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Personalized Service Delivery for Young People and Families: A Synthesis Review

Carol A. Stuart Dr.
Ryerson University, cstuart@ryerson.ca

Kiaras Gharabaghi Dr.
Ryerson University, k.gharabaghi@ryerson.ca

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Carol Stuart, Ph.D. and
Kiaras Gharabaghi, Ph.D.

The School of Child and Youth Care
Connecting, Transforming, Caring.

Acknowledgements

Table of Contents

Section I

Synthesis

This synthesis project, funded through a MCYS Strategic Research Grant, seeks to provide a foundation for developing a multi-disciplinary and cross-sectoral research approach to exploring 'personalized service' within the context of residential treatment services for children and youth. This focus was to include the continuum of pre-referral supports and interventions to post-discharge community and family re-integration and sustainable outcomes. A detailed literature review about current approaches to 'personalizing services' in Ontario, Canada, North America, and the United Kingdom was undertaken with an emphasis on identifying the core conceptual and logistical principles that frame approaches to personalized services. The approach was intended to encourage future research that would focus on identifying and testing the evidence supporting or challenging such principles. The literature review was structured around six core themes:

- The stories and experiences of challenging and successful personalized approaches (satisfaction) as compared to outcomes (client change).

- Diversity considerations, including cultural identity, linguistic groups, and gender orientations.

- Service outcomes at the client level, at the agency level & at the system level.

- Successful tools and protocols for implementing personalized services.

- Quality assurance protocols.

- Logistical and human resource considerations in service provision.

As we reviewed the literature available we realized that there was very little literature that spoke specifically to personalized services in residential care and that indeed the terminology "personalized services" is relatively new and had its genesis in services for the developmental delayed and young people with complex special needs.

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The Strategic Goal

The MCYS Strategic Framework: *Realizing Potential: Our Children, Our Youth, Our Future*, for 2008-2012 states as Goal #2 that "Every Child and Youth Receives Personalized Services". The Ministry is seeking opportunities for innovation and movement toward responsiveness, empowerment, and ultimately personalization of service. To this end, MCYS has identified three broad principles for the provision of personalized services:

1.   Needs, preferences and circumstances of children and youth are placed at the heart of service decisions;

2.   Young people and their families are active and informed participants in decision-making; and

3.   Service delivery is adapted to fit with clients' daily lives.

Implementation of these principles involves a focused set of priorities which will:

1.   Strengthen and develop multi-disciplinary service models that connect multiple sectors and create a cross-sectoral plan of care.

2.   Develop a continuum of service delivery where providers have greater latitude to respond to needs and current outcomes for youth are used to evaluate gaps and design new programs.

3.   Provide clients with access to information and supports to find and access easily appropriate services and to influence service design when there are no appropriate services.

MCYS has dual interests in the implementation of this strategic goal:

•   Ensuring that individual young people (and their families) have a service experience that is responsive to their expressed needs, chosen from a continuum of possibilities, integrated across multiple sectors, and experienced as beneficial and satisfactory (individual experience of programs and systems).

•   Ensuring that service design and delivery is shaped by young people and their families across multiple sectors (engagement of clients within system structures; providing them with agency in affecting future service delivery).
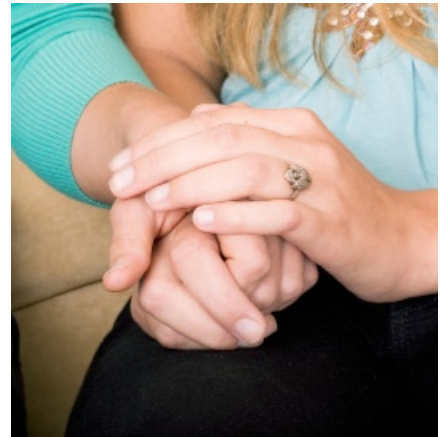
Strategic Goal #2:
"Every Child and Youth Receives Personalized Services".

Key Findings

A systematic review of material on personalized service delivery which examined published literature, grey literature, as well as policy documentation in national and international jurisdictions revealed several key findings:

- "Personalized service delivery" is a relatively recent terminology which is highly specific to the service sector meeting the needs of adults affected by developmental and physical handicaps. More common terminology related to the provision of service to young people and their families which operates under the same basic principles includes: individualized service planning; systems of care; integrated service delivery; and individualized service funds.

- Residential service providers use a wide variety of terminology according to the sector they serve and have begun to recognize and refine their place in the continuum of care; therefore any discussion of personalized services in residential care must be expanded to the full continuum of service delivery.

- The principles of Personalized Services and the existing models evolved to meet the complex special needs of young people who required services from multiple sectors and multiple providers. There is little indication of a comprehensive application of these principles and models within single service sectors, who by and large offer services consistent with the principles and philosophies of their historical approach.

- There is some evidence of selective incorporation of the principle of 'voice' through youth engagement initiatives related to service delivery in child welfare, children's mental health, youth justice, and education however, this continues to be primarily oriented around the needs and circumstances of program delivery rather than the needs and circumstances of the young person and the family.

Any discussion of personalized services in residential care must be expanded to the full continuum of service delivery.

Models of Personalized Service Delivery

Falling within the parameters of personalized services as outlined by MCYS are several models of service delivery. Some are models that are already implemented in Ontario and others are found in the United States, Australia, and the United Kingdom. We will describe these models briefly and then consider the common factors and the common challenges embedded within them.

Systems of Care

The **Systems of Care** approach is a ***philosophy*** which has created several nationally funded programs that are available to State governments, Tribal Councils, community-based and residential organizations to focus on young people with mental health needs requiring support in multiple service sectors. A close relationship between statutory ministries and service organizations is needed to facilitate effective collaboration initiatives (Cheers & Mondy, 2009; Jarvis, Jarvis, Beale & Martin, 2000).The initiative was established by Congress in 1992 and is funded through agreements with the United States Department of Health and Human Services (Substance Abuse & Mental Health Services Administration [SAMHSA], n.d). A **System of Care** facilitates an integrated service approach in a setting where numerous service providers, natural supports and consultants are involved in the child's life. A national evaluation indicated increased school attendance, decreased behaviour problems, decreased delinquency, and decreased suicide attempts amongst youth enrolled in the programs (Manteuffel, Stephens, et. al., 2008; Stroul & Manteuffel, 2007). Advocates and policy makers recognize that residential treatment is part of the overall service array, and that coordination and collaboration between residential and community-based service providers is essential to improving outcomes (Building Bridges Initiative, n.d.). The Building Bridges Initiative is a program funded by SAMHSA under the Systems of Care philosophy which includes quality assurance tools so that organizations can complete a self assessment of their processes and consistency with the underlying philosophy. Building Bridges supports smooth entries and transitions into placement settings by focusing on pre-entry activities, and relationship building activities between service providers, young people, families, and peers. Child and Family Teams (CFT) bring together the expertise of residential

treatment and community-based providers and capitalize on the strengths of the youth and family as part of a long-term recovery-oriented plan. Treatment is family-driven and youth-guided through practices advocated by Building Bridges such as:

- implementing CFTs;

- hiring family and youth advocates;

- developing youth and family advisory councils;

- providing education and support to increase self-advocacy skills;

- integrating cultural and linguistic competence; and

- implementing trauma-informed care, thus reducing the need for restraint and seclusion.

