such situations, children may benefit from trauma-focused therapy that takes into account the larger context of the child's life and is tailored to address more complex needs. Research has indicated that therapy can be effective even with the most traumatized young children, particularly if the therapy includes the involvement of a consistent caregiver or parent (Ippen, Harris, Van Horn, & Lieberman, 2011; Perry, 2002).

The impact of unresolved trauma has intergenerational implications. Citing the intergenerational effects of the residential school system on Aboriginal peoples, Chansonneuve (2005) asserts that many survivors find themselves trapped in repeating cycles of violence, substance misuse, shame, self-harm, and mental illness, at higher rates than the non-Aboriginal population. Involvement with the child welfare system and criminal justice system is common as a result of these issues.

### **Attachment**

One of the most critical developmental processes during the preschool years that is essential to well-being and serves as a resilience factor that buffers children, adolescents, and adults from a multitude of life stressors is the development of healthy attachment. Perry (2004) asserts that consistent, predictable and stimulating interactions with an attentive and nurturing caregiver create the optimum conditions within which a child's brain develops the neurological connections that foster what has become known as 'attachment' and serve to organize the individual's inner working models of his/her experiences.

'Attachment' can be defined as a bond between one person and another, which for children refers to an enduring emotional relationship with a specific person that brings safety, comfort, soothing and pleasure. Conversely, the absence or threat of loss of this relationship evokes intense distress (Perry, 2001). It is these absence or threat conditions that stimulate the development of attachment behaviour (Howe, 1995). Stress is experienced when the infant has pressing physical needs (such as hunger, pain, illness or fatigue), is exposed to environmental threats, or experiences a relationship problem (such as separation from or rejection by a primary caregiver), stimulating the following attachment behaviours:

1. *Proximity seeking*. The child will attempt to remain within protective range of his parents. The protective range is reduced in strange, threatening situations.
2. *Secure base effect*. The presence of an attachment figure fosters security in the child. This results in inattention to attachment considerations and encourages confident exploration and play.
3. *Separation protest*. Threat to the continued accessibility of the attachment figure gives rise to protest and to active attempts to ward off the separation. (Howe, 1995, p. 52)

Ainsworth developed a classification system based on four styles of attachment relationships that originate in early childhood: securely attached (at 1 year of age, 60 – 70% of infants are securely attached); insecure-avoidant attachment (at 1 year, 15 – 20% are characterized with this type of attachment); insecure – resistant/ambivalent attachment (10 – 15% of children at 1 year of age); and insecure – disorganized/disoriented (5 – 10% of children at 1 year of age) (Perry, 2001). The development of secure attachment can be disrupted by a range of negative experiences: inappropriate or abusive parenting, a lack of nurturing, chaotic home environment, cognitively or relationally impoverished environments, unpredictable stress, persistent fear, or persisting physical threats (Perry, 2004). Child abuse, neglect, parental substance misuse, family violence, inexperienced caregivers, socially isolated parents, and a high rate of family stressors are factors that can lead to these negative, attachment-disrupting experiences and maladaptive attachment styles. Studies of abused infants have consistently found that significantly more maltreated children display insecure attachments (see Morton & Browne, 1998, for a review). The intergenerational impact is evident:

Children who have not had the benefit of a secure attachment during childhood, including maltreated children, will be unable to form a secure relationship with their own children. This may be the primary process by which child maltreatment continues from one generation to the next. (Morton & Browne, 1998, p. 1098)

The quality of a child's attachment is predictive of the child's future social, psychological, behavioural and cognitive functioning (Mennen & O'Keefe, 2005). Children with attachment disorders develop increasingly sophisticated adaptive strategies for managing the risks of their familial relationships, for the purposes of self-protection and reducing danger or threat, according to Crittenden (1999). Common strategies include:

- *Compulsive self-reliance and punitive, aggressive control*: As a result of living with caregivers who are helpless or hostile, children begin to take responsibility for their own care and protection. They boss their parents, demand, are aggressive toward caregivers, and are often characterized as 'out of control'. They have learned to stay safe by not letting parents be in control. As adolescents, they are at great risk of developing externalizing problems.
- *Compulsive caregiving*: When parents' own needs overshadow those of their children, children become highly aroused and cannot develop strategies for emotional regulation. A role reversal often develops, where children take care of their parents, or take on the responsibilities of their parents for younger children or household tasks. As adolescents, these children are at great risk of developing internalizing problems and co-dependent adult relationships with those who need 'rescuing'.
- *Compulsive compliance*: In families where parents are predictably dangerous and abusive, children become hypervigilant and compliant. In order to be safe, they must anticipate parents' moods and behaviours. Survival strategies involve suppressing emotions and any feelings of dependency. As adolescents, these children are at great risk of developing mental health disorders and avoiding relationships with others. (Crittenden, 1999; Howe, 2005)

The 2008 Canadian Incidence Study (Trocmé, et al., 2010) reported that 14% of children in substantiated maltreatment investigations experienced attachment issues. Mennen and O'Keefe (2005) offer some helpful guidelines for child welfare practitioners for using attachment theory in case decision

making during investigation, at and during placement, and when making decisions about reunification. Additionally, there is a growing body of research that demonstrates that treatment can be provided to children, adolescents, parents and families to address attachment issues, such as the Circle of Security intervention (Marvin, Cooper, Hoffman, & Powell, 2002). The overall theme of attachment treatment is aptly summarized by Howe (2005, p. 274):

Being emotionally available and staying with people when they are anxious or frightened or aggressive strips away the fear that when the self feels helpless or out of control, no one can contain or help regulate you and your profoundly distressed state. Disorganized and unresolved clients feel powerfully destructive and alone. To experience someone who is prepared to 'stay in there', wanting to understand what is happening, conveys the hint that what is being experienced might be manageable, might be understood, might not be a hopelessly destructive force with which no one can live.

### **Disabilities**

Various studies have reported a higher prevalence of disabilities affecting children in care than in the general population: between 20% and 60% of children in care have developmental disabilities, compared to 10% in the general population (National Council on Disability, 2008). Children with disabilities are more at risk of maltreatment than children who don't have disabilities (Brown & Schormans, 2003; Brown & Schormans, 2004; Mandell, Walrath, Mateuffel, & Pinto-Martin, 2005; National Council on Disability, 2008). However, the actual prevalence of the maltreatment of children with disabilities may be obscured by the lack of documentation about the existence of children's disabilities when conducting child abuse investigations (Algood, Hong, Gourdine, & Williams, 2011). Factors that can contribute to a higher risk of child maltreatment for children with disabilities include the quality of attachment between parent and child, availability of social supports, extraordinary physical and emotional demands placed on parents, and financial strain (Algood, et al., 2011).

In Manitoba, one-third of all children in care in 2004 had a disability (Fuchs, et al., 2005). The most common disabilities were intellectual disabilities (affecting 75% of all children who had a disability) and mental health conditions (affecting 46% of all children with a disability). More than half of the children had more than one type of disability. Although children with developmental delay make up about 2.25% of the general population of children in Canada (Brown & Schormans, 2004), 11% of children in substantiated maltreatment investigations in the 2008 Canadian Incidence Study (Trocmé, et al., 2010) had an intellectual or developmental disability, and 2% had a physical disability. Brown and Schormans (2004) reported that children with developmental delay were over-represented in substantiated cases of physical and sexual abuse, and especially over-represented in emotional maltreatment and neglect cases, compared to children without disabilities.

Additionally, 11% of children in care in Manitoba from the study by Fuchs et al. (2005) had been diagnosed with FASD, a specific disability that is the result of prenatal alcohol exposure. FASD is increasingly recognized as the one of the leading causes of developmental disability in Canada (Health Canada, 2000). The impact of FASD on individual functioning is well documented to include primary disabilities, such as impulsivity, hyperactivity, behaviour problems, and difficulties in executive functioning, and secondary disabilities, such as mental health issues, conflict with the law, alcohol and drug abuse, and problems with employment (Brintnell, Bailey, Sawhney, Kreftin & Bhambhani, 2010;

Green, 2007; Malbin, 2004; Zevenbergen & Ferraro, 2001). Children with FASD were identified in 4% of the substantiated maltreatment investigations in the 2008 CIS (Trocmé, et al., 2010).

Parenting children and youth with FASD is also recognized as challenging, with a significant impact on biological, adoptive, and foster families (for example, see Brown, Sigvaldason, & Bednar, 2006; Caley, Winkelman, & Mariano, 2009; Jirkowic, Kartin & Olson, 2008; Olson, Oti, Gelo & Beck, 2009). In particular, FASD's effect on the occurrence of behaviour problems is well documented (D'Onofrio, Van Hulle, Waldman, Rodgers, Rahouz, & Lahey, 2007), especially the longer youth with FASD remain in care (Fagerlund, Autti-Ramo, Hoyme, Mattson, & Korkman, 2011). Studies also indicate that children with FASD are more likely to also be diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), mood disorders, oppositional defiant disorder, an anger disorder, and self-injurious behaviour (Burd, Klug, Martsoff, & Kerbeshian, 2003), as well as depression and anxiety (Hellemans, Sliwowska, Verma, & Weinberg, 2010). Despite this association, studies have indicated that child physical or sexual abuse was still more predictive of mental health issues such as anxiety disorders than prenatal alcohol exposure (Chasnoff, 2011).

### **Mental Health Issues**

Jurisdictions around the world report significant levels of child and adolescent mental health concerns (Belfer, 2008; Call, Riedel, Hein, McLoyd, Petersen, & Kipke, 2002; Logan & King, 2001; Rothi & Leavey, 2006), including Canada where as many as 15% of children and youth under the age of 19 experience mental health distress at any given time (Standing Senate Committee on Social Affairs, 2006; Statistics Canada, 2003). Manitoba's rate is at least 20% of all children over age 5 (Government of Manitoba, 2011a). However, a significantly lower proportion of adolescents ever receive mental health services (Essau, 2005; Logan & King, 2001; Rothi & Leavey, 2006; Standing Senate Committee on Social Affairs, 2006). Given evidence that the onset of 80% of all mental health disorders occurs during adolescence (Call et al., 2002), it is critically important that youth at risk be identified and provided with appropriate services and supports.

Mental health issues can affect any adolescent, but some youth are more susceptible due to environmental risks that contribute to experiences of chronic disadvantage, trauma and emotional distress. Poverty is one of the biggest risk factors, leading to exposure to more proximal environmental risks than experienced by youth who are not economically disadvantaged (Coulton & Korbin, 2007; Felner, 2006). Refugee youth in Canada may have been exposed to additional environmental traumas in their home country, such as civil war, sexual assault, child soldiering and prostitution, HIV/AIDS, and material deprivation (Belfer, 2008).

Adolescents may also be at increased risk due to personal factors such as attachment disorder, FASD, health conditions, developmental delay or other disabilities. Family characteristics such as parental substance abuse, parental under-functioning, and family violence also play a contributory role. Environmental factors include the chronic adversities of poverty, minority status, social and economic disadvantage, and other adverse social determinants experienced by indigenous populations, such as Aboriginal people in Canada (Raphael, Stevens, & Pedersen, 2006). The interaction of these individual, family and environmental factors can contribute to the activation of mental health disorders in adolescents, as well as increase the likelihood of youth involvement with some public services, such as the child welfare and criminal justice systems, and disengagement from others, such as the education system (Ungar, 2005). Young people with mental health issues who are involved with child welfare and

criminal justice are also at increased risk for suicide (Chavira, Accurso, Garland & Hough, 2010; Moskos, Olson, Halbern & Gray, 2007).

Research has also focused on understanding the specific contributory role that child maltreatment plays on the manifestation of mental health conditions, with the recognition that adverse events in childhood like maltreatment can result in Post Traumatic Stress Disorder (PTSD) (Raphael, Stevens, & Pedersen, 2006). Leverich et al. (2002) found that 49% of women and 36% of men diagnosed with bipolar disorder reported a history of childhood physical and/or sexual abuse. Further, the group with childhood maltreatment histories also experienced higher incidence of comorbid issues throughout their lives: anxiety disorders, eating disorders, substance abuse, and PTSD. Suicide attempts were also higher, with 45% of the group abused in childhood at risk of suicide compared to 26% of the group who did not experience childhood abuse. Childhood sexual abuse was identified as a particular risk factor contributing to suicidality. The group with a history of childhood maltreatment also reported a higher incidence of family alcoholism. In the 2008 Canadian Incidence Study, 19% of substantiated maltreatment investigations involved children who were depressed or anxious, 4% had suicidal thoughts, and 6% engaged in self-harming behaviour (Trocmé, et al., 2010). Analysis of the 2003 CIS data (Tonmyr, Williams, Hovdestad, & Draca, 2011) found a strong association between depression and/or anxiety with substantiated investigations of emotional maltreatment and sexual abuse. An Ontario study by Burge (2007) reported that 31.7% of permanent wards had been diagnosed with mental health disorders and were three times more likely to be placed in groups homes.

The fact that the majority of mental health disorders originate in adolescence underscores the vulnerability faced by individuals at this developmental stage of life. Research indicates that patterns of behaviour and maladaptive coping established during adolescence tend to persist into adulthood (Call, et al., 2002). Further, conditions such as ADHD and conduct disorder have been associated with the perpetration of intimate partner violence in adulthood (Fang, Massett, Ouyang, Grosse, & Mercy, 2010). Consequently, adolescence should be viewed as the most opportune time for intervention and, ultimately, for mitigation of the long-term effects of mental illness into adulthood (Liu, 2005).

However, fewer than 7% of countries that track rates of adolescent mental illness have clearly articulated policy on services for this vulnerable population (Belfer, 2008), and there is a serious shortage of services and qualified practitioners (Berland, 2008; Leavey, Flexhaug & Ehmann, 2008; Standing Committee on Social Affairs, 2006). According to Wharf (2002), where services do exist, they are rarely coordinated to adequately meet the needs of adolescents, especially those who are involved with the child welfare system or the youth justice system.

But the presence of adolescent mental health services alone is not necessarily sufficient to ensure that youth are accessing them. Numerous reviews have identified that mental health services are often not sought by minority groups (Berland, 2008; Standing Senate Committee on Social Affairs, 2006; Zimmerman, 2005) or families of lower socioeconomic status (Ungar, 2005), and that youth in general, as a manifestation of normative adolescent development, are resistant to accessing such services (Logan & King, 2001). There are also different interpretations of mental health and mental illness across cultures which affect decisions to reach out to services (Roberts, Alegria, Roberts, & Chen, 2005). Even for those youth already involved with a service system such as child welfare, where professionals may be more likely to identify mental health issues and be aware of community treatment resources, less than one-third of emotionally disturbed children in care receive mental health services (Hurlburt, et al., 2004). Without intervention, the prognosis for adulthood is grim: adolescents who

reach adulthood with untreated mental health issues are more likely to experience negative outcomes in adulthood (Keller, Salazar, & Courtney, 2010).

The presence of a mental health condition can complicate access to services for other comorbid conditions. For example, Elliott (2005) describes how the co-occurrence of mental health issues with either addictions or intellectual disability can create the most complex constellation of issues that result in this population suffering the greatest unmet needs. She advocates for system reform that supports the creation of professionals with comprehensive skillsets who are versed in responding to each of these issues, individually and in interaction with one another, as well as new interventions that include behavioural strategies and alternatives to incarceration for persons whose complex needs bring them into contact with the criminal justice system.

Frequently, prescription medications are utilized to mitigate the effects of many mental health disorders, most commonly Ritalin, Paxil, Dexedrine, and Prozac (Lambe, McLennan, Manser, Andrews, & Bentzen, 2009). While prescription medications have an appropriate role to play in the management of symptoms, the authors note that medicinal interventions were sometimes viewed by child welfare agencies as a quicker and easier method to manage behaviour challenges, reduce aggression, and enforce compliance (Lambe, et al., 2009).

### **Suicide**

Suicide is one of the top three causes of death among North American youth between 15 and 24 years of age (Mironova, et al., 2011; World Health Organization, 2005). Rates are particularly high among First Nations youth, especially males (Winnipeg Regional Healthy Authority, 2003). Depression and substance misuse are often associated with suicide risk, and are part of a constellation of contributing factors: genetic/biological factors, demographic/social factors, family characteristics, childhood experiences, and personality factors/cognitive style (Beautrais, 2000; Winnipeg Regional Health Authority, 2003).

Recent research has explored the impact of childhood maltreatment on increased risk of suicidality in adolescence or adulthood. A Canadian study of the life trajectories of youth and young adults (Séguin, Renaud, Lesage, Robert, & Turecki, 2011) found that 50% of individuals who completed suicide had been exposed to physical or sexual abuse before the age of 4, and by the time this group was 14-years-of-age, 77% had been exposed to child maltreatment. Early exposure to childhood adversity of this nature contributed to severe developmental difficulties, a lack of adult protection, and subsequent mental health issues. Individuals in a comparison group were not as exposed to these childhood difficulties, but 12% did present with major mental health difficulties, consistent with rates found in other studies of mental health in the general population (Statistics Canada, 2003).

These findings are also consistent with those of Chavira, Accurso, Garland and Hough (2010), who reported an increased risk of suicide behaviour among youth who were involved with child welfare, the youth corrections system, special education programs, alcohol and drug treatment services, and mental health services. The issues of childhood maltreatment, substance misuse, mental health concerns and learning disabilities were contributory factors that led to the youths' involvement in these sources of public care. Higher levels of depression, conduct disorder, and substance abuse were assessed in suicidal youth with a history of childhood abuse, compared to suicidal youth who had not been abused (Grilo, Sanislow, Fehon, Lipschitz, Martino, & McGlashan, 1999). Further, the abused group was more likely to have engaged in past acts of violence towards others, suggesting there is a

connection between violent behaviour and suicide risk. However, although substance abuse is associated with suicidal behaviour, Chatterji, Dave, Kaestner, & Markowitz (2004) assert that their research demonstrates that binge drinking and suicide attempts are not causally related.

There is still much to learn about suicidal behaviour (Burns & Patton, 2000; White, 2003). Brodsky and Stanley (2001, p. 334) state:

It is clear from numerous empirical studies that there is a strong relationship between a history of trauma and subsequent suicidal behavior in adolescence and adulthood. It is also clear that there is still much that is unknown regarding the mechanism(s) by which early childhood abuse/neglect makes an individual more vulnerable to suicide.

One theory is that suicide attempts are predicated by impulsivity, and that impulsivity is a common outcome in response to early childhood trauma, loss, and maltreatment (Braquehais, Oquendo, Baca-Garcia, & Sher, 2010; Brent, et al., 1994; Brodsky & Stanley, 2001; De Bellis, et al., 1999; De Bellis & Van Dillen, 2005; Pfeffer, 2001). The biological/neurological underpinnings of PTSD in response to early childhood trauma can lead to dysfunctional brain adaptations, which increases impulsivity, especially when the individual is under stress (Braquehais, et al., 2010; De Bellis & Van Dillen, 2005). With multiple possible factors (individual, familial, environmental, and neurodevelopmental) contributing to the risk of suicide, Pfeffer (2001) argues for a multi-modal approach to suicide prevention:

New approaches to suicide prevention should focus on management of risk factors by identification and application of effective interventions to reduce the presence of such factors. Thus, interventions to decrease suffering from psychiatric disorders, to reduce impairment in family functioning due to parental psychopathology and family discord, to limit the availability of lethal suicide methods, to provide external support in managing environmental stresses, to counsel those who suffered the suicidal death of a relative or friend, and to decrease media exposure to descriptions of suicidal behaviour should be issues to which effective suicide prevention strategies are directed. (p. 365)

### **Adolescent Substance Abuse**

Adolescent addiction has been defined as involving (a) a preoccupation with alcohol/drugs or alcohol/drug-related experiences, (b) repetitive alcohol/drug behaviours that interfere with normal activities, and (c) neurological adaptation to substances, resulting in withdrawal symptoms if substance use abruptly stops (Wekerle, Leung, Goldstein, Thornton, & Tonmyr, 2009). About 15% of adolescents in the general population in the United States have substance abuse disorder, but the prevalence rate for special populations, such as youth involved with the criminal justice system or child welfare, may be as high as 50% (Chatterji, Dave, Kaestner, & Markowitz, 2004). Numerous studies have demonstrated the relationship between adverse childhood experiences such as physical or sexual abuse (Harrison, Fulkerson, & Beebe, 1997), childhood maltreatment and depression (Clark, De Bellis, Lynch, Cornelius, & Martin, 2003), childhood abuse and sexual molestation (Bensley, Spieker, Van Eenwyk, & Schoder, 1999), childhood neglect (Cheng & Lo, 2010) and parental substance misuse (Hoffmann & Cerbone, 2002) and the abuse of substances by adolescents.

In Canada as well, specific groups of youth are more at risk for substance abuse: those who are homeless or street-involved, adolescents who were sexually abused in childhood, sexually exploited

youth, teens struggling with sexual orientation, those involved with the juvenile corrections system, Aboriginal youth, and adolescents with co-occurring disorders such as ADHD and other impulse control problems (Saewyc, 2007). These groups of youth share high rates of trauma exposure and, consistent with the literature on PTSD, “substance abuse or dependence disorders among young people in these risk groups may be attempts to manage, however ineffectually, intense stressors and toxic environments, the physiological effects of chronic stress, and psychological outcomes of untreated trauma, both prior and recurring” (Saewyc, 2007, p. 17). Peer substance use is also a strong predictor of alcohol/drug use by adolescents (Paglia-Boak & Adlaf, 2007).

Alcohol is the most common substance used by Canadian teenagers, with more than a third of adolescents having at least one experience of binge drinking and half engaging in heavy alcohol use at least once a month (Paglia-Boak & Adlaf, 2007). The consequences of substance abuse by adolescents are considerable: academic difficulties and school truancy, aggression, violence, sexual victimization, unprotected sex, driving under the influence, and injury to self. With prolonged use, substance abuse is also associated with physical health issues (Aarons, et al., 1999).

Saewyc (2007) makes a compelling argument for shifts in strategies to reduce adolescent substance abuse. She writes:

In order to reduce problem substance use, we need to recognize the potent influences of trauma, violence, stigma, and neurophysiological vulnerability on the risk for chronic substance abuse. We need further research to chart the complex pathways and potential causes more clearly, but there is enough evidence already to suggest new directions in prevention and treatment. We should focus our prevention efforts on addressing these underlying issues, rather than just the coping behaviours they elicit. Population-level prevention efforts may be more effective if they focus not on drug use itself, but instead on preventing sexual and physical violence, reducing stigma and discrimination, early identification and treatment of psychological disorders, promoting cultural continuity and self-determination for Indigenous communities, and helping all young people to find safe and nurturing environments. Beyond prevention, we need culturally-relevant interventions that help teens heal from trauma, learn healthy ways of coping with chronic stress and distress, and stay connected to protective resources in their lives. (Saewyc, 2007, p. 18)

### **Education Challenges**

There is a considerable body of literature documenting the disruptions in education experienced by the vast majority of children in care (Trout, Hagaman, Casey, Reid & Epstein, 2008). Variables that can interfere with children’s learning include the experience of maltreatment, which can initiate a developmental lag that widens as children progress through the school system (Snow, 2009), multiple adverse childhood experiences (Burke, Hellman, Scott, Weems & Carrion, 2011), and multiple experiences of victimization (Holt, Finkelhor, & Kantor, 2007). Stone (2006) suggests that different types of maltreatment affect academic performance differentially, with physical abuse resulting in lower grades, neglect contributing to greater behaviour problems in school, and both sexual abuse and physical abuse contributing to lower reading and math scores, compared to non-abused children.

A study of Manitoba youth with high risk factors (defined as being in child welfare care, living in poverty, and/or having a mother who was a teenager at her first birth) found that 41% - 57% of youth



with one of these risk factors failed to complete high school, while 84% of youth who had all three risk variables did not complete high school (Brownell, Roos, MacWilliam, Leclair, Ekuma & Fransoo, 2010). Individually, being a child in care as an individual factor was associated with 43% of youth not completing high school, compared to the impact that poverty had on 57% of youth who did not finish school. Notably, failure to complete at least eight Grade 9 credits was predictive of high school non-completion (Brownell, et al., 2010). The 2008 Canadian Incidence Study noted that 23% of children in substantiated maltreatment cases were experiencing academic difficulties (Trocmé, et al., 2010).

The outcomes of school disruption and incomplete high school for youth who grew up in care are concerning. Youth who do not complete high school tend to take on adult roles at an early age including parenting responsibilities while still in adolescence, be under-employed, lack the social supports to remain in or return to school, and suffer from low self esteem (Rosenthal, 1998) and struggle with mental health issues, often related to their childhood maltreatment experiences (Harris, Jackson, & Pecora, 2009). While many early intervention strategies have been implemented in schools with at-risk children, with demonstrated success in long-term results, vulnerable adolescents need something more, or something different, to enable them to have more success in school. Brownell et al. (2010, p. 822) note that “for many children, factors beyond individual ability prevent them from maximizing their educational (and developmental) potential”. Williams, MacMillan and Jamieson (2006) assert that helping adolescents to remain in school regardless of their level of academic achievement has the effect of reducing externalizing behaviours, although support for internalizing disorders such as mental health issues is still required. This finding suggests that emphasizing aspects of the school experience that provide youth with positive experiences (e.g. sports, extracurricular activities, vocational skills, social relations, etc.) that keep them engaged in school has a protective outcome in reducing problem behaviour, regardless of academic achievement.

### **Criminal Justice Involvement**

Even in the face of multiple risk factors, many youth reach adulthood without serious involvement in criminal activity, and most who do have juvenile criminal involvement do not become adult criminals (National Research Council and Institute of Medicine, 2001). However, it has been well established in the literature, as well as in this report thus far, that youth who experience adversity in their lives are likely to be involved with the child welfare system, mental health services, and the youth corrections system (Grisso, 2008; Zachik, Naylor, & Klaehn, 2010). Canada has a lower incarceration rate of youth compared to the United States (75 per 100,000 in Canada, vs. 125 per 100,000 in the US), attributed to the provision of the *Youth Criminal Justice Act* in Canada that reserves incarceration for the most serious, repetitive and violent young offenders (Gretton & Clift, 2011).

Similar to the child welfare system, Aboriginal people are over-represented in the criminal justice system (Trevethan, Auger, Moore, MacDonald, & Sinclair, 2001). A review of a sample of inmates in a Manitoba correctional facility found that 88% of Aboriginal inmates and 63% of non-Aboriginal inmates had not been living at home during adolescence (Skoog, Hamilton, & Perrault, 2001), mainly due to living in foster care. Similar findings were reported by Trevethan, et al. (2001): 50% of Aboriginal inmates reported an unstable adolescence with 63% living in care of the child welfare system, compared to 32% of non-Aboriginal inmates who had unstable lives and 36% who grew up in care. A quarter of those with unstable adolescence were assessed as maximum security inmates. The prevalence of incarcerated adults with intellectual disabilities (Riches, Parmenter, Wiese, & Stancliffe, 2006) and FASD have also been identified as a significant concern (Bracken, 2008; MacPherson & Chudley, 2007).

A British Columbia study found that youth were more likely to be incarcerated in a youth detention centre if they were Aboriginal, in child welfare care, experienced placement instability, had poor attachment to consistent caregivers, experienced trauma such as neglect or abuse, had mental health issues, and had developmental disabilities (Select Standing Committee on Children and Youth, 2009). Almost 72% of the incarcerated youth in this study had severe behaviour problems and/or mental illness, compared with only 2% of youth in the general population, with the majority having been diagnosed during childhood. About 70% had special education needs, compared with 15.5% of children in the general population. Of considerable concern: the study cites that more children in care in British Columbia become involved with the youth criminal justice system (35.5%) than graduated from high school (24.5%).

Risk factors for youth corrections involvement are well documented:

- A significant proportion of youth incarcerated in detention centres have been diagnosed with both internalized issues (depression, anxiety, and risk of suicide) and externalized behaviours (conduct disorder, antisocial behaviour, substance abuse) (Vermerien, Jaspers, & Moffitt, 2006).
- Incarcerated male youth have higher rates of conduct disorder, substance abuse disorder, ADHD, mood disorders, and anxiety disorders, compared to male adolescents in the general population. Incarcerated female youth are more likely to suffer from substance misuse issues and PTSD. Factors that contributed to these conditions were identified as poverty, neglect, abuse, and lack of mental health services (Thomas & Penn, 2002).
- Wierson, Forehand, and Frame (1992) found high rates of conduct disorder, personality disorder, affective disorder, ADHD, and substance misuse in a sample of incarcerated youth.
- Almost 100% of incarcerated youth had at least one of the following mental health issues: substance abuse, aggressive form of conduct disorder, childhood physical abuse, childhood sexual abuse, suicide ideation, depression, and/or Oppositional Defiant Disorder (Gretton & Clift, 2011).
- Most youth who have committed violent crimes have either been diagnosed with Conduct Disorder, or would have been had they been referred for mental health treatment (Frick, 2006).
- The most seriously emotionally disturbed youth comprise about 10% of all youth in the general population, but account for almost 20% of youth in juvenile corrections facilities (Grisso, 2008).

Increasingly, there is recognition of the need to incorporate mental health services into the youth corrections system. Kutcher and McDougall (2009) believe that because many Canadian youth do not receive the mental health supports they need early on, they are more prone to becoming involved in the youth corrections system. Grisso (2008) notes that the expression of mental health concerns in adolescence may contribute to an increased rate of arrests: for example, depressed youth are often sullen and belligerent, which can escalate into aggressive behaviour, leading to arrest. Often, their actual crimes are no more serious than property offences (Chapman, Desai, & Falzer, 2006), citing the experience in the United States, indicating that the interventions required are more about dealing with mental health and trauma issues than issues of criminality. However, violent crimes are more likely to involve youth with mental health disorders – up to 65% of youth arrested for violence (Leschied, 2008).

The need to focus on mental health treatment in youth justice is intensified in Canada. With youth only being detained as a last resort for the most serious of crimes, Gretton and Clift (2011) assert that “youth currently incarcerated in Canada may present with more extreme psychiatric, psychological and social issues than previously reported in Canada and in other jurisdictions” (p. 110). However, Grisso (2008) acknowledges that the juvenile justice system can’t provide long-term treatment, partly because it has to establish its jurisdiction over youth in relation to other service systems, and partly because youth are not incarcerated long enough. Consequently, mental health services in youth corrections are often limited to assessment and short-term treatment for the duration of the youth’s period of incarceration, and often only after the youth has been adjudicated (Thomas & Penn, 2002).

