



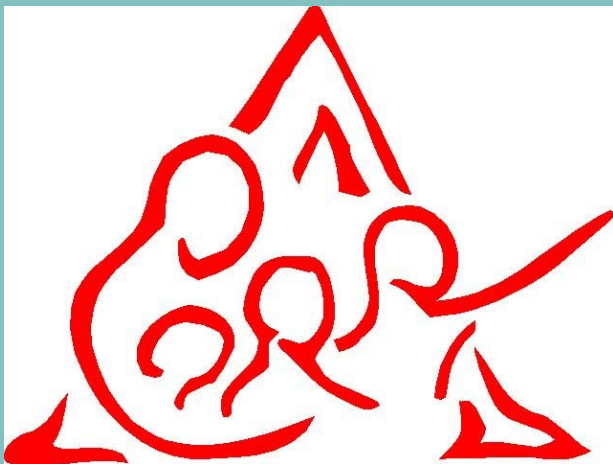
# Adolescent Services Program: A Success in Partnering.



Cornwall Community Hospital and  
Children's Aid Society Stormont,  
Dundas & Glengarry.

# Community Capacity

## Partnerships



# Program Overview

- The Adolescent Services Program is a joint venture between Children's Aid Society S.D.&G. and Cornwall Community Hospital: Child and Youth Counselling Services. This is a Ministry Community Capacity Initiative funded program developed to serve the needs of families in the Stormont, Dundas and Glengarry region.
- The goal of the program is to preserve families in the midst of parent-teen conflict by providing therapeutic and skills building programming and services.

# Recognizing a need for an Adolescent Program

- Traditional method of service delivery not effective; too diffuse
- Child protection workers not specialized
- Too many adolescents in care for too long a duration
- Frequent re-openings
- Limited coordination of community services
- Poor outcomes for adolescents and families

# Program Development

- Adolescent services committee was initiated in 2005
- Model of service delivery developed
- Team created in February, 2006
- Partnership between CAS and Cornwall Community Hospital initiated in spring, 2006. Mental Health counselor was added in June, 2006.
- Program expansion in March, 2008

# Guiding Principles

- Admitting an adolescent into care poses inherent risks to that child, and in most cases, is not beneficial to the child or family.
- While keeping an adolescent in the home should be considered a goal, it should not be considered an outcome. The continued safety of the child, family and community, as well as the re-establishment of positive family functioning, are the desired outcomes.

# Strengths of the model

- Centralized, customized services to adolescents
- Integrated child/protection/children's mental health services
- Increase in direct service to families
- Concurrent CAS/mental health assessments
- Group clinical supervision/team support
- Increased community collaboration

# The Adolescent Services Program

- Recognizes the distinction between parent/adolescent conflict and bona fide child protection cases
- Acknowledges that cases of extreme abuse or neglect are not appropriate for the program.
- Recognizes that the risk to the adolescent in the home may well outweigh the risk to the child out of the home.
- Does not replace or diminish parental authority, parenting and ownership of the problem remains with the family.

# Adolescent Services Program

- Works towards the goal to support parents and their children by helping to address the social, personal, behavioral, or systemic issues which may act as barriers to effective parenting.
- Assists with establishing multiple supports. It is crucial that wherever possible, community and family support systems be an integral part of the treatment plan.
- Recognizes that all families have inherent strengths.
- Is dedicated to identifying and building on those strengths.

# Adolescent Services Program

- The most effective interventions are responsive and flexible. Program interventions will endeavor to reflect the individual needs of the family , and treatment plans will be developed accordingly, with family collaboration
- Successful interventions are highly dependant upon positive relationships and mutual respect between the family and service provider.

# Transformation – Community Capacity

- Group supervision with all members of the team from both CAS and CCH
- Team strength oriented which meets the mandate of transformation for CAS.
- Confidentiality between two agencies.
- Linkages are stronger to other community partners (transformation).
- CYCW is attached to the program.
- Mental Health Therapist attends family meetings.
- Team approach means that the family has essentially three people to contact in case of family breakdown.

# ■ Philosophy

- Provide intensive reintegration strategies to return the child home when they have been taken into care.
- Multidisciplinary approach.
- Keeping children at home because they are better served at home.

