

Review and Model Development Specialized Residential Services

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“We envision a region with no new FASD births and where currently affected individuals are well supported”

EXECUTIVE SUMMARY

There are numerous agencies throughout Alberta that provide various levels of residential services for children and youth; however, few provide residential services that are exclusive to those diagnosed under the FASD umbrella. Instead, the FASD program is one of several programs offered and tends to be limited to a number of placements within a larger program. Across Alberta, residential placements are decreasing, especially specialized services beds. The apparent reason for these closures is multifaceted and includes inadequate funding, retention and recruitment of qualified staff and the increasing demand to provide quality services with existing staffing and funding. In an effort to provide quality services and retain qualified staff, many agencies have opted to close beds, thereby reducing the demand on staff; however, this fails to address the existing need or the increasing demand for specialized residential placements.

The Lakeland Centre for Fetal Alcohol Spectrum Disorder recognizes the need for specialized residential services for persons diagnosed with an FASD, specifically in the Lakeland area of North Eastern Alberta. It is recognized that to meet the needs of the 250 adults and children presently diagnosed in the Lakeland Service Area, a spectrum of residential services is required across the life span: services that are not currently available. Therefore, the Lakeland Centre for Fetal Alcohol Spectrum Disorder proposes the establishment of its first residential services program.

Based on practice based knowledge, research and recommendations the Lakeland Centre for Fetal Alcohol Spectrum Disorder's initial residential services program will target adolescent males who have been diagnosed and are unable to reside with their natural families or within traditional foster or group care placements, many of whom are expected to be street involved. Street involved can be defined as not having a fixed address, staying with friends and family for short periods of time, increased probability exploitation, substance use and having criminal justice experience. It is these youth who are currently in the cycle of abuse who need immediate attention. The consequence of continued behaviour as described is a population of adults who are unable to receive financial support due to their transience, who continue to use substances, develop secondary disabilities, are in and out correctional, addictions and/or mental health facilities and often return to their home communities with children, who are frequently substance exposed and affected.

The Lakeland Centre for Fetal Alcohol Spectrum Disorder proposes to establish an FASD specific residential services program in a rural Cold Lake location, to reduce the impact of urban influences but not so far as to inhibit access to services. The program will cater to no more than 6 clients enabling staff to meet the individual needs of each adolescent without neglecting the needs of others. The program will have a staff to client ratio that exceeds the intensive group and secure services ratios and will provide intensive lifeskills oriented programming. Program focus will be the maintenance of individual client strengths/interests and the further improvement of

deficit skill areas with an overall objective to heighten functional ability and to prepare for the client for transition to the next stage of life and living. The ultimate ambition of the specialized residential services program is to provide a home like environment that is safe and secure, supportive of individual growth and development and focuses on individual client needs.

The Lakeland Centre for Fetal Alcohol Spectrum Disorder continues to be at the forefront of FASD research and the application of research and evidence based practices. The residential services program further supports the Centre's commitment to their clients, the community and the evolution of practice based evidence with regard to successfully meeting the needs of those diagnosed with an FASD while respecting their individual rights and freedoms. Team members at the Lakeland Centre for Fetal Alcohol Spectrum Disorder have been chosen from amongst their peers for their knowledge, understanding, compassion and commitment to supporting persons and families affected by an FASD. Recruitment will continue to focus on the individual skills and life experience of applicants who are interested in being a part of the unique services provided by the Lakeland Centre for Fetal Alcohol Spectrum Disorder. To recruit and retain qualified employees, the Lakeland Centre for Fetal Alcohol Spectrum Disorder recognizes that it must continue to be competitive in the Alberta job market and is prepared to appropriately acknowledge the skills, education and experience of qualified staff and to provide valuable and beneficial training opportunities.

The Lakeland Centre for Fetal Alcohol Spectrum Disorder currently provides diagnostic services for adults and children, support services for children, adults and families affected by an FASD and employs 10 program positions including 1 Diagnostic Team Coordinator, 2 Mothers-to-be Mentors, 4 FASD Coordinators, 1 Project Manager and 2 Administrative. The proposed residential services program would generate an additional Management position, a Transition Worker, 12 front line workers, a Home Operator and a Clinical position bringing the total number of program positions at the Lakeland Centre for Fetal Alcohol Spectrum Disorder to 26, exclusive of the intended expansions to core support programs in the communities of Bonnyville, St. Paul and Lac La Biche as a result of the FASD Service Network Program Funding.

The cost of establishing a property such as the specialized residential services program proposed by the Lakeland Centre for Fetal Alcohol Spectrum Disorder will be in excess of one million dollars. As a not-for-profit community based agency, the Lakeland Centre for Fetal Alcohol Spectrum Disorder will require the support of the provincial and federal governments, the community and private benefactors to raise the necessary capital to initiate and sustain the project.

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LAKELAND CENTRE FOR FETAL ALCOHOL SPECTRUM DISORDER SPECIALIZED RESIDENTIAL SERVICES PROGRAM

PURPOSE

The Lakeland Centre for Fetal Alcohol Spectrum Disorder (LCFASD) and its Board of Directors has committed to the research and development of specialized residential services for persons affected by Fetal Alcohol Spectrum Disorder (an FASD). This decision has been in response to the demonstrated need for this type of services and the decreasing availability of program beds across the province. The Lakeland Service Area has its own defined set of needs~ large geographical area that includes the city of Cold Lake, the towns of Bonnyville, St. Paul, Lac La Biche, Smoky Lake, 4 eastern Métis Settlements, 7 First Nation Communities, 1 military base and about 25 small towns, rural, semi-isolated, lower overall annual income, lower levels of completed education, increased addictions/mental health concerns~ all of which support the need for residential services in the area that meet the needs of children, adolescents and adults affected by an FASD.

The report contains background information, a literature review, stakeholder consultations, licensing/accreditation requirements, program foundations based on practice based evidence and conclusions. This report examines a sample of residential services available in western Canada, in particular those which provide services for children and youth diagnosed with an FASD, and the viability of and support of the proposed establishment of specialized residential services for persons affected by an FASD.

INTRODUCTION

In 1989 the United Nations ratified the **UN Convention on the Rights of the Child**. The Convention contains 54 articles which recognize that persons under 18 years of age have rights which apply regardless of gender, race, creed, religion or abilities. It further recognizes that all organizations who are concerned about children should work toward what is best for each child. Outlined are several articles which apply most directly to the marginalized populations with whom the LCFASD works and which apply most directly to the Centre does within the Lakeland area.

Article 9 Children should not be separated from their parents unless it is for their own good.

Article 12 Children have the right to say what they think should happen, when adults are making decisions that affect them, and to have their opinion taken into account.

Article 20 Children who can not be looked after by their own family must be looked after promptly, by people who respect their religion, culture and language.

Article 23 Children who have any kind of disability should have special care and support, so that they can lead full and independent lives.

Article 25 Children, who are looked after by their local authority, rather than by their parents, should have their situation reviewed regularly.

Article 27 Children have a right to a standard of living that is good enough to meet their physical and mental needs.

Article 28 Children have a right to an education.

Article 30 Children have a right to learn and use the language and customs of their families, whether these are shared by the majority of the people in the country or not.

Article 31 Children have a right to relax and play, and to join in a wide range of activities.

BACKGROUND

In preparation for this project, the Executive Director of the Lakeland Centre for Fetal Alcohol Spectrum Disorder completed **A Brief Review of Residential Supports Available for Youth with an FASD**. The results of this review showed that

- there is a need for long-term out of home placement for adolescents diagnosed with an FASD
- earlier diagnosis results in earlier implementation of preventative measures
- the older a child at the time of diagnosis the less likely they will be able to remain in the family home
- implementing a wraparound approach for youth/family who have not previously experienced systemic support is difficult
- many who have been diagnosed with an FASD left home or foster care before the age of 18
- a majority have lead turbulent lives involving drugs, alcohol, crime
- in 2004 CFSA Region 7 suggested that an estimated 75% of children in care are confirmed or suspected to have been pre-natally exposed to alcohol
- the LCFASD estimates that 20% of the Lakeland Service Area population has been pre-natally exposed to alcohol (approximately 12,500+ persons)
- minimal literature with regard to providing support to families caring for adolescents

As outlined in her report, the Executive Director suggests there will be consequences for our community, and society as a whole, should the needs of youth diagnosed with an FASD not be addressed and met. There are a number of potential consequences to maintaining the *status quo* including:

- Continued multiple placements
 - Multiple placement disorder
- Transient and unsupported adults affected by an FASD
- Prostitution and exploitation
- Alcohol/drug use
- Early unplanned pregnancy
 - Increased probability of pre-natal exposure to substances
 - Polly drug use is prominent, if drug of choice can not be secured, alcohol will most likely be substituted
 - Between alcohol, cocaine and heroin, alcohol does the most permanent damage to a fetus
- Over representation in the criminal justice system

- Early death
- Increased cost to government and society
 - In 2005 the Public Health Agency of Canada estimated that the cost of supporting a person with FASD across the life span was \$1.5 million, not including criminal justice expenses
- Continued ineffective use of community support agencies
- Increased community frustration about today's youth, without understanding what being affected by an FASD means

CURRENT STATUS OF RESIDENTIAL SERVICES

In Alberta, and across Canada, there is a growing need for qualified foster parents, group placements and intensive services for children and youth who are unable to remain in the family home. Time, money and skilled personnel are becoming increasingly rare commodities and need to be carefully managed to ensure sustainability into the future. Unfortunately, this is not the case.