Further, the pathways of entry into the youth criminal justice system, and indeed the service needs both before and after discharge, point to the need for multiple service involvement, coordination and collaboration. The literature has identified the needs of youth for child welfare involvement, domestic violence intervention, mental health treatment, family income assistance, family therapy, educational supports, substance abuse intervention, and trauma counselling to deal with a host of adverse childhood experiences, risk factors which, if unaddressed, contribute to the risk of criminal behaviour in adolescence (Maschi, Hatcher, Schwalbe, & Rosato, 2008). These needs do not diminish during or after the youth’s period of incarceration. Others have also raised the necessity of multi-system collaboration (Chapman, Desai, & Falzer, 2006; Gretton & Clift, 2011; Hoge, 2008; Nelson, Jolivet, Leone & Mathur, 2010), sharing the perspective advanced by Grisso (2008, p. 154):

Many youth have multiple needs that do not fit the boundaries of individual agencies. They may receive services from various agencies, but lack of coordination between agencies creates conflict, inefficiency, frustration for the family, and sometimes harm when agencies work at cross purposes.

Due to the paucity of data regarding the prevalence of mental health disorders affecting incarcerated youth in Canada, especially concerning in light of the provisions of the *Youth Criminal Justice Act* described above, Gretton and Clift (2011) undertook a detailed assessment of the mental health of a sample population of adolescents in one of British Columbia’s three youth custody facilities, using the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), developed by Grisso and Barnum in the late 1990s. The MAYSI-2 is designed to help youth justice facilities identify youth with mental health needs as well as other issues related to their functioning (Grisso, Barnum, Fletcher, Cauffman, & Peuschold, 2001). Gretton and Clift (2011) found concerning rates of mental health issues, substance abuse, conduct disorder, and a history of childhood physical abuse, in their study of 142 male and 54 female incarcerated youth, of whom half of the males and a third of the females had been convicted of a serious violent offence, such as aggravated assault, assault with a weapon, manslaughter, or murder (Table 3, next page).

The rates found are consistently higher than those found in the general population of youth, and also slightly higher on most variables than the rates reported by Vincent, Grisso, Terry, and Banks (2008) in a similar American study of incarcerated youth. Both studies found a higher rate for females on most variables. Vincent et al. (2008) attribute this to a tendency for communities to avoid processing girls into the youth corrections system unless absolutely necessary, resulting in a population of incarcerated girls who may represent a more vulnerable or disturbed subpopulation.

Table 3: Mental Health Issues for Incarcerated Male/Female Youth in British Columbia

	<b>Males</b>	<b>Females</b>
Overall rate of mental disorder	91.9%	100%
Substance Abuse	85.5%	100%
Conduct Disorder	72.9%	84.3%
Aggression	80%	60%
Oppositional Defiant Disorder	19.3%	40.4%
ADHD	12.5%	40.4%
Major Depressive Disorder	4.2%	5.6%
Depression/anxiety symptoms	33%	46%
PTSD	1.7%	30%
Childhood physical abuse	60.8%	54.3%
Childhood sexual abuse	21.2%	42.2%
Suicide ideation	14.3%	29.8%
Schizophrenia	0.8%	1.9%

The closing remarks of the article by Gretton and Clift (2011) on the specific rates of mental health disorders affecting youth incarcerated in British Columbia compel Canadian social, health, education, and youth justice services to recognize and act on the presented evidence of the profound needs of Canada's youth:

[T]he information provided in this paper is intended to provide much needed data to assist clinicians, administrators, and policymakers in developing a framework for addressing the mental health-related needs of serious and violent youth in custody. Addressing and stabilizing general mental health needs, and those needs related to risk for violence, is an important task toward facilitating youth adjustment to custody, decreasing risk for aggression and violence, providing opportunities for a more productive environment so that other important aspects of youth development (e.g. education and vocational skills) may be more effectively addressed, and contributing to the improvement of mental health functioning among high-risk youth. (Gretton & Clift, 2011, p. 114)

It is important to note that this group does represent a small proportion of youth overall. For comparison, the Canadian Incidence Study reported that 2% of children who were the subject of a substantiated maltreatment investigation had youth criminal justice involvement. However, the needs of this group are high, given the multiple risk factors they face and the serious consequences of those risk factors these youth are already experiencing.

Finally, the role that developmental delay and FASD play in youth criminal justice involvement must be noted. Streissguth, Barr, Kogan, & Bookstein (1996) raised the issue of the over-representation of youth with FASD in the criminal justice system, reporting that 60% were in trouble with the law and experienced some period of confinement related to mental health issues, substance abuse, or criminal activity. FASD can play a role in the commission of a crime, false confession to a crime, misunderstanding the criminal justice process, lack of understanding of the consequences of criminal actions, and difficulty in altering behaviour resulting in further criminal acts (Gagnier, Moore, & Green, 2011). Consequently, individuals with FASD may be arrested and incarcerated at a higher rate than

individuals without the condition. The Manitoba Youth Justice Project was initiated in 2004 to screen youth whose presentation was consistent with FASD to ensure that their criminal behaviour was not misconstrued by the courts and that the youth were referred to receive appropriate services (Harvie, Longstaffe, & Chudley, 2011).

### **Sexual Exploitation**

The sexual exploitation of youth is a worldwide issue, with increasing awareness about the phenomena of human trafficking, street prostitution, internet child pornography, online luring, and child sex tourism (Broughton, 2009). While there are many Canadian examples of responses to each of these forms of sexual exploitation, particular attention has been focused on youth involved in street prostitution, now re-conceptualized as sexual exploitation. Sexually exploited youth are most often female, but about 20% of victims in Canada are male and transgendered youth (Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth, 2001). This report notes:

Individual factors associated with youth prostitution can all, by one path or another, be traced back to the larger society, and its failure to foster the healthy emotional and psychological development of young people and provide the economic environment for ensuring that healthy activities and work opportunities are available to them. (Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth, 2001, p. III.5)

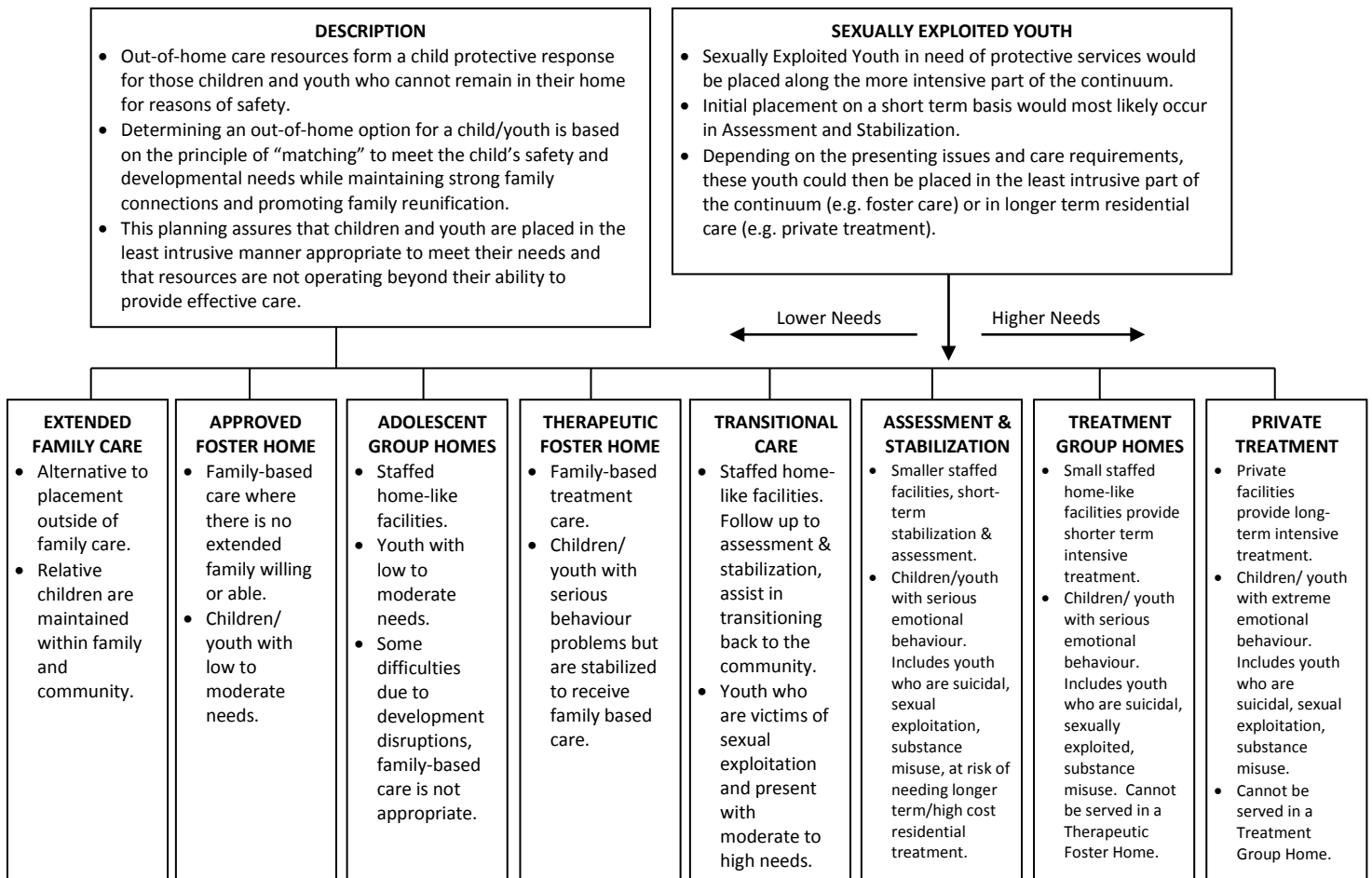
These individual risk factors include intrafamilial childhood sexual abuse, childhood physical abuse, dysfunctional and neglectful family environment, domestic violence, substance abuse by parents, growing up as a child in care, low academic performance, dropping out of school, and running away from home (Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth, 2001; Saewyc, MacKay, Anderson, & Drozda, 2008). Drug use is a common factor for entry into the sex trade, to obtain money to support one's drug habit, as well as being controlled by a pimp. These youth are also exposed to a host of risks to their physical and emotional well-being: drug dependence, physical and sexual violence, HIV and other sexually transmitted diseases, and threat of harm by one's pimp. About half reported episodes of self-harm and suicide ideation, with about a third having made a suicide attempt (Saewyc, et al., 2008). Aboriginal children are particularly at risk of sexual exploitation, due to their higher prevalence of these risk factors, issues that affect not only individuals and their families but often entire communities, largely as a result of the impact of residential schools (Assistant Deputy Ministers' Committee on Prostitution and the Sexual Exploitation of Youth, 2001).

In the past decade, Canadian jurisdictions have begun to develop comprehensive strategies to address the issues of child sexual exploitation, involving legislative amendments, increased penalties for those who exploit youth, treatment programs, and specialized residential placements (for example, British Columbia, Alberta, and Manitoba). Service coordination has been a key component of such strategies. The Manitoba strategy, *Tracia's Trust – Front Line Voices: Manitobans Working Together to End Child Sexual Exploitation*, originated in 2002 and has involved several phases of initiatives that address prevention, intervention, legislation, coordination, research and evaluation (Manitoba Family Services and Housing (2008). The Manitoba strategy acknowledges the complex underpinnings of the sexual exploitation of youth: "poverty, racism, colonization, the legacy of residential school experiences, social and cultural isolation, marginalization, peer pressure, past abuse or trauma, sex-based discrimination, medical problems such as mental health, neurological or developmental disorders, system gaps or inaccessible services, and other social and financial inequalities" (p. 3).

While specialized placement programs have begun to develop, including in Manitoba, there has been little research into the type of treatment sexually exploited youth need or the effectiveness of these supports. Thomsen, Hirschberg, Corbett, Valila, and Howley (2011) assessed a specialized residential treatment program for sexually exploited adolescent girls in Massachusetts, reporting improvement in stability and living in a safe environment three months post-discharge. The authors attribute some of the success of the program to its designation of a separate residential placement for this population, located on a campus near the main group homes, allowing the youth to go back and forth from the more restrictive setting to practicing for more independence in the community group home as needed. They state “this is more successful in than treating youth with a variety of problems in the same setting, or moving them immediately from more restrictive external placements, such as a correctional institution or the hospital, to the designated group home” (p. 2295).

A placement framework developed by the Saskatchewan government to demonstrate visually where specialized care for sexually exploited youth fits into the continuum of care services is reproduced in Table 4 (Government of Saskatchewan, 2006, p. 4). What is valuable about this model is the assertion that youth with special care needs, such as those that are typically associated with being sexually abused, merit entrance into the placement continuum at an Assessment and Stabilization level. This is based on the recognition that the outcomes of being sexually exploited are understood to require a level of care that is more intensive than the care needed by other children and youth.

Table 4: Out-of-Home Care Resources



However, it must be noted that youth who are suicidal or struggle with substance misuse are also included in the population that merits entry at a different point in the continuum. 'Assessment and Stabilization' is the starting point to determine what placement is 'least intrusive', rather than assuming that children must start their admission to care at the 'Extended Family Care' end of the continuum.

Certainly, appropriate placements and programming are critical for intervening with sexually exploited youth. However, it is also essential to address the causal factors originating at a societal level:

The intersection of poverty with the devaluation of women, previously experienced violence, marginalization and the ease with which prostitution is made available as an alternative, contribute to the sexual exploitation of girls through prostitution. Within this framework, one can argue that it is not the girls that need to be fixed, but rather the material conditions that give rise to the choice to prostitute and the governments that are mandated to service and protect the best interests of the child. This requires some innovation on the part of those institutions to understand that the decision to engage in sex work by youth goes beyond issues of victimization into issues of social and economic marginalization. Given that, to date, the strategies to address youth in the sex trade have not addressed a social-change perspective, they appear as little more than Band-Aid solutions. (McDonald, Gardiner, Cooke, & the Research Department of Wood's Homes, 2010, p. 123)

### **Deaths of Children in Care with Complex Needs**

Many jurisdictions conduct case reviews when a child in care has died (Durfee, Durfee, & West, 2002; Dufree, Parra, & Alexander, 2009), recognizing that the causes of death may be variables attributable to the child's need for child welfare services (for example, child maltreatment) as well as those variables that had no connection to child welfare services (such as terminal illness). Brandon et al. (2008) conducted a specific review into the characteristics of 15 youth with complex needs who died while receiving child welfare services in the United Kingdom. These youth tended to have had histories of rejection and loss throughout their lives, faced parental substance misuse and engaged in substance misuse themselves, had been maltreated by their parents, and were at risk of sexual exploitation. Most were no longer attending school, after numerous placement breakdowns and extended periods of being on the run. At the time of their deaths, most were receiving minimal agency supports.

In this study, child welfare agency issues were identified as failing to address the root causes of the youths' risky behaviours; that is, failing to address the underlying effects of loss, rejection and childhood abuse. Agencies tended to respond by containing the youth after each risky incident, rather than dealing with the issues of self harm, suicidality, or sexual exploitation. Often, the youths' running away behaviour resulted in their discharge from care, as they were deemed not ready to make the best use of available services. In reality, workers felt helpless to protect these youth, as they continued to expose themselves to high situations and they were resistant to engagement with agency staff. The study captured the pattern of interaction between youth with complex needs and the child welfare system, thereby bringing to light the role of the system in exacerbating their symptoms of distress by not adequately addressing the origins of the issues and deeming them "resistant to change". In addition, the review also revealed considerable conflict between community agencies, arguing about which agency was responsible for which service and whether the threshold for eligibility for services had been reached. For these 15 cases, the culmination of risk factors – individual, familial, and systemic – led to the death of the youth with complex needs.

## The Interaction of Risk Issues and the Development of Complex Needs

The multitude of issues experienced by some children in care is certainly a contributing factor to the characterization of those needs as “complex”. Finkelhor, Ormrod, and Turner (2007) note that “polyvictimization” is a more accurate term for the experiences of these children, as their victimization is more of a perpetual “condition” than the “event” portrayal often found in the early trauma literature.

A number of studies have examined the cumulative and interactive impact of adverse child events (ACEs) on child, adolescent and adult functioning. Building on the trauma literature (described above), these studies have demonstrated that stressful or traumatic childhood experiences have negative neurodevelopmental effects that increase the risk of a variety of behavioural, health and social problems throughout the lifespan (Anda, 2007; Brown, et al., 2009; US Department of Health and Human Services, 2007). Some particular adverse life experiences have been correlated with both short-term and long-term detriments in health and functioning, all of which are relevant to child protection work: physical abuse, sexual abuse, emotional abuse, and exposure to family violence, as well as parental substance misuse and parental mental health issues, an incarcerated parent, and parental separation or divorce, are all associated with an increased risk of mental health issues, behavioural problems, and risk-taking behaviour. For those who experience six or more of these adverse life experiences, the risk of premature death is twice as high. The number of adverse life experiences also contributes to initiation of alcohol use earlier in adolescence, which increases the risk of adult substance dependence (Dube, Miller, Brown, Giles, Felitti, Dong, & Anda, 2006). In particular, childhood sexual abuse was associated with experiencing additional adverse life experiences (Dong, Anda, Dube, Giles, & Felitti, 2003).

The main findings of the ACE Study, initiated in 1994 by the Center for Disease Control and Prevention and the Kaiser Permanente’s Health Appraisal Clinic in San Diego used a sample of over 17,000 people to describe the prevalence of individual adverse life experiences, as well as the cumulative rate of multiple adverse life experiences, shown in Table 5 (Anda, no date p. 3):

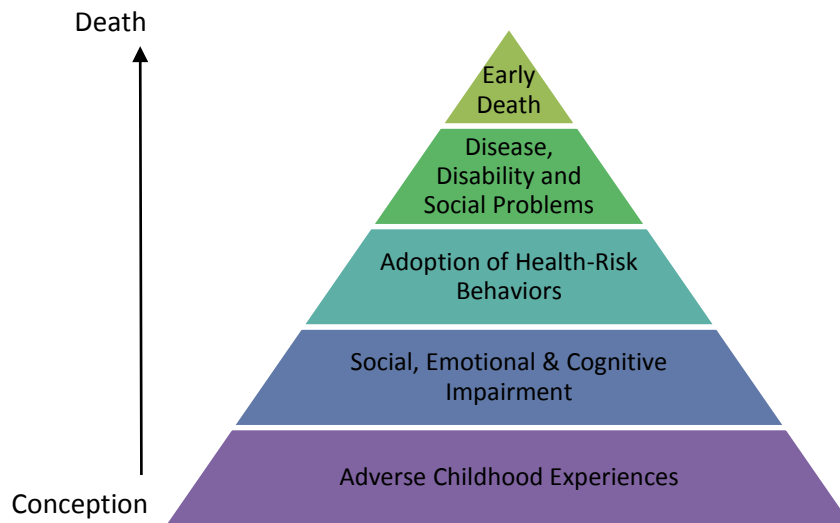
Table 5:

ACE Category	Prevalence (%)	Additional ACEs (%)				
		0	≥1	≥2	≥3	≥4
<b>Abuse</b>						
Emotional	10.2	2	98	90	77	62
Physical	26.4	17	83	64	46	32
Sexual	21.0	22	78	58	42	29
<b>Neglect</b>						
Emotional	14.8	7	93	79	63	47
Physical	9.9	11	89	75	61	50
<b>Household Dysfunction</b>						
Domestic Violence	13.0	5	95	82	64	48
Substance Abuse	28.2	19	81	60	41	29
Mental Illness	20.3	16	84	65	48	34
Parental Separation/Divorce	24.1	18	82	61	43	30
Crime	6.0	10	90	74	56	43

Further, Anda argues that the long-term effects of these adverse childhood experiences are increased health risks and early mortality, conceptualized in the following figure (Anda, no date, p. 3):



Figure 2: The ACE Pyramid



Anda (2007) asserts that “stressful and traumatic childhood and adolescent experiences literally become ‘biology’ affecting brain structure and function (as well as endocrine, immune, and other biologic functions) thus leading to persistent effects” (p. 14).

The relationship between early childhood adversities and physical health difficulties was also explored by Scott et al. (2011). They postulated that adverse childhood experiences can influence the physical, neurological, and behavioural stress response, increasing the risk of chronic health conditions such as heart disease, asthma, diabetes, arthritis, chronic spinal pain and chronic headaches. In addition, this overloading of the hypothalamus, pituitary and adrenal system (all part of the physiological response to stress or trauma) can also contribute to depression, PTSD, anxiety and panic disorder, conditions which predicted the onset of heart disease later in life.

A progressive examination of the impact of multiple adverse childhood experiences conducted by Green, McLaughlin, Berglund, Gruber, Sampson, Zaslavsky and Kessler (2010) found that the initial adverse experience (focusing on child abuse and neglect, parental substance misuse, domestic violence, and parental criminal involvement) tended to have the most detrimental impact on functioning, which was only exacerbated with each additional trauma. The authors found that childhood adversity could explain 32.4% of all mental health disorders identified in the sample population. Each type of adverse life experience was non-specific in its associations with particular mental health disorders in this study. Therefore, there is a complex relationship between the type of childhood adversities and the specific manifestation of mental health effects. Further, the authors note that the additive effect of multiple adverse life experiences in childhood suggests that addressing only one type of adversity is unlikely to have sufficient preventive effects on the onset of mental health conditions.

Many of the studies cited above focused on the retrospective histories of adults with mental health disorders. However, Raviv, Taussig, Culhane and Garrido (2010) had similar findings in their study of youth in care who had mental health symptoms. Exposure to multiple risks including child abuse, neglect, parental substance abuse, domestic violence, parental criminal involvement, and living in a single parent household had a cumulative effect on the child, increasing the likelihood of mental health issues. Further, physical and sexual abuse were identified as risk factors that led to more mental health symptoms. Other studies of children in care have examined specific associations between risk factors.

For example, childhood sexual abuse and family violence had direct effects on the occurrence of self-injurious behaviour and substance misuse, with depressed youth more likely to engage in self-harm and angry youth more likely to abuse substances (Asgeirdottir, Sigfusdottir, Gudjonsson, & Sigursson, 2011).

A Canadian study used data from the National Longitudinal Survey of Children and Youth (NLSCY) to examine the relationship between the number of risk factors experienced by children and the outcomes for their functioning (Landy & Tam, 1998). Family dysfunction (poor problem solving skills, poor communication, limited affective responsiveness, problems with behaviour control) and maternal depression were found to be associated with the poorest outcomes for children (measured in aggressive behaviour, hyperactivity, conduct disorder, emotional problems, relationship issues, and repeating a grade at school). Children with the most risk factors clearly had the most problem behaviours:

- 0.4% of children in the sample had 5 or more risk factors, and more than 50% of them had problem behaviours.
- 0.1% of children in the sample had 8 or more risk factors, and 80% of them had problem behaviours.

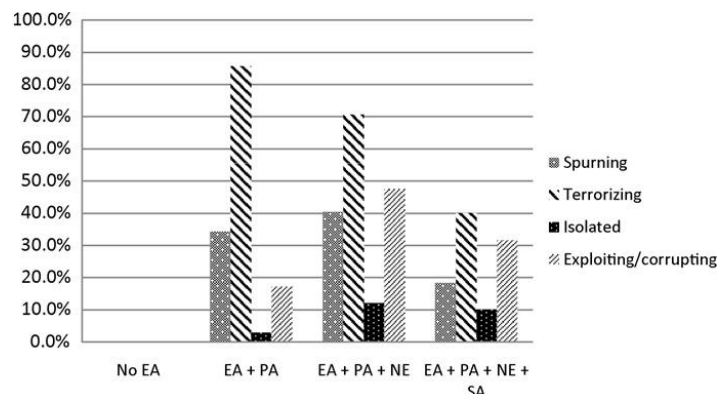
Further, this study found that the number of risk factors was an adequate predictor of problem behaviours for young children, but that the type of risk factor was important in determining the impact on problem behaviours for older children.

Some research is emerging on the effects of different types of multiple risk factors on child functioning. Trickett, Kim, and Prindle (2011) used four clusters of child maltreatment experiences to examine the developmental outcomes for a sample of 303 maltreated youth:

- Physical abuse and neglect (PA + NE)
- Emotional abuse and physical abuse (EA + PA)
- Emotional abuse, physical abuse and neglect (EA + PA + NE)
- Emotional abuse, physical abuse, neglect and sexual abuse (EA + PA + NE + SA)

Youth who had experienced three and four types of maltreatment had lower self esteem, more externalizing behaviours, and less optimal cognitive functioning than those who had been exposed to fewer types of abuse, demonstrating again that the more types of risk factors, the more likely children will experience detrimental outcomes in their functioning. However, this study also looked at the specific expression of emotional abuse, as depicted in Figure 3 (Trickett, Kim, & Prindle, 2011, p. 880):

Figure 3: Percentage of children who experienced each sub-type of emotional abuse



Terrorizing and spurning are considered to be the most insidious types of emotional maltreatment (Brassard & Donovan, 2006), occurring with the highest frequency in the EA + PA and EA + PA + NE groups. Children in these groups had the lowest levels of self esteem. However, this study also found that the experience of sexual abuse, a component of only the fourth maltreatment cluster which also had lower levels of emotional abuse, resulted in particularly adverse outcomes for children.

Another study by Boxer and Terranova (2008) also used a cluster model of maltreatment and found that youth who experienced more types of maltreatment struggled with greater mental health issues. Further, these authors reported that sexual abuse emerged as the type of maltreatment associated with the highest rate of mental health issues.

A study in Britain examined how multiple conditions crossing mental health, education, and child welfare affected a cohort of 60 children considered to have complex needs (Clark, O'Malley, Woodham, Barrett, & Byford, 2005). The children required costly cross-sector services because of the number of issues each child experienced (on average, 9 different issues each) and the disciplines that different factors influenced. Costs of services were most often borne by the child welfare system (51% - mainly due to the costs of residential care that many of these children required) and education (38%), and to a lesser extent by mental health (5%) and justice (5%). The group with complex needs was considered to be small, compared to the number of children in general who have mental health issues, but the costs of providing services to them was estimated to be ten times more.

Interestingly, Williams, Sherwin and Schwartz documented the effects of multiple adverse childhood experiences, including the impact of poverty, on future psychiatric impairment as early as 1969. They recognized that children were most vulnerable to the impact of adverse life experiences in their early development, and that the current approach to rehabilitative programming for adolescents and adults who were struggling with the detrimental outcomes of adverse childhood experiences was not sufficiently addressed. They wrote:

The problem that must be tackled begins in early childhood and it could well be that it is here that major efforts should be expended by antipoverty programs as well as community mental health services if significant progress is to be made. (p. 372)

In fact, recognition of the impact of adverse childhood events on the individual's mental health functioning throughout the lifespan was first made by Freud, and understanding of this phenomenon is advancing because of current science and technology, Nemeroff (2008) argues:

In the approximately 100 years since Freud first suggested that early life events markedly influence risk for adult psychopathologic behavior, we have learned much about the neurobiological consequences of child abuse and neglect – from their effects on specific neural circuits (investigated by using functional and structural brain imaging) to their effects on neurogenesis and specific neurotransmitters. (p. 624)

The frontal lobe of the brain (directly behind the forehead), particularly the prefrontal cortex, has the main responsibility for planning, judgment, memory, problem solving, impulsivity, and sexual behaviour (Sowell, Thompson, Holmes, Jernigan, & Toga, 1999). It is the last region of the brain to mature and continues to develop until early adulthood. With ongoing brain development, young adults begin to exhibit improved judgment, more control of impulses, enhanced problem-solving capacities, the ability to better anticipate the outcomes and consequences of behaviour (Burke, 2011). It is

understandable why many adolescents behave impulsively, focus on immediate pleasure rather than long-term consequences, and may not always use good judgment – this is a feature of normative adolescent development (Smith, 2011; Steinberg, 2007).

For youth whose development has been compromised in some way, the risks of brain adaptation and long-term impaired functioning are significant. A number of factors negatively influence the development and functioning of the brain:

- (a) Prenatal exposure to alcohol can result in FASD, a condition that affects brain development, particularly the prefrontal cortex that is responsible for executive functioning, such as anticipating consequences and planning (Palay & O'Connor, 2009);
- (b) This area of the developing brain can be significantly influenced, and possibly damaged, by alcohol use in adolescence, disrupting capacity for impulse control and decision-making skills (White, 2003).
- (c) Trauma triggers complex neurophysiological reactions in the brain, which also engage the autonomic nervous system, hypothalamic-pituitary adrenocortical axis (HPA) and the immune system, and when trauma is repeated or of a sufficient duration, the reactions may become the organizing framework within the brain, particularly when trauma occurs at a young age (Perry, 1994; Perry & Pollard, 1998). Such brain adaptations can also set the stage for future chronic health conditions (Scott, et al., 2011);
- (d) Children's trauma reactions, including the development of Post Traumatic Stress Disorder (PTSD), have many possible origins: child physical or sexual abuse, emotional abuse, neglect, exposure to intimate partner violence, for examples (Macdonald, et al., 2010);
- (e) Because of the stress-induced processes that are the basis of the neurological development of attachment, insecure types of attachment and their effect on functioning become neurologically-based (Perry, 2001; Perry, 2004);
- (f) Social and environmental factors also play a role in perpetuating children's vulnerability during prenatal and early childhood development, as socioeconomic deprivation such as poverty impacts the child's health and overall physical development (Chasnoff, 2010).

Collectively, these individual, familial, environmental and social variables interact in complex, neurosequential ways (Chasnoff, 2010, p. 15): "Neither nature nor nurture alone guides the trajectory of child development. Instead, it is an integration of biological and environmental factors that have direct impact on the developing fetal brain and the brain of the young child".

Determining the most effective way to address the cumulative effect of these variables, given what is known about their impact on child and youth functioning and the emerging evidence of their influence on brain development, is daunting. It is clear that no one service sector alone can meet all of the needs of this high-risk population. Intervention and treatment is critical, due to the probability of long-term harm and inter-generational repetition of coping patterns; prevention and early intervention to mitigate direct deleterious effects is equally imperative. Borrowing from a well-known parable, Chasnoff (2010) writes:

In so many ways, our children are drowning. We continue to pour resources into rescuing our children from the river rather than traveling upstream to find out who's pushing them in. And why? Because it's easier to hide behind labels of risk than to work to improve children's lives. (Chasnoff, 2010, p. 229)

### **Risk And Resilience**

While the evidence clearly demonstrates the impact of individual childhood adversities and other variables as well as the profound cumulative and complex effect of multiple adverse life experiences in childhood, the pathways of specific traumas to specific harmful effects is also complex. One theme that also influences the manifestation of detrimental outcomes is resilience. Resilience has been defined as a positive adaptation despite encountering adversity, a kind of resistance to psychosocial risk experiences (Fleming & Ledogar, 2008), or "good outcomes in spite of serious threats to adaptation or development" (Masten, 2001, p. 228). Much of what promotes resilience is thought to originate outside of the individual and develops as a result of interactions between these levels of factors (Caffo & Belaise, 2003; Fergusson & Horwood, 2003; Fleming & Ledogar, 2008; Jessor, Van Den Bos, Vanderryn, Costa, & Turbin, 1995; Rak & Patterson, 1996; Ungar, 2005):

- a) Individual factors: intelligence, communication skills, personal attributes;
- b) Family factors: parental warmth, family cohesion, belief in the child, close relationship with a caring adult;
- c) Community factors: supportive peers, positive teacher influences, success and achievement, supportive communities;
- d) Cultural factors: traditional activities, language, healing, spirituality.