Wraparound is a philosophical approach to working with young people

Wraparound

Like Systems of Care, **Wraparound** is a philosophical approach to working with young people who have complex special needs and ensuring that they are cared for and raised in community settings. **Wraparound** is both a child- and family-driven intervention as well as a system-level intervention that is individualized or personalized to each child's needs (Burchard, Bruns, & Burchard, 2002; Walker, Bruns, , & Penn, 2008). A facilitator works in partnership with the child, family, and other support persons, to identify strengths, cultural factors and priorities. The facilitator guides all participants through a highly structured and intense planning process toward a comprehensive personalized plan, one that addresses the top child and family priorities by developing strategies and activities that build on strengths and resources within the family and the community. In essence, the team "wraps" services and supports around the child and family. Any needs that are beyond the resources of the family and team are communicated within the team and a Community Mobilization Team, "community connectors", to find and acquire the necessary informal and formal resources.

The **National Wraparound Initiative** in the United States and **Wrap Canada** , have developed to bring together organizations and researchers involved in Wraparound program delivery and support them to evaluate and bring consistent implementation or fidelity to the program delivery. Training programs and consultation on the Wraparound principles are available through Wrap Canada with links to organizations delivering Wraparound programs in each province. The Wraparound Evaluation and Research Team (WERT) website

was created to facilitate the dissemination of the Wraparound Fidelity Index (WFI). The National Wraparound Initiative website provides access to tools that can be used to accomplish the activities that comprise the Wraparound process. Available tools include job descriptions, as well as descriptions of skill sets and competencies.

Looking After Children (LAC)

Looking after Children (LAC) originated in the United Kingdom (Kufeldt, Simard, & Vachon, 2000) as part of a reform of the child protection/ child welfare system and has expanded internationally to Canada and Australia. LAC was intended as a model for ensuring that looked after children in the care of the state experience the same attention to all aspects of development as children raised within their own families. LAC is fully integrated into the case management process, and requires both formal and informal assessments in relation to seven identified domains of development on a regular basis. A notable contribution of LAC has been the incorporation of multiple perspectives in the assessment of child and youth development. The voice of the young person, as well as the voices of caregivers, educators and those involved in the child's life on a regular basis are captured during the completion of the Action and Assessment Record. While the LAC model was not one designed for intervention within service delivery, it is a framework for developing service plans and monitoring their implementation across multiple outcome variables. Plans are developed with the specific circumstances of the child guiding the process. In Ontario, the LAC framework and its accompanying Action Assessment Record have been implemented primarily in relation to children with crown wardship status, therefore limiting the involvement of families in the planning process.

A notable contribution of LAC has been the incorporation of multiple perspectives in the assessment of child and youth development.

Integrated Case Management (ICM)

Integrated Case Management (ICM), implemented as a policy directive of the Ministry of Children and Family Development (MCFD) in British Columbia in 1999, is a team approach used to create and implement a personalized service plan for children and families. It is a shared planning experience in which all participants make unique and valuable contributions. This creates increased potential to build on the strengths of everyone involved and to prevent the escalation of difficulties. With the ICM model, an integrated case coordinator is chosen, who may be the child or a family member, functioning alone or with support from another team member. Depending on the needs and skills of the child/family and other team members, the role of the

ICM case coordinator may be primarily administrative or supportive. One key responsibility is the documentation of the process using a consistent format that considers the child's health, education, identity, family and social relationships, social presentation, emotional and behavioural development and self-care skills. These domains come from the Looking after Children model. The policy is supported by an evaluation, training materials, and manuals for both facilitators and participants in the planning process (Tate, Hubbersty, Hume, & Rutman, 1999a; 1999b).

Every Child Matters

The **Every Child Matters: Change for Children** programme has developed an integrated model for improving outcomes by building children's services with all service providers and sectors working together and communicating effectively (Every Child Matters, [ECM], 2006). The Common Assessment Framework (CAF) for children and youth guides the lead service provider and ensures information sharing and supports are integrated into personalized service for young people and families (Children's Workforce Development Council, [CWDC],2010b). Specific tools and processes have helped embed integration more fully across children's services. Guidance, training and support materials on information sharing are available (ECM, 2010c). Emerging practices in the workplace have been developed to make the implementation of integrated working more achievable (CWDC, 2010a; 2010c). A framework of basic knowledge and skills that all service providers need has been articulated and is a framework for managing human resource needs in integrated models of care. Similar to the vision of personalized services articulated by MCYS, "Every Child Matters" implemented in the UK in 2007, crosses all service sectors, ages and developmental needs. The two-year progress report (Dept. Of Children, Schools, and Families, 2009) indicated that while children were receiving personalized services in the education sector and early intervention in the 0 to 5 service sector with positive outcomes, system-wide implementation was lacking, working through partnerships required additional attention, and safeguards for vulnerable children as well as greater attention to ready access to mental health services were necessary. The struggle toward a system-wide implementation of integrated services that wrap around client's lives seems to be present in other jurisdictions.

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Commonalities and Challenges in Models of Personalized Service Delivery

All models of personalized service delivery have a critical common factor: they are philosophies of care and service with a specific value base and set of principles about how to treat people. The focus in most personalized service delivery models has been on the complex special needs of individuals, both adults and young people who are disempowered and lack a voice, because of medical, cognitive or physical concerns. The value base, therefore, includes principles of normalization, voice, empowerment, and choice. Personalized service models to date have commonly focused on service delivery to people whose needs do not fit neatly into a single service silo (education, child welfare, justice, physical or developmental disability). In most cases, the person also has significant mental health concerns along with at least one other set of developmental needs. These models have combined the case management functions of social workers in various service delivery systems with the case advocacy functions associated with an independent ombudsperson who defends the rights of individuals and populations who do not have the capacity to do so themselves. Management of personalized service delivery at the individual level implies a single point of contact or case coordinator, who ensures that all other professionals as well as the person and their family are aware of, and involved in, decisions that impact the daily life of the young person. The models make heavy use of existing social capital that is available to the young person and their family. By involving community members, extended family, and professional resources for support, the funded service system is not stretched to the same extent and the young person is supported by familiar people even as professionals inevitably change. With the recognition that services needed to adapt to difference based on ability, ethnicity, religion, and sexual identity, personalized services models stress the need to deal with cultural differences based on these aspects of diversity. The specifics of how this is done are not laid out as clearly as the case co-ordination functions.

The challenges to personalized service delivery reflect the growing demands for funding accountability and concrete outcomes and the difficulty with implementing a value based approach on a systemic level. The fundamental values of voice and choice require that service providers share power with clients and with each other. It is within these power dynamics that most of the challenges emerge. Funding for service delivery has historically been divided into services for health, education, social welfare and criminal justice. The most complex clients for whom personalized service delivery

Personalized service models to date have focused on service delivery to people whose needs do not fit neatly into a single service silo.

has been the solution do not fit neatly into jurisdictional boundaries. The differing professional expertise, philosophical orientations and understandings of the problems, needs and issues continuously push against the integration of service delivery in a personalized manner. Within local communities where service providers know each other, and community members may also know each other, the necessary personal relationships are present. As soon as service delivery extends beyond the local level the assurance of a common value base is increasingly less likely. The recognition of this difficulty is apparent in the development of common assessment frameworks, quality assurance assessments, training manuals, participant guides, and fidelity indices that help communicate the value base of personalized services and ensure that new team members, organizations, and families understand the intent and the professionals comply. Most personalized service delivery models have developed in a family context, where parents do not have the professional expertise to deal with the complex special needs of their children, but are interested and indeed demand and that they remain involved, offering important insight into the child's needs. LAC developed specifically in a child welfare context to ensure that the state acted more like parents when caring for children and therefore focused on understanding the perspective of the child and their needs across the spectrum of normal development. It has been a challenge in personalized service delivery models to ensure that the assessments do not become time-consuming paperwork instead of a support mechanism by which values are operationalised. A significant challenge to taking a model of personalized service delivery across multiple jurisdictions is the variety of differences in the extent to which young people, families, and communities are invested in being helped and receiving services. It takes a continuous effort on the part of the service provider and the service system to engage clients in receiving services, if it is initially or periodically rejected. There are no models of how personalized service delivery would look in a simplified environment, since it was developed explicitly for supporting complex needs in a community-based network; however, if successful implementation in complex systems can occur as indicated by the Systems of Care programs and Wraparound approaches then universal development of the value base should address situations where a single type of need or service jurisdiction is all that is necessary, thus ensuring that as young people and families change, so does the service delivery response.