## 2006-2007 A-Team

2 Child Protection Workers, 1 Child and Youth Care Worker,  
1 Mental Health Therapist, 2 Supervisors.





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# Services

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- Crisis Intervention
- Parenting Skills
- Counselling
- Family Mediation
- Skills Building Groups
- Behavioral Contracts
- Individual and Family Therapy
- Community support/liaison: Court, Police, Probation, School meetings, Youth Justice Committee, Native Services. CHEO and ROH Outreach, referral to community programs and services.

# Child Protection Worker Role:

- Child protection assessments
- Case management
- De-facto guardian if child comes into care.
- Follow the mandate to ensure the safety of the child.
- Ongoing supportive intervention.
- Crisis calls – intervention
- Central role in liaison with community partners for the family
- Identify behavioral or mental health concerns and refer to appropriate team member

# Roles **CYCW** Role in the **Adolescent Service Program**

- As a CYCW on the Adolescent Service Program, I work with a multi-disciplinary team that consists of a case manager (CPW) and mental health therapist. I must advocate for the clients and be a consistent and effective support for families. I must always look out for the best interest of the family.
- I am also working with community partners on a weekly basis such as Child and Youth Counseling Services, School Boards, Police Services, Children Treatment Centre, Youth Justice, Group Homes and Foster Homes.

# Techniques to establish positive interactions between family members

1. Rapport Building.
2. In-home service for families.
3. Role Modeling.
4. Crisis Intervention.
5. Therapeutic Recreational Activities.
6. Behavior Modification.
7. Behavior Contracts. (See Example)
8. Anger Management Techniques.
9. Social Skills Training
10. Group Work (Goldstein's Skillstreaming the Adolescent).
11. Reintegration for kids brought into care on a short term basis.
12. School Interventions

# Jane's Contract

## Respect

- Handout

# Clinician's Role on the Team

- Assessment and treatment of mental health or concurrent disorders
- CAFAS
- Individual and family therapy
- Family or sibling mediation
- Support of CAS team members
- Referral to CHEO, or other service providers
- Crisis intervention
- Groups
- Family and individual support: in School, Court, Youth Justice Committee, attendance to Police stations, Foster homes, Group Homes, Doctor's appointments and anything else (appropriate to the case) that comes up that I never thought I would be doing.

# Clinical Perspective: Pro's

- Joint initial interviews with families promotes teamwork, increases understanding of both the protection and mental health services, and increases motivation to work towards goals.
- Analysis of family functioning begins with the initial interview. Family systems from a clinical perspective are discussed from the start, resulting in increased 'buy in' from all members of the family.
- Introduction of roles and perspectives prevent splitting

# More pro's.....

- Family and teen functioning are discussed regularly in team supervision and on an informal basis so clinical and protection issues are known by all, leading to increased communication, better case management, and more effective crisis intervention.
- Joint home visits reinforce team perspective. Assessment of family progress in discussing contracting, as well as doing informal family therapy promotes further movement towards family goals. We can play “good cop bad cop”.



## and Con's

- CAS age mandate may end before clinical work with the teen has been resolved, therefore clinician carries an individual on their caseload. This reduces the ability to add clients to clinician's roster and creates an informal waiting list.
- Solo work increases time in court, school meetings and consultation visits while supporting clients. This is a different role than being purely a clinician; there are no pure 'office visits'.

# More con's.....

- A-Team clients tend to have difficult clinical or behavioral issues including; addictions, runaway behavior, criminal justice issues, truancy, which leads to difficulty finding the child, much less treating them.
- Increased travel time spent looking for kids.
- runaway behavior impacts initial contact and consistency/ effectiveness of sessions.

# ■ Teamwork: how we do it

- Stress relief: Chocolate, laughing, joking, coffee breaks
- Open communication often several times a day; always talking
- Coordinating visits and calls, filling in for each other, joint meetings or visits.

# Description of Family

- Whether married, divorced or blended, families seem to have one parent that is rather strict (rock) and the other who is too lenient (marshmallow).
- Poor communication between parents
- Competition between parents for the ‘best parent’ imaginary award.
- Child becomes the “identified patient” or ‘bad seed’ in the family.
- Parents wait too long to get services, therefore they want the child gone from the home by the time they call.