Ungar (2004) describes three kinds of resilience categories: factors that are *compensatory* and neutralize exposure to risk in the first place (such as a positive view of life, capacity for empathy, insight, intellectual competence, and an internal locus of control), *challenge* factors that enhance resilience when the risk is manageable for the individual (such as illness, significant loss, or family disruption), and *protective* factors that interact with risk factors to reduce the potential for negative outcomes (such as stable families, healthy parenting practices, safe communities, and individual coping strategies, emotional management skills, planning skills, problem-solving ability, and the ability to restore one's self esteem). However, the impact of risk factors is complex and variable:

A risk factor that appears as a single occurrence will not have the same impact (and may have a more acute impact) on development as one that is chronic...As risk and resilience are two sides of the same coin, with resilience only present when there is substantial exposure to risk, the problem of a definitional ambiguity of risk factors further complicates researchers' understanding of resilience. (Ungar, 2004, p. 350-351)

To further complicate our understanding of risk and resilience, Ungar (2004) cites a number of studies where "negative outcomes" may be indicative of resilience:

- While an internal locus of control could be viewed as a source of empowerment, Morgan (1998) postulated that this characteristic could also "cause children to, and in fact, question and rebel against a well-defined set of rules and expectations precisely because they see themselves as having more options, as being more capable or effecting change compared to

children who are more externally oriented vis-à-vis locus of control who may just simply go along with the structure of the program because they feel rather powerless to change or manipulate the system (Morgan, 1998, p. 44).

- Cirillo (2000) found that adults who had been abused as children who adopted an oppositional stance rather than one of passive victimization had better mental health outcomes.
- In a study of resilient and vulnerable high-risk youth, Ungar and Teram (2000) found that the most vulnerable youth derived self esteem, attachment to others, and a sense of community through their delinquent and disordered behaviours.

A similar study by Samuels and Pryce (2008) found that youth leaving child welfare care who adopted a survivalist strategy of self-reliance interpreted their experiences of adversity as giving them strength, but this positive outcome was tempered by their reluctance to seek help or access supports, a product of the emotional and psychological disconnections from parents and other caring adults throughout their lives.

Some further commentary on a reformulation of our perspective of at-risk youth by Ungar and Teram (2000):

Empowering experiences will positively affect identity and mental health when they strengthen the formation of a self-definition that the youth and a select group of significant others accept as powerful. Because this sense of power, experienced through control of one's identity, is so important to the well-being of participants, powerful identities are sometimes chosen in contradiction to social norms, particularly when mental health resources are scarce. Counterintuitively, a youth may choose to act in the role of the very good "delinquent" and be known and accepted for his or her capacity as a criminal rather than accept an "average" or "normal" identity that carries less status but is more widely accepted by society at large. The outcome, however, is the same, for both well-functioning and troubled youth in this study identified a sense of participation in the social discourse as the fulcrum in which their mental health pivots. (Ungar & Teram, 2000, p. 246)

One should not mistake this sense of empowerment, a characteristic of resilience, as an indication that troubled youth are not at risk. Risks cannot necessarily be controlled and they carry very real and dangerous, potentially lethal, consequences. But this resistance to adversity (returning to the definition of resilience offered at the start of this section) by adopting a contrary persona has elements of health that should not be ignored (Ungar, 2001).

### **Intervention Models**

Traditional models of placement for youth in need of alternative care have, in the last 50 years, mainly involved foster families, group homes, and residential care facilities in child welfare. More than a century ago, institutional care, often in the form of orphanages or residential schools, was the model of alternative care utilized by child welfare, but this approach gradually gave way to more family-style placements in the 1950s. Institutional care is still used by some systems (youth corrections, mental health facilities, for example), and many consider residential care facilities to be modern descendents of

orphanages and mental health hospitals (Leichtman, 2006). With the advent of family therapy and community models of mental health in the 1980s, residential care facilities faced criticism for not providing children with a family-based environment and not working closely enough with biological families to facilitate successful reunification. Additionally, advances in medications made it possible to manage difficult behaviour in the community, leading to the development of different models of outpatient treatment, family preservation programs, and wraparound services and resulting in considerable pressure to develop short-term residential models that operate along a continuum of care services, in which children move from inpatient to outpatient programs as their needs require. Leichtman (2006) also notes the impact of fiscal restraint on the residential care model, as the costs of institutional care (both residential care facilities and hospitalization) escalated in the past three decades.

Treatment foster care is one example of specialized, family-based services serving youth with complex needs (Robst, Armstrong, & Dollard, 2011), offering crisis intervention, short-term treatment (up to 18 months), and support for youth who are transitioning to independence. In the example provided by these authors, treatment foster homes were supported by the mental health system and intended to support community treatment, and prevent admission to a psychiatric hospital, crisis stabilization unit, or residential treatment program. The researchers compared outcomes for youth with complex needs placed in treatment foster care with those placed in treatment group homes (characterized by high structure, supervision, support, and clinical intervention in a home-like setting for up to 12 youth). While both groups of youth made gains in their respective programs and did equally well in addressing the mental health needs of the youth, the authors found that each placement type was actually serving a slightly different group of youth. Those in treatment foster care tended to be younger adolescents with no criminal justice involvement, while those in group care needed high structure due to more serious behaviour issues and were considered to be the most at risk. Turner and Macdonald (2011) maintain that while other studies on treatment foster care have also reported positive outcomes for youth, the evidence base is still in development.

In its origins, residential care facilities were developed as therapeutic modalities, characterized by Trieschman, Whitaker, and Brendtro (1969) as “the other 23 hours”. Leichtman (2006) describes this residential care treatment model as follows:

Apart from the small fraction of their time devoted to formal therapies, children spend most of their day sleeping and waking, dressing, tending to personal hygiene, eating, going to school, doing chores, interacting with caretakers, making friends, playing, and negotiating the myriad of other tasks of everyday life. Because the problems that lead to out of home placement are not typically discrete, episodic symptoms, but rather pathology that is woven into the fabric of lives, residential treatment rests on the assumption that helping children negotiate such tasks effectively is not merely an adjunct to more sophisticated forms of therapy, but rather a cornerstone of treatment...Consequently, much of what is described as the therapeutic milieu consists of strategies for helping children negotiate such tasks and dealing with the symptomology as it interferes with them. Although each such intervention may be modest, when used by staff members from morning until night, day after day, their cumulative effect can be considerable. (Leichtman, 2006, p. 287)

Although all group care models are based on similar foundations, Leichtman argues that group homes lie at one end of the continuum (focusing mainly on helping to negotiate daily living tasks) while residential care facilities (which include a multitude of in-house treatment modalities that are organized

around the work of helping youth to negotiate daily living tasks) lie at the other. There has been little research on the effectiveness of the group home model (Curtis, Alexander, & Lunghofer, 2001; Farmer, Dorsey, & Mustillo, 2004). The middle ground of the continuum contains the potential for new models that take advantage of advances in the field: the new psychotropic medications, brief therapy interventions, outpatient community models, and stronger partnerships with other service sectors such as mental health that allow for 'wraparound' service models.

The Wraparound model is an individualized, team-based approach to care for youth with complex behaviour issues and their families, led by a trained care coordinator and family member partner, and comprised of four phases: Engagement and Team Preparation, Initial Plan Development, Plan Implementation, and Transition (Bruns, et al., 2010). One of the model's strengths is the involvement of community services and cross-department programs (based on the assessment conducted during the Engagement phase), which requires partnership across sectors in advance to ensure that services are provided in a timely, collaborative manner. In many respects, Wraparound is considered to be a coordination model, attempting to "overcome the fragmented, uncoordinated way in which services traditionally were provided to youth with multiple problems who received services from multiple child-serving agencies (Farmer, Dorsey, & Mustillo, 2004, p. 867). Although Wraparound is fairly new and has not been extensively evaluated, early impressions are that the model is 'promising'. However, it is a model that requires extensive training and the availability of mental health supports (Winters & Metz, 2009).

The umbrella conceptual framework for specific models like Wraparound is the Systems of Care concept (Bartlett, Herrick, & Greninger, 2006; Brashears, Davis, & Katz-Leavy, 2011; Chenven, 2010; Erickson, C. D., 2011; Stroul & Blau, 2010). The aim of Systems of Care is to guide a coordinated network of services and supports across agencies to meet the multiple needs of adolescents with complex needs and their families. Systems of care are unique to each community, building on the strengths and resources available, and therefore are not prescribed models of service coordination but need to be developed for each community based on a guiding philosophy and network infrastructure (the contribution of the Systems of Care framework). They also need to be responsive to trends in need by children, adolescents and families, as service usage changes over time (Garland, Hough, Landsverk, & Brown, 2001). In many cases, Systems of Care has resulted in a revitalization of existing services and stronger collaborations between community agencies (Chenven, 2010). However, Levison-Johnson and Wenz-Gross (2010) caution that coordination models do not adequately address the need for systems to develop over time, recommending that communities utilize a "theory of change" process to ultimately map, implement and evaluate goals that lead to community transformation of services.

Similar to Wraparound, Multisystemic Therapy (MST) is a comprehensive home- and community-based family treatment model where a team of trained mental health clinicians (who consult with a psychiatrist) provide intensive, individualized, 24/7 intervention for a 3 to 5 month period intended to help youth change in their natural settings (Farmer, Dorsey, & Mustillo, 2004; Winters & Metz, 2009). The target population is youth with chronic aggression and behaviour issues, including youth with criminal justice involvement and substance abuse issues. The treatment team collaborates with and empowers parents by developing their natural support network and improving their capacity to parent. MST's effectiveness has been demonstrated in a number of studies, but is still new enough to merit further evaluation (Farmer, Dorsey, & Mustillo, 2004).

In comparing residential treatment with intensive home-based treatment (providing the same services available in residential care, but at the family home), Preyde, Frensch, Cameron, White, Penny,



& Lazure (2011) found that in general, youth made progress in both environments. However, one of the main differences between the two groups was that the youth in the intensive home-based placement came from families who were stable enough to participate in the treatment and for whom reunification was the goal. The youth who were in the residential care program did not have biological families with sufficient stability to engage in the home-based program, nor was reunification the goal of placement. Others have recognized that there are differences in the youth-in-care population that should be considerations in the development of placement resources. Fanshal (1992) maintains that foster care should be provided in a two-tier model: one tier for youth who will be reunified with family and one for youth requiring mental health treatment to prevent entry into the criminal justice system.

Ultimately, it may not be a question of “either/or”, but a need for both, with different sub-populations within the larger group of youth with complex needs. Leichtman (2006) asserts that there is no need for ideological battles over treatment models; alternative models will work for some youth but not for all – there will always be some youth who require the structure and long-term nature of treatment that is the hallmark of residential treatment facilities. In agreement with this position, Rich (2009) affirms that the specific model of care is less important than the ensuring that the model of care is based on “an established culture within the home, by sound leadership and supervision structures, and by appropriate training and resources” (p. 3). But, for residential care to be effective, some conditions must be met:

Implementing its basic concepts requires innumerable actions on the part of the many staff members, especially childcare workers, who differ markedly in personality, education, and clinical experience. Consequently, it is essential that clinicians and administrators constantly remember the central role childcare staff play in residential systems: that workers be chosen carefully for their temperament and investment in children; that they receive appropriate training, supervision, and support; that all members of the team share a unifying theoretical framework; that residential programs are structured and function in ways that pay particular attention to coordinating the efforts of teams and negotiating conflict within them; and that maintaining stable teams and environments in which they can function effectively are among the highest administrative priorities. If such conditions are not met, children will live in a milieu permeated by inconsistency, conflict, fragmentation, and bad parenting; they will again be exposed to many of the factors that necessitated their referral; and what purports to be therapy may well exacerbate the problems it is intended to alleviate. When these conditions are met, however, the result can be a treatment uniquely suited to the needs of children whose pathology pervades all aspects of their lives and who cannot be managed in their homes and communities. (Leichtman, 2006, p. 291)

It is clear that the needs of youth with complex needs vary enough to merit a range of services and placement options. The critical issue may be determining which resource is right for which youth. Rich (2009, p. 2) argues that it is far too common for children “to have to journey through a number of ‘failed’ foster placements before they are considered for residential care”, delaying their opportunity to access the support and expertise they need until their issues are further entrenched in a sense of failure, rejection, and low self esteem. Appropriate and comprehensive needs assessments will assist service systems in determining what level and type of service is most appropriate for the child or adolescent (Kroll, Harrington & Bailey, 2000). Conducting such assessment upon admission to child welfare care, hospital, or youth corrections facility is obvious. However, it is difficult to determine when to conduct this kind of assessment for youth who have been in care for a long period of time, whose manifestation

of complex needs may evolve over time (Keller, Salazar, & Courtney, 2010). How do we ensure that they receive the services they need in a timely way?

Ultimately, we must consider the inter-relationships between adverse life experiences and their manifestations in mental health, behaviour, and overall functioning. Anda (2007) asserts that we must move beyond our current model of treatment and consider collaborative and innovative approaches:

Facing the high prevalence and interrelatedness of ACEs is going to be tough. Categorical approaches to the individual ACEs as well as the health and social problems strongly related to them tend to be “siloes”. However, the professions, research priorities, organizations, and resources that are necessary to healing frequently exist in “silos” – separate, often competitive rather than collaborative, entities, each preserving and advancing the resources and work that is historically “theirs”. While this is understandable, to succeed, we must make this “ours”, a team effort that reaches beyond traditional boundaries and borders. (p. 14)

### **Summary**

Our understanding of youth with complex needs is advancing with the wealth of research into risk factors, neurodevelopmental processes, trauma, attachment, and resilience. While there is still much to learn, the common threads that run through each of these themes are converging in the professional literature. The following is a brief summary of the key points reflected in the literature review provided in this report:

1. The similarity in neurological processes that create attachment as well as trauma cannot be ignored. It appears that the development of resilience also involves similar processes, although literature describing the neurobiological development of resilience is not well developed.
2. Prenatal experiences can help to set the stage for optimum development at birth, through prenatal care and intervention to address socioeconomic factors that can compromise both maternal and child health.
3. Preventing use of alcohol and other substances during pregnancy is an important component of prenatal care, to reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) and other effects from prenatal substance exposure, which can have a profound effect on functioning throughout childhood and adolescence, including the manifestation of complex needs.
4. Other contextual and environmental variables that can increase vulnerability for children and their families are the traumatic legacy stemming from the residential school system, trauma from civil war atrocities experienced by refugee children and their families, poverty, oppression, and discrimination. These factors affect the capacity for caregivers to parent their children in a nurturing, safe, and supportive way.
5. Attachment is a fundamental neurodevelopmental process that creates an internal framework from which the child sees him/herself in relation to others in the world. The

quality of the child's attachment is predictive of future social, psychological, behavioural and cognitive functioning. Secure attachment may be a protective factor in the face of life adversities; insecure attachment adds to the vulnerability of the child for poor outcomes when faced with adverse experiences.

6. There are many well-known and well-researched adverse life experiences that can have profoundly damaging consequences on the development and functioning of children and adolescents: physical abuse, sexual abuse, neglect, exposure to intimate partner violence or other forms of family violence, emotional abuse, parental substance misuse, lack of family cohesion and stability, poverty, maladaptive parenting, childhood disabilities, FASD, to name some of the major risk factors reviewed in this report.
7. The risk factors mentioned above can be considered antecedents to deleterious outcomes for children: mental health issues, Post Traumatic Stress Disorder (PTSD), aggression, behaviour problems, education disruption, self-harm, suicidal ideation, adolescent substance abuse, criminal involvement, violence, sexual exploitation, among others.
8. Risk factors, that is, adverse life experiences, do not necessarily occur in isolation from one another, making it more difficult to determine the potential overall impact on a child's functioning, or the individual impact of specific types of adversities on child well-being.
9. The number of risk factors that children and youth experience – polyvictimization – can be considered one measure of 'complex needs', as the literature generally demonstrates increasingly compromised functioning as the individual endures more and different types of adverse life events. Deleterious consequences, based solely on the multitude of risk factors, is highest for preschool children, as children at this stage of development are most vulnerable to permanent brain adaptations that incorporate the experience of trauma.
10. Risk factors may occur as a single event of severe intensity or impact, or may be chronic, extending over long periods of time. Research has not yet determined if there are differences in risk between single vs chronic adverse experiences (and such determinations may be elusive, given the complexity of how risk factors interact with one another). However, severity and chronicity should be viewed as important considerations in the definition of 'complex needs'.
11. Despite the challenges in determining the impact of individual risk variables, research has identified childhood sexual abuse as a particular type of adverse life experience that tends to have more profound emotional and psychological effects than other risk factors.
12. While it is generally accepted that emotional maltreatment is detrimental to child well-being, it is a construct that has eluded operational definition and measurement. However, recent research has resulted in the development and field-testing of a promising assessment framework that can be used by many practitioners at the field level to more consistently assess the occurrence of emotional abuse.
13. The adolescent brain does not complete its development until well into early adulthood. Consequently, youth are vulnerable to poor decision-making and risk-taking behaviours

- without fully appreciating the possible consequences of their actions. However, the promise lies in the fact that, because development is not yet complete, there is still opportunity throughout adolescence and into early adulthood to provide reparative experiences for youth with complex needs.
14. Substance use during adolescence influences brain development, can temporarily impair impulse control and decision-making capacity (leaving youth at risk for unsafe choices), and may result in permanent brain alterations that lead to adult addictions.
  15. Research into resilience identifies a number of variables – individual, family, community, and cultural – that help to protect the individual from the negative outcomes of risk. However, we need to consider that the expression of resilience may sometimes look different than what we expect: at-risk youth who display defiance, act in rebellious ways, and identify with a negative peer group may derive a sense of empowerment from these characteristics, which should be viewed as a form of resilience.
  16. The consequences of adverse life experiences on the youth’s functioning often necessitate the involvement of multiple services providers: child welfare, mental health, youth corrections, education, and youth addictions services. Admission to the formal care of one or more of these systems is common: foster homes, group homes, or residential care facilities (child welfare), hospitals (mental health), youth detention facilities (corrections), or residential treatment programs (youth addictions). Specialized facilities for youth who have been sexually exploited generally fall under the child welfare system’s purview.
  17. The literature generally reports fragmentation and lack of coordination between these service sectors, as jurisdiction over the youth’s treatment is guided by differing legislative criteria that determine eligibility and length of service, contradictory definitions and assessments of the child’s needs, diverse treatment philosophies, lack of clarity over case management responsibilities, and overall lack of resources, especially as it pertains to youth with complex needs.
  18. Mental health issues have traditionally been assessed in accordance with criteria outlined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, with many conditions being very responsive to psychotropic intervention. However, the literature is clear that far too many youth do not receive mental health services when they need them. Given the proportion of youth with complex needs who suffer from mental health issues, partnerships among mental health and child welfare, youth corrections, education, and youth addictions are imperative.
  19. The emotional and psychological symptoms experienced by youth may not always meet the criteria for definition under the DSM. The lack of formal diagnosis does not diminish the risk of harmful outcomes nor the need for appropriate psychological supports and services.
  20. There are a number of models that address system coordination (e.g. Systems of Care, Wraparound), intensive home-based interventions (e.g. Multisystemic Therapy), and new thoughts about community-based group care and the role of residential care. It is clear that

'one-size-does-not-fit-all' and youth with complex needs require a range of different service and placement models to meet their needs.

21. The number of youth with complex needs is estimated in various studies to be about 10% of the overall general population of youth. The most extremely compromised youth represent about 1% and are the group most difficult to treat, who may require the creation of individualized treatment plans outside of the current service environment.
22. Although 10% is a relatively small proportion of youth, various studies have reported that the complexity and severity of the issues experienced by this at-risk group often require a high proportion of financial and human resources to adequately meet their needs, costs which have usually been borne by the child welfare system.
23. In order to access specialized services – at any level of the placement continuum – youth must first journey through a number of foster placements that break down. The principle of the 'least intrusive placement' does not work for youth with complex needs, whose risk factors are often well known prior to adolescence, when they are most likely to manifest themselves in problematic ways that contribute to placement breakdown, and further emotional trauma to adolescents.
24. Despite similarities across the population of youth with complex needs, there are distinct differences within the population as well. Evaluations of outcomes for youth with complex needs in different placement types – treatment foster care, treatment group homes, intensive home-based support, wraparound models, System of Care models, Multisystemic Treatment, and residential treatment programs – have found that each program type can effect positive changes for youth with complex needs, but that the youth who accessed each type of placement differed across key variables (e.g. age, involvement in the youth corrections system, working toward reunification with biological family, capacity for the biological family to be engaged in the treatment plan, availability of community resources, for examples). Therefore, there is a need for a wide continuum of placement options.
25. Assessment is the hallmark activity that needs to guide appropriate placement and service plans. For youth with complex needs who enter the system in adolescence, the timing of assessment is at the point of entry, but for youth who have been involved with the system (often child welfare) for a long period of time, guidelines need to be established as to when and how such youth become part of an assessment process to ensure that their needs are identified and addressed at an early stage.

These themes will form the foundation of an examination into the current trends and challenges experienced in the network of systems working providing services to youth with complex needs in Manitoba in a later section of this report.



## YOUTH WITH COMPLEX NEEDS IN OTHER CANADIAN JURISDICTIONS

The challenge of meeting the needs of youth with complex needs is increasingly being recognized in other Canadian jurisdictions, in addition to Manitoba. The themes and issues described above in the professional literature are also identified in these reports from across the country about the experiences of youth with complex needs. The perspective that coordination is required between child welfare services and the providers of other services to children, such as education, health, mental health and criminal justice, is recommended by many jurisdictions, along with the development of formal protocols to guide service coordination across sectors. Further, the heightened vulnerability of Aboriginal children to experience adverse life experiences and consequences is underscored (Canadian Council of Child and Youth Advocates, 2011). A number of these reports are summarized below:

### **New Brunswick**

One of the most thorough reports on youth with complex needs was prepared by the New Brunswick Ombudsman and Child and Youth Advocate (Richard, 2008). Incorporating the experiences of seven youth with complex needs whose experiences exemplified the gaps in services, the *Connecting the Dots* report's main recommendations focused on enhanced service integration (to ensure timely sharing of information across agencies and government departments, resolve jurisdictional disputes, and facilitate payment of services) and the provision of community-based residential care placements. Additionally, the report calls for the establishment of a research Centre of Excellence, where community-based interventions could be developed, piloted, and evaluated. The importance of mental health services, especially in response to crisis situations and support to families, was emphasized.

The response of the Government of New Brunswick, articulated in the report *Reducing the Risk, Addressing the Need* (Government of New Brunswick, 2009), included the commitment to develop a comprehensive youth-centred integrated service delivery model to facilitate information-sharing and provide a one-stop entry point for services, as well as to explore the establishment of a Centre of Excellence. The latter concept was addressed through the creation of a Task Force, co-chaired by the New Brunswick Ombudsman and Child and Youth Advocate and a community parent of a child with complex needs. The Task Force's final report, *Staying Connected* (Richard & Smallwood, 2011), envisioned a Centre of Excellence that would provide clinical direction and service coordination to meet the needs of youth with complex needs, accompanied by high standards for research and program evaluation to ensure that services embodied best practice principles. In particular, community consultations on the priorities of a Centre of Excellence stressed the importance of assessments of youth with complex needs, mental health treatment, and supports for families, such as respite, mental health mobile first responders, and training.

### **Ontario**

A regional report for the Hamilton, Ontario area prepared in 2004 (CONTACT Hamilton, 2004) assessed the capacity of community agencies and government departments to meet the needs of children and youth with complex needs. Concluding that the needs of this population exceeded the available resources, the report advocated for service coordination, strengthening as well as increasing respite, day treatment and specialized residential placements for youth with complex needs (especially in response to youths' mental health issues), and expanded in-home supports. Particularly in relation to

youth with complex needs in care of child welfare, the need for crisis stabilization placements where assessments could be conducted was emphasized. The report also underscored the importance of projecting the future impact of this population on the adult services system as they reached age of majority.

Specific focus on the need to coordinate child and youth mental health services was articulated in the 2009 report by Boydell, Bullock and Goering, entitled *Getting Our Acts Together: Interagency Collaborations in Child and Youth Mental Health*. Citing the integration work achieved by CONTACT Hamilton, this report advocates for standardized and centralized screening and assessment of children and youth with mental health problems and a province-wide framework to facilitate integrated services across organizations.

### **Newfoundland and Labrador**

The *Children in Care in Newfoundland and Labrador* report was released by Memorial University of Newfoundland in September 2008 (Fowler, 2008) and included recommendations to better meet the needs of youth with complex needs. These recommendations included the development of therapeutic foster homes and short-term residential treatment, and a standardized assessment process to help determine the most appropriate placement type for children requiring placement within the child welfare system.

A 2008 review of Child, Youth and Family Services clinical child welfare services in Newfoundland resulted in the recommendation that collaborative case conferencing be employed on a regular basis to assist in decision-making in complex or contentious cases (Abell, Moshenko, & van Leeuwen, 2008). This initiative is included in the province's 2010-2014 Strategic Plan (Department of Child, Youth and Family Services), and is supported by the development of new child welfare legislation.

### **Alberta**

The issue of youth with complex needs was identified in the 2002-2003 annual report of the Alberta Children's Advocate, describing how "too often child welfare workers are left on their own to try to find and provide the needed services" for youth with complex needs (p. 8). The response of the Alberta Government was to develop legislation (the *Family Support for Children with Disabilities Act*) that facilitated better service coordination for children with disabilities and implement a policy framework across government departments to support collaboration in service delivery for children and youth with complex needs (Alberta Children's Services, 2003; Alberta Children and Youth Initiative Partners, 2003). The policy framework has been the subject of review and some criticism in subsequent annual reports by the Alberta Children's Advocate (for example, 2008-2009, 2009-2010, and 2010-2011). The 2009-2010 annual report noted that the "*Provincial Policy Framework for Services for Children and Youth with Special and Complex Needs and their Families* (2003) and its vision of, '...an integrated (cross-Ministry) case management model for children and youth with complex needs, including regional integrated case management teams that conduct early identification, assessment, planning and service delivery...' has not come to pass for young people with complex needs who are in the care of a director." (p. 21). However, efforts are underway to ensure that families and child welfare staff are familiar with the framework and that service providers work together to meet the needs of children and youth with complex needs.



### **British Columbia**

Focusing on the impact of intergenerational loss as a result of the residential school experience, Mussell, Cardiff, and White (2004) examined the needs of Aboriginal children in their report *The Mental Health and Well-Being of Aboriginal Children and Youth: Guidance for New Approaches and Services*. The importance of incorporating an Aboriginal worldview into healing interventions was emphasized.

### **Nova Scotia**

The recently released 2010-2011 Annual Report by the province's Office of the Ombudsman (who is responsible for services to children and youth) identified gaps in appropriate treatment-based placements for youth with complex needs and the need for early assessment and intervention for children and youth facing a multitude of issues. Future discussions to explore means to address these issues are pending.



## CHILDREN AND YOUTH WITH COMPLEX NEEDS IN CARE IN MANITOBA

An important component of this project was an analysis of data from the Manitoba child welfare database (the Child and Family Services Information System, known as CFSIS) to determine if there was a way to quantify and describe the characteristics of youth with complex needs who are in care. Like most social services systems, trends are often first recognized in the field through anecdote and experience, much like the origins of this project – based on the number of cases that came to the attention of the Office of the Children’s Advocate involving youth with complex needs.

A foundational question to such an analysis is defining what is meant by “complex needs”. As noted previously, various studies in the professional literature define youth with “complex needs” in different ways, but the most common assumption is that the term refers to a youth who has multiple issues and consequently requires services from multiple service sectors. This basic definition, focusing on multiple risk issues, was utilized for the CFSIS data analysis, recognizing that there are limitations to this definition, as well as limitations to what the CFSIS data itself could adequately reveal:

- The definition does not necessarily include a description of the severity of a particular issue that a young person is experiencing;
- It does not account for the interaction of multiple issues in a direct way (but it is assumed that multiple issues intensify the impact on the youth and exacerbate the complexity of providing care to the youth, as a result of their interaction);
- It does not distinguish between antecedent issues (those which the literature has found to result in predictable deleterious outcomes for children, for example, being abused) and consequence issues (those which the literature has found to be the typical outcomes of adverse life experiences, such as behavioural issues), although some assumptions have been made based on this professional literature;
- There is no way to determine the sequence of multiple issues (and it may be that the sequence of issues plays a role in the manifestation of challenges experienced by the youth);
- There is limited capacity to determine which issues occurred prior to admission to care and which occurred once a child was placed in care;
- It cannot be determined when particular conditions affecting the child were identified and assessed or diagnosed (before or after admission to care);
- It cannot be determined whether the issues noted for a particular child are current concerns or historical issues that have now been resolved; and
- It cannot be determined whether the conditions and issues listed for a particular child were diagnosed by a qualified professional or are based on a layman’s assessment of presenting symptoms or indicators. For this analysis, the issues listed in CFSIS were accepted as “real”.

Data from the Child and Family Services Information System (CFSIS) for the period April 1, 2009 to March 31, 2010 was obtained from the Child Protection Branch to examine, to the extent possible,

the characteristics of youth with complex needs in care. A number of fields were included in the query that reflected issues or challenges experienced by children in care, but mainly revealed the limitations of the database, particularly missing data: for example, placement information was available for only 7,454 (69%) of children in care; only 2,283 (23%) of children in care had any data recorded in the “Social/Well-Being” windows of CFSIS, where issues such as behaviour problems and substance misuse can be tracked. A brief description of the population is provided:

The overall sample of children in care (CIC) was 10,765 children, age 0 – 17, who had been in care for at least one day in the 2009/10 fiscal year. Approximately half of the sample was male (51%) and half were female (49%). Legal status was noted for 9,443 of those children:

- 3,219 Permanent Wards (34%)
- 1,141 Temporary Wards (12%)
- 355 Voluntary Surrender of Guardianship (3.6%)
- 2,403 Under Apprehension (25.5%)
- 722 Petition for Further Order (8%)
- 38 Transitional Planning (0.4%)
- 1,565 Voluntary Placement Agreement (16.5%)

The reason for admission to care was noted for 7,564 children. The majority of children had been admitted to care due to the conduct of the parent (more than 70%), condition of the parent (18%), or refusal of the parent to consent to medical treatment (1%), while 5.5% were admitted due to the conduct of the child, and 3.5% were admitted due to the condition of the child. Although placement information was only available for 69% of the children in the sample, the majority of children for whom information was available were placed in foster homes (56%). It should be noted that 9% were placed in an emergency shelter.