...Common assessment frameworks, quality assurance assessments, training manuals, participant guides, and fidelity indices that help communicate the value base of personalized services and ensure that new team members, organizations, and families understand the intent and the professionals comply.

Defining Personalized Service

While MCYS has set personalized services as a strategic goal and called for strategic research initiatives to help service providers understand what personalized service delivery is, a clear definition of the concept is absent. Utilizing the Strategic Planning Framework and the principles and priorities outlined by MCYS, the following definition is proposed along with a framework of principles and processes that will connect those principles to provide a platform for enhancing personalized service delivery without limiting it to a single sector or a single model of delivery.

Personalized Service delivery is innovative, empowering, individualized, and personalized.

> *When every young person receives personalized service: Service providers make decisions in collaboration with young people and their families, based on a consideration of immediate and long term needs and circumstances and adapted to the existing life space of those young people and their families.*
>
> *Personalized Service delivery is innovative, empowering, individualized, and personalized. It connects multiple sectors, responds to the service gaps identified by young people and families, and creates a full-service continuum to support young people when family and community support falters.*

The strategic goal envisions an integrated service structure with a bi-directional influence of services on young people and families and they in turn on the service structure. Individualized and Personalized Service **models** have already been implemented to help young people with complex special needs because these young people are so unique that the service delivery structure required had to be unique and personalized. These models have also been implemented in the adult developmental services sector (Social Care Institute for Excellence, 2010) and more recently as a means of managing the "island" mentality of residential treatment centres in the United States (AACRC, 2009d; SAMHSA, n.d). If residential care is to become a personalized service it must operate from the same value base and fundamental pillars to support a platform of safety for young people and their families as they struggle with the challenges of growing up in today's complex society.
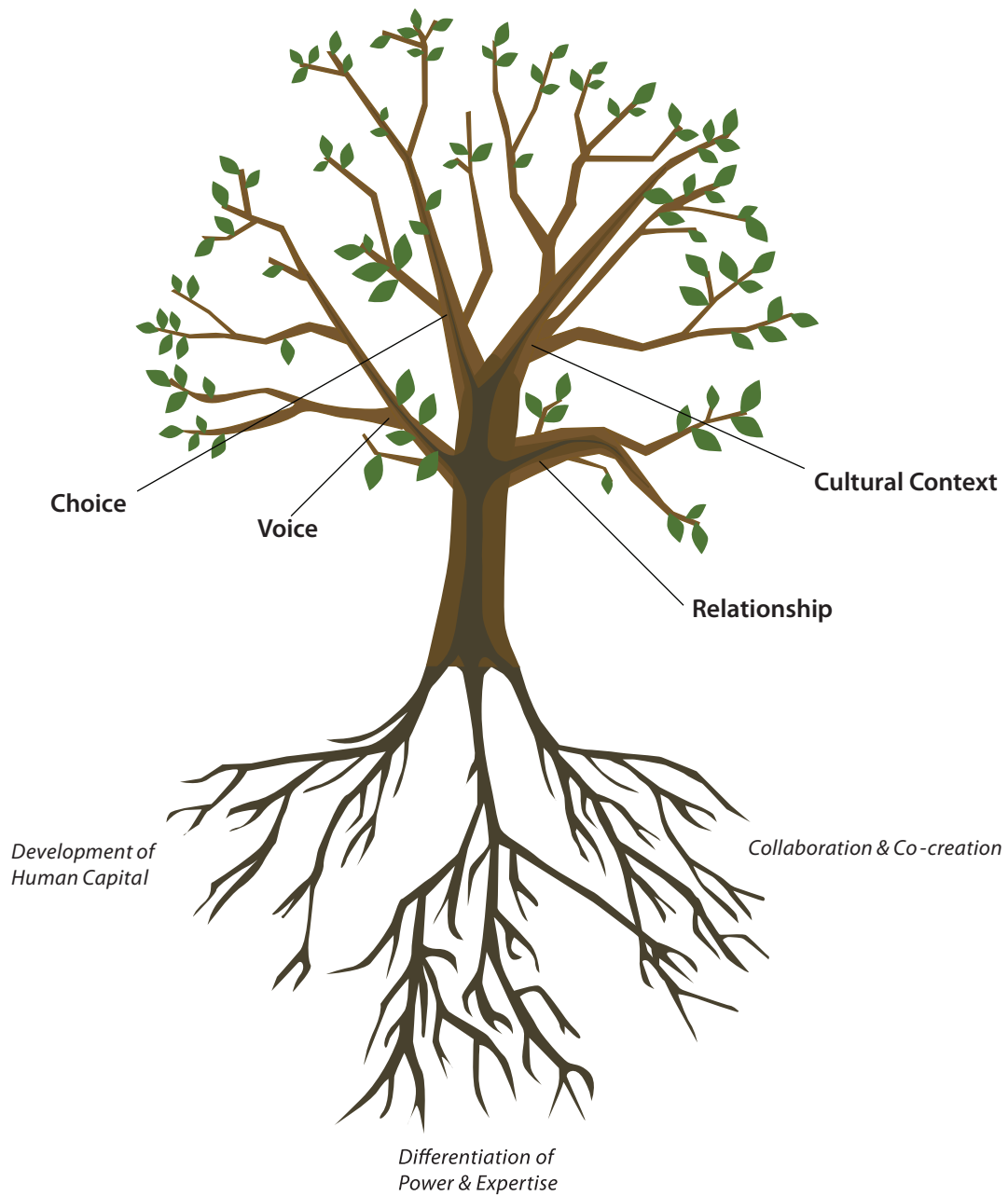
Principles for Personalized Services

The following core principles are common to models of personalized service. Each principle supports personalized service delivery but must be strengthened by processes that facilitate the implementation of these principles and create assurances that any conflicts between these principles can be resolved. Our analysis of the literature in residential care, children's mental health, child welfare, and justice services as well as social care services for developmentally and physically disabled adults indicates that the following principles underlie personalized services:

Voice
Choice
Relationship
Cultural Context

Table 1: Value-based Principles of Personalized Service Delivery

PRINCIPLES	IMPLICATION	DISCUSSION
Voice	Young people and families have a VOICE in defining what their most pressing **needs** for service are.	The principle of Voice defines not only the importance of listening to the young person and his/her family; it also recognizes the expertise of young people and families in articulating their needs and defining what types of services will best support them in today's complex environments leading to opportunities for expressing opinions and shaping service delivery within and across jurisdictions.
Choice	Young people and families have a CHOICE in deciding which **service best meets** their current needs.	The principle of Choice implies that young people and their families actively participate in the decision-making about what service they will use and that there is a continuum of choice which they are aware of, understand, and are able to access with relative ease. It also implies that they help the "system" determine priorities and make difficult choices.
Relationship	Young people have RELATIONSHIPS with their parents and with multiple practitioners in the service environment, who also have relationship with parents.	The principle of Relationship recognizes that the presence of relational engagements provides the safety and comfort of strong, inter-personal relational experiences during service delivery and a range of knowledge forms and expertise are valued and acknowledged. It also acknowledges the need for collaborative relationships between service providers and across jurisdictions to facilitate service delivery that fits into the young person's daily life.
Cultural Context	Young people and families exist in multiple CULTURAL CONTEXTS, which may provide natural supports and/or difficult conflicts either of which may significantly affect the outcomes of service.	The principle of Cultural Context demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the young person and family and their community. Client voice and choices are shaped by their culture and identity. Traditions, values and heritage are sources of great strength and social capital and children and families should be able to participate in culturally competent and relevant services. Program design and service delivery should also be undertaken with cultural sensitivity and appreciation of difference. Not all programs have been evaluated within the specific populations or communities where they are implemented.