Instead, skilled foster parents and groups homes are begged to take 'just one more' 'just this one time' by social workers who are in the legal position to find care for the children who have come under the guardianship of a Director of Children's Services. What this often means is that children are removed from their home communities to where there is an available bed which means separation and isolation of the children from their families and communities. Burnout, compassion fatigue and vicarious trauma are often the result for caring foster parents who want only what is best for children in need. It is often even more challenging to find supportive environments for children, youth especially, who have specialized needs. This is often due, in part, to the increased skill levels and time commitment required of the caregiver to effectively and compassionately meet the needs of the complex child in need.

Why is the number of foster parents decreasing when they need to be increasing? Why is the number of group placement beds available decreasing when they need to be increasing? While operational needs of foster and group placements continue to increase, many contract rates do not adequately reflect these increases. Programs and families who are committed to meeting the needs of children continue to provide services but, in an effort to maintain quality services, have reduced the number of available beds while the need for beds continues to increase.

Placement beds most often sacrificed are those requiring increased caregiver contribution, in other words, beds that meet specialized needs. The number of program beds available for children and youth diagnosed with an FASD who are unable to reside in a traditional foster placement are limited within Alberta and non-existent within the Lakeland Service Area. Agencies that are providing

FASD programming are operating at capacity and many have waiting lists, which further supports the development of additional residential services for youth who have been diagnosed with an FASD.

CHALLENGE: SPECIALIZED YOUTH SERVICES

Availability of placement beds aside, it is easier to place young children than it is to place an adolescent. Children are infrequently placed in group care situations as the majority of foster placements cater to the needs of younger children. There are many more group placements for adolescents than there are traditional foster placements and this speaks to the commitment and specialized skills required to work with youth, many of whom have had multiple placements, do not want to be in care and are often rebellious against the foster parent and the agent of the Director. However, many group placements are not designed to meet complex needs, let alone those of an adolescent diagnosed with an FASD; consequently, this lack of specialized programming generates more problems and concerns for the youth, the care giver and the agent of the Director.

Why is it increasingly difficult for youth affected by an FASD to remain in the family home or to be placed in traditional foster or group placement?

Anne Streissguth states that

“during these years [adolescence] ... parents realize ... their child is not catching up and is not fitting the expected developmental stages. A number of contributing factors including parental panic, professional uncertainty, decreased interest in school and other activities as rates of success diminish all work together to eliminate whatever balance was created during the childhood years.” (Fetal Alcohol Syndrome- A Guide for Families and Communities, 1997)

Add to these parental/caregiver realizations, normal adolescent hormones, peer influence and the adolescent’s own fear and lack of understanding of what having an FASD means. What living situation is going to prove to be the most beneficial for adolescents affected by an FASD? Ideally, a natural home environment that has been adapted and adjusted to meet the needs of the youth, however, this is an ideal and not the reality for many of our youth diagnosed, especially those who are not diagnosed as children, but instead during their adolescent years, making acceptance and understanding that much more difficult.

Living with FASD, by Sara Graefe, outlines a few key needs for residential placements for adolescents including:

- a safe, structured environment
- clear, predictable routines
- clear, consistent expectations and consequences
- supervision can not be decreased
- careful monitoring of social activities and structured leisure time
- do not leave alone for an extended period of time
- encourage talents
- discourage non-constructive use of leisure time
- identify strengths and interests, especially when looking for appropriate employment

To effectively meet these needs requires a caregiver who is committed to meeting the needs of a youth affected by an FASD. Combining affected and non-affected youth, who are not related, in the same home or program is often detrimental to both the youth and the caregiver and placement breakdown is inevitable. To effectively meet these needs requires more than one person, or couple. Additional support services and respite are required in traditional foster placements, both of which are increasingly difficult to secure, not to mention respite is frequently unsuccessful as the change, albeit short term, is too difficult for the youth. Clearly, meeting the needs of youth affected by an FASD is a challenge, but not one to be disregarded.

WHAT DOES THE FUTURE HOLD?

Children and youth affected by FASD will continue to have the same needs as they mature and will continue to require additional supports across the age continuum. The LCFASD recognizes that persons diagnosed with an FASD require life long supports and services, many and most of which are not available in the Lakeland area: prevention and support services provided directly through the Centre being the exception. Through client analysis, the Centre has identified two primary groups in crisis:

➤ **young adults who**

- have no fixed address,
 - living in a disorganized state from friend to friend and family member to family member
- may or may not qualify for PDD services (IQ <70)
- may or may not qualify for continued supports through CFSA
- may or may not qualify for AISH services

➤ **adolescents who**

- are legally in the care of the director who
 - are not receiving services
 - are receiving ineffective services
- are under parental care but
 - whose parents have reached burnout
 - whose parents are also likely affected but not diagnosed
 - whose parents no longer care
- are no longer in the care of their parents and
 - have not been for some time
 - are living in environments that are not working for them
 - are living in unsafe environments
 - have no fixed address
 - are street involved
 - are taken advantage of by others, including friends and family
 - are exploited
 - sexually
 - financially
 - criminally

DEMOGRAPHICS

As of February 2008, the LCFASD has diagnosed a total of 228 children in the Lakeland Service Area:

- 142 males
- 86 females
 - male to female ratio 1.65:1
- currently 5-12 years
 - 86
 - 37 females
 - 49 males
- currently 13-18 years
 - 75
 - 26 females
 - 49 males
- currently 19-24 years
 - 40
 - 14 females
 - 26 males

Of the 228 diagnosed:

- ◆ 99 are in foster care
 - 52 male
 - 47 female
- ◆ 5 are in group care
 - male
- ◆ 54 are living outside the parental home in a private arrangement including formal kinship, extended family and adoption
 - 33 male
 - 21 female

Based on this information, the Centre has 75 clients who are currently aged 13-18 years with an additional 86 clients aged 5-12. Early diagnosis, stability and education all contribute to the ease of transition from children's services to adult services. By addressing the needs of the adolescent age group, the objective is to reduce the number of young adults not receiving services they not only require but may be/are entitled; to support the transition between adolescence and adulthood and to interrupt the perpetual cycle of abuse by means of stability, education, advocacy and acceptance. The provision of intensive services between the ages of 14-16 years of age will permit the LCFASD to assess and determine what level of services will be required by those who have come into the direct care of the LCFASD Residential Services Program. This will allow the LCFASD time to collaborate with community support agencies including PDD, CFSA and Human Resources and Employment (AISH funding) to provide next level residential services.

As our young adults mature, their needs will continue to evolve and they will require continued and new supports and supervision over their lifespan. Stable young adults diagnosed with an FASD who are receiving appropriate services and contributing at a level consistent with their ability, further a more tolerant and adjusted community that respects and provides self worth to **all** its members.

SUPPORT AFTER EIGHTEEN

Adolescents with an FASD age into young adults with an FASD. Withdrawal of support services at the age of majority is neither advisable nor effective. Notwithstanding, children are only eligible for support services through Children's Services, under the guardianship of a Director or through the Family Support for Children with Disabilities (FSCD) program, up until the age of 18, or 21 under individual circumstances for those under the guardianship of a Director.

Continued, and new, supports are considered to be the most effective means to successfully transition adolescents into adulthood. Support services for those over the age of 18 are provided through the Persons with Developmental Disabilities Program (PDD). PDD is a division of the Ministry of Seniors and Community Supports, who in 2006-2007 had an annual budget of \$509 million to provide support services to 9100 adults and their families across Alberta. The role of PDD is to provide support services to adults with developmental disabilities, within the community, to create an Alberta where adults with developmental disabilities are included in community life.

To this end, the Executive Director conducted **An Exploration of Persons with Development Disabilities Services for persons with FASD in Alberta**. This report highlights the obstacles a person with an FASD and who qualifies for PDD supports faces in trying to access services. Without adequate support services and advocacy, young adults affected by an FASD are left to navigate their own way.

Typical profile of a young adult affected by an FASD:

- 18-24 years old
- IQ (<70) with functional deficits that qualify them for PDD services
- IQ (>70), which disqualifies them for PDD services, with functional deficits that make independent living more than difficult
- Traumatic life history
- Minimal family involvement
- No guardian
- Experience with the criminal justice system
- Poor judgment and working memory
- Looks and sounds more capable than they are

Persons affected by an FASD are often viewed as "difficult" due to the visible impact of their organic brain disorder. Persons affected by an FASD who qualify for PDD services, but often do not receive this support:

- have an IQ >70
- have a functional IQ that is lower than their IQ
- may not have a stable parent/caregiver or advocate to assist in accessing services
- have low levels of literacy and comprehension
- have poor working memory
- are not able to articulate what they want or need
- may have difficulties in group settings
- require consistent structure/routine and consistency
- require reminders from an outside source to complete daily chores

- are impulsive
- are unable to correlate behaviour and consequence

PDD services adhere to strict principals that are in contradiction to the general FASD characteristics outlined above. To receive PDD services, the client must want and be involved in the planning for services and must demonstrate stability: demands that are more than a challenge for many who are affected by an FASD and eligible for PDD services. Further complications include that PDD services

- are client driven
- view structure, routine and consistency as a loss of independence
- believe the client must 'learn' from mistakes
- believe the client is in control of their own behaviour
- view the ultimate goal is independence, to reduce services over time

As a result, it is often difficult, if not impossible, for those who have been diagnosed with an FASD and qualify for PDD services, to access services due to the conflicting PDD program principals, the characteristics of FASD, the individualized needs of the person and the required level of external support. The number of persons entering into the young adult/adult stages of life is increasing and will continue to do so as the number of children being diagnosed increases. The adult systems need to prepare to meet the needs of those who have been diagnosed with an FASD and qualify for PDD services, regardless of the perceived level of stability demonstrated by the applicant.