Given the limitations of the data, particularly around generating an understanding of the issues they experienced that may have affected their admission to care as well as the challenges in meeting their care needs, the analysis turned to the group of youth who had been referred to the Provincial Placement Desk (PPD) for consideration for placement in a residential care facility or group home. In general, child and family services agencies only make such a referral when the child has exhausted internal agency resources, such as Place of Safety arrangements with extended family and agency foster homes, and require specialized placement facilities such as treatment-oriented group homes and residential care. Therefore, children referred to the PPD are most likely to be those who have multiple (and therefore, under the working definition, complex) needs and who require specialized placement supports.

In CFSIS, children referred to PPD have the issues they are experiencing recorded in one place – the Provincial Placement Desk Risk Issues field – and the information reflects the constellation of issues that are known at the time the child is referred for placement (which is often more detailed than information that may have been recorded when the child was first admitted to care). Consequently, this is a rich source of information about youths’ multiple needs, meeting one interpretation of the definition of “complex needs”, youth who have more than one issue affecting their care needs. Additionally, one of the variables recorded, the need for 24 hour care and supervision, can serve as a proxy measure of the severity of issues experienced, although it is not possible to isolate specific issues that might be driving the service needs of the child. Further, there is no capacity to measure through

CFSIS data, including data from the PPD Risk Issues field, the capacity of placements or supportive services to meet the needs of the youth.

### **Summary of Analysis from the Provincial Placement Desk Risk Issues Data**

The Provincial Placement Desk Risk Issues fields have been utilized since December 2009 to track the kinds of issues experienced by youth who are referred by their child welfare agencies for placement in a group home or residential facility. The PPD Risk Issues field is completed by the Provincial Placement Desk Specialist, based on information provided in the referral information, social history and in supplementary assessments or reports on the child who is referred for placement. For the 2010/11 fiscal year, 567 referrals were received by the Provincial Placement Desk, of which 286 referrals were made to residential care facilities and 128 were referred to treatment foster care programs; the remaining referrals were either not suitable for specialized placement or required additional information to be submitted prior to taking further action. This analysis is based on all children age 0 – 17 who were referred to the PPD and had data entered into the PPD Risk Issues field from December 2009 until March 31, 2010. To reiterate some caveats about the PPD Risk Issues data:

- Data is only for children/youth in CFSIS for whom the PPD Risk field was completed. The data does not include children with complex needs who are not in CFSIS, who were not referred to PPD but do have complex/multiple needs, or who were referred to PPD but did not have the PPD Risk fields completed.
- The sample population doesn't include children who need individualized or semi-individualized placements, as those referrals are made directly by the CFS agency to specialized resources like the MacDonald Youth Services Specialized Individual Placements (SIPs program), DASCH, the Specialized Adolescent Treatment House (SATH), or Marymount's 2 – 3 bed homes.
- Definitions intended in the file material may not be the same as definitions utilized by the Provincial Placement Desk Specialist.
- Some conditions may be recorded as issues for a child, but it is not known how that issue was assessed or diagnosed. Criteria used for selecting diagnoses/conditions, both in the file documentation and by the Provincial Placement Desk Specialist, may be subjective.
- It is not clear when the issues were in existence – some may reflect historical issues, issues that are now resolved, issues that are new, and/or updated data regarding new issues may not have been entered after the initial entry to the PPD Risk field or provision of background information to the PPD Specialist.
- Because the information comes from a different source and is entered into the PPD Risk Issues windows by the PPD Specialist, there may not be corresponding detailed information in other aspects of the child's case in CFSIS. As a result, the information from the PPD Risk Issues field is rich and interesting as it pertains to the manifestation of complex needs in youth in care, but it is difficult to conduct similar research involving other children in care who are not referred to the PPD for placement. Still, it is likely that those children referred to the PPD are representative of those who have complex needs throughout the CIC population in Manitoba, and that this group is a significant proportion of those youth who are most challenging to place.

The following is a brief summary of the key findings from this analysis.

### **Demographic Description of the Sample Population**

- 289 unique children in care had entries in the PPD Risk field (2.7% of the total 10,765 CIC).
- 160 of the unique CIC who had entries in the PPD Risk field were female; 129 CIC were male
- Children ranged in age from 4 years to 17 years
- The average age was 14.24 years. The median was 15 years.
- Frequencies were as follows:
  - 47 children were age 17 (16%)
  - 65 children were age 16 (22%)
  - 58 children were age 15 (20%)
  - 48 children were age 14 (17%)
  - 16 children were age 13 (7%)
  - 15 children were age 12 (6%)
  - 12 children were age 11 (4%)
  - 10 children were age 10 (3%)
  - 3 children were age 9 (1%)
  - 2 children were age 8 (.5%)
  - 5 children were age 7 (2%)
  - 2 children were age 6 (.5%)
  - 1 child was age 5 (.3%)
  - 5 children were age 4 (2%)
- 267 of the 289 children had a legal status entered in CFSIS: 119 were Permanent Wards (41%); 30 were Temporary Wards (10%); 15 had a Petition for Further Order underway (5%); 30 were under apprehension (10%); and 73 were in care under a Voluntary Placement Agreement (25%). No information was recorded for 22 children (7%).
- 121 children were from the Southern Authority (41%); 94 were from the General Authority (33%); 48 were from the Northern Authority (17%); 26 were from the Metis Authority (9%). The proportions in the overall CIC population for the 09/10 fiscal year were 45% from the Southern Authority, 23% from the General Authority, 22% from the Northern Authority, and 10% from the Metis Authority.

### **Reason for Admission to Care**

- 72 children were admitted to care due to the conduct/condition of the child (about 25%, compared to 329 other children from the 10,765 children in care ages 0 – 17 or about 3%). 129 children were admitted to care due to conduct/condition of the parent (about 45%, compared to 4,458 other children from the 10,765 children in care ages 0 – 17, or about 42%)
- The remaining children referred to PPD mainly had “Transfer in from MB Agency” as the reason for admission to care, reflecting a) the reason that was commonly used at devolution of the child welfare system to denote cases that were being transferred from one CFS Authority to another or b) that the case was transferred from a Designated Intake Agency (DIA).
- There were a few children in the PPD referral sample who had “Voluntary Relinquishment” (9 children) or “Abandonment” (5 children) as the listed reason for admission to care.

### **Placement Information**

- 223 of the 289 children had a placement recorded in CFSIS: 28 were placed in an Emergency Shelter (10%); 142 were in a general foster home (49%); 2 were in a child-specific placement; 1 was in independent living; 29 were in a family Place of Safety (9%); 1 was in a hotel; and 20 had no placement (6%). No information about placement was entered for 66 children (23%).
- 8 children had had more than one placement entered for them in the 2009/10 fiscal year.

- 84 children (29%) referred to the PPD were also noted in the File Action Required section of CFSIS to have had multiple placements throughout their time in care: 32 male and 52 female. Their ages ranged from 4 to 17 years of age with the following frequencies:
  - 19 children were age 17 (23%)
  - 18 children were age 16 (21%)
  - 21 children were age 15 (25%)
  - 14 children were age 14 (17%)
  - 4 children were age 13 (5%)
  - 4 children were age 12 (5%)
  - 1 child was age 11 (1.5%)
  - 1 child was age 10 (1.5%)
  - 1 child was age 7 (1.5%)
  - 1 child was age 4 (1.5%)
- The average age of youth with multiple placements was 14.9 years of age. The majority of them (47) were permanent wards (56%); 20 VPA (25%); 9 Temporary Wards (11%); 3 Petition for Further Order (3%); 3 Under Apprehension (3%). Most of the youth who had multiple placements were in general foster homes (51 or 60%), with 13 placed in emergency shelters (15%). 6 had no placement (7%).
- Other risks noted in the File Action Required section of CFSIS for this population: 29 children (35%) were noted to have been victims of abuse (21 females and 8 males), with all but 8 having had multiple placements. 27 youth were noted to have AWOLs or unplanned absences (8 males and 19 females). All but 5 had multiple placements. 14 were in foster homes, 3 in shelters, and 8 had no placement.

### **Overview of the Provincial Placement Desk Risk Issues Field**

A total of 62 unique issues can be recorded into the PPD Risk Issues fields, conceptualized in two themes, as follows, and as depicted in Table 6:

- a) Antecedent issues are those that:
  - are well known in the professional literature to be conditions/experiences that have a deleterious impact on a child's functioning;
  - are well known in the professional literature to be issues that contribute to a child's admission to child welfare care;
  - are likely to have occurred prior to the child's admission to care (but not exclusively so - antecedent issues could also occur after a child's admission to care); and
  - are experiences that may not have been within the child's control.
- Antecedent issues are grouped according to similarity (e.g. those caused by prenatal alcohol exposure, attachment, disability type, protection issues of abuse/neglect, family violence, medical/health conditions, parental issues, parenting practices, ADHD)
- b) Consequence issues are those that:
  - are considered in the professional literature to be the typical outcomes of adverse childhood experiences;
  - are often the focus of therapeutic intervention (to reduce symptoms, change behaviour, protect child/youth from harm, improve child's/youth's functioning, etc); and
  - are often the source of stress for caregivers who are caring for a child with these consequence issues.
- Consequence issues are grouped according to similarity (e.g. those that are related to degrees of problematic/aggressive behaviour, lying, elimination issues, behaviours that harm others, criminal behaviours, somatic/self-care issues, mental health issues, medication issues, day program issues, extreme care needs, exploitation by others, sexual offending, substance misuse, and AWOL.

Table 6

ANTECEDENT ISSUES	CONSEQUENCE ISSUES
<ul style="list-style-type: none"> <li>• ARND – Diagnosed</li> <li>• ARND – Suspected</li> <li>• FAS/E – Diagnosed</li> <li>• FAS/E - Suspected</li> </ul>	<ul style="list-style-type: none"> <li>• Aggressive</li> <li>• Behaviour Issues</li> <li>• Physical Assaultive</li> <li>• Violent</li> </ul>
<ul style="list-style-type: none"> <li>• Attachment Issues</li> </ul>	<ul style="list-style-type: none"> <li>• Lying</li> </ul>
<ul style="list-style-type: none"> <li>• Disability – Cognitive</li> <li>• Disability – Medical</li> <li>• Disability – Physical</li> <li>• Disability - Sensory</li> </ul>	<ul style="list-style-type: none"> <li>• Bedwetting</li> <li>• Encopresis</li> <li>• Enuresis</li> </ul>
<ul style="list-style-type: none"> <li>• Emotional Abuse</li> <li>• Physical Abuse</li> <li>• Sexual Abuse</li> <li>• Neglect</li> </ul>	<ul style="list-style-type: none"> <li>• Biting</li> <li>• Fire Setting</li> <li>• Hurts Animals</li> </ul>
<ul style="list-style-type: none"> <li>• Family Violence</li> </ul>	<ul style="list-style-type: none"> <li>• Criminal Activity</li> <li>• Criminal Charges</li> <li>• Delinquencies</li> <li>• Stealing</li> </ul>
<ul style="list-style-type: none"> <li>• Medical Needs</li> </ul>	<ul style="list-style-type: none"> <li>• Eating Disorder</li> <li>• Hygiene Issues</li> <li>• Sleeping Issues</li> </ul>
<ul style="list-style-type: none"> <li>• Parental Mental Health Issues</li> </ul>	<ul style="list-style-type: none"> <li>• Emotional Issues</li> <li>• Mental Health – Diagnosed</li> <li>• Mental Health – Suspected</li> <li>• Self Harm</li> <li>• Suicidal</li> </ul>
<ul style="list-style-type: none"> <li>• Parentified Child</li> </ul>	<ul style="list-style-type: none"> <li>• Medication – Multiple Prescriptions</li> <li>• Medication – Non-Compliant</li> <li>• Medication - Prescribed</li> </ul>
<ul style="list-style-type: none"> <li>• ADHD – Diagnosed</li> <li>• ADHD - Suspected</li> </ul>	<ul style="list-style-type: none"> <li>• Education Program Needed</li> <li>• No Day Program</li> </ul>
	<ul style="list-style-type: none"> <li>• 24 Hour Care and Supervision</li> </ul>
	<ul style="list-style-type: none"> <li>• Sexual Exploitation</li> <li>• Gang Involvement</li> </ul>
	<ul style="list-style-type: none"> <li>• Sexual Offender</li> </ul>
	<ul style="list-style-type: none"> <li>• Substance Abuse</li> <li>• Substance Abuse – Alcohol</li> <li>• Substance Abuse – Drugs</li> <li>• Substance Abuse – Solvents</li> <li>• Substance Use – Alcohol</li> <li>• Substance Use – Drugs</li> <li>• Substance Use - Solvents</li> </ul>
	<ul style="list-style-type: none"> <li>• AWOL</li> </ul>

\* Note: Antecedent issues in the left column may lead to any of the consequence issues in the right column.



## **Provincial Placement Desk Risk Issues**

- 2,425 issues were recorded in total for these 289 CIC in the PPD Risk Issues field.
- On average, each child had 8.4 issues.
- Number of issues per child ranged from 2 – 19.
- Child with 2 issues was male, age 15, with Delinquencies and Criminal Activity as the two issues.
- Child with 19 issues was female, age 15, with neglect, sexual abuse, emotional abuse, attachment issues, emotional issues, depression, self-harming, suicidal, aggressive, behavioural issues, criminal activity, delinquencies, stealing, criminal charges, gang involvement, substance abuse drugs, substance abuse alcohol, AWOL, and needs 24 hour care and supervision.

### ***Antecedent Issues***

#### **Prenatal Alcohol Exposure**

- 70 children were noted to have been diagnosed, or were suspected of having, FAS/E or ARND (25% of the total 289 children).
- 17 children were age 12 and under; 53 were age 13 – 17.

#### **Attachment**

- 244 children were identified as having attachment issues, out of the total 289 children who had PPD Risk Issues listed (85%).
- 224 of the youth who had attachment issues also had behavioural issues.
- 132 youth with attachment issues had also been emotionally abused.

#### **Disability**

- 17 unique children had at least one type of disability noted (7 male and 10 female).
- In all, 15 children were diagnosed with cognitive disability.
- 13 of the cognitively challenged youth also had behavioural issues; 8 youth with cognitive disability were also described as aggressive (5 male, 3 female).

#### **Abuse and Neglect**

- 16 youth had experienced physical abuse (8 male, 8 female).
- 49 youth had been sexually abused (11 male, 38 female).
- 45 youth had experienced neglect (18 male, 27 female).
- 149 children were noted to have been emotionally abused (50 male, 99 female), representing 52% of the 289 children in the sample.
- 140 of the emotionally abused children were noted to have behavioural issues.
- 13 of the physically abused children had behavioural issues (7 male, 6 female).
- 40 of the sexually abused children had behavioural issues (10 male, 30 female).
- Sexual offending behaviour was noted for 4 of the 11 males who had been sexually abused.
- 36 youth who had been neglected also had behaviour issues (all 18 of the males, and 18 females).

- 84 unique youth experienced at least one of physical abuse, sexual abuse, or neglect (approximately 30% of the total 289 children in the sample).

#### Family Violence

- 59 children had experienced family violence (26 males; 33 females), representing 21% of the 289 children in the sample.
- 52 of these children also had behavioural issues.

#### Medical Needs

- 4 children had medical needs, all male, ages 4, 11, 15 and 15.
- 2 of these children also have physical disabilities.
- All 4 youth with medical needs were also noted to have behavioural issues and were aggressive.

#### Parental Mental Health Issues

- 13 youth (5 male; 8 female) had parents with mental health issues.
- 9 youth were identified as having a diagnosed (5) or suspected (4) mental health disorder themselves.
- All 13 youth were deemed to have behavioural issues.
- Parental mental health issues were not strongly associated with physical abuse, sexual abuse, or neglect for this group of 13 youth.
- However, 10 of the youth whose parents had mental health issues also had attachment issues.

#### Parental Substance Use/Abuse

- 7 youth (3 male, 4 female) had parents who used/abused substances.
- Children who were diagnosed with FAS/E or ARND were not documented to have parents who used/abused substances.
- 6 of the 7 youth whose parents used/abused substances also had behavioural issues.

#### Parentified Child

- 9 children were noted to have been parentified (5 males, 4 females).
- All 9 also had behavioural issues.
- 8 of the 9 were also deemed to have attachment issues.
- Neglect was experienced by half of the children; sexual abuse by 2 children.

#### ADHD

- 39 children were either diagnosed with (22) or suspected of having (17) ADHD (14% of the total 289 population).
- The majority of children were male, with 19 males diagnosed with ADHD (compared to only 3 females), and 11 males suspected of having ADHD (compared to 6 females).
- Behavioural issues were identified for 36 of the youth.

## ***Consequence Issues***

### Aggressive, Physically Assaultive, Violent Behaviour

- 260 youth had at least one of these three risk factors listed in the PPD Risk field (90%).
- 139 of these youth were male; 121 of the youth were female.
- “Aggression” was the most common of the three risk factors: 196 youth were noted to be aggressive (104 males; 92 females).
- Of the 20 youth noted to be “violent”, 13 were male and 7 were female.
- 42 children were listed as both “aggressive” and “physically assaultive”: 11 of these youth also required 24 hour care/supervision.
- 45 children who were listed as “aggressive” also required 24 hour care/supervision.

### Behaviour Issues

- 265 children were noted to have “behavioural issues”: 118 male and 147 female. This represents 92% of the total 289 children.
- 53 youth had behaviour issues and need 24 hour care/supervision: 33 male/20 female.
- Behavioural issues are most commonly associated with attachment issues (224 children had both attachment issues and behavioural issues) and emotional abuse (140 children who had been emotionally abused also had behavioural issues).
- There were 63 unique youth with behavioural issues who had either criminal activity (9), criminal charges (38) or both criminal activity and criminal charges (16) noted.

### Specific Behaviour Issues: Bedwetting, Encopresis, and Enuresis

- 11 children and youth were noted to struggle with bedwetting, ranging in age from 9 – 17 years of age (7 males and 4 females).
- A total of 14 unique children struggled with 1 or more of these conditions; 7 of them also experienced emotional abuse, 2 had experienced physical abuse, and 2 had been sexually abused. 10 also had attachment issues. 4 grew up in homes marked by family violence. 11 were also noted to be aggressive.

### Specific Behaviour Issues: Biting, Fire Setting, Hurts Animals

- 13 children, ranging in age from 4 – 14 years of age, were noted to engaging in biting (8 males and 5 females). Ten of the children were noted to have attachment issues.
- 4 youth (ages 12, 14, 14 and 17) were noted to engage in firesetting. The 12-year-old was female. One of the 14-year-old males had also been sexually abused.
- 6 youth were known to hurt animals. They ranged in age from 12 – 17 years of age (3 males and 3 females). Two of the males had been physically abused.

### Criminal Activity

- 34 youth were involved in criminal activity (19 males and 15 females); 56 youth had been charged with a criminal offence (33 males and 23 females); and 29 youth were noted to have delinquencies (14 males and 15 females). Ages ranged from 14 – 17 years.

- Of all the types of criminal activity noted above, 84 unique youth in total (48 males and 36 females) had at least one kind of criminal involvement noted (29% of the total 289 children with risk issues). Thirty youth had more than one kind of criminal activity noted.
- 33 youth were involved in gangs (17 males and 16 females), ranging in age from 14 – 17 years. 25 of these youth were also noted to have attachment issues. One third of the youth (11) came from homes with family violence, and 4 had been sexually abused.

#### Health Concerns: Eating Disorder, Hygiene Issues, Sleep Issues

- 4 youth were noted to have eating disorders: 3 females (age 14, 15, 16) and one male age 14. All four had attachment issues and 3 had been emotionally abused. None of the youth were diagnosed with a mental health disorder.
- 13 youth, ranging in age from 9 – 17, had hygiene issues (4 males and 9 females). Hygiene issues were associated with cognitive disability for 3 youth.
- 8 children had sleep issues, ranging in age from 4 – 16 (7 males, 1 female). Three of the children had been sexually abused and 4 experienced emotional abuse. 7 were noted to have attachment issues.

#### Mental Health Issues

- Mental health issues were diagnosed or suspected for 44 youth: 17 male and 27 female
- 25 youth were identified as being “suicidal”: 6 male and 19 female; only 3 of these youth were also diagnosed with a mental health issue. One additional youth who was suicidal was suspected of having a mental health issue.
- 27 youth with mental health issues were listed as being “self harming”: 5 male and 22 female
- 16 youth who were diagnosed with a mental health condition also had attachment issues. A further 16 who were suspected of having a mental health condition also had attachment issues.
- 15 youth who were suicidal also had attachment issues (60%).
- 21 youth who were self harming had attachment issues (78%).

#### Emotional Issues

- 229 children and youth were noted to have emotional issues (93 males and 136 females – 79% of the total 289), ranging in age from 4 – 17 years of age. The majority were age 14 – 17.
- 5 children had been physically abused; 10 children had been sexually abused; 48 youth had been emotionally abused.

#### Medication

- 15 youth had prescription medication of some kind (8 males and 7 females), ranging in age from 7 – 17 years. An additional 3 youth were noted to have multiple prescriptions (2 males ages 10 and 16, and 1 female age 16). One female, age 16, was noted to be non-compliant with medication.
- Medication was associated with a diagnosed mental health condition for 9 youth.
- 3 children who were diagnosed with ADHD were also prescribed medication. Together, the 9 youth with mental health diagnoses and the 3 with ADHD account for 12 of the 15 children with

prescription medications. The other 2 youth had behavioural issues, although mental health issues were suspect.

#### Day Programming

- 27 youth were not in an educational program (13 males and 14 females), ranging in age from 11 – 17 years. An additional 4 youth were noted to have no day program (3 females age 15, 16, 17 and one male age 17).
- 24 of the total 31 youth who did not have an education or day program also had behaviour issues. 13 were described as having aggression issues.
- 12 youth who needed some kind of day program also required 24 hour care and supervision.

#### 24 Hour Care and Supervision

- 57 children were identified as requiring 24 hour care and supervision (35 males and 22 females), ranging in age from 4 to 17 years of age. 44 of the 57 were youth ages 13 – 17.
- 53 of the children who required 24 hour care/supervision also had behaviour issues; 45 who needed this level of care were aggressive; 3 were considered to be violent; and 6 were noted to be physically assaultive. Two youth were noted to be sexual offenders. Another 6 engaged in sexualized behavior.
- 10 of the youth who required 24 hour care/supervision had been diagnosed with cognitive disability; 8 were diagnosed with FASD, and an additional 2 were suspected of having FASD; 11 youth were diagnosed with ARND, and an additional 4 were suspected of having ARND.
- 8 youth who required 24 hour care/supervision had also been diagnosed with a mental health condition; 7 were suicidal; 6 were self harming.

#### Exploitation: Sexual Exploitation and Gang Involvement

- 19 youth were sexually exploited (2 males and 17 females), ranging in age from 10 to 17 years.
- 14 of these youth also had attachment issues; 6 were victims of sexual abuse; 10 were also emotionally abused.
- 12 youth were also involved in substance abuse, with all 12 abusing drugs and 11 abusing alcohol.
- 33 youth were involved with gangs (ages 12 – 17): 17 males and 16 females.
- 25 youth with gang involvement are also involved in criminal activity, including 20 who have had criminal charges.
- Three youth involved with gangs were also diagnosed with either FASD or ARND.

#### Sexual Offending Behaviour

- 11 youth, ranging in age from 13 – 17, were identified to be engaged in sexual offending behaviour. All were males.
- 4 of the youth were victims of sexual abuse; 1 was a victim of physical abuse; 2 were victims of emotional abuse; 1 had experienced family violence.
- None of the sexual offenders was diagnosed with FASD or ARND, however, ARND was suspected for one of the sexual offending youth.

## Addictions

- 69 youth were noted to abuse alcohol: 26 male and 43 female.
- 76 youth were noted to abuse drugs: 31 male and 45 female.
- 65 youth were identified as abusing both alcohol and drugs.
- Alcohol use was noted for a further 38 youth: 15 male and 23 female.
- Drug use was noted for 44 youth: 19 male and 25 female.
- 37 youth were identified as using both alcohol and drugs.
- 158 youth of the total 289 had at least one substance misuse issue noted (55%).

## AWOL

- A concern about AWOLs was noted for 108 youth (32 male and 76 female).
- 67 youth who went AWOL also had behavioural issues.
- 41 youth who went AWOL were also noted to be aggressive.
- 68 youth who went AWOL were also noted to have attachment issues.
- 49 youth who went AWOL also had involvement with alcohol and/or drug abuse.

### **Proxy Measures for Severity of Issues**

#### **24 Hours Care and Supervision**

Of the 289 children with risk issues listed in the Provincial Placement Desk Risk Issues fields, 57 (20%) were noted to require 24 hour care and supervision (35 males and 22 females). It may be assumed that children who required this level of care have issues that have reached a level of severity that intensive placement services are needed. A summary of this population is as follows:

- Only 12 of the 57 were under the age of 13, with 45 (almost 80%) age 13 – 17.
- Of the 57 children/youth, 22 were admitted to care due to the conduct of the parent; 17 were admitted to care due to conduct of the child. As noted earlier, information for the remaining children was usually recorded in CFSIS as “Transfer in from MB Agency”.
- 11 of the sample were permanent wards.
- Of the 57 children/youth who required 24 hour care/supervision:
  - 1 had 4 additional risk issues;
  - 3 had 5 additional risk issues;
  - 8 had 6 additional risk issues;
  - 9 had 7 additional risk issues;
  - 8 had 8 additional risk issues;
  - 5 had 9 additional risk issues;
  - 7 had 10 additional risk issues;
  - 4 had 11 additional risk issues;
  - 6 had 12 additional risk issues;
  - 1 had 13 additional issues;
  - 2 had 14 additional issues;
  - 2 had 15 additional issues; and
  - 1 had 18 additional issues.

- 24 hour care/supervision was associated with multiple risk factors, ranging from 4 issues to 18 issues. The four who had the fewest number of issues, suggesting that even these few issues involved some degree of severity to require 24 hour care/supervision, were dealing with these challenges:
  - male, age 16: aggressive, sexual offender, emotional issues, behavioural issues;
  - male, age 10: aggressive, emotional abuse, attachment issues, emotional issues, behavioural issues;
  - male, age 14: aggressive, sexualized behaviors, emotional issues, physically assaultive, behavioural issues; and
  - male, age 13: aggressive, sexual offender, attachment issues, emotional issues, behavioural issues.
- The five youth with the highest number of issues were characterized as follows:
  - female, age 15: aggressive, depressed, suicidal, self-harming, criminal activity, criminal charges, delinquencies, behavioural issues, stealing, gang involvement, drug and alcohol abuse, emotional issues, emotional abuse, neglect, AWOLs, sexual abuse, attachment issues;
  - male, age 14: aggressive, violent, criminal charges, delinquencies, suspected ARND, drug and alcohol abuse, AWOLs, physical abuse, sexual abuse, emotional abuse, family violence, attachment issues, emotional issues, behavioural issues;
  - male, age 14: aggressive, fire setting, criminal activity, criminal charges, drugs and alcohol abuse, behavioural issues, delinquencies, emotional issues, suspected ADHD, AWOLs, neglect, emotional abuse, family violence, attachment issues;
  - female, age 13: aggressive, cognitive disability, diagnosed ARND, diagnosed FASD, diagnosed ADHD, sexualized behaviour, diagnosed mental health condition, stealing, hygiene issues, emotional issues, attachment issues, behavioural issues, emotional abuse, parental mental health issues; and
  - male, age 15: aggressive, sexual exploitation, diagnosed FASD, diagnosed mental health issue, criminal charges, delinquencies, behavioural issues, prescribed medications, physically assaultive, drug and alcohol use, sexual abuse, neglect, parental mental health issues.
- The three youngest children who required 24 hour care/supervision can be characterized as follows:
  - male, age 4: aggressive, diagnosed ARND, diagnosed FASD, suspected ADHD, biting, behavioural issues, attachment issues, neglect, physical abuse, sleeping issues;
  - male, age 4: aggressive, suspected FASD, suspected ADHD, biting, behavioural issues, attachment issues, neglect, emotional abuse;
  - female, age 7: aggressive, diagnosed ARND, diagnosed FASD, behavioural issues, neglect, emotional abuse; and
  - male, age 8: aggressive, behavioural issues, emotional issues, suspected ARND, sleeping issues, attachment issues.
- 45 of the 57 (80%) who required 24 hour care/supervision had both behavioural issues and attachment issues. Another 10 had behavioural issues but not attachment issues. Put another way, of the 269 children who had behaviour issues and attachment issues, 45 (17%) required 24 hour care/supervision.
- 6 children/youth who required 24 hour care/supervision had behavioural issues and a mental health diagnosis.

- 35 of the 57 who required 24 hour care/supervision had behavioural issues and had experienced emotional abuse.
- 9 who required 24 hour care/supervision were sexual abuse victims who also had behavioural issues.
- Of the 57 children/youth, antecedent issues were noted for only 37. 20 youth only had consequence issues listed for them (no antecedent issues), without any hypotheses about where these issues might have stemmed from. 13 had more than one antecedent issue noted.
- Issues most commonly associated with Post Traumatic Stress Disorder, according to the professional literature (physical abuse, sexual abuse, and family violence), were noted for 19 children/youth (34%): 3 had been physically abused, 8 had been sexually abused, and 8 had witnessed family violence.
- A total of 28 children/youth were noted to have experienced emotional abuse, although 11 also had experienced another antecedent issue such as sexual abuse or family violence. However, 17 only had emotional abuse listed as an antecedent issue, which leaves questions about what kind of experiences had happened and how such experiences were defined, measured, and diagnosed.
- 5 children/youth experienced neglect as an antecedent issue.
- 10 of the sample (18%) who required 24 hour care/supervision had been diagnosed with cognitive disability.
- 8 were diagnosed with FASD, and an additional 2 were suspected of having FASD; 11 were diagnosed with ARND, and an additional 4 were suspected of having ARND. Therefore a total of 25 unique children/youth who required 24 hour care/supervision had been diagnosed with or were suspected of having a condition caused by prenatal alcohol exposure (44%).
- 8 who required 24 hour care/supervision had also been diagnosed with a mental health condition; 7 were suicidal; 6 were self-harming.