Choice

Voice

Cultural Context

Relationship

Development of
Human Capital

Collaboration & Co-creation

Differentiation of
Power & Expertise

**Figure 1: Principles and Processes for the Cultivation of Personalized
Service Delivery**

Processes to Connect the Principles

To adopt these principles and ensure that personalized service is cultivated at both the individual and systemic levels the principles must be connected and strengthened by active processes that help to resolve emerging value conflicts between the principles. These processes should guide decision making at every level of interaction. Decision making occurs at multiple levels: client/provider; provider/provider (within and across sector); provider/funder; sector/sector.

Differentiation of power and expertise

Collaboration and Co-Creation

Development of Human Capital

Table 2: Connecting Processes

Principles	Implication	Discussion
Differentiation of power and expertise	**Differentiation of power and expertise** must be an active process that involves negotiation of power and expertise within both the **cultural context** of the young person and family and the **relationships** that develop between the young person, the family and the service provider. It must also be negotiated in the areas of **voice** and **choice**.	Expertise is typically vested in the knowledge and skill of the service provider and the expertise of the young person or family is devalued or minimized. Power is then vested in the practitioner's expertise, without discussion. In reality each member of the team has a different type of expertise and therefore power should be discussed and equalized by virtue of the differing expertise. The young person and/or family is the most knowledgeable about the problem, their relationships, and about the cultural context that surrounds them. The needs that are associated with that problem, and the relevant choices for managing problems and concerns require a combination of the providers expertise and the expertise of the young person and family. When expertise is assumed to lie in the knowledge and skill gained by professionals during their education OR when expertise corresponds to the values and assumptions of the organization about problem solving for practice then decision-making power is invested in theory, logic and deductive reasoning often based on broad outcomes achieved by clients collectively. This approach to expertise and power is the anti-thesis of personalized service. Potential power struggles and the different types of expertise must be recognized, discussed and resolved in the implementation of the principles of personalized service. Methods and processes must be in place at every level to address the resolution of power differentials and conflicts between specialized expertise. We must also recognize that in providing services for children and families there will be disagreements and power struggles between children and their parents or other primary caregiver.
Collaboration and Co-Creation	**Collaboration and co-creation** are processes that mediate potential conflicts between the principle of relationship and the principle of choice.	The process of collaboration encourages service providers in their relationship with the young person and family to identify services most relevant to client needs and present a spectrum of service options, rather than choosing for the family. The service provider is aware of the spectrum of choice, perhaps created through the process of collaboration between service providers. Co-creation is the process by which new services are created when there is no appropriate choice for young people and families. Co-creation can happen between service providers based on the voices of young people OR based on the unique individual needs of a particular young person. The relationships between service providers facilitate the joining with young people and families to create individualized, personalized, service delivery choices.

Development of Human Capital	**The development of human capital** is a process that helps to mediate between the voices of young people, families and the cultural community context within which they live.	When young people and families voice their needs, service providers must first identify the social capital within their own community and maintain any existing connections with that community. Service providers and their organizations also have an obligation to develop strong community based representation of the voices within it. Agents of social capital, community leaders, extended family members, and neighbors can assist both young people and families as well as service providers in many different ways, including helping to under-stand the essential community and cultural unique-ness. The development of social capital within the service provider community itself is also important. Policymakers and program developers need to listen to provider voices about the context that they exist in and how to develop a personal orientation across sectors.

Future Directions

Significant questions remain to be answered about the implementation of personalized service delivery models in work with young people and their families. The literature could not comprehensively answer questions posed by MCYS such as:

1. How are personalized services delivered across the range of social services (at the system level), service providers (at the service level), and presenting issues and needs (at the individual client level)?

2. How are personalized services delivered to clients at different ages, stages of development, level of ability, location, (urban/rural), service involvement (E.G., type of service received, receiving multiple services), etc?

3. What mechanisms/processes/feedback systems are in place to self-monitor initiatives related to personalized service delivery in terms of the core principles, goals and objectives of this approach?

In many cases there will be no singular answer to these questions because the unique individual context of the young person, family, and community will prevail, but the questions need to be answered, minimally at the level of the individual who receives service. Broad trends can determine some guidelines for programs and services to create the systemic change required to support the strategic goal of personalized service delivery.

This synthesis review of the existing literature on personalized services (with an original focus on residential care) indicated that the implementation of personalized services, in isolation, in a residential care setting, is impossible. Personalized service delivery requires that residential programs be connected to families, communities, and other service providers forming a network of options for young people and families as their needs change and as they are involved with a variety of services.

Implementing personalized services across a range of services and sectors at the system level requires an understanding of the successes and challenges of personalized and individualized service delivery in response to complex needs as well as an understanding of the different needs of young people and families with a range of less complex needs.

Personalized service delivery requires that residential programs be connected to families, communities, and other service providers forming a network of options for young people and families as their needs change and as they are involved with a variety of services.

- 19 -

Challenges to personalized service delivery across a range of services include:

- Transfer of information, including multiple information systems and diverse approaches to the collection of data;

- Protocols for coordination of service, multiple care plans and case managers;

- Highly specific funding streams;

- Highly specific program mandates.

Challenges for service providers in the development and delivery of programs include:

- Cultural relevance of evidence-based programs;

- Attitudes toward young people and families with mental health concerns;

- Facilitating young people's engagement in determining their service needs versus requiring engagement in order to provide service and define individual service needs (eg: imposed treatment contracts);

- Finding creative youth-friendly methods of including young people in service delivery development.

Challenges at the level of young people and their families include:

- Fit between need and program;

- Lack of awareness of programs;

- Readiness to engage in treatment or service;

- Stigma;

- Need for respite from the presenting issues as young people break the law, enter and exit health care systems in crisis, and attempt to progress through school;

- Standardized outcome measures that do not reflect individual needs and goals.

The next phase of understanding how to implement the personalized services approach is to identify the existing challenges and supports to systemic implementation by synthesizing information from multiple service providers as they begin to understand and implement personalized service delivery in Ontario.

Questions that need to be answered include:

1. Identifying how organizational values, principles, goals and objectives are consistent with the personalized service delivery approach defined by MCYS.

2. Identifying existing service delivery protocols and tools, human resource processes, inter- agency collaboration forums, opportunities for the involvement of young people and families, and decision-making processes, which ensure that "service is oriented towards client outcomes rather than programs and that an integrated system of services wraps around client lives".

3. Identifying the challenges and existing supports for personalized service delivery across a range of social services as young people and their families interact with the child and youth service delivery system.