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## ■ parents

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- Parents see the team as “the cure” for the child’s negative behavior, not invested to change themselves.
- “Magic Wand”

# ■ Parents/dynamics

- Parent/ peer relationship: no routines or boundaries for the child to follow leads to difficult adolescent separation issues.
- Attachment issues with the child.
- Inability of parent to set firm limits and follow through with the child.
- Parent has reverted to over-consequence the child in response to repeated offences against the rules. Therefore the child has nothing to lose by making bad choices.

# Strategies with the family

- Set limits with parent's limit setting skills
- Outline appropriate consequences
- Reorient thinking: bad choices vs. bad child
- Define the meaning of “respect”
- Focus on positives and positive reinforcement.

# Case study

- Extensive involvement with Mental health services since the age of 5, including outpatient, inpatient, hospitalization and residential care
- CAS care for 2 years; out of area group home.
- Based on the Provincial Ombudsman report the file was transferred from CAS to Children's Mental Health to provide case management until 18 yrs old due to special needs of child. This enabled mom to keep her custodial rights rather than have her become a crown ward.
- Section 23 /Day Treatment school Program
- Intensive Home Support Program to successfully reintegrate home, which did not achieve the desired results.

# Case cont'd

- Introduction of Adolescent Services Program; Clinician and CYCW.
- Outcome: fully integrated into a community school, and home with bi-weekly weekend respite at group home.
- CAFAS assessment was halved (12 month CAFAS) 1 month after return to home full time.
- Non compliance by parent (premature exit from service) required a supervision order granted in order to ensure clinical follow-up on a long term basis, providing a buffer past the age of 16.
- Annual cost of \$101,000.00 for Group Home residence, verses bi-weekly weekend visits at a cost of \$23,000.00
- Cost savings for 1 client \$78,000.00.

# ■ Experimentals

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- School behavior program
- Art therapy; hands-on



# Art Therapy

- Art Therapy provides a non-verbal means for clients to express what is going on with them.
- Art Therapy can be used as an assessment tool, or clinically, a pictorial record of progress/regression, a means to express painful experiences in a non threatening way.
- Group work, family work or individual.
- Consultation
- Con's: There is often not a consistent space to work.

# Relevant Statistics 2006/7

- **Child in Care Stats for 2006/7 fiscal year (Adolescent Program)**
- # of children admitted into care in the 2006/7 fiscal year: 14
- Total number of days in care: 1311
- Average # of days in care: 93.6
- Average # of days in care (excluding the 4 children identified as beyond the program's scope: 60.8
- Percentage of children admitted to the adolescent program who remained in care as of March 31, 2007: 14% (2 children, both of whom were admitted just prior to the end of the fiscal year)

## Stats continued .....

- # of placements in residential settings: 6 (42%)  
(One of these children was replaced to a regular foster home at 30 days)
- Average number of days in residential care: 128.8 days
- Total cumulative days in residential care to March 31, 2007: 773
- Average # of days in foster/kin care: 59.7 days
- # of foster care placements: 7 (50%)
- # of in care kin placements: 1 (8 %)

## Child in Care Stats for 2005/6 fiscal year (children aged 12 to 15 and admitted to care due to parent/child conflict/child's disruptive behaviour)

- Total # of adolescents admitted into care in the 2005/6 fiscal year due to parent/child conflict of child's disruptive behaviour: 22
- Total # of days in care as of March 31, 2006: 2788
- Average # of days in care as of March 31, 2006: 126.7
- Average # of days in care as of March 31, 2007: 278.6
- Percentage of children placed in residential care: 72.7 % (16 children)

# Children in care stats cont'd

- Percentage of children still in care as of March 31, 2007: 31% (7 children)
- Percentage of children in residential settings: 72.7 % (16 children)
- Percentage of children placed in residential settings still in care as of March 31, 2006: 68% (15)
- Percentage of children in foster care settings: 27.3%
- Average number of days in care to March 31, 2006 (residential settings): 151.62 days
- Average number of days in care (residential settings) carried to March 31, 2007: 359.13

# Future

- Formalize clinical visits to the office to increase structure vs. crisis driven services.
- Earlier intervention / expansion of the program to serve pre-adolescents.
- Formalizing community linkages.
- Leadership role in youth advocacy in the community.
- Unsure about Community Capacity Funding.