### **Level V Children**

A second proxy indicator for severity of issues facing youth with complex needs is how many youth have been accepted by the Child Protection Branch for Exceptional Circumstances/Level V funding. This designation is conferred by the Child Protection Branch upon application by a child and family services agency if the child meets the Branch's eligibility criteria. Level V children are those who have a multitude of issues of a serious nature, resulting in significant care needs (as defined in a prescribed assessment process and assessed by a committee), whose per diem may therefore be very high and present financial constraints to an agency. Child and family services agencies are reimbursed in full for those children who have qualified for Level V funding.

- 12 of the youth referred to PPD were designated as Level V. An additional 120 children in care in 2009/10 age 0 – 17 also had Level V designation, but were not referred to PPD. Brief profiles of the 12 Level V youth referred to PPD and their issues were:
  - female, age 15: attachment issues, emotional abuse, behavioural issues, aggressive, criminal activity, substance abuse, needs 24 hour care;
  - female, age 15: attachment issues, emotional abuse, behavioural issues, aggressive, ADHD, physically assaultive, criminal activity, substance abuse, needs 24 hour care;
  - female, age 15: attachment issues, emotional abuse, behavioural issues, aggressive, gang involvement, criminal activity, substance abuse, AWOLs, needs 24 hour care;



- female, age 14: attachment issues, behavioural issues, aggressive, sexual exploitation, diagnosed mental health condition, criminal activity, substance abuse, self-harming;
- male, age 16: attachment issues, family violence, parentified child, neglect, behavioural issues, criminal activity, aggressive, AWOLs;
- male, age 14: attachment issues, FASD diagnosed, behavioural issues, substance use, diagnosed mental health condition, needs 24 hour care;
- female, age 14: attachment issues, FASD suspected, behavioural issues, sexual exploitation, diagnosed mental health condition, criminal activity, substance abuse;
- female, age 16: attachment issues, behavioural issues, physically assaultive, ARND and ADHD suspected, substance use, suicidal;
- female, age 13: attachment issues, emotional abuse, cognitive disability, behavioural issues, FASD diagnosed, sexualized behaviour, diagnosed mental health condition, needs 24 hour care;
- male, age 13: attachment issues, emotional abuse, cognitive disability, behavioural issues, diagnosed mental health condition, sleeping issues, hygiene issues, needs 24 hour care;
- female, age 10: attachment issues, emotional abuse, sexual abuse, family violence, neglect, behavioural issues, sexualized behaviour, bedwetting, biting, sleeping issues, aggressive; and
- female, age 16: attachment issues, FASD suspected, behavioural issues, aggressive, sexual exploitation, substance abuse, mental health issues suspected, AWOLs.

### **Summary**

This overview of youth with complex needs provides helpful information about the multitude of issues experienced by children in care and illustrates the most pressing issues facing this population and the child-serving agencies and government departments responsible for meeting their needs. Some inferences about issues that likely contributed to youths' admission to care are possible, and based on findings in the literature about the impact of adverse life circumstances on children, some hypotheses about antecedent and consequence issues can also be made.

The sample population of 289 youth referred to the Provincial Placement Desk (PPD) can be considered to be a representation of many youth in care with complex needs. All the youth referred to PPD experienced a multitude of issues, on average 8.4 per child. While representing only 2.7% of the total Child in Care population throughout 2009/10, this sample provides a rich description of the nature and scope of issues experienced by this group. Other youth with complex needs who were not referred to PPD, did not have sufficient referral information to complete the PPD Risk Issues fields, or need individualized placements because of their complex needs, are not included in this group, but it is likely that the nature of their issues is similar.

The sample population of 289 children and youth ranged in age from 4 – 7 years, with an average age of 14.2 years. Importantly, the median age was 15 years, indicating that children referred to PPD tend to be older than the overall population of children in care: 50% of the PPD sample was age 15 or older. This suggests that complex issues may have not yet manifested themselves in younger children, or are more manageable during the childhood years and/or that placements may be easier to secure and sustain when youth are younger. Placement breakdowns are most common in adolescence, according to the professional literature, and by the time youth have reached mid-adolescence and have likely experienced at least one placement breakdown, they may be particularly vulnerable to placement

instability. Coupled with their multiple complex issues, finding an appropriate placement that can respond to their needs may be very difficult.

Interestingly, although a large proportion of the youth were permanent wards (41%), there were also many youth in this group who were placed under Voluntary Placement Agreement (25%). Another 10% were Temporary Wards, and 10% were still under apprehension. Given the older age of this population, legal status alone does not give a clear indication of how long these youth have been in care or how much previous history the youth has with the child welfare system, as youth over age 14 can remain in care under a series of VPAs.

One quarter of youth in the PPD sample were admitted to care for a child-based reason (condition or conduct of the child, such as disability, behaviour issue, etc). In the overall child in care population, only 3% were admitted due to child condition/conduct issues. Therefore, those youth referred to PPD are more likely to have been difficult to care for prior to their admission to care, suggesting that the origin of their needs are likely related to the child's unique characteristics. In this sample, antecedent issues that might explain this were rarely included in the PPD Risk Issues field and may not have been part of the referral material sent to PPD. Of the child-related antecedent issues, it is known that 6% of the youth referred to PPD had a disability (mainly cognitive disability), 14% had ADHD, and 25% had FASD. However, previous research has demonstrated that children with FASD tended to be admitted to care prior to a diagnosis of the condition and that they were mainly admitted due to parental factors (Fuchs, Burnside, Marchenski, & Mudry, 2007). At this stage, all that can be surmised is that 25% of children referred to PPD in this sample were originally admitted to care for child-based reasons that were not the focus of referral to PPD. Instead, the consequence issues – the challenges that necessitated a referral for specialized placement – were the driving force behind the referral.

Hypotheses about the origins of consequence issues are more possible for the group of youth referred to PPD for parent-based reasons. About 45% were admitted due to parent-related issues (condition or conduct of the parent), fairly consistent with the overall CIC population at 42%. Because youth came into care as a result of parent-based issues, it is likely that antecedent issues had occurred (recalling that the antecedent issues include deleterious or traumatic issues instigated by parents: abuse, neglect, parental substance misuse, family violence, for examples). In the PPD sample, 30% had experienced at least one type of abuse or neglect (5.5% had been physically abused; 17% had been sexually abused; 16% had been neglected). Family violence had been experienced by 21% of youth in the PPD sample. Parents with mental health issues were identified in 4.5% of cases.

Two antecedent issues were clearly significant themes. First, emotional abuse was identified as an experience affecting 52% of youth referred to PPD. This is an interesting finding, given that (a) emotional abuse is the most difficult type of abuse to prove for the purposes of admission to care under the *Child and Family Services Act* because it requires demonstration that the emotional abuse has resulted in long-term or permanent effects on the child (very difficult to ascertain at the time of admission to care) and (b) emotional abuse is among the least frequent types of abuse recorded in numerous studies of types of abuse (for example, see the Canadian Incidence Study, where 9% of children were found to have been emotionally abused – Trocmé, et al., 2010). In the PPD sample, it is not known how emotional abuse was assessed and attributed to the child's experience. Certainly, in the common understanding of the term, it is likely that many children referred to child welfare have experienced emotional abuse, but it is impossible to ascertain what criteria were used to make the "diagnosis" in the PPD sample.

The second antecedent theme that arose was the high proportion of children referred to PPD with attachment issues – 86%. Similar to emotional abuse, it is difficult to determine how attachment issues were assessed and attributed to the child's experience, as attachment disorder has particular clinical assessment criteria but is also a label commonly assigned based on the layman's experience of interacting with a child (e.g. the foster parent, the social worker, etc). The features of attachment disorder may certainly be present in a child's relationships with caregivers, and certainly attachment disruption may be an expected reaction when children are admitted to foster care. However, it is unlikely that all the children in the PPD sample who have been identified with attachment issues have been formally diagnosed with an attachment disorder (although they may well have an attachment disorder that remains undiagnosed).

Consequence issues, as noted above, are the likely drivers of referrals to the PPD. Chief among them is behaviour issues, affecting 93% of all youth referred to PPD. Most youth with behaviour issues had the most extreme and challenging manifestations: 90% of all youth referred to PPD were described as either aggressive, physically assaultive, or violent (although only 7% were deemed to be violent). Almost 80% of youth referred to PPD were identified as having emotional issues – not an unexpected finding given that many of the issues experienced by children in care are known to cause emotional difficulties, but it is not clear in the sample how an assessment of "emotional issues" was made. Additional consequence issues that were challenging to address include criminal activity, affecting 22% of youth, and mental health issues, affecting 15% of youth.

As of March 31, 2010, 49% of youth with complex needs were living in a foster home, but were referred to the PPD for a Group 2 placement resource. Of greater concern, 10% were in an emergency shelter waiting for a Group 2 placement; almost 20% of these youth had been in the shelter since at least 2009. Also concerning was that 6% were listed as having no placement (although it was not clear where they were living – still at home? With extended family?) while waiting for an opening in an appropriate Group 2 resource. Almost one-third of the children referred to PPD experienced multiple placements, with 86% being age 14 or older. This points to the well-known phenomenon of placements breaking down in adolescence, when placement breakdown can also significantly contribute to school disruption as youth move from one placement (and often, from one community and school) to another. Specifically, 11% of youth referred to PPD were not in a school or day program.

The sub-group assumed to have the most severe needs, youth requiring 24 hour care and supervision, represented 20% of the PPD group. As with the larger PPD group, the most common issues resulting in the referral to PPD pertained to behavioural issues, mainly aggression, and emotional issues. About 34% had experienced child abuse or family violence, which often result in emotional issues and can be associated with the symptoms of Post Traumatic Stress Disorder. Almost 45% of the youth requiring 24 hour care/supervision had a type of FASD; another 18% had a cognitive disability of other origin. Therefore, 63% of all youth requiring 24 hour care/supervision had a condition that impaired their developmental and cognitive functioning in a significant way – a condition of vulnerability that would continue into adulthood, necessitating some kind of supports and services after discharge from care.

While the PPD sample captures the characteristics of only a small proportion of Manitoba children in care with complex needs, the findings are consistent with the issues described in the growing body of literature about the impact of multiple adverse life experiences on children and the deleterious outcomes they encounter, especially in adolescence.



## Education and Youth with Complex Needs

One of the key variables with significant amounts of missing data from the CFSIS database is information about the child's education status. Therefore, for the purposes of this project, permission was obtained from Manitoba Family Services and Manitoba Education to link the names of 271 youth ages 9 – 17 involved in the PPD Risk Issues population to their school data tracked by Manitoba Education (eliminating those children who were not yet old enough to go to school or to have significant school changes, as the database only tracks the school of registration each September; therefore, school changes within the academic year are not recorded). The following information about the school experiences of this population was generated as a result of this data matching.

Data was available for 244 of the 271 children (90%) in the sample. According to Manitoba Education, missing information was most likely due to the child attending a First Nations school (data which is not tracked in the Education database). The data provided identified whether or not the child was in school in September 2010 and their current grade. For children not in school in September 2010, their last recorded year of attending school was noted, as well as their last recorded grade.

School history was also provided to determine how many schools the child had attended throughout their school-age years on an annual basis; the history includes both normative school transitions (e.g. elementary to middle school) as well as annual school changes, which could be the result of the family moving prior to the child's admission to care, changes in school due to admission to care or placement breakdown, as well as the number of schools available in the child's community (such as a small community that combines both middle and senior years grades in one school). As children age, it is expected that they will experience more school changes: at a minimum, the majority of urban youth will attend three different schools in their lifetime, each school change considered to be a normative transition. Therefore, in order to assess the impact of school changes, only those youth with a significant number of school placements (6 or more for youth older than age 16; 5 or more for youth age 15; 4 or more for youth age 14; and 3 or more for youth under the age of 13) were considered as having a concerning number of school changes.

- **Seventeen-year-olds: 43 youth**

There were 29 youth age 17 who were still in school in September 2010. In high school, students are generally registered in the grade where they are taking the most credits, although they can take courses from any level of high school programming. Eleven youth were considered to be in an appropriate grade for their age, taking a majority of Grade 12 or Grade 11 courses. One student was in a Special Education program, also considered to be age/grade appropriate. Seventeen youth were not taking a majority of age/grade appropriate courses, with 15 in Grade 10 and 2 in Grade 9. Fourteen youth were no longer in school: 11 had not been in school for 1 year and 3 had not been in school for 2 years. The last recorded grade was Grade 11 (2 youth), Grade 10 (5 youth) and Grade 9 (7 youth). Twenty youth had attended more than six schools in their lifetime, ranging from 6 schools to 9 schools. Two youth had attended the school at the Manitoba Youth Centre, and 1 attended school at Marymount.

- **Sixteen-year-olds: 60 youth**

There were 40 youth who were in school in September 2010, with 27 taking age/grade appropriate courses (Grade 11 or 10 courses). Two students were in Special Education programs. Eleven students were not in age/grade appropriate programming, with 10 taking Grade 9 courses and 1 in Grade 8. Twenty youth were no longer in school, with 15 not in school

for 1 year, 4 not in school for 2 years, and 3 not in school for 3 or more years. The majority had last been in Grade 9 (15 youth), although 1 had been in Grade 10, 3 in Grade 8, 1 in Grade 7, and 1 in Special Education at their last enrollment. Twenty-one of this group had multiple school placements, ranging from 6 to 11 different schools in their lifetimes. An additional 13 youth had been enrolled in 5 different schools.

- **Fifteen-year-olds: 52 youth**

There were 36 youth enrolled in school in September 2010. Thirty would be considered in age/grade appropriate settings, with 7 students in Grade 10 and 23 in Grade 9. Additionally, three students were in Special Education. Three students were in Grade 8. Of the 16 youth no longer in school, 13 had not been in school for 1 year, and 3 had not been in school for 2 years. Last recorded grade was Grade 9 (6 youth), Grade 8 (6 youth), and Grade 7 (4 youth). Thirty-two youth had more than 5 school changes in their lifetimes, ranging from 5 to 10 different school enrollments. Eighteen youth had 6 or more school changes.

- **Fourteen-year-olds: 41 youth**

There were 32 youth still in school in September 2010, with 1 in Grade 10, 16 in Grade 9 and 15 in Grade 8. Nine youth were no longer in school, with 7 out of school for 1 year, 1 not in school for 2 years, and 1 out of school for 3 years. The last recorded grade was Grade 8 (3 youth), Grade 7 (5 youth), and Grade 6 (1 youth). Sixteen youth had four or more school changes, ranging from 4 – 7 different school enrollments.

- **Thirteen-year-olds: 14 youth**

Twelve youth were still in school in September 2010. Ten could be viewed to be in age/grade appropriate classes (with one in Grade 9, two in Grade 8, and seven in Grade 7, and one in a special education program), but one youth was listed as in Grade 6, not likely appropriate for the youth's age. Two youth were not listed in school in 2010 and both had not been in school for a year. The last recorded grade for each of them was Grade 7.

- **Twelve-year-olds: 14 youth**

There were 13 youth in this age group in school in September 2010. All could be considered to be in age/grade appropriate classes, with 7 in Grade 7, 4 in Grade 6, and 3 in a special education program. For the 1 youth who was not in school in 2010, the student had not been in school for 1 year. The last grade recorded was Grade 5.

- **Eleven-year-olds: 11 youth**

Ten of the youth were in school in September 2010, and all could be considered to be in a grade appropriate for their age: 5 were in Grade 6 and 5 were in Grade 5. For the 1 youth who was not in school in 2010, the student had not been in school for 1 year and was last in Grade 5.

- **Ten-year-olds: 6 youth**

All six children were in school in September 2010. Two were in Grade 5, two in Grade 4, and two in special education programs – all age/grade appropriate placements.

- **Nine-year-olds: 3 youth**

All three children were in school in September 2010, with one in Grade 4 and two in Grade 3, age/grade appropriate classrooms.

This sample of 244 youth who had been referred to the Provincial Placement Desk represents a segment of the population of children in care with complex needs. Information about the adverse life experiences they have faced and the impact on their behavioural and emotional functioning has been summarized in an earlier section of this report. Consistent with other research on at-risk children in school in Manitoba (Brownell, et al., 2010), children in this sample were at risk of not completing high school by the time they entered adulthood. Although the majority of youth were still in school up to age 13, the rate of school disruption increased by age 14. A third of youth were not listed in school at age 14, a rate that was consistent for the 15-, 16- and 17-year-old age groups. In total, of the 196 youth age 14 – 17 years of age in the sample, 59 (30%) were not in school in September 2010. Over 14% of the sample was not in a grade consistent with their chronological age.

Multiple school placements were mainly an issue for youth age 14 and older, partly a reflection of the smaller number of children in the younger age groups but also an indication that school disruption may be a phenomenon of adolescence in this sample. A total of 89 youth experienced multiple school placements (37%), with the upper range of about 10 different school placements for youth ages 15, 16 and 17. While normative school changes are also counted in this figure, the number of school placements that occur during an academic year are not tracked, suggesting that the number of youth with multiple school placements is probably under-estimated.

It is also notable that of the students still in school in September 2010, the majority were taking courses that were generally appropriate for their age. However, for those who were no longer in school, Grade 9 was most frequently identified as the last year that they had attended school, which corresponds with age 14, the normative age for Grade 9, when school disruption emerged as a concern.

Overall, this analysis provides some support for themes that have been found in other studies about the educational experiences of youth with complex needs. While placement breakdown (and moving to a new placement, which may be in a different school catchment area) and mental health issues are considered to account for a proportion of school disruptions, the importance of education as a factor of resilience and as a foundation for future life skills and employment cannot be overstated. The role of the education system in helping to retain youth in school merits review and the development of creative strategies.





## Supplemental Data

Additional data about youth with complex needs was also derived from reports and summaries that were generated for other projects by key stakeholders connected to the child welfare system in Manitoba. The main themes from these documents are summarized here.

1. *Emergency Placements for Children in Manitoba's Child Welfare System: An Update on Recommendations made by the Office of the Children's Advocate in the Hotel Review (2000) and the Review of the Operation of the Winnipeg Child and Family Services Emergency Assessment Placement Department (EAPD) Shelter System (2004) – Schibler and McEwan-Morris (2009)*

As a result of concerns about children and youth being placed in hotel rooms and emergency shelters due to a shortage of foster homes, group homes and residential treatment beds, the Manitoba Office of the Children's Advocate conducted two reviews (in 2000 and in 2004). In March 2009, an additional report was commissioned to assess the status of recommendations from the original two reports (Schibler & McEwan-Morris, 2009). For the purposes of this project, only those recommendations pertaining to youth with complex needs will be discussed.

The 2009 Update Report noted a number of service delivery trends over the past decade that have contributed to the difficulty of the child welfare system to meet the needs of children and youth with complex needs:

- the steady increase of the overall number of children in care in Manitoba;
- the shortage of foster homes and residential placements for youth with complex needs and high-risk behaviours;
- an overall increase in foster home beds and emergency foster placements due to a concerted recruitment strategy, which could not keep pace with the growing number of children in care, especially those with complex needs;
- the reduction in the use of hotel rooms as placements, except under strict criteria when no other option is available, coupled by the growth in the number of shelter facilities;
- the lack of treatment placements for children and youth with complex needs in most rural and remote communities of Manitoba;
- the increasing cost of providing care in an emergency shelter (mainly due to increased staffing costs);
- reliance on purchased-service staff to provide a large proportion of emergency care; and
- the absence of a centralized body to track, monitor and coordinate emergency placements throughout the province.

The report found that, although emergency shelter care was limited to 30 days (with provision for an additional 30-day extension) – a guideline that was mainly met for the majority of children placed in shelters – youth with complex needs were more likely to remain in emergency placement for longer periods of time due to the lack of alternative resources. Special care needs are met by limiting the number of children with complex needs in a single shelter, using double or (on occasion) triple staffing, hiring staff with specialized skills (such as health care aides), and providing staff with training to meet the child's specific needs. A high proportion of these youth come to emergency placement after discharge from the youth criminal justice system or a mental health facility, with the concomitant issues of behaviour challenges, aggression, violence, impulsivity, substance abuse, suicidality and

developmental disabilities. As noted by Schibler and McEwan (2009, p. 151), “the emergency shelter system is the only system that can’t refuse to [provide] care”.

Across these three reports, a number of recommendations were made to respond to the placement and service requirements of youth with complex needs. They included (with status noted in brackets, where available):

- development of a strategy to ensure integrated service planning for high needs children and youth (in progress through the creation of the Child Welfare Intersectoral Committee – CWIC – in 2008);
- establishment of a multi-disciplinary High Risk Youth Committee, including collaboration with police services, to plan for this high-risk population (established in 2006);
- review of the working relationship between the emergency shelter system and the Youth Emergency Crisis Stabilization System (YECSS), which provides community-based crisis intervention when children/youth are experiencing acute mental health or behavioural issues (some initial meetings occurred prior to 2009);
- collaboration between the Department of Family Services and the children’s mental health system to develop innovative and integrated approaches to service delivery (no progress);
- creation of an Educational Specialist for the emergency placement system to oversee and coordinate the educational needs of children in shelters;
- the development of a provincial continuum of care, targeted to at-risk youth, including coordinated assessments, prevention services, and early intervention supports; and
- a review of the Provincial Placement Desk and the restructuring of Group 2 resources.

While some steps have been taken on some of these recommendations since the release of the 2009 report, there has not yet been sufficient progress to significantly change the realities of meeting the needs of youth with complex needs. There are more and more children in care, too many long-term placements of children with complex needs in the shelter system, and too few options to adequately meet the multitude of needs that they face, both in the community and within the shelter system.

## *2. General Child & Family Services Authority Shelter Analysis: April 1, 2008 – March 31, 2009*

This report by the General Child and Family Services Authority (July 2009) reviewed the circumstances of 87 children and youth in the care of one of the Authority’s child welfare agencies placed in an emergency shelter for 60 or more continuous days, with at least one of those continuous days occurring during the 2008/2009 fiscal year. The intent of the analysis was to better understand why some children remained in shelters for extended periods of time and identify the predominant issues that might prevent them from being transitioned to long-term community placements. Issues experienced by the sample were those noted by the child’s social worker in CFSIS and were accepted at face value in the study as being ‘valid’ for that child. However, it was noted that the identified issues were likely an underrepresentation of actual occurrence of issues, due to the limited information entered into the relevant fields of CFSIS (the same issue identified in the data analysis for children in care in Manitoba described above).

The main findings of the 2009 study by the General Authority (GA) are consistent with the characteristics and issues of the PPD population described earlier in this report. The majority of youth in the GA sample were age 12 and older (64 youth, or 75%), divided fairly evenly between those age 12 –

15 years of age and those older than age 16. Only 7 children were younger than age five (6%) and the remaining 16 children (19%) were ages 6 – 11 years of age. About a third of the population was male. Almost half of the group was under apprehension (47%), with 23% in care under a VPA, 15% under a permanent order of guardianship, and 7% temporary wards.

All of the issues identified in the report were “consequence” issues; there was no information about “antecedents” – the kinds of experiences these children and youth had that might have led to these challenging issues. Most common issues were aggression (47 children or 54%, an issue that increased in frequency with advancing age of the youth) and mental health concerns (47 children/54%). The most common mental health conditions were ADHD (30%) and depression (16%), and 20 children and youth were suicidal or engaged in self-harming behaviours (23%). Almost a third of the sample was involved in criminal activities, and a quarter had addiction issues. Consistent with other studies (Fuchs, et al., 2005), 10% of the group were children with FASD. A small proportion (8 youth or 9%) were the only child placed in the shelter, suggesting that their needs were high and there may have been safety concerns that prevented the placement of other children in the same shelter. Of this group, all but one were noted to be aggressive.

### *3. Winnipeg Child and Family Services Complex Case Committee*

Since 2008, a Complex Case Committee has been in place, bringing together staff and senior management of Winnipeg Child and Family Services (WCFS), the General Child and Family Services Authority, the provincial Community Service Delivery Branch, and the Director of Programs at the Manitoba Adolescent Treatment Centre to review high risk complex cases. The committee reviews about a dozen cases per year, inviting stakeholders and service providers relevant to the child’s issues to the case discussion. In addition to resolving case-specific service and placement issues, the aim is to also address systemic issues that affect more than one child or youth with complex needs.

A summary of issues facing the children and youth who are the subject of these complex case reviews was provided for the purposes of this report. Of the 44 cases reviewed since 2008, 14 (32%) youth experienced mental health issues, with 5 also at risk of suicide. Concerns about cognitive functioning were identified for 11 youth, with an additional 6 diagnosed with FASD. Some youth were engaged in risky behaviour, such as substance misuse (7 youth), criminal activity (5 youth), and being sexually exploited (4 youth). Most of the youth had a multitude of issues that they were facing.

Service planning issues often revolved around securing or developing a specialized community placement, accessing mental health supports, and identifying appropriate adult services once the youth transitioned from child welfare care at age of majority. The need for a comprehensive assessments, mainly for mental health functioning, intellectual functioning (for referrals to adult services) and behavioural management strategies, was a common feature of case plans that emerged from the Complex Case Reviews. Many of the children and youth reviewed were considered eligible for Level V funding. In all cases, multiple systems were involved in the provision of services (mental health, youth criminal justice, Winnipeg Police Service, disability programs, education, FASD services, emergency shelters, Provincial Placement Desk, and placement specialists from the Authority and the Child Protection Branch.



## PROVIDING SERVICES TO YOUTH WITH COMPLEX NEEDS IN MANITOBA – PERSPECTIVES FROM THE FIELD

One of the key aspects of this review of youth with complex needs was exploring the perspectives of the various service sectors that serve this challenging population – in particular, focusing on those systems that provide specialized care, programming and services related to specific therapeutic issues, and collateral systems that concurrently serve the same population (mental health and the youth criminal justice system). Interviews were conducted with more than 40 representatives from child welfare, residential treatment, disability services, child and adolescent mental health, adult mental health services, youth criminal justice, education and other specialized programs, focusing on the sectors that are involved in providing care to youth with complex needs and intersect with the child and family services system due to the multitude of issues facing youth with complex needs. To aid in the confidentiality of comments from those who participated in interviews, the findings from the interviews are collated into themes based on the main findings from the literature review. Their comments are supplemented by references to the professional literature and current programs and policies in Manitoba. The list of participants is included in Appendix 1.

1. *The similarity in neurological processes that create attachment as well as trauma cannot be ignored. It appears that the development of resilience also involves similar processes, although literature describing the neurobiological development of resilience is not well developed.*

The impact of trauma on the lives of youth with complex needs was identified as a fundamental issue by the majority of professionals who participated in interviews for this project. They also recognized how relationship development (and attachment work) can be an important component of healing from trauma. However, respondents also felt that in general, there is not a good understanding of the importance of trauma work, especially before children reach adolescence, to mitigate the negative effects of trauma. A year delay in treating trauma can have a significant impact on the manifestation of trauma symptoms and compromise the child's development and functioning, participants noted. Trauma work needs to be incorporated into all sectors where children and youth receive services, with child welfare, justice, and education specifically mentioned as sectors where trauma-focused interventions need to occur.

Too often, the focus is on the problematic behaviour, without looking at the origins of that behaviour, respondents said. This phenomenon was evident in examining the characteristics of the youth referred to the Provincial Placement Desk who were characterized as needing 24 hour care and supervision; 'consequence' issues were commonly documented, while 'antecedent' issues were not, leaving gaps in our understanding of why this sample of young people was struggling so much.

Many respondents distinguished between trauma and mental health disorders. Trauma can be viewed as an issue that underlies other diagnoses, including various mental health disorders. A more detailed review of their thoughts about the differences (and similarities) between trauma and mental health is provided under #18 and #19, below. In general, the lack of supports and services to respond to either trauma or mental health issues was identified as a serious concern that needs systemic attention.

One respondent noted the recent establishment of the Manitoba Trauma Partnership, an outcome of a 2007 provincial forum on trauma, intended to "promote and facilitate systemic change in order to increase the capacity of organizations and systems to better respond to needs of people

affected by trauma, and increase the capacity of individuals, families and communities to recover from trauma” (Manitoba Trauma Partnership, 2010, p. 4). The forum resulted in a number of recommendations, including the creation of a trauma toolkit for practitioners (available since 2008 at nominal cost from Klinik Community Health Centre, and viewable at <http://www.trauma-informed.ca/>), standardized trauma training (available through Klinik), and the establishment of a comprehensive trauma recovery system and resource centre (Proulx & Nighswander, 2007). The first planning day for a trauma care centre was held in 2009 (Proulx, 2009). While the population to be served at this centre will include children, it should be noted that the child welfare system was not involved in any of the planning activities related to enhancing the response to trauma in Manitoba.

Finally, participants noted that the long-term cost of trauma to society was significant, considering the scientific evidence of trauma’s effect on physical and mental health, as well as on behaviour and overall development, and ultimately, on adult functioning and parenting of one’s own children. One individual stated “Governments need to realize that the costs they prioritize – health, justice and education – are exacerbated by the needs of people who were traumatized in childhood, did not have their traumas addressed, and became struggling adults. We need to invest in children, and especially in those children and youth who are compromised by adverse life experiences”.

- 2. Prenatal experiences can help to set the stage for optimum development at birth, through prenatal care and intervention to address socioeconomic factors that can compromise both maternal and child health.*

With the focus of interviews on youth with complex needs, many respondents did not speak specifically about prevention strategies that precede the birth of children, focusing mainly on the population of adolescents that they actively serve. However, there were some comments made about the importance of the primary prevention of adverse childhood experiences, such as abuse, neglect, and parental substance abuse. Participants cited programs such as Families First, which provides a universal screening for all new off-reserve births to identify risk factors and the need for home visiting, a support that is available to families with children up to 5 years of age, as an important primary prevention model. It was also recommended that social services programs, such as child welfare and disability programs, could look at how to work with families to reduce risk factors, build on family strengths, and prevent the admission of children to child welfare care. The differential response model underway in Manitoba’s child welfare system is one pathway to this kind of primary prevention and support work.

- 3. Preventing use of alcohol and other substances during pregnancy is an important component of prenatal care, to reduce the incidence of Fetal Alcohol Spectrum Disorder (FASD) and other effects from prenatal substance exposure, which can have a profound effect on functioning throughout childhood and adolescence, including the manifestation of complex needs.*

Respondents were keenly aware of the challenges of providing services to youth with FASD. Despite this awareness, they recognized that there were not enough services, specialized placements, or program adaptations to adequately meet the needs of youth affected by FASD. The lack of diagnoses of the condition was identified as a barrier, as it is sometimes difficult to confirm maternal alcohol use during pregnancy (one of the key diagnostic criteria, according to Chudley, Conry, Loock, Rosales & LeBlanc, 2005). Without diagnosis, participants said, youth may not get the educational supports they need, may not receive the right community services in a timely way, or may be punished by the youth criminal justice system for criminal behaviour they could not developmentally comprehend as wrong or illegal. Innovations such as the Manitoba Youth Justice Project (Harvie, Longstaffe, & Chudley, 2011)

were identified as important strategies to ensure that youth with FASD receive treatment, not incarceration, where appropriate. The vulnerability of youth with FASD to be exploited by gangs to commit crimes, due to the likelihood that they may not get in trouble with the law due to their disability, was mentioned by several individuals.