4. Identify promising practices that ensure that young people and their families are active and informed participants and that service delivery is adapted to the needs and circumstances of their daily lives.

5. Develop a tool/quality assurance mechanism for the purpose of self-monitoring and evaluation of personalized services initiatives that can be customized to the specific needs of a range of service providers across a variety of sectors.

Section II

Focusing on Implementation Issues
Relative to
Personalized Services

There are six focus-papers in Section II that synthesize information relative to both residential care services and personalized service delivery. A short summary of the main implications of the literature reviewed in each area and the questions not answered by the literature are provided as abstracts for each paper.

Client Experiences

Sometimes when they tell you this is all they have to offer, this is the best they can do, I've gotten to the point where I tell them, 'I want more than this. I want you to offer something different. . . . No, it's not going to 'have to work,' you're going to do something different.' (Semansky & Koyanagi, 2004, p. 2)

There is limited research and discussion which specifically describes the experiences of young people and families with personalized service delivery. However, there is considerable discussion about the experiences of young people when the unique needs of each young person is sacrificed for program design or for the sake of institutional expediency (Phelan, 2009).Within and beyond the literature on residential care, to settings that include pediatric facilities and community-based services the following main ideas arise:

- Provincial, national, and international associations are encouraging organizational members to go beyond engaging families to having them actively collaborate on developing and directing service delivery.

- The common youth experience is that voices and preferences remain unheard and unacknowledged. Communities do not consistently involve young people in planning their services, in asking their opinions about services, in discussing their progress, or in reviewing their case with other partners.

- Young people feel stigmatized when they are accompanied by staff in the community and/or when they must use the generic "agency pass" to access community services.

- The use of supportive and descriptive language versus condescending and stigmatizing language as well as the use of common terminology rather than clinical terms or acronyms is critical to help parents and young people understand and feel comfortable with providing input. Without an approach to "plain language" young people feel pathologized and the labels that facilitate obtaining support lead to decisions where they have limited information and limited choice.

- Young people and families reported that services which have the greatest impact balance structure with flexibility,

rules with understanding, and concern for program integrity and consistency with recognition that the development and healing of an individual youth follows a unique path.

- The benefit to personalized service delivery, in the minds of parents, is the ability to focus on the young person's enjoyment and quality of life.

Client Experiences of Personalized Services

Jessica Sauve-Griffin

Incorporating the voices of children, youth and families into the delivery of personalized services ensures that "the important role youth play in being active stakeholders in their own mental health care" (Gyamfi, Keens-Douglas & Medin, 2007, p. 383) is recognized. To date, the approach to including children, youth and families directly in their own service planning has been inconsistent. "If the youth wants to tell the staff that the rule should be changed they are told that if you don't like the rules then you can leave (the program)" (Behavioral Health Collaborative Consumer Satisfaction Project - BHCCSP, 2008, p. 2). Research unique to personalized services in residential settings is limited, and the language for personalized services includes "individualized," "personalized," "family-centred," "person-centred" and more. The research for this section has been obtained from literature on client perspectives in a variety of settings. For research on how to effect lasting change and move towards personalizing services, instead of sacrificing the unique needs of each youth for program design or for the sake of institutional expediency (Phelan, 2009), we need to look beyond the literature on residential care to settings that include pediatric facilities, community-based services and residential care. The following synthesis of feedback from children, youth and families regarding their experiences with services is presented with the hope that client experiences from other service jurisdictions can inform the development of a personalized service delivery model within residential care.

Experiences of Young People

There is a growing body of evidence that suggests that promoting the voice of youth in service delivery can improve outcomes for them and the programs that support them (Gyamfi et al., 2007). It is also important that the voices of youth be seriously considered and valued. However, the literature reveals the common youth experience that "too often a youth's strengths, voice and preferences remain unrecognized and unheard by their service providers" (Lombrowski, Fields, Griffin-Van Dorn, & Castillo, 2008, p. 1).

The Behavioral Health Collaborative Consumer Satisfaction Project (2008) sought to assess the satisfaction of youth who received behavioural health services. Researchers became "… painfully

aware that the youth voice was largely missing from policy and planning activities" (BHCCSP, 2008, p. 1). Youth were asked to comment on their impression of the importance of their opinions. The overall feedback indicated that they did not feel they had a voice. One youth responded:

> [a] therapist is assigned to you and if you do not get along with that person, or you have a prior relationship with another therapist, it does not matter. Youth reported that they are told that they have to continue seeing that therapist. (BHCCSP, 2008, p. 1)

They reported that when they are "sent" to a program, without choice this has a negative impact on their experiences of the care received (BHCCSP, 2008). Youth reported that they "felt under-used and under-empowered by the limited access they had to informing and being informed by their system of care, particularly within their own service plan" (Gyamfi et al., 2007, p. 340).

Youth involvement in service planning has traditionally been inconsistent. Gyamfi et al. (2007) reported that youth involvement in a system of care model exhibited

> … several challenges with active engagement that may impede the receipt of appropriate services. For example, communities do not consistently involve youth in planning their services, in asking their opinions about services, in discussing their progress, or in reviewing their case with other partners. (p. 393)

The importance of flexibility in service delivery, challenging the one size fits all model, has been highlighted. Youth have reported that inflexible rules also had a negative impact on their experience of services (Helgeland, 2010) and authors emphasize that it is a disservice to young people when adults lump them all together. Differences should be respected and individualized care should be individualized (Gray, 2004; Kurtz et al., 2000). They used inflexibility as an example of having limited voice in services received:

> ... [b]oys are not allowed to go into a girl's room (in a transitional living program). But if the youth are friends and one of them really needs someone to talk to there is no place for the two to have privacy and not break the rule (BHCCSP, 2008, p. 2).

The BHCCSP study revealed that the experience of services not being individualized had a direct impact on the youth's experience. One youth reported, "… life skills classes are too basic like how to open a savings account when what youth need to know is how to take out a loan" (BHCCSP, 2008, p. 3).

Young people expressed concern that residing in a residential treatment facility can result in children and youth feeling stigmatized or pathologized: "[We] were on an outing at a store and wanted to buy something. The staff say 'no you can't because that's against the rules'; and then everyone knows that the youth are in a program" (BHCCSP, 2008, p. 4). Services delivered to children, youth and families cannot exist without the relational element. However, the power differential that exists between staff and clients needs to be addressed within the implementation of a personalized services model in order to avoid the stigma associated with being in care. Participants in a study of homeless youth "… provided numerous examples of encounters with helpers that made them distrustful include breaking confidentiality, pathologizing youth, not keeping promises, and being treated like an object" (Kurtz et al., 2000, p. 394). Even in today's climate of children's rights and youth engagement young people fear the imposition of staff power. "If we make too much of a fuss about a problem with services then we could get sent to the doctor and get put on meds" (BHCCSP, 2008, p. 2). With limited information and choice, youth are left feeling pathologized, or more like a file number than an individual (Kurtz, et. al., 2000). Even organizational attempts at youth engagement seem, to young people, to be " more "for show" or for political purposes rather than to engage youth in meaningful input" (BHCCSP, 2008, p. 4).

A number of authors identified the factors that contributed to youth feeling positive about the services they received. These included: feeling engaged and supported, feeling that their voices were heard, feeling that they were mentored and feeling that their culture was respected. Young people are capable of offering guidance on "the different ways in which their involvement in systems of care can shape their mental health care and how adults can help increase their level of involvement" (Gyamfi et al., 2007, p. 393).