The LCFASD has diagnosed 42 adults, has an adult caseload of 15 clients, 10 of whom have been active in the past year, 4 of whom are currently eligible for PDD services but are not receiving them because they do not conform to the strict PDD guidelines: the single most influential factor is transience, they do not have a residence and are therefore considered unstable. These clients have been labeled as "difficult to serve"; however, this does not eliminate their need for and entitlement to supportive services, including financial support.

EMERGENCY YOUTH SERVICES

Alberta Children's Services, Community Strategies and Support Division Community Partnerships Branch completed a review of emergency youth shelters in Alberta in February 2007: **Youth Emergency Shelter Review Report**.

The report shows that Region 7, North Central Alberta, which includes the LSA, Region 9, Northeast Alberta, which borders on the northern edge of the LSA, and Region 10, Métis Children's Services, do not have emergency shelters.

When necessary, youth can be transported to the Edmonton Youth Emergency Shelter from these regions. The report indicated that the Edmonton Youth Emergency Shelter is infrequently utilized by Regions 7, 9 and 10 and further suggests that the need for shelter space in rural north central/ north eastern Alberta remains unclear.

The Edmonton Youth Shelter operates at 90% or more capacity. Teenage mothers and youth with disabilities face challenges in accessing shelter services. Youth who access shelter services range in age from 12-21 with the average being between 15 and 17 years and the provincial ratio of males to females is 3:2. The typical male is 16-17 years while the typical female is 15-16 years.

The single largest group accessing services was from foster/group care and had already experienced multiple placements due to complex issues and placement breakdown. It may be deducted that the 19.9% of youth accessing emergency shelter because Children's Services, including Region 7, contract with provincial emergency shelters to ensure youth in care have a safe place to go in the event of placement breakdown.

During youth focus group sessions, youth indicated they need

- support to make a successful transition back to the community
- connections to other resources
- caring staff who listen and work with them
- additional supports for addictions
- a stable place to stay that meets basic needs
- access to educational, recreational and cultural activities while in the shelter
- to be treated with understanding and respect
- to be recognized as individuals with differing needs
- access to foundational life skills

The results of this review raise several questions for the Lakeland Service Area. Where do youth in Regions 7 and 10, both of which provide services in the Lakeland Service Area, go when in crisis? What services are available for them? It should not be speculated that because Regions 7 and 10 have low incidences of use there is not a need for emergency shelter services. Instead it raises the question of is it in the best interest of youth in these regions to be sent, generally by bus, to Edmonton where they will have fewer natural supports and may be at increased risk to exploitation and harm, especially those youth who may be affected by an FASD?

The LCFASD recognizes that there are youth in crisis in the Lakeland Service Area. It further recognizes that there is a need for emergency services for youth; however, at this time the LCFASD is not prepared to directly address the issue of emergency shelter services. Instead, the intention of the LCFASD is to address the need for emergency services by working to effectively reduce the incidence of secondary disabilities in adolescents affected by an FASD using evidence based intervention techniques.

The Edmonton Community Drug Strategy Task Force prepared the document, **“Tolerant Shelter for Youth (18-24) with Concurrent Disorders”** in May 2007.

The Edmonton Community Drug Strategy advocates for the establishment of safe and secure shelter for youth 18-24, with a focus on concurrent disorders utilizing harm reduction and treatment pillars and ensures additional supports outside the shelter.

The goals of the working group is to advocate for a vulnerable and distressed population that currently have no alternative but adult shelters that may be unsafe places for those with concurrent disorders, to create an environment that addresses safety for 18-24 year olds with concurrent disorders and to build relationships with youth to improve their quality of life.

Tolerant Shelter recognizes the need for a continuum of services ranging from a 24-7 full service night shelter to transitional housing with available 24-7 assessment and referral to shared apartment units with accessible and optional supports on an as needed basis to independent self contained suites with community connections. This range of shelter/support provides for the long term needs of youth with concurrent disorders, helps to establish long term housing situations and the necessary life skills to live independently and manage their lives.

A number of other concerns were highlighted in the **Tolerant Shelter** report including a lack of communication between mental health, addictions and shelter systems. The report indicated that, optimally, mental health, health and addictions services should be available on site to avoid waiting lists, transportation issues and trust issues associated with multiple service providers. There is a need to think outside the box to provide a range of services in a non-traditional manner to a non-traditional population group.

While the **Tolerant Shelter** report specifically addresses the needs of youth with concurrent disorders, it inadvertently addresses the needs of many who have been diagnosed with an FASD. Those who do not receive an early diagnosis and/or adequate support throughout the developing years are more

prone to the development of secondary disabilities, which run not only concurrent to each other but also concurrently with the original diagnosis under the umbrella of Fetal Alcohol Spectrum Disorder. While the diagnosis can not change for those who were exposed to alcohol in utero, what can change is the probability of secondary disabilities including substance abuse, mental health disorder and repeated criminal justice involvement.

Secondary disabilities are defined as those disabilities a person is not born with but can be the result of the impact of prenatal alcohol consumption on the brain.

In 1996 Anne Streissguth and colleagues Barr, Kogan and Bookstein completed the FAS Secondary Disability Study at the University of Washington. The results of this study suggest there are several commonalities between affected persons and the types of issues they have. The results suggest there may be a number of primary protective factors against the development of secondary disabilities including

- stable nurturing environment for more than 72% of life,
- diagnosed before the age of 6,
- eligible for disability benefits,
- never experienced violence against oneself,
- staying in each living situation for an average of more than 2.8 years,
- good quality home between the years of 8 and 12,
- having basic needs met for 13% of life.

The study further indicated that these factors, in combination with appropriate support and interventions, may have the potential to decrease the incidence of secondary disabilities. A number of risk factors were identified including that males, ages 12 and up had an increased potential for disrupted school experiences, experience with the criminal justice system, confinement (hospital, jail) and for dependent living. Consequently, early diagnosis and appropriate support services may have the potential to ease the difficulty of the different transition phases across the life span. Having access to consistent support services that are in continuum with each other and understand what was provided at the previous developmental stage may have the potential to reduce the probability of secondary disabilities and improve the outcome and quality of life for the affected individual and caregivers.

WHAT APPROACH WORKS BEST WITH YOUTH?

Health Canada's ***"Best Practice: Treatment and Rehabilitation for Youth with Substance Use Problems"*** identifies that youth 15-24 are more likely to report suffering from a mental illness and /or substance use disorders than any

other age group which is consistent with Anne Streissguth's indication that males over the age of 12 are at increased risk of developing secondary disabilities. Many factors contribute to youth substance use and it is these factors that must be taken into consideration in developing a successful approach to working with youth.

As a part of the report, at risk youth identified what they need or would like to see in a shelter environment including

- a mental health component,
- a desire to build healthy relationships and
- a desire for a safe and secure environment.

A number of gaps in service including shelter, transportation, clothing, food, appropriate placements, day programs, financial assistance and addictions treatment were also identified by the youth. Shelter was the most primary need and group homes were identified as being 'too restrictive', resulting in short stays before returning to the street. A harm reduction approach was identified as a successful intervention in so far as youth given an opportunity to problem solve in their own time and context.

"Best Practice" defines the Harm Reduction (HR) approach as a set of strategies and tactics that encourages individuals to reduce the risk or harm to themselves and their communities by their various behaviours with a goal to educate the person to become more conscious of the risk of the behaviour and provide them with the tool and resources with which they can reduce the risk.

In 1998 AADAC adopted a position on HR approach to addictions and treatment. The Alberta Drug Strategy states that

HR recognizes that it may be impossible to completely eliminate any given behaviour and that there is a need to minimize harms caused by the behaviour.

Overall, HR aims to improve health, social and economic outcomes using a range of pragmatic treatment and public health approaches. HR approaches respect personal autonomy and support practical interventions to assist in addressing most pressing challenges and concerns. HR aims to lesson the potential dangers and health risks associated with high risk behaviours, including injury, disease and overdosing.

In 2007 AADAC released a policy background paper which outlines the history of harm reduction (HR) and samples HR programs throughout Canada, the US, Europe and the UK.

Author Darlene James indicates that the first priority of HR, which is an accepted approach to addictions with youth populations, is to actively engage youth to recognize and address their most prominent needs. From this, youth should be treated with respect and as members of the community who need help. HR acknowledges that while a particular behaviour is not likely to stop, the objective is to teach safer conduct to reduce risks to the individual and others.

HR approaches are non-judgmental, practical and multi-dimensional: looking at several influential factors that directly affect drug use and stopping drug use and the access of other resources that may have a direct impact on quality of life including housing, physical and mental health services and financial support.

HR occurs where the young person is at, both psychologically and physically. Examples of known HR programs operating in Alberta include methadone and needle exchange programs and, locally, the **PARTY** program (**P**reventing **A**lcohol **R**elated **T**rauma in **Y**outh). One of the LCFASD's Directors is the Lakeland PARTY Program Coordinator and the Cold Lake Mothers to-be Mentor has been active participant in the program for the past several years. The LCFASD's involvement acknowledges the reality of teen alcohol use and sexual behaviour and seeks to educate youth about the long term and permanent effects of alcohol on fetal development.

HR, in its truest definition, is not the goal of the proposed residential program. Rather it is the philosophy behind the approach that is of interest. Instead, the goal of the residential program is to reduce the incidence of risky behaviours by providing a safe secure living environment that promotes and supports desirable replacement behaviours that encourage long term stability and safety.