Participants did not speak specifically about their role in the primary prevention of FASD, as most often, their role was to work directly with the young person affected by the condition. However, given that parental substance abuse is associated with childhood maltreatment (Sheridan, 1995; Trocmé, et al., 2010), the role of child welfare in responding to issues of parental substance abuse can be considered an important component in reducing the prevalence of FASD and identifying alcohol-exposed children and adolescents who need supports. Considerable research suggests that parental substance abuse is a common issue that brings families to the attention of child welfare systems, estimated to affect 40% to 80% of families involved with child welfare (Besinger, Garland, Litrownik, & Landsverk 1999; Curtis & McCullough, 1993; Department of Health and Human Services, 1999; Dore, Doris, & Wright, 1995; McNichol & Tash, 2001; Semidei, Radel, & Nolan, 2001; Young, Gardner, & Dennis, 1998), putting child welfare systems in a key position for early intervention. Again, differential response programs targeting families with substance abuse issues are one approach to addressing this issue, which may reduce the occurrence of FASD, as well as traumatic experiences such as child maltreatment.

- 4. Other contextual and environmental variables that can increase vulnerability for children and their families are the traumatic legacy stemming from the residential school system, trauma from civil war atrocities experienced by refugee children and their families, poverty, oppression, and discrimination. These factors affect the capacity for caregivers to parent their children in a nurturing, safe, and supportive way.*

The high proportion of Aboriginal youth involved with the child welfare and criminal justice systems was recognized by the professionals interviewed for this report. Poignantly, one individual noted that for some Aboriginal youth with complex needs, there is often no family involvement once a youth is in care, either due to protection concerns or ongoing dysfunction of the parents: “The system is all the youth has”. Consequently, the importance of having culturally appropriate caregivers and service providers was emphasized by many respondents. Some mentioned that this could be achieved by building the capacity of Aboriginal service providers through training (such as training in trauma-focused services and in attachment disorders), but there was also strong weight placed on the need for all service providers in all sectors to have a better understanding of how the residential school system continues to exert a traumatic influence on many First Nations families. Additionally, this work needs to occur at the administration level, involving key decision makers who initiate, develop, support and guide programs and services throughout the system, respondents stated.

Throughout the systems that work with youth with complex needs, opportunities for cultural programming, access to an elder, and developing a healthy sense of cultural identity need to be provided. This kind of cultural training could be a preventative force, helping to reduce criminal activity and problematic behaviour, participants said. Many of the organizations that respondents represented have incorporated spiritual healing and cultural programming into their roster of services, as have the child and family services Authorities and their agencies, but more development and integration of cultural values is needed.

An additional traumatic outcome of the residential school system was the response of the child welfare system during the 1960s, where many First Nations children were apprehended from their families and raised in foster care, without opportunities to learn about, appreciate, and experience their cultural heritage (Bennett, Blackstock, & De La Ronde, 2005). It was raised by one respondent that today's child welfare system may be sensitive to criticism about the system's role in the '60s scoop' and, in an effort to not replicate those practices, may leave children in vulnerable situations too long, increasing their exposure to adverse life events. Training that integrates the historical experiences of Aboriginal people and its effect on trauma, attachment, and parenting will help staff throughout the child welfare system to become better skilled at assessing risk to children and making decisions about intervention.

5. *Attachment is a fundamental neurodevelopmental process that creates an internal framework from which the child sees him/herself in relation to others in the world. The quality of the child's attachment is predictive of future social, psychological, behavioural and cognitive functioning. Secure attachment may be a protective factor in the face of life adversities; insecure attachment adds to the vulnerability of the child for poor outcomes when faced with adverse experiences.*

Awareness of the importance of attachment processes has grown considerably in the past decade and respondents were very cognizant of the impact of attachment disorders on the lives of children and youth, especially those with complex needs. They also maintained that there is not enough knowledge about attachment development and attachment disorders throughout the service systems that work with youth with complex needs. This expertise is critical, they stated, because so many youth who have been traumatized also struggle with attachment. Participants also noted the scarcity of resources available to do reparative attachment work with this vulnerable population. Additionally, they stressed the importance of considering the youth's extended family in attachment work, including natural as well as formal supports in the youth's circle of care network.

Essential to attachment work is ensuring that youth with complex needs have stable, loving environments to live in. Since placement breakdowns can be both the outcome of attachment issues as well as a contributing factor to the exacerbation of attachment issues, there was recognition that foster parents need considerable support – through training in attachment and trauma, consultation with behavioural and mental health professionals, and other resources such as consistent respite arrangements – to minimize placement disruptions, especially during adolescence. Matching the needs of youth with the skill sets of foster parents was viewed as a critical step towards fortifying placement stability (which, of course, requires that comprehensive assessments be conducted to understand what youth need in placement). Further, respondents stated, it is important to help foster parents see that behaviour issues, often an expression of attachment issues, are not indicative of failure on the part of caregivers. Foster parents need to be prepared for how youth with attachment disorders may enact these problematic patterns in their environment, and that these challenges are 'normal' and 'expected' expressions of attachment issues that can be navigated, with support from the system.

Treatment foster care works with many youth with complex needs who have attachment disorder, but not every child can succeed in this type of placement. Participants noted that foster care placements may not be effective when foster parents cannot engage with the child due to the child's behaviour, when the child has significant defense mechanisms due to multiple moves throughout his/her life, when the child is not motivated by relationships, and when the child has been diagnosed with reactive attachment disorder, the most severe and rare type of attachment disorder, caused by



parental rejection and severe neglect and/or abuse and characterized by children being emotionally removed and distrustful (Kagan, 2010).

Whether treatment foster home, group home, or residential care facility, respondents asserted that collectively, we don't focus enough on relationships in our work with youth with complex needs. Part of the gap in relational work is built into the system's infrastructure: youth transition from one placement to another (for example, due to licensing restrictions based on age for group homes, requiring children to move from one group home to another upon reaching adolescence), but may experience no continuity of caregivers or staff, even in these normative transitions. Placement breakdowns result in youth being placed in new communities, disrupting relationships with neighborhood supports and local schools. High turnover of staff in child welfare agencies also disrupts relationships between youth and their case managers, and it takes time for new workers to get to know the youth on their caseloads, especially if caseloads are high. Staff turnover affects group homes and residential care facilities as well. Without staffing stability, teams are not relationally connected and coordinated, which impacts staff's ability to engage with youth in their placements to build trust. Emergency shelters have to rely on shift staff from external community care services, meaning that youth in shelters may not have the same caregiver from day to day. Relational models are more challenging to implement in youth detention centres because periods of incarceration may be of short duration, and staff may not 'buy in' to a relational philosophy, as it may be viewed as contradicting the corrective function of criminal justice systems. One professional stated that we don't know who is expected to provide a relationship to youth with complex needs: CFS workers? Group home staff? Residential care staff? All of the above? Too often, the overall result is that youth lack relational connections in all aspects of their lives.

Attachment training will address some of the issues identified by participants. Other barriers, like high caseloads, staff turnover, and the lack of continuity of relationships through periods of transition, will require the development of other strategies to strengthen relationship continuity for youth with complex needs.

6. *There are many well-known and well-researched adverse life experiences that can have profoundly damaging consequences on the development and functioning of children and adolescents: physical abuse, sexual abuse, neglect, exposure to intimate partner violence or other forms of family violence, emotional abuse, parental substance misuse, lack of family cohesion and stability, poverty, maladaptive parenting, childhood disabilities, FASD, to name some of the major risk factors reviewed in this report.*

While some systems (for example, the child welfare system) are familiar with the issues listed above and their negative impact on children's functioning, other systems (the education system and criminal justice system were two mentioned by participants) are just beginning to recognize the impact of these adverse childhood experiences (ACEs) on how children and youth function. Professional development training for practitioners throughout the service sectors to build awareness of how ACEs affect children and adolescents is one strategy put forth by respondents to strengthen service delivery to those with complex needs. Foster parents were also identified as needing training in the effect of trauma and other ACEs at different ages/stages of child and adolescent development.

Consistent with the professional literature, respondents agreed that the emotional impact of ACEs experienced by children seem to intensify in adolescence, and are often expressed through problematic behaviour. Unresolved trauma and mental health issues were identified as the main

underlying causes of behaviour problems, from their perception. Without attention to these origins, respondents felt that it is more difficult to have success in helping youth to develop self-regulation skills. The need for early intervention was emphasized by many participants. However, regardless of their origin, behaviour issues were cited by participants as the most common reason for placement breakdown, school suspension, and referral for specialized placement in adolescence. Behavioural issues were also identified as one of the most challenging issues for the system to address, with many youth with behaviour problems ending up in the shelter system.

Even children who had no prior involvement with the child welfare system were more likely to come into care due to challenges that became exacerbated in adolescence. This phenomenon was specifically noted for children receiving provincial disability services. When parents feel overwhelmed by the care demands of a child with disabilities or complex medical needs, there are limited in-home and respite supports available; consequently, parents often turned to the child welfare system for their children to be admitted to care when they are no longer able to cope. The lack of specialized placements to manage the needs of children with disabilities, especially significant developmental delay and cognitive disabilities, often means that families wait months, and reportedly, sometimes years, for an appropriate placement to become available. In critical situations, these youth may be placed in an emergency shelter until an appropriate long-term placement is available or developed.

*7. The risk factors mentioned above can be considered antecedents to deleterious outcomes for children: mental health issues, Post Traumatic Stress Disorder (PTSD), aggression, behaviour problems, education disruption, self-harm, suicidal ideation, adolescent substance abuse, criminal involvement, violence, sexual exploitation, among others.*

While child and family services workers may be aware of how adverse childhood experiences may place children and youth at risk, participants asserted that they do not have enough training or expertise to always be able to assess the impact of these life events on children's functioning. Referrals made by CFS workers for specialized placements (treatment foster home, group home or residential care) were often not accompanied by a comprehensive assessment of the youth's needs and how specialized placement could meet those needs. To quote one respondent, "We have to be able to anticipate what comes next when kids have had adverse life experiences", in order to arrange the right kind of placements and support services for youth with complex needs.

Participants described a systemic environment where placements break down due to youths' behaviour issues, but with an alarming lack of skilled placements capable of managing youths' challenging needs in the community, youth often end up in an emergency shelter waiting for a specialized placement. Due to the risks associated with escalating issues in adolescence, placement instability, and lack of relationships with family/extended family or consistent caregivers, youth are more vulnerable to substance misuse, running away, sexual exploitation, criminal activity, self-harm, suicidality, living on the street, and victimization by others. Within the context of intense public scrutiny and the fear of liability that child welfare agencies face, the crisis nature of this systemic environment leads to a perpetual focus on "keeping the youth alive until adulthood", according to one professional.

Respondents raised challenging questions about what outcomes all of the systems hoped to achieve for youth with complex needs: Safety? Stability? Health? Skills? Well-being? Without knowing what the goals are, in an environment of 'not enough resources' and 'prevent a tragedy from occurring today', it is harder to know how to capitalize on what is available within the current service

network, identify the gaps, and develop strategies to meet the needs of youth with complex needs more comprehensively.

8. *Risk factors, that is, adverse life experiences, do not necessarily occur in isolation from one another, making it more difficult to determine the potential overall impact on a child's functioning, or the individual impact of specific types of adversities on child well-being.*

Too often, contributors to this project stated, issues experienced by youth with complex needs are categorized and compartmentalized, which only results in service fragmentation and gatekeeping, preventing youth from getting the supports they need. As noted earlier, behaviour issues are the most common manifestation of multiple origins, and the system needs professionals who can meet youths' needs by focusing on the common skills and interventions that lead to improved functioning. Most youth with complex needs have multiple diagnoses, and their treatment needs cannot be divided across services and treated in isolation. While specialized skills and knowledge are required to a degree, the extent to which they contribute to service fragmentation is concerning.

The issue of fragmentation was seen as a barrier to resource development. When individual issues exclude youth from some services or placement options, or when no existing services have expertise in a particular issue, there is pressure to develop resources that deal with that specific issue. One example raised was the range of specialized services developed to meet the needs of sexually exploited youth in recent years (*Tracia's Trust, Manitoba Family Services and Housing, 2008*). However, sexual exploitation is usually only one part of the youth's struggles, requiring partnership with other types of treatment and other service sectors. The multitude of issues that are characteristics of 'complex needs' means that all organizations that serve youth with complex needs have to develop the capacity to manage the realities of polyvictimization, and the realities of inter-dependence across service sectors in the province. For one respondent, these realities only highlighted how the four child and family services Authorities don't have the capacity nor the resources to develop appropriate resources without partnerships with other organizations and service sectors.

9. *The number of risk factors that children and youth experience – polyvictimization – can be considered one measure of 'complex needs', as the literature generally demonstrates increasingly compromised functioning as the individual endures more and different types of adverse life events. Deleterious consequences, based solely on the multitude of risk factors, is highest for preschool children, as children at this stage of development are most vulnerable to permanent brain adaptations that incorporate the experience of trauma.*

Many respondents maintained that throughout the system, we are missing opportunities to address trauma early, when children are young, which may help to mitigate the effect of issues at adolescence. In particular, there is a need to develop foster homes for younger children who have been traumatized, train foster parents to support children with a trauma focus, and prepare them for the challenges of caring for youth with complex needs through adolescence. We need to think about the future implications of our placement decisions, of our interventions (or lack of interventions), to prevent the exacerbation of issues.

This is difficult for the child welfare system, among other service sectors, because of the tendency to practice from a risk aversion model, not a risk management model, participants asserted. The complexity of issues affecting children in care has increased in the past decade, especially in terms of family-of-origin issues, violence, and trauma, but we have not increased the capacity of the system –

through skill development of staff or corresponding salaries – to respond to these complex issues. A preventive strategy identified by one participant was to focus on 7 – 10-year-olds who have had experiences of abuse or trauma: As we provide stability, treatment, and other supportive interventions, we may reduce the number of children whose issues become ‘complex’ in adolescence.

*10. Risk factors may occur as a single event of severe intensity or impact, or may be chronic, extending over long periods of time. Research has not yet determined if there are differences in risk between single vs chronic adverse experiences (and such determinations may be elusive, given the complexity of how risk factors interact with one another). However, severity and chronicity should be viewed as important considerations of the definition of ‘complex needs’.*

The most difficult issues to deal with, according to respondents, are self harm/suicidal ideation, violence toward staff, mental health disorders, sexual offending behaviour, and significant cognitive delay – each of which manifests itself in concerning behaviour. These are often conditions that contribute to placement breakdown or prevent admission to placement altogether, as organizations state they do not have adequate staffing or the requisite skillset to provide safe care, due to risk to the youth themselves, to other youth in the placement, or to staff. The limited resources for youth with these severe issues contribute to the crisis mindset that plagues decision-making in these situations. Therefore, the intervention of choice becomes whatever keeps the child safe that day, they stated.

Too often, the intervention of choice – extended placement in an emergency shelter – begins as an intervention of default. As noted in the review of a sample of cases of youth with complex needs referred to the Office of the Children’s Advocate, when no other placement option exists, youth are placed at emergency shelters. To respond to these youths’ high needs, the Emergency Placement Resources (EPR) program, which manages the shelter system, has been forced to “rise to the occasion” by keeping a shelter limited to an individual child, employing double or triple staffing, providing specialized training to staff, and, in one case, hiring a security guard to ensure the safety of staff. Over time, youth may respond favourably to these efforts to create a consistent, caring environment in the shelter, and when they stabilize, child welfare case managers are reluctant to move them if another placement option becomes available in the community. Respondents noted that long-term care isn’t the intended purpose of EPR shelters, and the costs of providing youth with the necessary supports and safety measures to “rise to the occasion” were significant, but currently, there appear to be no other pathways to pursue.

However, some respondents did feel that other pathways could be possible, but require adequate funding to hire and train staff who could meet the needs of youth with exceptionally complex needs. More than one participant commented that the high level of funding to adapt a shelter to an individualized placement was usually expended after similar proposals by other organizations were turned down by the Child Protection Branch due to the projected costs. There were also examples raised of placement plans that were only accepted after the youth had already spent a year in a shelter without receiving the full roster of supports he or she needed, adding to the severity of issues experienced by the youth. Respondents contended that these were illustrations of how the system itself perpetuates the development of complex needs.

Participants also noted that each service sector had different interpretations of severity of issues. For example, some felt that schools had a low threshold for what constitutes “violence”, resulting in too many youth being suspended from school for relatively minor behaviour infractions, with no plan for school reintegration. The disruption in school involvement easily becomes permanent

for youth with complex needs. As discussed earlier, one-third of the youth in Manitoba in the child welfare sample examined for this report were no longer in school in 2010. Others noted that for youth involved with the criminal justice system, the severity of criminal charges may not be indicative of the complexity of youth's issues; a youth may be charged with a very serious crime, but the crime may have been situational and out of character for the youth. The nature of the charge, however, may prove to be a barrier for placement in a specialized environment.

*11. Despite the challenges in determining the impact of individual risk variables, research has identified childhood sexual abuse as a particular type of adverse life experience that tends to have more profound emotional and psychological effects than other risk factors.*

In the past decade, a comprehensive strategy to respond to the sexual exploitation of youth has been implemented in Manitoba (*Tracia's Trust*, Manitoba Family Services and Housing, 2008). This progressive strategy has generated a range of placements, programs, and supports for sexually exploited youth and has been an example of intersectoral collaboration and partnership. Information about the youth who make use of these programs confirms their histories of childhood sexual abuse, according to respondents.

However, the trauma of childhood sexual abuse is not specifically treated to the degree this issue merits, respondents have said, until youth become involved in exploitation services. This leaves too many youth with unresolved trauma related to their childhood experiences of being sexually abused and increases their vulnerability for being sexually exploited. Given the devastating impact that childhood sexual abuse has on children, well articulated in the professional literature, we need to do more to address the foundational trauma, instead of intervening only once youth are entrenched in a life of exploitation. Respondents spoke of a general reluctance in the system to deal with childhood sexual abuse. Disclosures are supposed to be "spontaneous", so workers don't ask if children have been sexually abused. For youth with multiple issues, sexual abuse may not be specifically identified or recognized for its unique bearing on an individual's functioning.

It has been the experience of participants that youth who are being sexually exploited are dealing with a number of concerns: Post Traumatic Stress Disorder (both from adverse childhood experiences as well as from what may have happened to them in the sex trade), FASD, mental health issues, aggression, violence, ADHD, among other difficulties. The importance of comprehensive services, including supports from service sectors such as mental health, was emphasized by respondents. It was also recognized that knowledge of sexual exploitation was also important for those who work in other service sectors. For example, as partners in the Manitoba Sexual Exploitation Strategy, staff of the Manitoba Youth Centre are cognizant of the dynamics of sexual exploitation and can focus efforts on planning for the safety of sexually exploited youth when they are discharged from youth detention, even if their period of incarceration is relatively brief.

*12. While it is generally accepted that emotional maltreatment is detrimental to child well-being, it is a construct that has eluded operational definition and measurement. However, recent research has resulted in the development and field-testing of a promising assessment framework that can be used by many practitioners at the field level to more consistently assess the occurrence of emotional abuse.*

Respondents did not comment specifically on emotional abuse to a great extent – perhaps a reflection of the challenges in defining and assessing this type of maltreatment, as discussed earlier in

this report. However, a few participants stated that more training in the impact of emotional abuse was warranted. In particular, their remarks were directed toward staff of the child welfare system, citing examples where youth from stable placements were reunited with biological family with seemingly little recognition of the unhealthy emotional dynamics of family that were still unresolved, with the subsequent deterioration in functioning in the youth after reunification.

*13. The adolescent brain does not complete its development until well into early adulthood.*

*Consequently, youth are vulnerable to poor decision-making and risk-taking behaviours without fully appreciating the possible consequences of their actions. However, the promise lies in the fact that, because development is not yet complete, there is still opportunity throughout adolescence and into early adulthood to provide a reparative experience for youth with complex needs.*

While acknowledging that development continues into early adulthood, participants still stressed the importance of providing as many services as possible before youth reach age of majority. Part of their rationale was that earlier intervention may prevent more compromised functioning, but respondents also recognized that youth may not be able to access the same range of services once into adulthood, so maximizing the opportunities available in adolescence was critical. Protective strategies such as keeping youth engaged in school throughout adolescence (or reintegrating them back to school after education disruption) give youth more skills and more options in adulthood. The education system has found that youth tend to do better in school once they reach adult age, but they need to stay engaged with the education system to feel motivated to continue with school into adulthood. Additionally, providing youth with a stable living arrangement also sets the stage for more effective treatment to address their issues in functioning. Having a safe place to live, consistent caregivers, and emotional support may be even more effective than weekly counselling sessions, which some adolescents struggle with because of their limited capacity for insight at this stage of development. Without these efforts, youth with complex needs are vulnerable at adulthood to living in poverty, living with an abusive partner, transient housing, and a lack of social supports, they stated.

Many participants asserted that the opportunity to extend care through the child welfare system into early adulthood is an important resource for youth with complex needs, as their compromised functioning leaves them quite unprepared for the challenges of autonomous adulthood at age of majority. However, extensions of care are only available for youth who are permanent wards. Additionally, providing care to young adults through extensions of care is fraught with issues that are not yet easily resolved. The emergency shelter system often cannot accommodate youth who are extended into adulthood due to licensing restrictions against facilities placing children and adults together, especially if the youth commits a crime, as they are charged as an adult. Youth in extended care are also able to engage in behaviour that is otherwise prohibited for adolescents (consumption of alcohol, for example), which contradicts the general expectations of behaviour within group care environments. Respondents noted that youth were sometimes discharged from extended care if they violated the expectations placed upon them, such as not attending school. Finally, participants argued that youth in extended care need different options for community placement that are responsive to their complex needs, such as supported independent living, and landlords who are understanding of their challenges. The announcement of the Manitoba Youth Transitional Employment Assistance and Mentorship project (MYTEAM) in 2009 (Government of Manitoba, 2009) to help youth aging out of temporary care of the child welfare system is a promising step in this direction, but to date, has not been widely implemented.

Planning for transition to adulthood is critical, whether that transition happens at age of majority or after a period of extended care. However, respondents felt that transitional planning was inconsistent throughout the child welfare system. One of the main barriers to transitional planning is the high turnover of CFS staff, respondents stated, as new staff are often unfamiliar with the needs of youth with complex needs on their caseloads and the availability of adult services to meet their needs. An additional factor is the lack of clarity as to when transition preparations should begin, despite the availability of provincial guidelines that recommend initiating transitional planning when the youth reaches the age of 16 (Healthy Child Manitoba, 2008). Other literature suggests that youth are not developmentally ready to take advantage of transitional services, such as independent living skill development, until the latter stages of their development in early adulthood (Fuchs, Burnside, Reinink, & Marchenski, 2010). Respondents stated that we need to respect youths' readiness for transitional planning in order to optimize the benefits they can derive from these kinds of services.

Activities that will facilitate smoother transitions to adulthood for youth with complex needs were identified by participants as comprehensive assessments (particularly assessments that will help confirm eligibility for adult services), training and support for foster parents to prevent placement breakdown in adolescence, resolving licensing conflicts between the child welfare system and the adult system (especially for those youth who are able to continue to live in the same placement into adulthood), and more collaboration with the range of adult services that are available. Youth in extended care are viewed through an outdated lens, asserted one participant – like children who have to comply at all times or agencies will terminate their placement and extension care. Policies need to be reviewed and developed that reflect the realities of delivering services to youth, who are technically adults, who have complex needs. Finally, one respondent suggested a common table of representatives from the various adult services could be formed, where child welfare workers could consult about appropriate adult services for youth with complex needs and bridge transitions to adult services in advance of the youth reaching age of majority.

*14. Substance use during adolescence influences brain development, can temporarily impair impulse control and decision-making capacity (leaving youth at risk for unsafe choices), and may result in permanent brain alterations that lead to adult addictions.*

Youth with complex needs are at risk of substance misuse at an early age, participants noted, especially if their mental health needs are not being addressed, as substances can be a means to blocking emotional disturbances through self-medicating. Heavy substance abuse can be a barrier to effective treatment and is associated with risky lifestyle activities to support one's addiction, such as sexual exploitation (in exchange for drugs or alcohol) and criminal activity. One participant has found that some youth even experience a rush from their criminal activity, a dopamine high that is similar to the effect derived from substances which only reinforces criminal behaviour. Addictions treatment needs to be incorporated into placement planning and integrated into the range of services youth with complex needs require.

*15. Research into resilience identifies a number of variables – individual, family, community, and cultural – that help to protect the individual from the negative outcomes of risk. However, we need to consider that the expression of resilience may sometimes look different than what we expect: at-risk youth who display defiance, act in rebellious ways, and identify with a negative peer group may derive a sense of empowerment from these characteristics, which should be viewed as a form of resilience.*

Participants acknowledged that organizations struggle with youth who won't engage in services or who refuse services, especially those who are involved in risky lifestyles, such as sexual exploitation or criminal activity. There is recognition that a degree of rebellion against the structure of services and the rules of organizations is normative for adolescents, but viewing this behaviour as a precursor to resilience is a new perspective. One respondent pointed out that specialized placements take youth out of 'normative society' and opportunities to have safe social outlets, places to meet friends and be part of a peer group are important considerations that help to foster resilience.

*16. The consequences of adverse life experiences on the youth's functioning often necessitate the involvement of multiple services providers: child welfare, mental health, youth corrections, education, and youth addictions services. Admission to the formal care of one or more of these systems is common: foster homes, group homes, or residential care facilities (child welfare), hospitals (mental health), youth detention facilities (corrections), or residential treatment programs (youth addictions). Specialized facilities for youth who have been sexually exploited generally fall under the child welfare system's purview.*

The professionals who participated in these interviews represented a wide range of programs and service sectors, each of which has involvement with youth with complex needs. Participants noted that youth with complex needs often required placement in more than one of these systems of care throughout adolescence, but the pathways to placement were not smooth. The involvement of multiple service providers and placements often occur as a result of crisis: placement breakdown, school suspension, criminal justice involvement, self-harming behaviour, aggression towards others, and other significant behavioural issues. Suicidal ideation is often viewed as an unmanageable risk factor, generating fears of liability and blame of the system if a youth completes suicide. There are few specialized services or placements available for youth with complex needs in rural or northern communities, requiring that youth move to Winnipeg, often after situations have reached a crisis point. Referrals for services or specialized placement are met by long waitlists, ineligibility for services if the presenting issue is interpreted as behavioural in nature (as opposed to a consequence of mental health issues), and no mechanisms exist to meet critical service needs through other means (such as private service providers), respondents said. These delays only add to the complication of issues for youth.

In particular, detention at a youth criminal justice facility was considered to be most disruptive to the continuity of services being provided to youth with complex needs, respondents said. Too many youth are detained at the Manitoba Youth Centre (MYC) due to breaches, not actual charges, and breaches are a manifestation of the youth's primary issues: substance misuse, trauma, mental health issues, etc. When youth are detained at MYC, the healing benefits of placement, support services, and other treatment interventions already in place for the youth in the community lose momentum. In youth detention, therapeutic work often doesn't begin until after the youth's court case has been adjudicated (so that they do not incriminate themselves), adding to the delays and disruptions in treating the youth's issues. This is especially true for youth facing sexual offence charges. During incarceration, placements end and youth are placed back on the waitlist for placement services; upon discharge, planning for services and specialized placement often has to start all over again. Respondents advocated for stronger working relationships between child welfare and youth criminal justice to develop better ways to support youth who are detained to MYC through their admission, period of incarceration, and their discharge back into the community. It was also noted that the philosophy of youth corrections practice needs to include a stronger emphasis on addressing the antecedents of criminal behaviour – trauma and mental health issues, specifically – not just the reduction of criminal behaviour and anti-social thinking. Without this philosophical shift, youth with complex needs



(reportedly the vast majority of incarcerated youth) remain without treatment services until their discharge to the community.

*17. The literature generally reports fragmentation and lack of coordination between these service sectors, as jurisdiction over the youth's treatment is guided by differing legislative criteria that determine eligibility and length of service, contradictory definitions and assessments of the child's needs, diverse treatment philosophies, lack of clarity over case management responsibilities, and overall lack of resources, especially as it pertains to youth with complex needs.*

The fragmentation of services for youth with complex needs was a frequent theme throughout the interviews for this project. Respondents spoke about eligibility criteria that seemed to serve 'gatekeeping' or 'turf war' functions, especially in relation to the provision of mental health services to youth with complex needs (a theme that will be discussed more fully in #18 and #19 below) or the IQ criteria used to determine eligibility for adult disability services. Their criticism about being unable to access the services youth with complex needs require was, in many respects, a reflection of the overall paucity of resources available to this vulnerable population. One respondent noted that "everyone is vying for the same limited resources...the system is set up to compete with one another". This competition for resources was evident among child welfare agencies, between EPR and CFS agencies, and across Authorities, participants said. Efforts to resolve issues by seeking approval for specialized plans or out-of-province placements through the Child Protection Branch were stymied, sending cases back to the paralyzed system of limited resources and perpetuating the extended placement of youth in shelters.

Although the need for partnership and collaboration across the system was frequently raised, participants noted that the impetus for negotiations across sectors currently only seemed to happen in extreme cases – when the case is in the media, when it has been brought to the Minister's attention, or when there is risk to the public. Current funding policies create barriers; a specific example raised was the policy to not pay for two beds for the same youth at the same time, such as when a youth has a placement bed that needs to be held while they are staying in a respite bed. Consequently, the system has to rely on crisis respite beds through the Crisis Stabilization Unit (CSU) or the hospital in Child and Adolescent Health, as there is no cost to the child welfare system for that type of emergency bed. A second example identified was the system's reluctance to pay for empty beds, such as when youth were incarcerated, on the run, or in respite, leaving long-term placements vulnerable to being terminated if youth were absent for more than ten days. Recognizing that there are no easy answers, respondents still argued that the system needs to move from a crisis reactionary approach to a planned, therapeutic model of intervention. This will require cooperation, planning and creativity, participants stated, as well as changes to funding policies.

Another strategy identified by participants to reduce competition within the system is to standardize pay for child care staff across the systems, ensuring that wages reflect the expectations placed on staff and are commensurate with academic background and training. Innovations also need to be considered in organizing shift work, to accommodate the work/life balance of staff but also to take advantage of staff receptivity to less traditional working hours than in the past.