Youth reported that, "… caring did not involve trying to cure or solve their problems. Rather caring entailed individualized attention, unconditional acceptance, non judgmental listening, and emotional support" (Kurtz et al., 2000, p. 388). When asked about what they felt made a great service provider, one youth responded that:

> "… caring did not involve trying to cure or solve their problems. Rather caring entailed individualized attention, unconditional acceptance, nonjudgmental listening, and emotional support"

> *…[t]he staff who are closest to working with youth on a daily basis seem to be the ones who understand youths' struggles and challenges the most and are the ones who are the most helpful. Youth stated that it seems like the higher up the staff person is in the administrative structure of an agency, the less responsive he or she is to youth (BHCCSP, 2008, p. 3).*

One of the most important qualities a staff in residential care could have is the ability to listen. "Because so many youth have not been included in planning for their own care and are turned off to services, the development of good engagement and listening skills is critically important" (Lombrowski et al., 2008, p. 4). The types of professional help that youth reported had the greatest impact on them balanced structure with flexibility, rules with understanding, and concern for program integrity and consistency with recognition that the development and healing of an individual youth follows a unique path. (Kurtz et al., 2000). Families "… placed importance on individualized care, provision of information, and inclusion of family in care planning and delivery (Law, Hanna, King, Hurley, King, Kertoy, et. al., 2003, p. 358). These are all issues that agencies will need to address in adopting a personalized services model.

Satisfaction with mental health services is related to reported greater choice/motivation when seeking treatment (Scott, Munson & White, 2009). Youth indicated that when they felt they participated in their own mental health treatment, it enabled them to develop positive relationships with adults, learn responsibility and new skills, and feel positive about themselves and their community as well as an increased sense of self-esteem, pride, identity and self-empowerment (Gyamfi et al., 2007).

Ensuring that the opinions of children, youth and families are heard, validated and incorporated is critical to the model of personalized service delivery. Within the principles of personalized services, mechanisms to ensure that the voices of children, youth and families are at the forefront of service planning and delivery are of paramount importance. When they are involved in the planning of their services, youth feel heard. Similarly, it is imperative that as consumers of services, youth and families play a role in directing their recovery and feel committed to their own well-being (Matarese et al., 2005).

Experiences of Parents & Families

Research indicates that the involvement of families is important to the success of residential care programs. The American Association of Children's Residential Centers (AACRC) offers comprehensive suggestions for increasing parent involvement in service directions, based on the results of interviews with parents who assisted in the development of the policy paper. Recognizing families as collaborative partners in the care of their children is key to new approaches to providing residential treatment and organizations are encouraged to "move beyond engaging families to drawing upon them to help guide and drive treatment" (AACRC, 2009d, p. 252). The voices of refugee parents in the child welfare system indicate:

> We don't know everything about parenting but we know a lot. … Child welfare workers need to understand that we know a lot and they must not take our children from us if there is a problem but instead must learn to work with us to solve the problem. (Dumbrill, 2009, p. 160)

Child welfare workers need to understand that we know a lot and they must not take our children from us if there is a problem but instead must learn to work with us to solve the problem.

The voices of parents are important when delivering services under a personalized services model because the amount of emphasis on being seen as collaborative partners, feeling supported, and respected influences the parent's perception of care (Raghavendra, Murchland, Bentley, Wake-Dyster & Lyons, 2007). Using parent-based advisory groups fosters the development of empathy and understanding for the lived experiences of parents whose children are in residential care (AACRC, 2009d). Extended families should also be included when appropriate (Darlington, Healy & Feeney, 2010). Providing family-driven versus program-driven service increases parent satisfaction and results in positive child outcomes (Law et al., 2003).

Parents have indicated that the use of supportive and descriptive language versus condescending and stigmatizing language made a difference in their perception of service receipt (AACRC, 2009d). Also critical is that service providers use common versus clinical terms or acronyms. The mother of a child with a severe emotional disturbance stated, "… [t]hey had a behavior grading system for the kids. They called them 'steps', and the first step was 'crawling'. But I really did not know what the terms stood for . . ." (Spencer & Powell, 2000, p. 35). As services are revamped towards the implementation of a personalized services approach, attention will be needed to

the method in which parents are included in service planning. As well, programs need to be conscious of when they do not include parents. The same mother spoke to her limited involvement in service delivery, and the impact it had on her, as well as on her son's progress:

> *Why put him in a residential home . . . Stephen was there for a year-and-a-half . . . and have staff do all these wonderful things with him, teach him different behaviors, how to cope, and then just send him home? Not teaching me what they discovered would be defeating the purpose of placement. He would likely end up right back there in a few weeks. Reluctantly, they began to work with me so that I could begin to incorporate some of these things at home. (Spencer & Powell, 2000, p. 35)*

The inclusion of the voices of children and youth in guiding the decision made during service delivery has a direct positive impact on the family as they view their children as resilient and competent individuals who have developed independence and self-worth. When families see the positive changes in the lives of their children the family system is strengthened (Gyamfi et al., 2007).

Particularly critical are the experiences of new immigrants and aboriginal families in their interactions with a system that was not created with their needs in mind. In Your Policies, Our Children: Messages from Refugee Parents to Child Welfare Workers and Policymakers, a mother, new to Canada tells us that "… [t]he whole vision we have about our children coming to Canada is shattered because the society we found ourselves in is a very different one" (Dumbrill, 2009, p. 155). In a personalized services model, it will be important to ask what they had hoped for, and understand their vision for their children within their cultural context. The same mother continued: "When we get here, we become frustrated that our way of doing things back home can't be implemented on this side of the world because it's just all so different. We can't bring our children up our way" (Dumbrill, 2009, p. 156). Throughout service delivery, inquiring about and developing an appreciation for a mother's "way" would be an important factor as services are personalized and parents are engaged.

Learning's from Beyond the Child and Family Serving System

The concept of personalized service transcends medical, community and residential models. The terminology has been popularized in the United Kingdom, within the field of adult social care where they put "real power in the hands of individuals and their carers; giving real choice and control to the people who know best what support and services they need and how, when and where these should be delivered." (London Borough of Richmond upon Thames, 2010, p. 4) One principle that guides service delivery in adult social care is that each individual is the expert on their needs, and how to address those needs. The second principle involves working in partnership with individuals in designing and delivering the services and supports they need; it is essential to success within a personalized framework. Within their model, 75% of clients indicated feeling a greater control over their lives. Parents of a son with disabilities indicated that the personalized model of service delivery "… has enabled us to make decisions and choices to improve Chris's quality and enjoyment of life" (London Borough of Richmond upon Thames, 2010, p. 15).

When service users are placed in the role of expert and empowered to direct their own service delivery, their experiences are similar to the mother who participated in The SPEaK (Support Planning, Empowerment and Knowledge) Partnership. SPEaK was a collaboration between service and care providers that focused on training around support planning. In the mother's words: "… [f]or the first time in my life I understand what people are talking about and I can see how it could work for my daughter" (DH Department of Health, 2010, p. 10).