Intensive services for youth require a philosophical shift to *where youth are given a chance to come to terms with their problems, where they are listened to and involved in the planning for their recovery and their future* opposed to being told what they are going to do, how they are going to do it without resolving the why of their past and present actions. ("**Best Practice: Treatment and Rehabilitation for Youth with Substance Use Problems**")

In 2005 AADAC released, ***Building Capacity: A Framework for Serving Albertans Affected by Addictions and Mental Health Issues***, which examines the need to address concurrent disorders and suggests that the key to better meeting needs is prevention and early intervention services and a seamless delivery of treatment and community support services. The report identified that persons with concurrent disorders have a complex set of

individual needs that require support services from a variety of agencies including

1. Children's Services who offer a number of programs including FSCD, PCHIP, PCHAD, and Drug Endangered Children Acts.
2. Children's Services further recognize the need to provide financial and other supports to youth up to the age 22.
3. Alberta Employment and Immigration have the responsibility to train, help find and maintain employment as well as provide financial and health benefits, child support services and employment training to Albertans in need.
4. Municipal Affairs and Housing has a role is assisting in ensuring safe affordable housing is available.
5. Alberta Education has the responsibility to see that youth receive and education and complete high school.

While the above support services have been identified as important for those with concurrent disorders, the same support services are required by those who have been diagnosed under the umbrella of FASD, many of whom may already have or are at risk of developing concurrent disorders should appropriate support services not be available in the community.

Building Capacity suggests that despite the high correlation between mental health disorders and substance use it is difficult for persons to access services for both disorders at the same time because each are served by different community supports. This leads to poor outcomes for either disorder, overuse of the criminal justice, primary health care and child welfare systems as well as women's and homeless shelters.

Building Capacity suggests that strategies and services for youth must acknowledge the culture of youth and be designed to truly engage youth in addressing their problems and needs. It is suggested by this writer that identification with youth culture may be appropriate for street level outreach services with youth workers as mentors and role models, but is not appropriate for a residential program designed to model and teach acceptable, desirable and safe replacement behaviours intended to provide long term stability and quality of life.

The report recognizes that the implementation of addiction and mental health services that have traditionally been successful with adults, often do not work with youth. Youth often do not identify with the expectations of treatment; consequently are viewed as non-compliant and/or resistant. To be effective, support, care and treatment approaches need to recognize the developmental stages of this age group, including the developmental capacity of the individual.

Essentially, one approach is not going to work with all youth, a theory well known to those who work with children who are affected by an FASD: each child's diagnosis is as different as their abilities and deficits, all of which need to be taken into consideration in the process of developing an adequate care plan.

STAKEHOLDER CONSULTATIONS

An internet search was completed to determine what residential services are available for those affected by an FASD. This search revealed a number of programs in Western Canada and throughout the US including:

- Bocso Homes, AB
- Woods' Homes, AB
- Hull Homes, AB
- Elk Island Boys' Ranch, AB
- Oak Hills Boys' Ranch, AB
- Spirit of our Youth Homes, AB
- Soaring Eagle Support Services, AB
 - PDD supported placement
- McMann, AB
- Catholic Social Services, Edmonton
 - developing street level transition services, start date July 31, 2008
- Crossroads, AB
- Cedar Place, BC
- West Coast Genesis Society, BC
- White Crow Village, BC
- Mennonite Central Committee, MB
 - developing residential services
- Life's Journey, MB
 - residential services not yet operational
- New Directions, Bridges Program, MB
- MacDonald Youth Services, MB
- Ranch Ehrlo Society, SK
- Options for Independence, YK
- Northwood Children's Services, MN
- The Glen Holme School, CT
- Sommerville Young Adult Community, TX
- 3 M Community Service Delivery Model, Alaska
- Little Keswick School, VA

Telephone interviews, face to face interviews and facility tours provided significant information with respect to program operation, what has been learned over the years, the physical location and overall appearance and

functionality of the program homes. Written descriptions of the Hull, Wood's, Bosco, Elk Island Boys Ranch, Oak Hills Boys Ranch, Spirit of Our Youth, Cedar Place and White Crow Village programs can be found at the conclusion of this report in Appendix A.

Information and recommendations obtained from residential service providers that currently offer some degree of FASD programming will be taken into consideration throughout the development of the proposed LCFASD residential services program. It is necessary to look at what is being provided and what gaps may exist to determine how to best meet the need of the identified target group: adolescent males.

The primary concerns raised by existing programs include:

1. Recruitment qualified staff
2. Retention of qualified staff
3. Sustainability
 - a. ability to offer competitive wage and benefit packages
 - b. ability to continue to provide services
4. Renovation and maintenance of facility
5. Discordance between the Child, Youth and Family Enhancement and the Dependant Adult Acts
6. Gaps in services for those who do not meet the requirements for support through PDD
 - a. lack of transition placements
 - b. lack of financial support
 - c. lack of support oriented services

While there are many stakeholders in the development and establishment of a specialized residential service, for the purposes of this report, informal interviews were conducted with those persons directly affiliated with both Children's Services and the Centre's diagnostic teams. One worker, alone, has 15 of 22 clients who are in the permanent guardianship of a Director and affected by an FASD and a minimum of 8-10 who are currently 13yrs and older who could benefit from specialized residential services.

Participants were asked straight forward questions about residential services for children diagnosed with an FASD. Responses have been summarized below. It is significant that participants frequently had similar responses; however, each response has been recorded only once.

What doesn't work?

- One program applied to all children
- Rule oriented programs that stick to the rules

- A non-structured environment

What works?

- Forgive and forget approach- know they are going to screw up, deal with it and move on
- Individualized approach recognizing need and ability
- Highly structured environment
- Kind staff

Qualities from existing residential programs that work with FASD affected children:

- Maximum of 5 clients
- Individually based activities in combination with group activities/work
- Appropriate mix of planned activities, counselling, life skills
- Staff who can stay with the child at school if necessary
- Healthy approach to food/nutrition
- Lots of outdoor activity- some programs have good animal programs
- Therapist who knows the dynamics of the home/program, the children, is a part of the staff component not just a 'guest' in the home
- Spirituality/culture
- Staff who are involved with the children when they are in the bio home environment- see the home environment, develop a relationship with the family
- Supportive of the children when family backs out or disappears
- Home environment versus passes, consequences and rules
- Expectations but not time oriented or rigid
- Good relationship with the school
- Nature/nurture, caring environment versus group care environment

If you could have a dream, what would it be?

- Home setting
- Secure
- Trained staff who understand FASD
- Restricted age group (child, adolescent or young adult)
- Gender specific
- High staff to child ratio, ideally 1:1
- Quality services and environment reflective of per diem rates
- Support family involvement
- Staff function as an 'external brain'
- Structure
- Small group setting
- Rural

- Opportunities for adolescents who can not go home or be independent after the age 18- continue on at a different level of support based on their needs in an adult living setting
- Someone meaningful and constant in their lives, who is not a social worker or the public guardian
- Recognize individual needs- i.e.: drive to/pick up from school, half day school, vocational versus academic
- Set up for success not for failure (i.e.: rules they can't comply with)
- Vocational options

Concerns related to providing residential services for youth affected with an FASD

- Risk of community criticism if seen to be too lenient with the children
- The Dependant Adults Act (DAA) is not consistent with the Child, Youth and Family Enhancement Act
 - application process for DAA can not be completed until after 18th birthday;
 - must prove dependency
- Qualification for PDD services hinges on IQ less than 70 versus functionality
- Services of the Office of the Public Guardian are difficult to obtain.
 - representative does not advocate, will not convince client to remain in a placement and the client must be perceived as cooperative and compliant to be eligible for services

Gaps in available services?

- Inconsistencies between CFSA workers, offices and Regions
- Services to those who have reached the age of 18, are in care but do not meet the guidelines of continued support through transition plan
- Services for those 18-26- young, immature, no life experience
- Basic work and life skills to provide stability, balance and consistency for the future
- Benefit from the services of a banker, a job coach
- Teens are in crisis right now
- Appropriate group/foster/family placements for children with an FASD

The input provided by those who are knowledgeable about FASD and are in the position to provide care for children who are affected by an FASD is considered to be invaluable. Their concerns and recommendations will be carefully considered throughout the program development phase of this project. Inevitably, not all points will be able to be immediately recognized but the objective is to provide the most appropriate residential services possible for

children affected by an FASD who are not able to reside either in a family home, traditional foster care or group care.

PROGRAM FOUNDATIONS

There is significant value in establishing a firm foundation beneath any new program or service. A firm foundation will help ensure the future promise of the program and will help to maintain the established reputation of the Lakeland Centre for Fetal Alcohol Spectrum Disorder.

ACCOUNTABILITY

Ensuring that the children of Alberta receive the care they deserve is the responsibility of the Ministry of Children's Services. Between 2001 and 2004, the Ministry reviewed the Child Welfare Act and introduced amendments to the Act. The Act was subsequently renamed the Child, Youth and Family Enhancement Act when the amendments were formally adopted in March 2004.

The Vision of the Ministry is

an Alberta where children and youth are valued, nurtured and loved, and develop to their potential supported by enduring relationships, healthy families and safe communities.

The Mission of the Ministry is to

work together to enhance the ability of families and communities to develop nurturing and safe environments for children, youth and individuals.

The Enhancement Act defines a residential facility as

A facility that provides residential care to a child in the custody of or under the guardianship of a director and includes a secure services facility, a foster home and a group home, but does not include a facility that provides medical care, educational services or correctional services.

Foster and group care placements are accountable to the Ministry of Children's Services at many levels, most primarily at the licensing level. Any agency or person providing care to a child in care of the Director must be licensed by the Ministry and Children's Services can not place children under its guardianship in a facility that is not appropriately licensed. Licensing provisions have been established to ensure quality care for children in care. Residential services

outside the definition of a 'residential facility' include Supported Independent Living and Independent Living situations.