Challenges in working across systems whose main purpose is much broader than serving youth with complex needs were identified. For example, respondents spoke about the need to work more closely with schools, citing that too many youth with complex needs are suspended from school due to behaviour problems and have difficulty getting back into school – any school – after this kind of issue

arises. Participants acknowledged that schools weren't primary treatment facilities, but given their central role in children's lives, more opportunities to bring therapeutic interventions into the school environment are required. Schools also need more information about the needs of youth with complex challenges, and better strategies to forge working partnerships with foster parents, group home caregivers, and child welfare case managers. Creative models, such as mobile school programs, should be considered as a means to keep youth connected to their education when other disruptions, such as placement breakdown or school suspension, prevent them from attending school.

Respondents spoke about one of the first examples of formal intersectoral collaboration in Manitoba for youth with complex needs was the development of the *Interdepartmental Protocol Agreement for Children/Adolescents with Severe to Profound Emotional/ Behavioural Disorders* (Government of Manitoba, 1995), commonly known as the "EBD Protocol". The EBD Protocol mandates a multisystem case management approach between child welfare, child and adolescent mental health, youth corrections, and student services, and was intended to ensure that "available resources in the context of fiscal realities are utilized in an effective and highly focused manner" (p. 1). The process involves meetings at the local level of service sectors relevant to the child's needs (as well as the child's parents, extended family and/or other significant persons in the child's network, if appropriate), to assess the child's needs, develop an intervention plan, and ensure the coordination of services. There is provision to involve the oversight committee in consultations if the process reaches an impasse at the community level. However, the issues raised by respondents suggest that the EBD Protocol has not resolved the issues of service fragmentation and lack of collaboration across services. In many instances, the issues of youth with complex needs are too complicated to be resolved at the local level and require resolutions that are more complex: the variance of policies, exceptional funding, and/or the creation of innovative placement options. The Protocol is currently under review.

Some recent examples of partnerships across service sectors are emerging. Participants identified the creation of Ji-zhaabwiing, an assessment facility that aims to develop placement plans for children age 7 – 12 and youth age 13 – 17, as an example of partnership between the Southern First Nations Network of Care, mental health services, Manitoba Education, and Manitoba Justice toward responding to youth with complex needs in a more comprehensive way. Manitoba's new youth suicide prevention strategy, *Reclaiming Hope* (Government of Manitoba, 2008), was also cited as an example of linking services and communities together, with one component of the strategy involving the use of Telehealth to provide direct assessments of youths' risk of suicidal behaviour in northern First Nations communities, without always requiring that they leave their communities for assessment. However, these partnerships are at an early stage of implementation and the benefits to youth with complex needs are not yet known.

Another model of partnership raised by participants was the need for consultation across sectors about youth with complex needs. The fractured nature of services requires a formalized infrastructure for consultation. The Provincial Placement Desk was intended to provide a framework for intersectoral consultation but that function never got off the ground, participants advised. There is reported reluctance, if not distrust, across the child and family services Authorities to discuss the issues of youth with complex needs who come from different Authorities at a common table. There is also an interdepartmental committee that meets to discuss complex cases, but addressing placement issues is not part of their mandate. This same interdepartmental committee has been revising and strengthening the EBD Protocol, which may address the issue of service coordination and collaboration more effectively. Finally, as a result of the reviews of the Manitoba child and family services system in 2006, a Child Welfare Intersectoral Committee (CWIC) was established to consider, among other

recommendations, strategies to ensure greater collaboration across systems. The CWIC has examined the Wraparound model (discussed earlier in this report) and is about to initiate a pilot Integrated Systems Working Group model in three communities – Sandy Bay, Gimli, and The Pas.

The necessity of collaboration and partnership to best meet the needs of youth with complex needs seems obvious, but efforts to cultivate partnerships to overcome systemic barriers have had limited success in the past. Although new initiatives are underway, there is pessimism that the requisite ‘buy-in’ – in terms of philosophy, resources, training, and commitment – is sufficiently in place. As summarized by one respondent: “We all need to be on the same page in order to provide seamless services”.

*18. Mental health issues have traditionally been assessed in accordance with criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM), with many conditions being very responsive to psychotropic intervention. However, the literature is clear that far too many youth do not receive mental health services when they need them. Given the proportion of youth with complex needs who suffer from mental health issues, partnerships among mental health and child welfare, youth corrections, education, and youth addictions are imperative.*

One of the biggest challenges facing many service providers who participated in interviews concerns the issue of mental health: the high need for mental health services for youth with complex needs, the scarcity of mental health supports, outreach, or treatment facilities, and the limited availability of the mental health resources that do exist in Manitoba. Repeatedly, participants spoke about the barriers to accessing mental health services:

- mental health issues being viewed as a secondary issue, not the primary cause of a youth’s struggles;
- mental health services not available to sexually exploited youth;
- mental health services not integrated into the youth criminal justice system (although respondents were divided as to whether this was due to reluctance on the part of mental health services or youth corrections);
- mental health services are available to provide initial assessments but few services beyond assessment; and
- mental health services are not available to support caregivers, whether foster parents, group home staff, or residential care staff.

The dynamics of mental health conditions also add to the challenges of providing services. Respondents noted that some youth are not compliant with taking their medication, creating cycles of crisis and risky behaviour when youth were not on medication, leading to placement breakdown. Further, a youth who is not in a stable placement is often not diagnosed, either because no one knows the youth well enough to notice the indicators of mental health disorders, or because the system expends so much energy responding to endless rounds of crisis that the youth is never in one place long enough to see a mental health practitioner for assessment. The risk of suicide as an outcome of mental health issues was a common stressor for placement providers, which was magnified by the perception that there were no mental health services available to the youth to mitigate the risk of suicide or self-harm. This leaves many in the system feeling vulnerable and concerns about liability issues should a youth complete suicide.

Respondents also discussed the capacity of the system to provide emergency mental health services. Limited beds in the Crisis Stabilization Unit (CSU), the short duration of emergency mental health placements in either CSU or hospital, and the difficulty in accessing emergency placements for youth in crisis were cited as drawbacks of the system. The Emergency Placement Resources (EPR) program has struggled with its relationship with the Youth Emergency Crisis Stabilization System (YECSS) for more than a decade, as documented in the 2004 and 2009 reports by the Office of the Children’s Advocate on the emergency shelter system. Current struggles include EPR’s reliance on the Winnipeg Police Service to respond to youth who are out of control, due to the perception that mobile crisis services are not “responsive enough”.

However, the definition of mental health issues does not necessarily include youth who are struggling because of unresolved issues from childhood, especially issues of trauma, attachment disorder, and other adverse life experiences. One respondent stated that the mental health disorders “envelope” is quite narrow, and trauma is not, in general, considered to be a condition that requires a psychiatrist and medication. Traditional mental health interventions, such as psychotropic medications, are not appropriate for or effective with many of these issues, and even when there is a role for medication, their utility is often limited to stabilization, not resolution, of the effects of adverse childhood experiences. Mental health practitioners acknowledged there are limited resources currently available for long-term inpatient treatment for youth with complex mental health issues such as psychosis or bipolar disorder, but asserted that most youth with complex needs do not have the kinds of mental health disorders that current services are set up to treat. This leaves youth whose origins of complex needs come from attachment disorder, trauma, abuse and neglect, and neurodevelopmental challenges such as FASD and cognitive disability without the range of services and supports that they require, and contributes to considerable misunderstanding of the mental health system for children and adolescents.

The lack of trauma treatment resources was cited as one of the reasons that the EBD Protocol developed in 1995 has not fully achieved its mission. The original plan to provide resources for the treatment of trauma and behavioural issues was apparently never implemented in Manitoba, stemming back to the creation of the Manitoba Adolescent Treatment Centre. As a result, youth with diagnosable mental health disorders do get the services they need, but those whose struggles are related to unresolved trauma do not. Consequently, those who utilize the Protocol continue to feel that youth with mental health issues, defined in the broad sense to include youth who are struggling emotionally and behaviourally, are not able to access services through the mental health system.

The professional literature supports a distinction between mental health disorders and trauma while also viewing these issues as connected along a continuum. Trauma can lead to a specific mental health disorder, such as Post Traumatic Stress Disorder (PTSD), but may otherwise manifest itself in compromised functioning that does not fall under a specific diagnosable disorder. In general, the perspectives of mental health and mental illness are undergoing shifts that describe this continuum more clearly. An example of this shift is contained in an excerpt from the Mental Health Commission of Canada’s (2009) framework for a Canadian mental health strategy:

#### Mental Health and Mental Illness

- Mental health is more than the absence of mental illness.
- People can have varying degrees of mental health, whether or not they have a mental illness.

- Mental health problems and illnesses are believed to result from a complex interaction among social, economic, psychological and biological or genetic factors.
- Mental health contributes to our enjoyment of life, to physical health, as well as to our ability to achieve our goals at work, at school and in our relationships.
- Having good mental health helps to reduce stress, prevent mental health problems and illnesses, and foster recovery.
- Each year, about one in every five Canadians will experience a diagnosable mental health problem or illness. (p. 1)

Similarly, Manitoba's strategic plan for mental health emphasizes the importance of shared responsibility (Government of Manitoba, 2011a):

Everyone has a role to play. Mental health is no longer seen as only a "health" issue. At every stage of life, health, including mental health, is determined by complex interactions between social and economic factors, the physical environment and individual behaviour, also known as the determinants of health. Everyone has a role to play in promoting mental health and well-being, supporting individuals experiencing distress, and improving the health and social outcomes for those living with mental health problems and illnesses. Responsibility extends to workplaces, classrooms, boardrooms, communities, and other formal and informal settings. (p. 10)

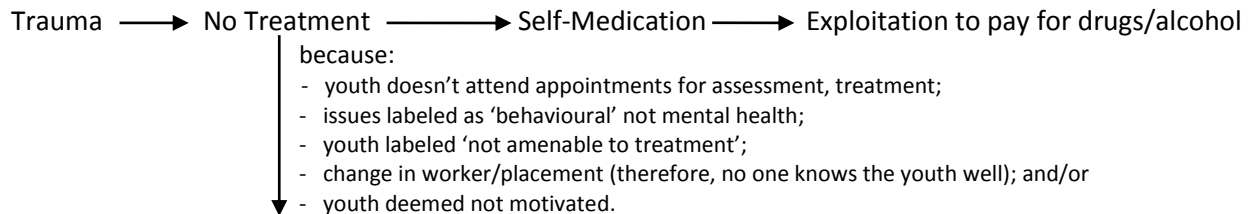
While this broad definition of mental health and the concept of shared responsibility for responding to mental health problems and illnesses may be a new perspective for those providing services and care to youth with complex needs, the reality is that the majority of youth with complex needs experience emotional and behavioural needs that are not adequately addressed anywhere in the system. Medication, hospitalization, and long-term inpatient treatment may be the appropriate treatment for some youth with complex needs, but clearly not for all. Solutions may lie in the development of a robust continuum of mental health services which clearly include a comprehensive range of treatment services and supports for trauma, attachment disorders, and other adverse life events, available both in the community and integrated into placement resources at all levels: treatment foster care, group homes, and residential care facilities.

*19. The emotional and psychological symptoms experienced by youth may not always meet the criteria for definition under the DSM. The lack of formal diagnosis does not diminish the risk of harmful outcomes nor the need for appropriate psychological supports and services.*

Building on the discussion shared under #18, respondents recognized that many youth did not meet the criteria for a mental health disorder under the DSM. This did not alleviate their concerns that youth with complex needs had mental health problems that were not adequately addressed in the current service structure. Youth with cognitive delay or FASD were often not able to access, or make good use of, mental health services. A mental health assessment and diagnosis was often required in order to access mental health services. Respondents highlighted the tendency throughout the system to focus on behaviour as the presenting issue and not look at the underlying causes. Particularly in situations where youth have experienced polyvictimization (most common for youth with complex needs), it is difficult to isolate the impact of mental health issues on functioning, leaving youth again ineligible for mental health services. To quote one participant:

Because mental health is interwoven with trauma, deprivation, multiple placements, school breakdown, etc., there is no clear mental health diagnosis. Depression after all of these factors is understandable, 'normal', but interventions lie in the community, in relationship-building, consistency, stability, and building coping skills. There is often the perspective that a mental health diagnosis will make something magical happen, a new trajectory will emerge for the youth. This may be true for a handful of youth, but most don't result in that kind of dramatic change. Some will get medicated as a result of diagnosis, and that will be effective, but most need consistency, routine, relationships, natural consequences, and stability.

Many behavioural issues are therefore interpreted as caused by family-of-origin factors – attachment problems, neglect, abuse, poor parenting, family violence, etc. – not mental health disorders. Unfortunately, if youth are not eligible for mental health services, they may not receive any treatment to address the origins of their compromised functioning, with alarming consequences. One respondent described this chain of events as contributing to the occurrence of sexual exploitation in the following way:



Participants also appreciated how other variables, such as placement breakdown, exacerbated youths' functioning and made accessing mental health services, whether for assessment or treatment, more complicated. They also noted that it is more difficult to transition youth into independent living or otherwise prepare them for age of majority when they are still in crisis – suicidal, struggling with addiction, and dealing with unresolved trauma and/or mental health issues. The importance of developing seamless services for youth with complex needs who need mental health supports in adulthood was emphasized.

Some respondents suggested that one option may be for residential treatment facilities to hire their own, in-house mental health services for assessments, treatment, and consultation with staff, but they lack the financial resources to do so. There are also shortages of qualified practitioners who specialize in child and adolescent mental health. Others focused on the need for trauma training for staff throughout the system, especially for child welfare staff and foster parents on how to work with children and youth who have been traumatized. Some systems, such as youth corrections, have already taken action to implement training that includes a focus on identifying risk of suicide and managing behaviour issues. Another idea put forward is the creation of a halfway house to manage youth who are in crisis who are ready to be discharged from hospital or CSU but need more supports than are available in their community placement. This suggestion might be particularly appealing to programs that are reticent to caring for youth who are suicidal, both due to liability issues as well as the traumatic effect on staff should a youth succeed in self-harm or completing suicide. One practitioner offered these sobering thoughts about the issue of risk:

The CFS perspective seems to be that there is no degree of acceptable risk for self harm or harm to others. Therefore, the worse youth behave, the more resources they receive. But at adulthood, you can't sustain that level of supervision/oversight, and youth haven't learned to grow. Interventions have constrained their development. Political issues drive these liability issues – we can't risk a child getting harmed. But by trying to do too much in the wrong way, we inadvertently interrupt the autonomy and control development processes youth need to experience.

*20. There are a number of models that address system coordination (e.g. Systems of Care, Wraparound), intensive home-based interventions (e.g. Multisystemic Therapy), and new thoughts about community-based group care and the role of residential care. It is clear that 'one-size-does-not-fit-all' and youth with complex needs require a range of different service and placement models to meet their needs.*

Participants had many ideas about what Manitoba needs in order to respond to youth with complex needs more effectively. Models of placement and service delivery suggested were:

- more one- and two-bed resources with double staff, and provincial approval to license homes with a stable roster of caregivers, even though the model is not a traditional foster home approach;
- more behaviour specialists, with consistent training and the capacity for one expert to train others in behaviour management interventions;
- using education funding to hire a therapist instead of an educational assistant for youth with complex needs;
- the capacity to approach families with an integrated team for assessment: psychiatry, psychology, occupational therapy, medical, social work, etc., formed through a provincial infrastructure that creates and mandates teams to work together, across disciplines;
- multidisciplinary case management teams that include a case manager, treatment coordinator, medical practitioner, dental services, education coordinator, and cultural coordinator, all operating within a relational model;
- the ability to purchase services from the adult system for youth in extensions of child welfare care;
- more three-bed units, to create small, family-like environments, but staffed like group homes due to the complexity of youths' needs;
- shared caregiving models, involving combinations of foster parents and staff, rotated to ensure that the youth doesn't have to leave the placement when respite is needed for the foster parents;
- intersectoral child welfare teams with a mental health focus (achieved by having a mental health consultant to work with youth as a regular part of the team);
- weekly case conference opportunities involving all disciplines to ensure coordinated case planning and service provision; and
- assigning a case coordinator to each youth with complex needs who is the point person across all sectors of knowledge, and is able to ensure communication and coordination across all sectors.

However, respondents were clear that the solutions were more complicated than simply adding placement options to the system. Coordination across placement options is critical and requires a

planned admission process based on detailed information about the needs of youth referred for specialized placement. In smaller communities where there are not the economies of scale, collaborations and partnerships across systems and boundaries to share services are even more critical. Procedures for smooth transitions from one system to another, from one sector to another, need to be developed. Funding models need to be developed that consider both operational costs of the range of placement options and appropriate staff compensation. Of note, many participants emphasized how the youth criminal justice system needs to be included in the continuum of services, given that so much of youth corrections work is focused on the youth's complex needs, not solely on the criminal behaviour.

Before embarking on the development of new placement options and models of system coordination, participants spoke about the need for a common, provincial direction for caring for youth with complex needs. One respondent noted "We all say it takes a village to raise a child, but we don't work like a village." As noted earlier, the system is characterized as operating in a crisis, risk-aversion mode that makes individualized decisions to keep youth safe, but this process hasn't led to lessons or themes about what youth with complex needs require from the system. That is the ultimate goal of this report: to gather what has been learned about caring for youth with complex needs in an individualized way and bring those lessons together in themes that point the way to system development and strengthening.

*21. The number of youth with complex needs is estimated in various studies to be about 10% of the overall general population of youth. The most extremely compromised youth represent about 1% and are the group most difficult to treat, who may require the creation of individualized treatment plans outside of the current service environment.*

While advocating for the development of additional placement options and support services for youth with complex needs, respondents recognized that there was no formula for determining what the right number of resources would be – a daunting task given that it is difficult for the child welfare system to even determine how many youth should be characterized as having 'complex needs'. The concept of considering about 10% of the general adolescent population children in Manitoba to have complex needs was a consistent estimate in many studies examined in the literature review section of this report. Applying this formula to Manitoba's general population of adolescents (Government of Manitoba, 2010):

- There were 286,938 children in Manitoba in 2010, ages 0 – 17.
- 85,564 youth in Manitoba were ages 13 – 17 in 2010.
- Based on the 10% estimate, 8,556 youth in Manitoba's general population have complex needs.
- The rate of placement of children in the general population into child welfare care in Manitoba is about 3.3%, therefore 2,824 youth ages 13 – 17 (out of the 85,564 youth in this age category in Manitoba) would be expected to be in care based on this rate. This estimate, however, is lower than the 3,475 youth in this age group who actually were in care in the CFSIS sample of 10,765 children examined in this report (therefore, the actual rate of youth in the general population age 13 – 17 in care in Manitoba is 4%).
- The rate of youth with complex needs at 10% therefore ranges from 282 to 348 youth – an underestimation if one accepts that a higher proportion than 10% of youth in Manitoba's general population with complex needs are likely to be involved with child welfare.



- Of this group, 1% (28 to 35 youth) will still have issues that cannot easily be met with existing resources and will require the development of individualized placement plans, variances to current policies, and specialized funding across service sectors. This is likely an underestimation as well, since it is based on figures that underestimate the rate of complex needs affecting children in care.

Although these figures are relatively consistent with the sample reviewed from the youth referred to the Provincial Placement Desk (289 youth) or the “Top 200” at-risk youth reviewed regularly by the provincial High Risk Committee, they should still be considered to be an underestimation. It is more likely that among the 10% of the general adolescent population with complex needs, those with complex needs will be over-represented in the child in care population, at least at double or triple the rate as those with complex needs who remain in the community without child welfare involvement. Further, the sample of 289 youth referred to the PPD are not yet in specialized placements, such as a treatment foster homes, group homes or residential care facilities, and represent only 2.7% of the total child-in-care population, indicating that there are not sufficient resources for youth with complex needs.

To explore this estimate in a logical way, one could assume that 25% of all youth in care are likely experiencing the impact of complex needs (a reasonable proportion of the concept that if 10% of youth in the general population have complex needs, they are likely represented in the child welfare system at double or triple the rate). Therefore, with 3,475 youth in care age 13 – 17, 869 (25%) would be considered youth with complex needs. If the estimate is raised to one-third, then 1,158 of all youth in care age 13-17 would be considered to have complex needs. These proportions do not seem unreasonable, given the perception in field reports and the professional literature that complex needs are increasing in frequency, and are likely still an underestimation of the actual rate of occurrence of youth with complex needs in the child-in-care population.

In 2010/11 in Manitoba, 689 children and youth were placed in group homes or residential treatment centres (Government of Manitoba, 2011b), with 749 licensed beds in 139 licensed facilities in the province. With almost 300 children referred to the Provincial Placement Desk waiting for a vacancy in specialized resources and an estimated range of 869 – 1,158 youth age 13 – 17 needing specialized placements prepared to care for youth with complex needs, it seems evident that Manitoba does not have sufficient resources to meet the needs of this population.

But, how should the system proceed to review and assess its current capacity to care for youth with complex needs and strategically develop a path to build its capacity in ways that are most needed by this vulnerable population? Respondents stated that government decision makers need to be knowledgeable about the population, the issues youth face, the models of placement and service delivery that are most conducive to meeting their needs, and the real costs of providing for their care. The real costs are often hidden in one-off placement plans, in extended placements in EPR, and in decisions made in reaction to crisis, they noted – all individualized decisions that keep youth in crisis safe at considerable expense. Instead of focusing only on individual cases, participants stated, we need to look at the bigger picture, and big picture solutions, to develop a common, proactive, provincial strategy for caring for youth with complex needs.

*22. Although 10% is a relatively small proportion of youth, various studies have reported that the complexity and severity of the issues experienced by this at-risk group often require a high proportion of financial and human resources to adequately meet their needs, costs which have usually been borne by the child welfare system.*

The interviewees for this project discussed two themes related to the high costs of providing care to youth with complex needs. One theme was that high costs are currently driven by the overall lack of placement options and resources, which too often result in youth with complex needs remaining in emergency shelters for extended periods of time with double and triple staffing to manage their care needs. Those that spoke about this issue noted that EPR is sometimes used as a safety net – once a youth has been placed there, workers move on to the next youth in crisis, confident that EPR will rise to the occasion and keep the youth safe. Since there are no other placement options, individualized care plans for youth in shelters generally get approved. However, a shelter that becomes a long-term placement is no longer available as a shelter, and the license needs to be transferred to one of the child and family services agencies, meaning that EPR inadvertently develops resources for the child welfare system, an outcome that defeats the purpose of EPR, participants said.

The second theme raised is that the funding model for residential care is based on an outdated formula that doesn't meet the needs of today's child in care population, particularly youth with complex needs. Staff have not received adequate compensation to cover the expectations in providing care to youth with complex needs, where the work is demanding, at times risky, and emotionally exhausting. Foster parents are funded on a model that is based on fostering from the heart, rather than funding fostering – especially of youth with complex needs – as a full-time job with particular expectations. As stated by one respondent: “You can't ‘nickel and dime’ this – then you only have a supervision system”. To really address the needs of this population, adequate resources need to be provided at the front-end, resources which ultimately will have a preventive, cost-saving impact on the future use of health care, justice, and mental health services in adulthood.

*23. In order to access specialized services – at any level of the placement continuum – youth must first journey through a number of foster placements that breakdown. The principle of the ‘least intrusive placement’ does not work for youth with complex needs, whose risk factors are often well known prior to adolescence, when they are most likely to manifest themselves in problematic ways that contribute to placement breakdown, and further emotional trauma to adolescents.*

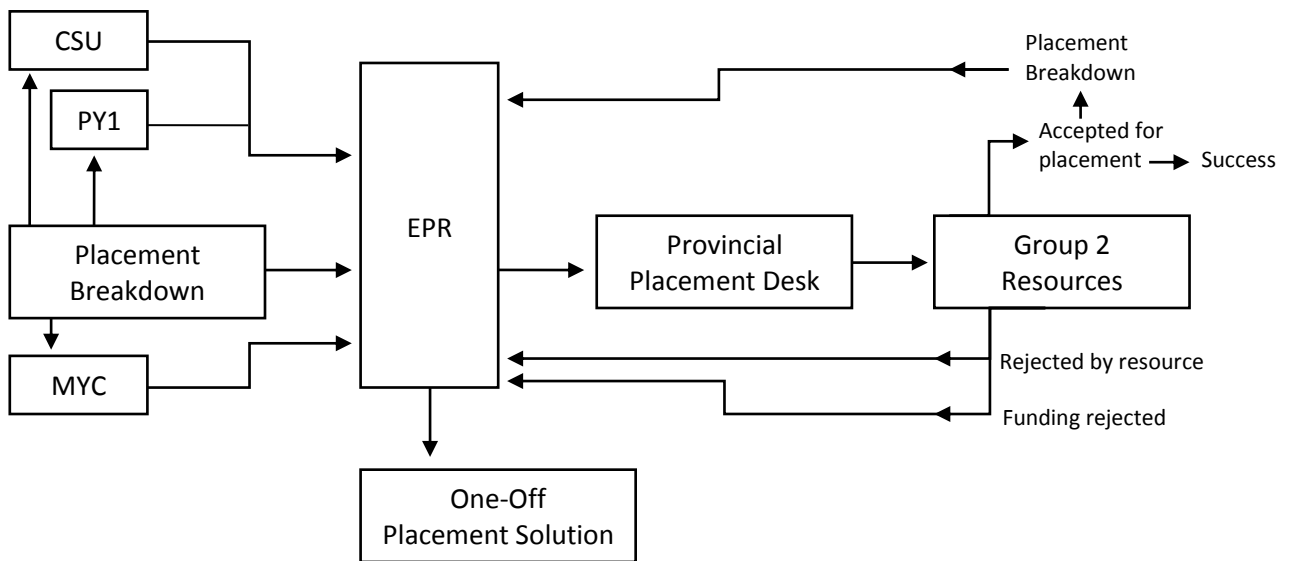
The pathway through specialized placements is not planned or coordinated, respondents stated. Most referrals to the Provincial Placement Desk come from EPR, and youth in the shelters are usually there because of a prior crisis: placement breakdown, discharge from hospital or the youth criminal justice system, or emergency admission from the community when biological family are no longer able to provide care. Even when youth are transitioned to specialized resources, when placements in group homes or residential care facilities break down, there is no other emergency option but EPR. Placement in the shelter may be intended to be short term, but for many reasons (as discussed throughout this report), youth remain stuck in the shelter system and eventually, this may become the placement of ‘choice’, rather than disrupting the youth with another move.

Staff from specialized placement resources also interpret referrals as an indication that there are no other options, “everything else has been tried”, respondents stated. Facility staff feel a great deal of pressure to respond in these circumstances, knowing that the child welfare system is desperate for a youth to be placed, but feel they also have to weigh the needs of the youth with the capacity of their staff. Given the challenges currently experienced in the system (noted above in relation to adolescents' behavioural issues and risk of self-harm, the lack of treatment services for mental health issues and/or trauma, and service fragmentation), it is not unusual for some youth with complex needs to be turned away, only for the child welfare system to find itself with no other option but a shelter.

Some participants were frustrated by the inability to access specialized placements out-of-province, when it seemed evident that the high needs of the youth and lack of suitable Manitoba placement options indicated that there is no other suitable option within the province. However, respondents described approval processes for out-of-province placements as complicated, and often, all local options need to be attempted before more costly out-of-province alternatives can be accessed. Other respondents described how even placement proposals within the province were rejected due to the high cost of funding the placement, only to have the youth sit in a shelter for a year before the same plan, with the original funding proposal, would be approved. Funding models also need to better contemplate the costs and benefits of one-bed facilities, recognizing the detrimental impact of the practice of reducing per diems once youth have stabilized or trying to maximize operational costs by placing another youth in the home, ignoring the costs that go into maintaining that stability over time and through the youth's transitions in life.

The system is caught in a very unfortunate and unhealthy cycle, as described by respondents and depicted in Figure 4, below. Without sufficient placement resources that can manage the care of youth with complex needs, they end up placed in emergency shelter. Efforts to move them into specialized placement are thwarted by the funding proposed to provide for their care, or if they are placed in specialized care, there are no options except for the shelter system if that specialized placement breaks down. Detention at a youth corrections facility or admission to a crisis stabilization facility can disrupt placement; upon discharge, placement arrangements may need to be made all over again, with youth again ending up in a shelter. By the time the system is prepared to fund a more comprehensive placement, either by accepting the proposal developed by a Manitoba resource or approving an out-of-province facility, the issues youth are experiencing are more pronounced and problematic.

Figure 4: Common Placement Pathways for Youth with Complex Needs in Manitoba



24. *Despite similarities across the population of youth with complex needs, there are distinct differences within the population as well. Evaluations of outcomes for youth with complex needs in different placement types – treatment foster care, treatment group homes, intensive home-based support, wraparound models, System of Care models, Multisystemic Treatment, and residential treatment programs – have found that each program type can effect positive changes for youth with complex needs, but that the youth who accessed each type of placement differed across key variables (e.g. age, involvement in the youth corrections system, working toward reunification with biological family, capacity for the biological family to be engaged in the treatment plan, availability of community resources, for examples). Therefore, there is a need for a wide continuum of placement options.*

Continuing the themes that were raised under #20 above, respondents had no shortage of innovative ideas for reforming the system. A wide range of placement resources, supported by services across the sectors, is needed in Manitoba, they stated. While there are many current resources that fulfill part of that range, more development of a comprehensive and unified system is required.

Participants envisioned a system for youth with complex needs that included treatment foster homes, group homes, and residential treatment facilities, with variations of each of these models along the continuum, many of which were described under #20. Variations include team-based foster homes (where foster parents work with assigned support workers and a respite team, so that the youth does not have to leave the home when crises arise, or models based on three youth-care staff who share the parenting function), and a continuum of one-bed, two-bed, three-bed and four-bed options – adequately staffed with a reasonable funding model that supports the best interests of the youth. Youth may also benefit from having private bedrooms, where they can escape to unwind and refocus and receive therapeutic support from a staff in times of stress or behavioural/emotional difficulty. Crisis response services – both those that support the youth within his or her placement and those that involve the youth’s placement in a stabilization unit – would be available, as well as longer term crisis management placements (termed ‘halfway house’ by one participant, and a 7-10 bed ‘assessment/stabilization’ unit by another). To meet the demand, more mobile crisis services are required.

Staff would work in teams, with a mental health consultant assigned to each team for biweekly consultation and crisis intervention – for foster parent caregivers, group home staff, and residential treatment staff. Child welfare case managers would also be included in the team consultations. Teams also need to have access to occupational therapy, speech therapy, psychiatry, and behavioural consultants, in all regions of the province, shared across programs, organizations, even regions where necessary. Training in child development, attachment theory, the effects of trauma, and behaviour management techniques are critical for all staff.

The capacity to deliver therapeutic services for a given youth across systems needs to be developed. How can youth continue to receive treatment while at school, when suspended from school, when detained at the youth centre, when in a respite placement, etc.? Efforts to bring the service to the youth, where the youth happens to be, need to be prioritized, respondents asserted.