From a parent's perspective, structures and processes for services had a direct impact on their satisfaction with services received. Structure and processes include;

> *Components such as interpersonal relationships, providing respectful care, and service continuity. Aspects of service delivery structure that influence perceptions of care and satisfaction consist of environmental characteristics of the service organization such as physical comfort, waiting lists, and ease of access to service. (Law et. al. 2003, p. 358)*
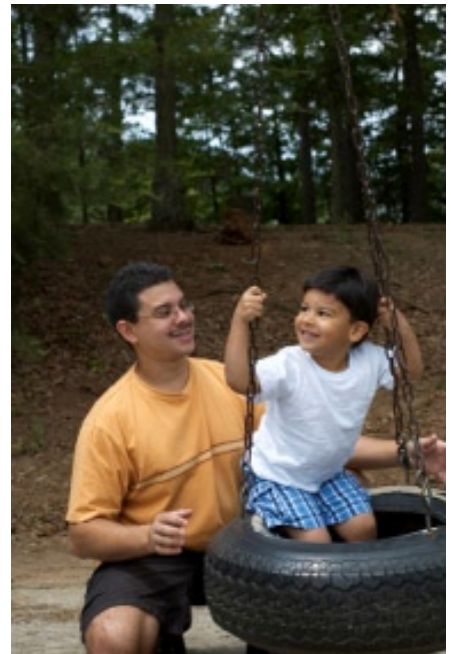
Families with children with disabilities indicated that they felt that individualized care, access to information, and being included in the planning and delivery of services were important (Law et al., 2003).

Educational settings have become more oriented to personalized services because " … without individualized, tailored care, many youth are unable to be successful in completing their education" (Matarese et al., 2005, p. 7). An individualized plan of care or service promotes the development of partnerships between clients and the program. This allows goals to be set that reflect the child or youth's emotional, psychological and practical needs, and influence the success of the outcome (Matarese et al., 2005).

The experiences of parents using the Medicaid system in the US indicated, "… most families who received services felt that they had to accept existing services and were given little choice in terms of types of services and providers" (Semansky & Koyanagi, 2004, p. 2). Parents involved in this study did not believe that services were individualized, even though this is a principle of care supported by the federal Center for Mental Health Services. Parents were disappointed in the level of choice and voice they had when it came to the services their child received:

> *Sometimes when they tell you this is all they have to offer, this is the best they can do, I've gotten to the point where I tell them, 'I want more than this. I want you to offer something different. . . . No, it's not going to 'have to work,' you're going to do something different. (Semansky & Koyanagi, 2004, p. 2)*

Conclusion

Studies on client experiences and satisfaction highlight the voices of service users, and provide valuable feedback to service providers. Further research is required to determine the extent that voice, choice and relational and cultural context impact the client's perception of service delivery. Going forward, it will be important to conduct an analysis of the existing systems in residential care, and adopt a mechanism to obtain client feedback about these systems in respect to the principles of personalized services. Finally, it will be of the utmost importance to seek input from children, youth and families in regard to how residential care can better ensure that their voices, choices, and cultural context are reflected in service delivery models.

Diversity

Barriers with respect to culture and other forms of diversity can create disparities in access and service utilization for members of diverse populations therefore service adaptations that enhance participation are essential. Consideration of diversity is fundamental to the work and yet other than cultural factors and factors associated with disability, there is little direct consideration in the literature of other types of difference in personalized services (e.g. differences due to gender, sexual orientation, religion or spirituality-apart from culture). Key factors to consider in managing the diversity of young people and their families are:

- Incorporating non-judgmental and culturally sensitive practices improves client engagement and enhances the therapeutic relationship. In order to make service meaningful and responsive to the child's lived experience, cultural competence must be viewed as an ongoing process of becoming rather than a state of being. Service providers need to either commit themselves to lifelong learning, or accept their lack of competence in cross-cultural matters. This helps to equalize the balance of power and minimize bias and prejudicial thinking.

- Biases and disparities within systems create barriers to effective personalized mental health care. Due to socioeconomic conditions, stigma, poor access to health and education, lack of activism, skill deficits, service location, organizational culture, and other social determinants of health young people and families are unable to navigate the complexities of the service provision available to them.

- Aboriginal children are fifteen times more likely to enter foster care than non-aboriginal children, yet the child welfare system has few services that respond to the levels of poverty, poor housing, and substance misuse in indigenous communities Non-indigenous service providers working with native communities would benefit young people by focusing on a strength-based, holistic systems perspective that includes spirituality in their treatment goals. Recognition of the special needs of Aboriginal young people is more than just cultural sensitivity; it is a recognition of the special status that Aboriginal people hold in Canada.

- Considerations apply when evaluating services for diverse populations and evaluators must ensure they have a good

Recognition of the special needs of Aboriginal young people is more than just cultural sensitivity; it is a recognition of the special status that Aboriginal people hold in Canada.

understanding of program evaluation models and methods that transcends particular cultures or types of difference. Researchers need to involve and collaborate with the community and key informants from the populations who are receiving the service, including service recipients, service providers, funding representatives and other professionals.

• Service providers must have an awareness of self and of their own value systems and biases, and how these affect interactions with children and families receiving care. It is important to understand these diverse contexts in order to facilitate the development of service plans that reflect the voices and choices of children and families through collaborative partnerships with young people and families. The child's physical and cognitive abilities, health, gender, sexual orientation, and religion also require consideration in the development of an effective personalized plan.

Reflecting Diversity in Personalized Services

Tamara Este

The culture of service recipients, service providers, and program evaluators has a significant influence on the quality of care and the outcomes for young people and families. Each service user has a unique demographic profile that affects how service is delivered, the child and family's level of participation, and the relationship between the service provider and young person. Barriers with respect to culture and diversity can create disparities in access and service utilization for members of diverse populations, making personalized service adaptations that enhance participation essential. Incorporating non-judgemental and culturally sensitive practices improves client engagement and enhances the therapeutic relationship (Jackson, 2009; Owens, Richerson, Murphy, Jagelewski & Rossi, 2008; Pumariega, Rogers & Rothe, 2005; Surgeon General, 2001; Weiner, Schneider & Lyons; 2009; Wells, Merritt & Briggs, 2009). This paper reviews literature that identifies the significance of institutional and individual biases within care systems, defines and describes cultural competence, and identifies practice approaches that facilitate personalized service in diverse contexts.

Biases Within Care Systems

A number of barriers to effective personalized mental health care exist because of biases and disparities within systems; including population barriers (socioeconomic, stigma, poor health education and access, lack of activism), service provider factors (deficits in skills and cultural sensitivity) and systemic/Institutional factors (service location, organizational culture, training, culturally competent services) (Pumariega et al., 2005). Prejudices and biases embedded within the operations of service organizations create an unwelcome environment, and keep young people and families in an inferior, dependent, helpless role (Bell, Wells & Merritt, 2009; Pumariega et. al, 2005). Consequently, a service that is meant to be helpful may in fact be the source of added trauma, exclusion, disadvantage, and poor health (Dumbrill, 2008; Wells, Merritt & Briggs, 2009). A general distrust, and fear of being misunderstood or judged due to a history of structural inequalities, can threaten the therapeutic alliance and the success of the care plan. This historical mistrust may create suspicion during the provision of personalized service, even if the service is provided in

Barriers with respect to culture and diversity can create disparities in access and service utilization for members of diverse populations, making personalized service adaptations that enhance participation essential.

a manner that is sensitive to diversity. Institutional change for the implementation of personalized services may meet structural barriers similar to those that young people and families have experienced (Backlar & Cutler, 2002; Bell, Wells & Merritt, 2009; Blackstock, Cross, George, Brown & Formsma, 2006; Briggs, 2009; Dumbrill, 2008; Pumariega et al., 2005; Jackson, 2009; Owens et al., 2008; Surgeon General, 2001). Service providers must critically assess the potential for structural bias within their organizations and make efforts to welcome young people and embrace their differences.