A licensing application must be made directly to the Minister and once granted is valid for a period of no more than one year; renewal applications must be received and granted, a 60-90 day process, prior to the expiration of the previous license. The initial licensing application generally takes three months, provided there are no complications. Each license is facility specific. The development of an additional facility would require a new licensing application and license; however, should there be multiple residences located on one site, one license may be applied to all the facilities.

The licensing requirements outline what is required of the proposed residential services program for the application process including job descriptions and many of the programs and procedures. With respect to the LCFASD, the agency must prove that it is an incorporated body and criminal records checks, no more than six (6) months old at the time of application, for the chief executive officer and board members must be submitted with the licensing application.

A further requirement of the licensing process is that the agency be accredited after one year of providing residential services. There are four accrediting bodies approved by the Alberta Ministry of Children's Services. A review of each agency has been completed for the purpose of determining which agency is most appropriate for the accreditation of the proposed LCFASD residential services program and can be found at the conclusion of this report in Appendix B.

Based on the information gathered, it is recommended that the LCFASD specialized residential services program accredit with the Canadian Accreditation Council. The CAC is Alberta based, has a lengthy history of working with child welfare organizations and the support staff understand FASD and applaud the objectives of the LCFASD.

It is further suggested that policy and procedure required for licensing be completed at the level required for accreditation. This initial completion of policy and procedure at the intensive level required for accreditation will ensure that the LCFASD exceeds the requirements of the Ministry of Children's Services and further provides the LCFASD with one year to work through any problems or issues with the policy and procedure before commencing the accreditation process.

The CAC standards stipulate that to be accredited an agency must meet 100% of the Safety Standards, 90% of the Required Standards and 80% of the Excellence in Practice Standards. It is suggested that the LCFASD aim to meet 100% of standards in all three categories from the outset of policy and procedure development. This

objective is consistent with quality of support services provided by the LCFASD to the community and clients.

GUIDING PRINCIPALS

After careful collection, review and analysis of the literature and information gathered directly from existing residential service providers, the initial foundation of the LCFASD specialized residential program has begun to take shape.

It is suggested that the Guiding Principals of the specialized residential services program include

- Acceptance
 - Unconditional caring, respect and honesty
- Accountability
 - High standards of care
- Comprehensive
 - Whole person approach in context with their life situation
- Capacity focused
 - Youth engaged & involved in decisions
- Sustainable
- Practice based

(based on Building Capacity: A Framework for Serving Albertans Affected by Addictions and Mental Health Issues)

PROGRAM PHILOSOPHY

The literature review revealed that the Harm Reduction approach to addictions is compatible with many of the desired outcome objectives of the specialized residential program. Based on elements of the Harm Reduction philosophy, the philosophy of the LCFASD residential services program

- Aims to improve health, social, economic outcomes
- Utilizes practical approaches
- Examines the whole person in context of their life
- Examines range of complex needs
- Aims to lessen potential dangers and risks associated with behaviour
- Recognizes may be impossible to eliminate a behaviour

PROGRAM VISION

The vision of the Lakeland Centre for Fetal Alcohol Spectrum Disorder states

We envision a region with no new FASD births and where currently affected individuals are well supported.

The development of specialized residential services is consistent with the Centre's vision to ensure that affected individuals are well supported within their community.

The proposed vision of the proposed specialized residential services program is

To provide residential care and support services across the age continuum to those diagnosed with an FASD.

PROGRAM MISSION

The proposed mission of the LCFASD specialized residential services is

To provide a safe secure living environment for youth affected by an FASD that cares for and respects their needs and helps to prepare them for their future.

PROGRAM GOALS

Identified goals of the LCFASD specialized residential services program include

1. Active involvement of the youth and his family, when appropriate
2. Unconditional provision of service
3. Clear and consistent expectations
4. Provide educational or vocational opportunities consistent with the needs of the youth
5. Use of effective protective factors to reduce occurrence of secondary disabilities
6. Address gaps in services for youth
7. Interdependence not Independence
 - With continued supports not without supports

FOUNDATIONAL ELEMENTS

Ensuring the residential services program is built upon a solid foundation will promote a successful program. The following are recommended program elements only. Additions, deletions and details will become evident through the development of the policy and procedures.

1. Outreach work to transition clients

2. Qualified and skilled staff

3. Elevated staff to client ratios

- a. Propose ratio of 2 front line staff to 5 clients (1:2½)
 - i. Exceeds secure services ratio of 1:4
 - ii. Exceeds intensive group ratio of 1:6
- b. Augmented by supplementary staff
 - i. Residential Manager
 - ii. Transition Worker
 - iii. Clinician
 - iv. Home Operator

4. Home like environment

- a. A safe environment with
 - i. consistency, routine & structure
 - ii. predictable expectations
 - iii. accountability consistent with functional ability
 - iv. a place where youth feel respected, safe, secure, supported and happy

5. Rural location

- a. Not more than 30 minutes from Cold Lake office
 - i. Decreased environmental stimulation
 - ii. Reduced access to negative influences
 1. Substances
 2. Peer groups
 - iii. Reduced probability of AWOL behaviours
 - iv. Lower initial expense (purchase price)
 - v. Lower annual expense (property tax)
 - vi. Potential for onsite programming opportunities
 - vii. Potential for onsite residential program expansion

6. All clients diagnosed with an FASD

- a. Residents of the LSA may be given preference on admission

7. Services to no more than 6 adolescent males ages 14-16 years

- a. program concept developed for 4 clients is not sustainable
- b. increasing client number to 5 accrues a moderate revenue
 - i. provide competitive wages
 - ii. finance physical property

8. Multi-systemic

- a. Wraparound approach
 - i. Meet individual needs of each youth

9. Highly structured and individualized

- a. Monitoring of social activities and structured leisure time
 - i. Supervision needs do not decrease with age
 - ii. Reduced potential for peer manipulation
 - iii. Reduced exposure to negative influences
- b. Incorporation of social activities at youth level
 - i. Encourage good physical health
 - ii. Resolves negative situations
 - iii. Stress reduction
 - iv. Sense of accomplishment
 - v. Improve self confidence
- c. Encourage constructive use of talents and leisure activities
 - i. Identify, become aware of, understand and accept strengths and weaknesses
 - ii. Foster positive growth
 - iii. Reduce impact of negative influences

10. Clear and consistent expectations

- a. House and staff must be organized
- b. Provide external brain
- c. Use visual cues, lists and verbal reminders
- d. Use the same words for the same instructions
- e. Sameness: seat at the table, location of furniture
- f. Routine i.e.: bedtime
- g. Be prepared to repeat instructions or requests
- h. Do not generalize, they can't
- i. Adjust what is acceptable
- j. Plan for the unplanned times
- k. Prepare client for change if necessary
- l. Keep trying differently until you find what works

PROGRAM DELIVERY MODEL

Documents reviewed throughout this report have provided considerable information for the development of program goals with respect to meeting the needs of adolescents, not only from their perspective, but also from the aspect of practice based evidence.

It is recommended that the Program Delivery Model should consider including the following components:

- Consumer participation
- Continuity of services
- Individuality
- Leadership
- Safety
- Service coordination
- Stabilization

(based on the *Framework on Serving Albertans Affected by Addiction and Mental Health*)

Matters to be considered in developing support programs for adolescents include:

- Harm reduction approach
- Client centered
- Flexible
- Engage and involve youth
- Recognize many youth do not view their behaviour as a problem but do recognize it has created problems
- Caregiver involvement and support of placement
- Broad psycho-social approach
- Focus on skill building
- Culturally appropriate activities
- Provide broad learning opportunities
- Recreation at level of the youth
- Modeling of desired behaviour, habits and life choices

(based on *Best Practices: Treatment and Rehab for Youth with Substance Use Problems*)

PROGRAM FOCUS: TRANSITION

The LCFASD has established itself in the Lakeland area by recognizing the needs of those affected by Fetal Alcohol Spectrum Disorder and working to deliver the necessary and required support services for children, families and adults affected by an FASD. The needs of adolescents have previously been combined with those of children and families; however it is becoming apparent that many adolescents who have been diagnosed with an FASD are no longer in the care of families and many are not receiving the level or quality of services required in group placements. Because of this situation, many adolescents affected by an FASD are developing secondary disabilities that have significant impact on their ability to function as part of a community including instability due to chronic housing concerns, substance use, experience with the criminal justice system and an increased vulnerability to exploitation.

During the initial research phase two age groups were identified as being in need of immediate supplementary services. As a result, the LCFASD has determined that the first residential services program shall have a narrowly defined focus

1. Single gender clients
 - ✓ Males
2. Narrowly defined age group
 - ✓ 14-16 years of age on admission
3. Capacity
 - ✓ 5 clients maximum
4. Long term placement
 - ✓ Until youth is prepared to move to the next level of living
 - ✓ Determination of next level needs
 - ✓ Transition to the next level of living
 - independent or supported

One of the unique aspects of the proposed LCFASD residential services program is the emphasis on the 14-16 year age group, addressing in particular the next level or 'transitional needs' of the this age group. Transition is difficult for many adolescents but particularly difficult for adolescents who are affected by an FASD. For those adolescents affected by an FASD coming of age merely provides more opportunities for exploitation should the youth not receive the necessary level of support from their immediate caregivers, including foster, adopted or biological family, extended families, schools and communities.

Transition can be defined as

“experiencing a process of change from a familiar environment and a known support network to a different environment with a continued support network” (POPFASD, BC)

To be effective and successful, transition needs to be

- ✓ Thoughtful
- ✓ Collaborative
- ✓ Comprehensive
- ✓ At the pace of the youth

Transition services are designed to enhance quality of life, to increase potential for success, accommodate primary disabilities and targets the prevention and/or decreased incidence of secondary disabilities.