Transition supports need to be created to assist youth as they move from one part of the system to another. Examples raised by participants included:

- Specialized placements, with trained foster parents or staff, to accept a child being discharged from youth detention, crisis stabilization, or a mental health facility when no other placement is available, to provide stabilization, assessment, and integration supports until the youth has transitioned into his or her next long-term placement; and
- Transition services that focus on guiding the youth with complex needs, as well as his/her placement, to adult services.

A small proportion of youth will require, for time-limited periods (for example, three weeks maximum), placement in a locked facility, respondents asserted. Clear criteria for admission and discharge would need to be developed, with a focused expectation on stabilization and assessment for the duration of placement in such facilities, which would be for only a small number of youth at any given time. Part of the goal of locked placement would be to ensure safety for youth at high-risk, remove them (even temporarily) from negative community influences, and develop a trusting relationship that can aid in engaging youth in a plan for care after discharge.

The foundational changes required to support such innovations are long-term and evolutionary, respondents declared. They require trust, communication and collaboration, as well as changes in infrastructure: funding models, staffing models, resource development practices, and policy revisions to break down silos. One example of policy restrictions raised in interviews was the limitations service purchase agreements (SPAs) place on how staff are moved around in a program, preventing adjustments according to the youth's needs. A Common Table process for reviewing complex cases and planning collectively for service provision is integral to supporting an enhanced system. A final thought presented by a participant: There may be value in structuring two levels of resource development for youth with complex needs – one for resources developed and managed directly by the child welfare system, and one for resources developed and managed intersectorally.

*25. Assessment is the hallmark activity that needs to guide appropriate placement and service plans. For youth with complex needs who enter the system in adolescence, the timing of assessment is at the point of entry, but for youth who have been involved with the system (often child welfare) for a long period of time, guidelines need to be established as to when and how such youth become part of an assessment process to ensure that their needs are identified and addressed at an early stage.*

A key component of a reformed system for caring for youth with complex needs is an enhanced capacity for assessment. Currently, respondents have found that thorough assessments of youths' needs are lacking, due to turnover of staff in the child welfare system, their high caseloads, and their inexperience in preparing comprehensive assessments. Without an assessment, it becomes difficult to determine if youth referred to the Provincial Placement Desk are eligible for specialized placement when information about their functioning is missing, and placement resources struggle to determine if youth are a good fit for their services.

Assessments serve an important proactive function, respondents asserted: once an assessment is completed, cases often feel more manageable to case managers and become more stable because a direction for services is often identified. Ideally, assessments are more than an end unto themselves – they should result in action to provide appropriate short-term intervention to stabilize the youth and long-term placement and treatment to help the youth work through their issues and become healthier individuals over time. Because assessments facilitate matching to appropriate placement resources, they also help to prevent placement breakdown.

Conducting assessments of youth with complex needs may require a skillset that most child welfare staff do not have, especially the ability to assess trauma, attachment disorder, cognitive capacity, FASD, and mental health issues – common issues affecting youth with complex needs. Further, some services require assessments to be conducted by professionals with certain expertise, such as the assessment of mental health issues, the diagnosis of FASD, and the measurement of cognitive functioning to ascertain eligibility for adult disability services. Consequently, respondents felt strongly that the assessment process was more than a training issue, but a resource development issue.

A recent example of an assessment resource is Ji-zhaabwiing, described earlier in this report, intended to provide short-term residential assessment to children and youth involved with the child welfare system. The youth justice system is also implementing an assessment tool, the MAYSI-2 assessment described in the literature review, to better identify youths' needs while they are incarcerated. Other resources for assessment need to be identified and developed.

Assessment should not be limited to when a youth is first admitted to care or first referred for specialized placement; youths' needs change and periodic re-assessments will be required. Criteria for when and how assessments are reviewed and updated must be developed to support the system. For example, some respondents noted that specialized placements sometimes breakdown and youth must be moved to another placement. Developing an assessment facility would provide a placement option for youth where their needs could be reassessed to determine what worked/did not work in the previous placement and what resources were required to make the next placement more successful. Ultimately, every youth who leaves an assessment unit should have a comprehensive assessment and intervention plan developed, with the requisite resources to meet that youth's needs available.

## **Summary**

The practitioners who shared their perspectives about youth with complex needs clearly understand the challenges this population faces, the reasons behind their challenges, and the efforts of the system to meet their needs. Their dedication to providing the best possible services to youth with complex needs is unmistakable, and is indicative of one of the most important strengths of the system – its people.

However, it is evident that committed staff alone are not sufficient to meet all the needs of this vulnerable population. This group of adolescents have multiple, serious issues that compromise their safety, well-being and development, necessitating the involvement of services from many different disciplines across various service sectors. Although the system serves a number of these youth well, the challenges strain and exceed the system's current capacity. These practitioners were candid about the current weaknesses of the system: fragmentation, "siloism", service gaps, and lack of coordination are some of the key characteristics that prevent the system from comprehensively caring for youth with complex needs today. The overall climate is one of crisis response and risk aversion – qualities that perpetuate the deleterious effects of complex needs and strain the system even more.

The interaction between the dynamics of youth with complex needs and the overall scarcity of specialized placements forces the shelter system to provide long-term care for too many youth with complex needs. Events such as placement breakdown and discharge from youth corrections or crisis stabilization often leave youth who have complex needs with no available placement options except an emergency shelter. While there are many commendable examples of how EPR has created service plans to support youth who have no other options, the costs – financial and otherwise – of doing so are

considerable: double and triple staffing to compensate for the staff's gaps in specialized training on managing youth with complex needs, frequent rotation of purchased-service staff preventing the establishment of caring bonds between youth and consistent caregivers, and the exacerbation of youths' issues that are not being adequately treated. Managing behaviour and keeping the youth safe become the priorities.

Based on the professional literature that estimates that 10% of the general population of youth should be considered as having 'complex needs' (with a higher proportion represented in the child-in-care population), Manitoba requires specialized placement resources and multidisciplinary services for 869 – 1,158 adolescents with complex needs. A small proportion of that group (1%) will have exceptional needs that cannot easily be accommodated in the service system; special adaptations and accommodations will be required to adequately meet their needs. However, the issue is not just in ensuring that there are "enough" specialized placement beds – the population of youth with complex needs are only one segment of the youth-in-care population that have multiple, challenging issues.

In every system, there are youth whose needs are growing in complexity who are in need of skilled caregivers, treatment for trauma and other adverse life experiences, mental health assessments and intervention, and who may also require specialized placements. Participants who were interviewed for this project asserted that the system not only needs to be more responsive to the needs of the current group of youth with complex needs, it needs to take proactive steps to intervene with children and youth whose multiple issues will escalate and intensify – becoming 'complex needs' – either because of the dynamics of adolescence, multiple placement breakdowns, and/or the current lack of treatment services to address the root causes of their issues. A very practical recommendation was made to provide assessment and treatment to children ages 7 – 10 who have had experiences of abuse or trauma, in an effort to prevent or diminish the exacerbation of issues in adolescence.

Much is known about the characteristics of youth with complex needs and their placement and service requirements. Participants in this project emphasized the importance of relational models of practice with this population, but recognized that treatment foster care was not a suitable option for all youth with complex needs. Additional resources and different service models must be developed in order to meet the volume and complexity of needs facing this group. Respondents had many ideas for placement innovations based on a relational model that could meet the diverse challenges facing youth with complex needs. These ideas included small units of 1 – 3 beds, with caregiving provided by foster parent/support worker teams with planned respite provided in the home, regular consultation with behaviour specialists and trauma experts, and the provision of treatment programs that addressed attachment issues, adverse life experiences, and trauma. The continuum of services requires a robust capacity for assessment (to determine what youths' needs are, match them to the best specialized placement, and arrange the necessary collateral services to treat issues), enhanced crisis response services, and transitional supports to improve the movement of youth with complex needs through placement breakdown and admission to alternative placement settings. In order to strengthen the system in these ways, mechanisms such as funding models, licensing criteria, staffing models, and policies will need to be reviewed and modified, as participants were clear that these mechanisms were based on outdated knowledge about youth with complex needs and outdated strategies for managing their care.

It was recognized by respondents that there is a tendency to focus on the behavioural issues that many youth with complex needs exhibit; behaviour issues are among the most common challenges that contribute to placement breakdown in adolescence. Risky behaviours – self-harm, suicide

attempts, aggression or violence towards others, substance abuse, criminal activity, sexual exploitation, for examples – place considerable stress on caregivers throughout the system. It is often assumed that the origin of these risky behaviours is a mental health disorder, and participants of this project expressed frustration with the inability to engage mental health services on behalf of youth with complex needs. However, many youth with complex needs do not have a mental health disorder that can be effectively addressed with medication, despite their seriously compromised functioning. The current perspective in the mental health field emphasizes the broad continuum of community services and supports that promote mental health and respond to mental health problems, viewing the more traditional approach to mental health services – the diagnosis of mental health disorders and treatment by psychotropic medication – as a small part of mental health services.

Instead, the growing body of literature on the effects of trauma helps to explain the struggles youth with complex needs face as a result of their adverse life experiences in childhood. However, trauma-specific services and programs are not in abundance in Manitoba, leaving many youth with complex needs with untreated trauma. The importance of establishing a range of trauma-informed services, throughout the service system and across sectors, cannot be underestimated. It was noted by respondents that treatment services for trauma were intended to be implemented in Manitoba at one time, but resources for the development of trauma services were never provided. Trauma services are greatly needed by youth with complex needs involved with the child welfare system, integrated into all of the services they receive and appropriately situated within the continuum of mental health services in all communities of the province.

Some special considerations for youth with complex needs were identified by practitioners who were interviewed for this project. Participants noted that some youth with complex needs have challenges that will require different interventions and placement models, with youth with cognitive disabilities and youth with FASD identified as two groups with exceptional needs that need special consideration. Additionally, respondents stressed the importance of providing treatment to children and youth who have been sexually abused, given the acute trauma that this type of maltreatment produces and the risks of lifelong effects.

It is evident that meeting the needs of youth with complex needs cannot be accomplished by the child welfare system alone, nor any single service system. Their issues are complex and challenging and necessitate the involvement of many service sectors and disciplines. Further, their care needs are more than most foster homes can manage without comprehensive supports and intensive consultation, provided in a team-based format. The availability of specialized group placement is critical to managing the care needs of this population. In order to provide safe, therapeutic care to youth with complex needs, partnerships across the agencies, programs, Authorities, and service sectors are necessary. The professionals who have worked with youth with complex needs are committed to providing them with high quality services, working towards resolving the barriers, and creating new models of service delivery. This commitment must be recognized and employed to review and reform the network of services for youth with complex needs.



## RECOMMENDATIONS

Although no universal definition exists, youth with complex needs are characterized in the professional literature as having multiple needs, often as a result of exposure to multiple stressors or adverse life experiences, which compromise their functioning in multiple ways (most notably, affecting behaviour and emotional stability) and require services from multiple service providers across multiple service sectors. Considerable research has documented in detail the devastating impact of adverse childhood life experiences on functioning, physical health, and overall well-being, effects that escalate in adolescence and continue to impair the individual's functioning throughout adulthood. The professional body of literature also estimates that 10% of all youth in the general population are youth with complex needs.

The limitations of the Manitoba Child and Family Services Information System (CFSIS) prevent the determination of exactly how many youth in care meet the definition of 'complex needs'. However, examination of the 289 youth referred to the Provincial Placement Desk (PPD) confirmed that there is a sizeable group of adolescents with multiple needs, on average 8.4 issues per child, waiting for placement in a specialized therapeutic placement, such as a treatment foster home, group home, or residential care facility. Their challenges included issues that could be considered to be causal or antecedent issues, such as physical abuse, sexual abuse, neglect, family violence, and other adverse childhood experiences, as well as issues that are usually the consequences of these kinds of childhood traumas: aggressive or violent behaviour, self-harm and risk of suicide, mental health issues, attachment disruption, sexual exploitation, and substance abuse. One fifth of the sample was characterized as needing 24 hour care and supervision, an indication of the severity of the issues they were facing. Almost a third of the youth referred to the PPD were involved in criminal activity of some kind. A third of the adolescents were no longer in school, and 14% of those still in school were not in a grade that was appropriate for their chronological age. Almost 40% of the youth had experienced multiple school placements, considered to be an underestimation of actual school changes due to limitations in how often school placement changes are tracked.

Given that the 289 youth on the PPD list represented only 2.7% of the total child-in-care population, efforts were made to estimate how many adolescents one might expect to experience complex needs in Manitoba and require specialized placement and support services. Based on the estimate in the professional literature that 10% of all youth in the general population have complex needs, it was calculated that 8,556 youth age 13 – 17 in Manitoba have complex needs. At least 4% of this group are in care (3,475 youth), but it is likely that more than 10% of this sub-group (348 youth) have complex needs; in fact, conservative estimates are that 25% (869) to 30% (1,158) of youth in care age 13 – 17 have complex needs. With 749 provincially licensed beds in Manitoba (some licensed for out-of-province children from northern Ontario), 689 in residential care beds in 2010/11, and almost 300 youth waiting for a vacant bed in a specialized residential placement, it seems evident that Manitoba does not have sufficient resources to meet the needs of this population. The challenge of attaining and maintaining appropriate placements for youth with complex needs has been identified by many in Manitoba, such as those who are involved with the Provincial Placement Desk, the Emergency Placement Resources (EPR) program, the High Risk Committee, the Winnipeg Child and Family Services Complex Case Review Committee, the Child Welfare Intersectoral Committee (CWIC), the partners involved in the development of Ji-Zhaabwiing, and the committee undertaking the review of the *Interdepartmental Protocol Agreement for Children/Adolescents with Severe to Profound Emotional/Behavioural Disorders* (known as the *EBD Protocol*).

The many professionals who participated in interviews for this project (members of the groups and committees identified above, as well as from other services and sectors who work with youth with complex needs) identified numerous issues affecting the current service system in Manitoba that is responsible for supporting youth with complex needs. Weaknesses such as fragmentation of services, “silos”, service gaps, and lack of coordination across services were cited as key barriers to comprehensive service delivery for this vulnerable population. Coupled with the risks associated with complex needs – such as placement breakdown, school disruption, criminal behaviour, victimization, mental health crises, sexual exploitation, self-harm, and suicidality – interview participants described a climate of crisis response and risk aversion that contributed to short-sighted planning for youth with complex needs. Solutions that kept the youth safe that day were generally favoured over the development of long-term, cross-sector strategies, particularly those that required the development of costly individualized placements. Consequently, respondents noted that many youth with complex needs ended up spending considerable periods of time in emergency shelters, such as after the breakdown of their foster home placements, after discharge from facilities such as crisis stabilization or the Manitoba Youth Centre, as well as after the breakdown of specialized group home or residential placements. Overall, respondents had many creative ideas for alternative placement models that would meet the diverse needs of youth with complex needs and felt that the willingness among individual organizations and service sectors to partner was strong, but asserted that the policy and funding infrastructure necessary to support the development of such models was not yet in place.

One of the major service themes that arose was the differing perceptions of the role of mental health services in responding to the issues facing youth with complex needs. While there was general agreement that youth with complex needs have emotional and behavioural issues as a result of their early childhood experiences, whether the origin of these issues was attributable to mental health issues or amenable to traditional mental health interventions was a theme of diverse interpretation. What became evident is that too many youth with complex needs have experienced adverse life events in childhood and too few have received any kind of treatment to help them recover from these traumas.

Taking the results of the literature review, the analysis of youth in care in Manitoba with complex needs, and the interviews of many dedicated professionals who are committed to providing the best possible services to youth with complex needs into consideration, the following recommendations are made to improve supports and placement resources for youth with complex needs:

- 1. Trauma services for youth with complex needs must be prioritized for development.**

In Manitoba, there are insufficient supports for children and youth who have been traumatized by adverse childhood experiences. Children and youth often express the harmful effects of trauma in their behaviour – through actions that present risk to their safety and well-being, can threaten the safety and well-being of others, and contribute to placement breakdown and school disruption. These issues have lifetime consequences for individuals, affecting their need for long-term supports and services. The impact of these traumatic events merits a comprehensive range of treatment responses, including support services which fall under the domain of mental health services. The importance of responding to trauma has recently been recognized in Manitoba through the establishment of the Manitoba Trauma Partnership and plans to create a trauma care centre in the province. While this is an important start, the mandate of these bodies is broader than focusing on children in care, and specifically youth in care with complex needs. A provincial strategy to augment the range of services for children and youth who have been traumatized is required, complemented by training of staff who work

with traumatized children and youth and opportunities for caregivers and child welfare staff to consult with professionals who have expertise in trauma, mental health issues, and behaviour management.

**2. Early intervention, especially to prevent and mitigate the deleterious effects of adverse childhood experiences, must be prioritized.**

There is ample evidence that entering adolescence tends to exacerbate unresolved issues from childhood, such as attachment disorders and trauma. Although younger children may not present in as challenging a manner as adolescents, younger children who have been exposed to adverse childhood experiences should be prioritized for assessment and preventive intervention – through supports in their foster homes, daycares and schools, and communities, and with individual or group treatment where necessary – in an effort to reduce the negative effects of childhood trauma in adolescence. The profound effects of these early adverse life experiences, which have the potential to alter patterns of brain functioning in long-term dysfunctional ways, sets the stage for increased service utilization and costs to society in adulthood (such as in health care services, mental health supports, and involvement in the criminal justice system) and compromises adult functioning in employability and, most critically, in parenting capacity, perpetuating the effects of early childhood trauma into the next generation.

**3. To complement early intervention strategies, children in care who are currently age 7 – 10 years old should be specifically targeted for assessment of their life experiences of trauma on their emotional and behavioural functioning and provided with appropriate trauma-informed, behavioural and mental health services to determine their placement and treatment needs, support their alternative care placements, strengthen their connections to school, and address the impact of their adverse childhood experiences prior to adolescence.**

While adolescence will remain a challenging stage of development for many youth, services must be strengthened to focus assessment and intervention activities on children before they approach puberty in order to reduce the impact of complex needs in adolescence. The aim is to ensure that the child has a stable foundation and strong network of supports in place to navigate the challenges of adolescence, as well as to address issues that may worsen as the child enters adolescence. Although these interventions won't eliminate the effects of complex needs on youths' functioning due to the profound impact associated with trauma, they may help to reduce the severity of symptoms, help youth and their caregivers to develop stronger coping strategies, and reinforce relationships among youth and their caregivers to prepare them for the challenges of adolescence.

**4. Relational models of practice are critical to supporting youth with complex needs throughout adolescence and through periods of change and transition.**

The importance of relationship – as a fundamental aspect of child development through the development of attachment and as the basis of many therapeutic interventions – is well documented. However, relational models are compromised for youth with complex needs by turnover of staff in the child welfare system, placement breakdown, school disruption and discontinuity in specialized placement caregivers. Strategies to strengthen a relational approach to service delivery include training for child welfare staff and foster parents (as well as other caregivers of youth with complex needs) in understanding attachment and relational models of practice, developing policies and practices that minimize placement breakdown (for example, supporting foster homes by providing caregivers with opportunity for consultation with professionals on the mental health and behavioural management needs of youth in their care), strengthening efforts to keep youth in school (such as through re-entry

plans when youth are suspended from school for behavioural issues or mobile school options that keep youth engaged in school while they transition between placements or service providers), and ensuring that youth are connected to at least one healthy adult who can play a guiding role in their lives, across systems, placement changes, and the challenges of adolescence.

- 5. The especially harmful effects of childhood sexual abuse need to be recognized and children and youth need to be provided with services that respond to these traumatic experiences in a timely and comprehensive way.**

Manitoba's Sexual Exploitation Strategy under *Tracia's Trust* is recognized as a progressive constellation of support services, placement resources, staff training, public awareness campaigns, and focused interventions to respond to the sexual exploitation of children and prevent its occurrence. However, responding to the needs of youth after they have been sexually exploited ignores a critical opportunity for preventive action. Although the majority of sexually exploited youth report having been sexually abused within their families in their childhood years, there are few treatment services available that specifically treat this type of adverse childhood experience, increasing their vulnerability to sexual exploitation in adolescence.

- 6. Given that transition periods present the most risk of disruption to relationships for youth with complex needs, known transition periods point to opportunities to provide better services to youth with complex needs, such as by developing service and placement models that ensure a smoother transition and as much continuity as possible of relationships and information about the needs of youth with complex needs.**

Key transition points that require the development of specialized placements and transition supports are needed for youth being discharged from a criminal justice detention facility, from a crisis stabilization unit, or from a mental health facility, especially when the youth is not returning to his/her former placement, to provide stabilization, assessment, and integration supports until the youth has transitioned into a long-term placement. Transition supports must also be strengthened to assist youth with the transition to adulthood, including to adult services, given the impact of complex needs on functioning throughout the lifespan.

- 7. Critical to responding to the needs of youth with complex needs is an enhanced capacity for assessment, especially when a referral for specialized placement is being considered.**

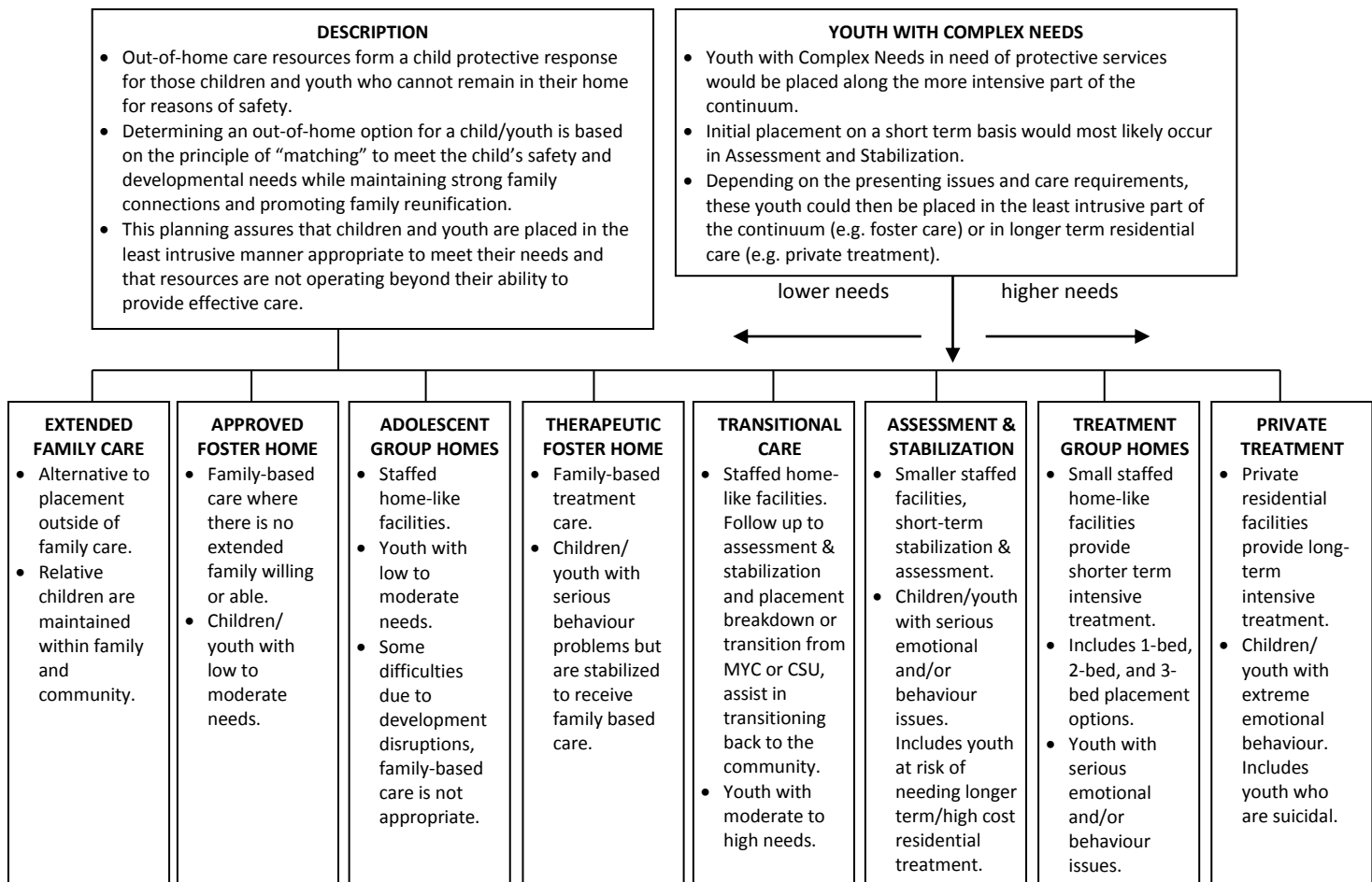
A recent partnership example of an assessment resource is Ji-zhaabwiing, a short-term (90-day) residential facility designed to provide assessments of children age 7 – 12 and youth age 13 – 17 and facilitate planning for placement and support services. However, its capacity to serve only 10 individuals at any given time is not sufficient for the number of youth with complex needs in Manitoba. In particular, assessments are critical when referrals to the Provincial Placement Desk are made, to ensure that appropriate placement matching occurs, and when a placement (including specialized placement resources) has broken down, to better determine how to meet the needs of youth with complex needs.

- 8. Due to the challenges of caring for youth with complex needs, a wider range of placement options, including innovative models that challenge the current policy and funding infrastructure, is required.**

The current approach to providing care to youth with complex needs leaves too many youth on a waitlist for specialized placement, in a placement that is not suitable for their needs, in an emergency shelter on a long-term basis, or in a costly individualized placement that is developed in the absence of other suitable resources. While the literature makes it clear that there will always be a very small proportion of youth with complex needs who will require the creation of individualized placements, the majority of youth with complex needs can be cared for within a comprehensive range of placement options, supplemented by treatment services across many service sectors. A number of innovative placement models were identified in this report to augment the current system: a continuum of one-bed, two-bed, three-bed and four-bed placement options, alternative caregiver models that build teams of foster parents and respite staff (supported by professional consultation in mental health and behaviour management), in-patient and out-patient trauma services, and expanded crisis stabilization services. Such models will require a review of policies, staffing formulas and funding models in order to create the placement resources that best meet the needs of youth with complex needs. It will also be an opportunity to update these aspects of the alternative care system that may be outdated and no longer fits the needs or realities of providing care to youth with complex needs in today's society.

Considering the need for more assessment services and a wider range of placement options for youth with complex needs, the model proposed by Saskatchewan to respond to the high needs of sexually exploited youth (described earlier in this report and adapted below in Table 7) is worth consideration as a framework for caring for youth with complex needs in Manitoba:

Table 7: Prioritizing Youth with Complex Needs for Assessment and Placement



- 9. In order to meet the recommendations identified above, a unified vision for services for youth with complex needs is required. One of the main goals of a unified vision is to address the issues of service fragmentation, “siloism”, service gaps, and lack of service coordination throughout the system, especially across service sectors.**

It is clear that providing services and care for youth with complex needs is a responsibility that must be shared across service sectors. The issues facing this vulnerable population require more than the involvement of multiple service providers – they require partnerships, collaboration, shared resources and shared responsibility. The need for collaboration was recognized by all the practitioners who were involved in the preparation of this report. Each individual expressed strong dedication to providing the best possible services to youth with complex needs and an interest in finding creative and innovative ways to breaking down silos and work in partnership. An important component of developing and enacting such partnerships lies in the development of a unifying vision for services and placement supports for youth with complex needs, involving all the relevant service sectors.

- 10. Given the strong interest in developing creative, innovative strategies and partnerships, a process to bring together stakeholders to create a multi-year strategy to enhance services and supports to youth with complex needs is imperative.**

Complex issues often require multi-year strategies to plan and implement specific interventions incrementally. The achievements of the Manitoba Sexual Exploitation Strategy serve as an ideal model for responding to complex issues across a wide range of service sectors. Although the origins of the Strategy date back to 2002, the Strategy advanced considerably with a multi-disciplinary summit held in 2008 which brought together representatives from all the relevant service sectors to review what was known about the issue of sexual exploitation, what gaps and issues require attention, and what activities are possible to better address this issue. The result was a multi-year strategy with a unified vision and incremental plans to expand services and supports and increase collaboration across the system.

A similar approach is warranted for responding to the issue of youth with complex needs. In many respects, this report serves as a collection of what is known about the issues facing youth with complex needs, the challenges in our current system, and the innovations that members of the intersectoral community identify as critical to meeting the needs of this vulnerable population better. Partnerships will be critical to building the capacity of the system to care for youth with complex needs. Therefore, developing the strategy needs to start with building those partnerships, by bringing together the intersectoral stakeholders for a summit to develop a unified vision and a multi-year strategy.

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## APPENDIX 1

Many individuals, representing a wide range of professionals who are dedicated to working with children and youth in Manitoba, contributed to this report by participating in interviews throughout 2011, sharing their experiences, perspectives, and thoughts about the state of services for youth with complex needs. Their candid insights about how to best meet the needs of this vulnerable population are greatly appreciated.

Joanna Blais	Manitoba Education
Allie Boardman	New Directions
Leanne Boyd	Healthy Child Manitoba
Michael Burdz	Knowles, Inc.
Charmayne Dube	New Directions
Murray Enns	WRHA Adult Mental Health Program
Diva Faria	Manitoba Family Services
Louis Goulet	Manitoba Justice
Larry Hardy	Manitoba Family Services
Shirl Hauser	New Directions
Elaine Hawkins	Manitoba Family Services
Keith Hildahl	Manitoba Adolescent Treatment Centre
Ian Hughes	Marymount, Inc.
Paul Johnston	MacDonald Youth Services
Ron Kane	MacDonald Youth Services
Lisa LaCroix	Manitoba Family Services
Donna Lalonde	Southern First Nations Network of Care
Jane Littlefield	Marymount, Inc.
Ruth Loeppky	Manitoba Family Services
Stephanie Loewen	Manitoba Health
Mick Makar	Manitoba Justice
Andrea McKenzie	Knowles, Inc.
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Tracy Moore	Manitoba Family Services
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Irmie Nickel	Aulneau Renewal Centre
Alicia Ordonez	New Directions
Andy Orobko	Manitoba Family Services
Sheila Pinkerton	New Directions
Dave Purpur	Knowles, Inc.
Jim Richardson	Winnipeg Child and Family Services
Brian Ridd	Manitoba Family Services
Daniel Rothman	Ellerby, Kolton, Rothman & Associates
Jane Runner	New Directions
Wendy Scheirich	Manitoba Family Services
Sandy Sullivan	Manitoba Family Services
Marg Synyshyn	Manitoba Adolescent Treatment Centre
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