During a recent presentation of the proposed residential services project to Region 7 Children’s Services, the matter of transition was of paramount significance to those in attendance. Transition of those affected by an FASD should be commenced sooner than later and will need to be completed more than once across the lifespan. It is anticipated that intensive work around assessing and increasing skill levels, adaptive functioning and learning abilities will be completed with the adolescents who are accepted into the program. It is not the intention of the LCFASD residential services program to build one home for 4-5 residents for life. The original vision of the program was, and continues to be, to provide specialized residential services that have been designed to meet the complex needs of adolescent males, with or without secondary disabilities, in order to provide them with the lifeskills and support services required to graduate to next level living services. Each resident will have a different care plan designed around their abilities and disabilities and focuses on preparing them for their future.

It is anticipated that the LCFASD will have approximately two years to prepare for the transition of the first client to next level living. The LCFASD does not expect to provide next level of living services. Instead, the LCFASD envisions an enhanced working relationship between the Centre, Children’s Services, PDD, Human Resources and Employment and various education providers to meet the determined needs of each of the youth as they prepare to transition to next level living. Next level living includes, but is not limited to, supported independent living (SIL), independent living (IL), return to a family environment, adult group living. The concept of providing next level services in the form of SIL or IL with access to support services has not been extensively

explored and remains a possibility; however, it is not the preference of the LCFASD to become the sole support services provider for those affected by an FASD in the Lakeland area, particularly residential services, as support services are the foundation of the LCFASD as is evident through its existing, ongoing and expanding programs.

STAFF MODEL

Having a desire to provide specialized residential services is admirable; however, in order to effectively meet the needs of youth diagnosed with an FASD, the LCFASD must consider the realities of such an endeavour. The recruitment of qualified staff persons was a primary concern raised by each of the existing program providers interviewed for the purposes of this report. The LCFASD acknowledges the importance of recognizing the value of its team members and has an established practice of providing competitive salaries, valuable training and the flexibility for staff to meet their own needs while also meeting client needs.

Careful consideration has been given to the staff model that could be applied to the proposed residential program, noting the various models currently employed by other agencies. While exact shift schedules have not been defined, it is suggested that a successful program will require nine full time front line staff, a residential manager, 3 part time front line relief workers, a part time home operator and a contract clinician. An additional position, a transition worker, will not be exclusive to the residential program. Instead the position will operate in conjunction with both the LCFASD and the residential program and will work out of the central Cold Lake Office, meeting the youth where they are: not necessarily providing services in an office environment.

These staff numbers will permit a ratio of greater than 1:3 staff to youth at all times, thereby enhancing the ability to meet the needs of each youth without compromising the needs of another. Higher staff ratios will necessitate a higher per diem rate but will result in an increased quality of services available.

QUALIFIED STAFF

The key to providing quality services begins with employing a qualified team that is knowledgeable about FASD and understands the objectives of the program. As previously indicated, it is suggested that policy and procedure be developed at the accreditation standard level, including the development of job descriptions and qualifications. Requirements that are not negotiable include no previous Children's Services involvement, a clean Criminal Record Check and

a clean Driver's Abstract as this will directly affect the cost of insurance for the program vehicle.

Based on CAC accreditation standards it is recommended that

- Front line staff
 - ✓ Degree or diploma in human services (75% staff)
 - ✓ Life experience & working on degree/diploma (25% staff)
 - ✓ Minimum 2 years related work experience
- Residential Manager
 - ✓ Degree in human services
 - ✓ Minimum 5 years related work experience
- Clinician
 - ✓ Registered/chartered by professional association

Other employment assets include

- ✓ Experience with adolescents
- ✓ Experience with hard to serve clients
- ✓ Understanding of FASD
- ✓ Team oriented
- ✓ Able to work with others to achieve goal
- ✓ Able to multi-task
- ✓ Teaching skills

Accreditation standards also ensure that appropriate training be completed within specified period of time upon commencement of employment. Necessary and recommended training should include but is not limited to

- ✓ FASD Training
- ✓ First Aid/CPR
- ✓ Suicide Intervention
 - ASIST program offered through 4 Wing Cold Lake
- ✓ Non-Violent Crisis Intervention
 - Look at SIVA, Supporting Individuals through Valued Attachments, a Canadian specialized safety management service based on communication and trusted relationships, designed for persons with special needs, training available in Cold Lake.
- ✓ Aboriginal Awareness
- ✓ WHIMIS
- ✓ Self Care

RETENTION

The retention of qualified staff was a primary concern mentioned by each of the existing services providers interviewed for this report. The development of a specialized residential program in the Lakeland area is an innovative and new project that the LCFASD is hoping will draw qualified applicants from the immediate communities, other parts of Alberta and other provinces including Saskatchewan and British Columbia. To date, the LCFASD has not experienced difficulty recruiting qualified staff as qualified persons often attend the Centre to express their interest in working with the Centre's programs, whether there is an active recruitment campaign or not.

Key components of staff retention, as identified by front line management in existing programs, include

- ✓ Positive, supportive work environment
- ✓ High staff to client ratios
- ✓ Acknowledgement of a job well done
- ✓ Qualified, trained staff
- ✓ Competitive salary and benefits package
- ✓ Professional development opportunities
- ✓ Support to continue education
- ✓ Quality supervision
- ✓ Clinical support
- ✓ Cognizant of frustration, compassion fatigue, burn out
- ✓ Ensure employees meet their own needs

SUSTAINABILITY

Another primary concern raised by existing programs was that of sustainability. A number of organizations are finding it increasingly more difficult to maintain the standard of service established at the outside of service provision. A number of reasons were given including that contract per diems have not been increased in accordance with the cost of living, the cost of living has increased substantially over the past several years, in particular 4% in 2007 and it is anticipated that the cost of living will continue to increase as demonstrated by the 4% increase experienced in the first quarter of this year over 2007.

The decision to establish a service that exists in other areas, but is new to the Lakeland Service Area, is one which must be given careful consideration to ensure that has long term viability. The LCFASD has traditionally established programs that will contribute not only to the needs of the clients but also to the

community. Further, the implementation of these services has been based both on need and the ability to ensure the longevity of the program: the LCFASD does not wish to initiate a program that will not endure the test of time.

The World Commission on Environment and Development states that sustainable development

meets the needs of the present without compromising the ability for future generations to meet their own needs.

The Commission further states that

time money and capital can be scarce commodities and need to be carefully managed to ensure viable options to improve the quality of life in a community.

What must be carefully considered is whether or not there is a need for additional services, who will financially support the additional services, whether qualified professionals available for employment and will the creation of additional services have a negative impact on existing services or the community in which the program will be established.

RESEARCH COMPONENT

Despite the increased knowledge and the evolution of diagnosis and support of persons diagnosed under the FASD umbrella there continues to be limited scientific, evidence based information or practices available. Instead information pertaining to FASD and the support of persons and families affected continues to be empirical and practiced based.

As the services of the Lakeland Centre for Fetal Alcohol Spectrum Disorder continue to grow and prove themselves, it is recommended that the Centre engage a research partner to assist in the evaluation of programming, especially the residential component, to determine how this information can contribute to the growing database of practice based evidence.

CONCLUSION

Based on the information gathered for this report, it is clear that there is need for increased specialized residential services across the life span for persons affected by an FASD. No specialized residential services are available in the Lakeland Service Area. Based on the demographic information of LCFASD clients, there are two age groups in crisis and in need of residential services: adolescents and young adults. Across the province, service providers are reducing the number of placement beds available for specialized residential services, thereby increasing the demand for such services. Region 7 Child and Family Services Authority have expressed an interest in the program as it directly relates to long term stability of children in care, keeping children in their home communities, appropriate involvement of immediate families and the successful transition of youth in care to next level services as required.

The establishment of specialized residential services for youth is the first step in stabilizing a growing and aging population within the Lakeland Service Area. It will afford the Centre the opportunity to work with adult oriented programs to meet next level services for young adults diagnosed with an FASD need to live within the community with their required level of support. The Lakeland Centre for Fetal Alcohol Spectrum Disorder has been successful in educating other community support services. The development of residential services is the next step in educating a community to support all its members, including those who have been diagnosed with an FASD and whose contributions remain unknown and untapped.

INTERDEPENDANCE NOT INDEPENDENCE is the ultimate goal.

APPENDIX A

Hull Homes, Cottage 1

A facility tour of Hull was completed for the purposes of this report. Hull Homes is located on a 2 city block parcel of land in the Woodbine suburb of Calgary, AB. It is comprised of several residences, a school, treatment program, gym administration and maintenance buildings. Originally, in the 1960's, Hull was located outside city limits but is now only minutes from the centre of one of Canada's fastest growing cities.

Hull provides a number of residential programs including Under 8, secure treatment for PCHIP and PCHAD, transition and independent living programs, several homeless shelters and Cottage 1 which serves adolescents with mental health and development disabilities. Hull is affiliated with the CFSA and all placements are made through the placement committee. As a result, Hull has little input as to who attends the program, although there are strict entrance criteria, one of which is that they do not accept youth with criminal involvement.

Cottage 1 is an 11 bed treatment program which focuses on mental health disabilities and program concentration is skill development, primary identified deficit areas. The program is behavioural based with a token economy. Based on the level of supervision required and the needs of the youth, there are different levels of privileges. Staff indicated that the program has worked for children diagnosed with an FASD, but once a trusting relationship with one of the staff has been established. Cottage 1 has two secure rooms and staff employ restraint techniques when required.

Programming is broken down into 3 six month sections designed to improve social competence and functionality, to improve interpersonal skills and finally to build on independent living skills. These are delivered daily in group sessions. The program is presently working on a Developmental Curriculum based on the initial assessment.

There is an on site school that is part of the Calgary School Board and is considered to be the most behaviour oriented school in the Calgary school system. Approximately 135 students attend the school, a 50-50 split between Hull and the community. Two Hull staff work as aides in each classroom during the school day (Salaries paid by the Calgary School Board).

Concerns expressed the Program Director at Cottage 1:

1. Recruitment and retention- operating at 60% staffing capacity for past year
2. The poor working relationship between the Disable Persons Act and the Child, Youth and Family Enhancement Act at the crucial age of 18.
3. Gaps in service for youth at 18 who do not meet requirements for PDD or PDA.
4. Inability to establish new programs to meet identified needs
5. Renovation and constant maintenance

Woods' Homes, Catalyst Program

A facility tour of Woods' was completed for the purposes of this report. The Wood's Homes is located on a two city block parcel of land in the Foothills area of Calgary, AB. The campus belonged to the Foothills Hospital Mental Health Department and was purchased by Woods in the 1980's. Woods provides a number of residential services on two campuses including Under 12, Catalyst, sex offender, family violence, young adult services and emergency intervention services.

The Catalyst program is the end of the road for children who are in care and require residential placement. Catalyst accepts youth who have had conflict with the law, and Woods has specialized programs to meet the needs of criminally involved youth in need of residential placement outside the criminal justice system. Many children in the Catalyst program have experienced multiple placements and many have no involvement with family: there are currently two male children who have no one in their lives outside the staff at Woods. Woods works to stabilize behaviour and to facilitate a relationship with family or the next placement. Standard duration of stay is one year, and many do not transition to a family placement but another Woods program

The current focus of the Catalyst program is Aggression Replacement Training, which is a social skills program out of Montreal. The group meets 3 times per week to work on skill deficits that have been determined during the initial assessment phase. Other than applicable life skills, focus is on anger management and reasoning components. The program is very hands on.

There is an onsite Calgary Board approved School with an FASD classroom and teacher. Woods has onsite counselors in art, talk and play therapy, including a multi-sensory room, a room with padded walls and floors to permit children to physically express themselves without risk of injury or self harm and a climbing wall. Recreation plays a primary role in the program. Woods does not have a secure room and although restraints are used, staff is working to reduce the incidence of completed restraints.

There are no more than 8 children in the Catalyst program at any one time with 3 staff and a team leader. The Catalyst program has 10 front line workers and 1 supervisor on staff. In addition, Woods has 3 nurses and art/play therapists on site. The clients see either their own Psychologist or the program Psychologist through the Jones Hospital. In addition, pediatricians rotate through from the program at the children's hospital.

Concerns expressed by the Program Director at Woods:

1. Recruitment and retention of qualified staff.
2. Maintenance, renovation and rebuilding to meet increasing demands
3. Multiple placement syndrome, significant trauma and lack of external supports for the youth

Bosco Homes

A facility tour of the Bosco Ranch was completed for the purposes of this report. The Bosco Ranch is located approximately 20 minutes outside the Edmonton sub-urban area of Sherwood Park on a dead-end road. The Ranch houses an administrative building, a school and several residential programs on the property. The FASD program is located in the basement suite of the Asota Ranch. It provides services to 4 adolescent male clients, all of whom have been diagnosed under the FASD umbrella. Asota is a treatment program that focuses on providing stabilization and long term care. Initially, the program was designed to be short term; however the current residents have been in house since 2005 and 2006. The current residents are not able to return to the care of their families and are in need of transition placements.

The treatment focus of the program is the provision of applicable lifeskills. Group sessions are conducted 4x/week and each module is broken down into 4 weeks. In addition, each boy participates in sessions with a psychologist and a counselor and attends school. Students attend classes geared to their cognitive level of functioning.

The on site school program has two classrooms geared to low and lower functioning students which have a higher ratio of teachers/aides than the more mainstream classrooms. Once students have achieved optimum academic performance they are moved into a more vocational program. In addition, there is significant focus on recreation and aboriginal culture (all current residents are Aboriginal).

The program does have an accountability approach for each environment: for example, what happens at school stays at school. The general approach to discipline is a loss of privileges according to the grade: When a client receives

a grade of Basic Programming (BP) they made aware of it and have the opportunity to work off the grade, thereby earning back the lost privileges.

The program has a secure room; however the Program Director feels that the best deterrent for behavioural acting out is an individual relationship with the clients.

Concerns expressed by the Program Director of the Asota program at Bosco Homes:

1. Lack of transition placements for youth ready or required to leave the program that can not return to a family environment

Elk Island Boys Ranch

A facility tour of the Elk Island Boys Ranch was completed for the purposes of this report. Elk Island Boys Ranch is a private, for profit intensive treatment program located in Lamont, approximately 1 hour NE of Edmonton, adjacent to Fort Saskatchewan. It provides long term programming for up to 16 adolescent male clients. They also provide some transition programming. Because the ranch is private, it is very selective in choosing what boys come to the ranch, in part because of the 30 staff, only 6 are male: 2 Managers and 4 Front Line. Elk Island has a wait list.

Elk Island employs a psychologist who is a part of the treatment team and works with the boys on a weekly basis. The boys attend school in town, some full time, others half day dependant on their needs. All boys are transported directly to and from school or work, not just because the homes are located outside the centre of town, but because staff recognizes the limitations of impulse control and the objective of getting from point A to point B. Elk Island further supports the vocational development of the boys when academic achievement has reached its peak.

Outside of therapeutic work, the ranch employs a Medicine Wheel approach to programming: each quarter of the wheel begins empty and the boys work to fill up the quarters. Over time the boys will complete more than one medicine wheel, each with different quarters but with the primary focus to round out the life of each boy.

Concerns expressed by the Program Director at Elk Island Boys' Ranch:

1. Recruitment and retention of qualified staff
2. Maintenance of 3 separate ranch locations
3. Sustainability

Oak Hills Boys Ranch

A facility tour of the Oak Hills Boys Ranch was completed for the purposes of this report. Oak Hills is located in Bon Accord, approximately 20 minute from the outskirts of Edmonton. It is a non-profit residential treatment facility that has been providing services to adolescent males since 1961. It is located on 160 acres in a rural setting; however, all program buildings are located on the same small parcel of the ranch, the remainder of which is leased out to a local farmer from whom the Ranch purchases hay for the on-site animals. The ranch provides a therapeutic environment with an onsite school, a farm environment, on-site recreational opportunities and cultural elements.

There are four separate residences at the Ranch; however the fourth is not operational at this time due to staff restrictions. The FASD program provides intensive support, supervision and external controls. There is a behavioural component to the program in that the boys earn and loose points throughout the day and at the end of the day the number of points is associated with a colour which outlines privilege eligibility.

Staff to youth ratios are higher than average, as there are a minimum of 2 staff on shift, including overnight. The school has 6 teachers and 2 teacher's aides for a classroom ratio of 1:5. On site psychologist dedicated to the ranch who provides individual services to the boys, no group work.

Concerns expressed by the Assistant Program Director at Oak Hills Boys Ranch:

1. Recruitment and retention of staff.
2. Sustainability

Cedar Place

Both an in-depth telephone interview and face to face interview with the Program Director of Cedar Place were conducted for the purposes of this report. Cedar Place is a group care placement located 15 hrs north east of Vancouver in Hazelton, BC. It is run by the Hazelton Family Life Society, a non-profit group. The home is exclusive to the Ministry of Children and Family Development and the property, land and home, is owned and maintained by the Ministry of Housing. In addition to Cedar Place, the Society operates the Satellite Home designed to meet the needs of one child with complex mental health needs. A total of 10 staff and 2 team leaders are employed by the Hazelton Family Life Society.

Cedar Place is a four bed co-ed home that has been in operation for 18 years and serves adolescents 13-18 years of age, most of whom are affected by an FASD but not formally diagnosed: diagnosis is only conducted in Vancouver. Program focus is to stabilize behaviours and establish skills for independence as some return to family placements while others move into more independent situations. For the most part the placement is longterm, more often due to parents not having the necessary skills for the youth to return home, than the behaviours of the youth. Staff to youth ratio is 1:4 at all times, not including the team leader, unless individual arrangements have been made with the MCFD to increase staffing, which is often the case for a child under the age of 14 or a respite child.

The Team Lead at Cedar Place strongly advised to recognize that many of the clientele will be First Nations or Metis, to recognize cultural challenges, history and needs and to ensure that complimentary staff is hired to meet these needs. 80% of staff at Cedar Place are First Nations while 99% of the clientele are First Nations. In addition to the staff compliment, several female elders come into the home throughout the week to do traditional activities and food preparation with the youth.

Concerns expressed by the Team Leader of Cedar Place:

1. Availability of qualified staff
 - Because they are located in a remote northern British Columbia community, retention of employees is not a concern as the Society is one of a limited number of local employers: the Team Leader and one male employee have been with the program since its inception eighteen years ago.
2. Cedar Place is exclusive to the Ministry of Children and Family Development and have no representation in who is placed in the program
3. Majority of the youth are not diagnosed
4. Many youth do not return to family environments but transition to next level services, which cease in BC at the age of 19
5. Extreme remote location: 16 hours drive to Vancouver, 5 hours to Prince George and 3 hours to Prince Rupert and 2 hours to Terrace, the nearest airport where a flight to Vancouver is \$600

Spirit of Our Youth Homes Inc.

In in-depth telephone interview was conducted with the Director of Operations for purposes of this report. Spirit of Our Youth Homes located in Edmonton and has been in operation since 2000. It is a for profit aboriginal residential placement program approved by INAC and FNIHB. It provides group care, supported independent living and parented group care to aboriginal sibling

groups ages <1-21. It is the only parented group care program revealed through the literature review.

Spirit of Our Youth has 5 group placements, 4 of which provide care to sibling groups and follow a parented model: the home operators are in the house 24-7 from Sunday night to Friday afternoon, at which time relief staff run the program for the weekend. They have found that the parented model does not work well outside sibling placements and have chosen to staff the single non-sibling group home. One of the sibling homes provides services to 3 siblings who have been diagnosed as full FAS, consequently the house parent is provided with an additional staff to meet the needs of the children.

Spirit of Our Youth uses a wraparound approach with all the children, not just those who have an FASD. They use the 'kudos' reward program to which the children respond well to, regardless of diagnosis. While many of the clients have been diagnosed, others have not and many of whom are suspected of prenatal exposure to alcohol. The children all attend community schools; some are mainstream while others require more specialized programs.

Concerns:

1. Recruitment and retention of qualified staff
2. Sustainability: Raise per diem due to mandated INAC salary increase
3. Many children can not return to family and require long term placement with transition to next level services

White Crow Village

A literature review provided information on White Crow Village for the purposes of this report. White Crow Village is a summer camp program founded by Kee Warner, a parent of five boys affected by an FASD. She originally wanted children with an FASD to have a positive camp experience; however, this concept has grown into a mobile program that works with children, families and professionals to have a positive experience together. The program takes into consideration the strengths and challenges of people with an FASD and creates an environment based on relationships and respect for all. The camps began as camps for children but have evolved into family camps that provide a guided positive experience for parents and their children.

The rules of the camp are finite and apply to everyone, parents, children and staff alike. The rules are simple and straight forward. For example, when eating, ones bottom must be in the seat, one hand on the bowl/plate, the other on a fork/spoon- this definition leaves little room for negotiation and direction is

simple- hand on bowl- volunteers and parents are taught to 'say more with fewer words'. Camp is the beginning of positive change for the future.

White Crow Village offers staff training to any interested persons in the community and has taken the camp away from its home base to provide a positive camp experience to children affected by an FASD around the world. This training is not only applicable to the camp environment but to also to the overall improvement of daily living. This permits communities to take what White Crow presents as the basics and tailor them to meet their specific needs.

APPENDIX B

ACCREDITATION

There are four primary accrediting bodies accepted by the Ministry of Children's Services in Alberta:

- ◆ Canadian Accreditation Council of Human Services
<http://www.cacohs.com/default.htm>
- ◆ Accreditation Canada
(previously the Canadian Council on Health Services Accreditation)
<http://www.cchsa.ca/Default.aspx>
- ◆ Commission on Accreditation of Rehabilitation Facilities
<http://www.carfcanada.org/Providers.aspx?content=content/Canada/TOC.htm>
- ◆ Council on Accreditation
<http://www.coanet.org/front3/index.cfm>

Canadian Accreditation Council of Human Services (CAC)

Canadian Accreditation Council of Human Services is an Alberta based accreditation agency that has been actively accrediting human services agencies for twenty years. It began in 1967 as the Alberta Association of Child Care Centre and was renamed the Alberta Association for Children and Families, from whom they split in 2004 but remain affiliated. The LCFASD is a member of the Alberta Association for Children and Families.

The CAC advocates a practice based model, which, in turn, supports the establishment of a solid foundation of structure and process to ensure excellence in practice, which evolved in 1967 out of a lack of standardized practices. In 1978 the CAC published the first set of standards and partnered with the Ministry of Children's Services to accredit residential programs in Alberta in 1991.

The CAC accredits programs within an organization, not the entire organization. As per Calvin Wood, CORE Support, CAC, there are several fundamental differences between program and organization accreditation including:

1. Organization accreditation fee structure is based on the complete operational budget of the organization, which can be a considerable expense.
2. Program accreditation fee structure is based on the budget of the program under review.
3. Organizational accreditation looks at the governance outcome activities
4. Program accreditation looks at the practice and service delivery
5. Organizational reviews provide good feedback in terms of how the organization is working as a unit to deliver the service

6. Program based reviews provide ensure quality control measures are in place and that risk management is addressed

In short, Organizational Reviews render the broad strokes on how the organization functions while Program Based Reviews are detail oriented and will ensure that the structures and processes in place are effective and being implemented.

Accreditation fees consist of

- a \$1000 application fee which includes one half day session with Calvin Wood, CORE support, a link to another like agency to assist with the process, all required standards, guides etc.
- Accreditation fees are a percentage of the total budget of the program being accredited and are required to be paid in full no later than 3 months before the on site review.
- On-site fees are \$450/reviewer/day with a minimum of 2 days and usually 2 reviewers for a total \$1800. These fees are required to be paid in full before the result of the review are presented to the Accreditation Panel, who meet 8-9 times per year, to make the accreditation decision.
 - **Total cost: \$2800 plus % of program budget**
- Annual fee of \$350.00 in the intervening years between accrediting and re-accrediting

If the decision to not accredit is made, a review can not be scheduled for at least one year. 1-2 months following the decision, the organization will be presented with a certificate and plaque.

CAC is based out of Edmonton.

Accreditation Canada

(aka Canadian Council on Health Services Accreditation)

Accreditation Canada has a long involved history in the field of the development of standards in hospitals and healthcare dating back to 1917 when the first standardization program was developed by the American College of Surgeons. This single entity has grown to encompass not only hospitals but health care centres, rehab facilities, substance abuse facilities and most recently, in 2006, child welfare organizations. In 1995 one of the standardizing bodies was renamed Canadian Council on Health Services Accreditation and this body has been renamed Accreditation Canada.

Accreditation Canada accredits nine health authorities in AB and eleven in SK, Correctional Service Canada, Canadian Forces Health Services, and Veteran's Affairs. On a more local level CASA, Wood's Homes, Kapown Rehabilitation Centre, Footprints Healing Centre and all three Cancer Centres/Institutes in Edmonton.

AC accredits the entire organization as it is their belief that programs should adhere to the standards of the organization. As a result of a provincial mandate in Quebec, the AC developed a 'primer' to accreditation which permits an organization to implement a small number of the standards for a limited time, staff and clients are interviewed and a downscaled version of the site survey is completed, at which time the surveyor can advise of the AC standards are appropriate for the organization.

Accreditation fees are all inclusive and provide access to computer based programs and data bases and all standards with the AC. Fees include:

- Registration \$1095
- Surveyors \$1925 each/day
- Annual Fee (op. budget x 0.01304% or minimum of \$555)
 - **Total cost: \$5500 minimum**

Accreditation Canada is based in Ottawa; however there is an Edmonton Office and a service delivery team dedicated to the West.

Commission on Accreditation of Rehabilitation Facilities

Commission on Accreditation of Rehabilitation Facilities is a American based accreditation organization established in 1966 that has recently made its way into Alberta. A search of CARF members revealed that only CHIMO, Edmonton is accredited through CARF.

CARF focused exclusively on Rehabilitation facilities until, 1995 when it introduced standards on child protection, adoption, child/youth day care and early intervention services.

Accreditation fees are

- variable
- all materials are at the expense of the applicant including
- Standards Manual \$175,
- Survey Guide \$105,
- Survey Prep Package \$675 and
- Standards Confirmation Checklist \$55.
- On site survey fees are paid in advance, based on the number of surveyors and days required

The accrediting organization is required to purchase above listed items, implement and use the standards for a minimum of six months prior to the site survey (this is a condition of accreditation). When ready for the on-site survey, fees are to be paid, a survey team is chosen and the organization given 30 days notice as to the survey date. 6-8 weeks following the survey an accreditation decision will be made and the organization will receive a detailed report. Within 90 days of the accreditation decision, the organization is required to submit a Quality Improvement Report outlining how it intends to respond to items laid out in the report (this is a condition of accreditation).

Further, the organization is required to submit an Annual Conformance to Quality Report (this is a condition of accreditation).

CARF Canada has an Edmonton office.

Council on Accreditation

Council on Accreditation is also American based and has been accrediting Child Welfare and Family Services organizations in the US for almost 30 years. In Canada there are 4 Ministry of Children and Family Development funded organizations in BC that are accredited through COA and Catholic Social Services across the country, Alberta included, are accredited through COA.

The COA standards are developed using a community based social services model and are introspective, based in the use of collected data to assure quality, develop improvement plans.

Accreditation costs consist of

- a \$675 application fee,
- the accreditation fee is based on a sliding scale based on the gross annual revenue of the program in the year preceding accreditation,
- the on-site visit is a flat rate based on the number of reviewers and days on site, however there is a minimum of 2 reviewers for 2 days and
- an annual maintenance fee invoiced between accreditation and re-accreditation.

Although COA has Canadian Standards, they have no Canadian office, online contact information shows the nearest office to be in New York, New York.

The decision to be accredited with one agency or another is not one to be easily made as the accrediting body must have objectives similar to those of the LCFASD to ensure a harmonious relationship between the two bodies. Through the research phase of this report, information was gathered from a number of agencies providing residential services in Alberta, including accreditation information.

Results showed that 8 of 9 residential programs surveyed are accredited (6) or (re)accrediting (2) with the Canadian Accreditation Council; most emergency shelters in Alberta are accredited with the CAC and of those agencies who are accredited with the CAC, the majority indicated that the process is user friendly, involved but not difficult and that the people at CAC are easy to talk to and willing to assist in any way they can to facilitate the process. Joanne Frank, Elk Island Boy's Ranch, and Barb Lessard, Spirit of Our Youth Homes, are peer reviewers for the CAC. Calvin Wood, CORE Support @ CAC, raised 2 FASD foster boys and was involved in the initial development of the FASD program @ Bosco.

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