Cultural Competence & Sensitivity

The culture and family context in which a child's emotional and behavioural problems are formed, and the culture and context in which treatment is sought and provided, play an important role in the examination of service disparities, including issues of power (Shin & Brown, 2009). Without knowledge of diverse populations, providers are at risk of developing service plans that contradict the beliefs and values of the young person and family (Dumbrill, 2008; Surgeon General, 2001). Personalized service must be adapted to the child's cultural context, which requires specific qualities and behaviours on the part of the service providers. Cultural competence includes an awareness and acceptance of differences, an awareness of the intrinsic biases of one's own culture, an understanding of the dynamics of working across cultures, and the acquisition of cultural knowledge and practice skills to fit the cultural context of the client (Cross, Bazon, Denis & Isaacs, 1989). Jackson (2009) describes culturally sensitive interventions as the degree to which the cultural characteristics, experiences, norms, values, behavioural patterns, and beliefs of a population, as well as relevant historical, environmental and social forces, are incorporated in the design, delivery, and evaluation of targeted health promotion materials and programs. In order to make service meaningful and responsive to the child's lived experience, cultural competence must be viewed as an ongoing process of becoming rather than a state of being, one that requires humility and open-mindedness (Pumariega et al., 2005; Wells, Merritt & Briggs,2009). Service providers need to either commit themselves to lifelong learning, or accept their lack of competence in cross-cultural matters; this helps to equalize the balance of power and minimize bias and prejudicial thinking. Effectiveness in providing culturally sensitive interventions is not only related to ongoing knowledge about a child's and family's culture, but also the service providers ability to form a child-and family-centred alliance in which the service provider respects the child and family's knowledge and unique perspectives, avoids

Without knowledge of diverse populations, providers are at risk of developing service plans that contradict the beliefs and values of the young person and family.

stereotypes and empowers them to make treatment decisions. Failure to form positive therapeutic alliances contributes to significant barriers in assessment, intervention and subsequent use of mental health services by diverse groups (Pumariega et al., 2005).

Personalized Service Considerations with Diverse Populations

> ... [A]cting unquestioningly upon what one thinks one "knows" about a particular culture in one's interactions with an individual is racist behaviour. Rather than using trait-based cultural competency models, practitioners need to adopt a more dynamic, interactive view of culture and communication and pay attention to important cues that could help improve the delivery of ... care. (Lee & Farrell, 2006, p. 4)

Service delivery is affected by different aspects of identity, including religion, dietary requirements, and cultural traditions (Chuan & Flynn, 2006). Although family members may identify their traditions, preferences and needs, it is important for service providers to ensure they incorporate questions about diversity when exploring placements in residential care. Networking with community or religious groups and providing staff with training on cultural sensitivity and awareness will enable personalized services and support to children and families (Chuan & Flynn, 2006).

Approaches to Culturally Sensitive Evidence-Based Interventions

Culturally appropriate interventions are those that have demonstrated effectiveness with a specific diverse population, and are owned or accepted as relevant and helpful by community members (Wells Merritt & Briggs, 2009). However, the lack of attention paid to culture in child welfare and mental health means that very little or no effort has been devoted to the design and delivery of evidence-based programs that are culturally sensitive (Briggs, 2009; Wells, Merritt & Briggs, 2009; Jackson, 2009). The literature on culture and diversity suggests various practice approaches that enhance ownership and empowerment among diverse groups, and should be incorporated into the implementation of personalized service delivery. Strategies include:

- systemically gathering information about cultural needs;

- developing policies and procedures that address cultural needs;

- using cultural differences as an opportunity for practitioner learning;

- validating and empowering clients to pursue their choices and values;

- developing and reviewing individually tailored programs to meet cultural needs;

- modifying care settings to reflect the customs, rituals, and expressions of diverse clients;

- involving the birth parents, as well as people, organizations, and media from the same or a similar culture, in the care plan;

- celebrating commonalities across human diversity

- ongoing organizational self assessment and training.

(Briggs, 2009; Chuan & Flynn, 2006 ; Integrated Case Management (ICM) User's Guide, 2006; Pumariega, Rogers & Rothe, 2005).

While specific research addressing evidence-based interventions with culturally diverse young people is limited, some work has been done in this area. Three evidence-based practices addressing trauma among foster care youth were found to be equally effective among African Americans, biracial, Hispanic and white populations: Child-Parent Psychotherapy (CCP), Trauma-Focused Cognitive Behavioural Therapy (TFCBT), and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) (Weiner, Schneider & Lyons, 2009). The Positive Peer Culture (PPC) and Positive Group Interaction (PGI) programs have been effective in offsetting the potential for the development of an antisocial culture among youth in residential treatment regardless of culture, ethnicity, ability and sexual orientation. The PPC adopts holistic methods to work with youth in therapeutic settings, and the peer group is viewed as a resource rather than a negative influence. It has reported effectiveness in increasing self-awareness, positive self-image, self-esteem, the ability to identify personal problems and make more rational decisions, academic achievement, and the level of concern for oneself and others. The PGI program infuses residential treatment with the nuances of the peer group being treated. A focus on peer culture creates a safe and healthy environment, and an atmosphere of trust, to achieve behavioural change for group members (Steiker, 2008). Culturally diverse groups

A focus on peer culture creates a safe and healthy environment, and an atmosphere of trust, to achieve behavioural change for group members

are more accepting and responsive to therapeutic approaches with a practical cognitive-behavioural and interpersonal focus; additionally, group and family psychotherapy, approaches that integrate cultural and ethnic identity themes, and psycho-education have also been reported as effective (Pumariega et al., 2005). Diverse populations require culturally sensitive approaches which address factors such as acculturation pressures, discrimination, marginalization, gender role pressures, past traumas and losses, and poverty (Pumariega et al., 2005) since these factors contribute to mental health challenges and play a role in symptomatology and outcomes.

An important starting point for working across differences is for service providers to respectfully identify and build on parent's concern for the well-being and future of their children; this approach will facilitate access and service use

Refugees & Immigrant Populations

Along with parenting challenges, immigrants and refugees face issues related to settling in a new country such as culture shock, employment challenges, and a lack of appropriate community support. Populations also report experiencing service providers who lack compassion and exhibit openly racist approaches whereby deficits are readily identified while strengths and abilities are diminished (Dumbrill, 2008). Language and communication are critical in obtaining accurate information and establishing a supportive therapeutic alliance. However, translation and interpretation can be viewed as a menial or informal task rather than one central to the provision of service in many organizations. Additionally, differences in childrearing, interpretation of emotional experiences, responses, symptoms, and degree of self-disclosure affects the validity of clinical assessment and intervention (Dumbrill, 2008; Pumariega, et al., 2005). Typically services that are associated with institutions

that are viewed favourably in the community such as religious institutions and non medical settings such as schools are often less threatening and more easily accessed than traditional mental health clinics, or centers (Pumariega, et al., 2005). An important starting point for working across differences is for service providers to respectfully identify and build on parent's concern for the well-being and future of their children; this approach will facilitate access and service use (Dumbrill, 2008; Pumariega et al., 2005).

Aboriginal Populations

Native children are fifteen times more likely to enter foster care than non-native children, yet the child welfare system has few services that respond to the levels of poverty, poor housing, and substance misuse in Indigenous communities (Blackstock et. al, 2006). The voices of Indigenous communities in Ontario speak extensively of care systems that were built on the assumptions and principles of non-aboriginal people, without acknowledging traditional Native systems of ensuring child safety. Indigenous communities oppose "one size fits all" approaches to service delivery modeled after Western treatment philosophies (Blackstock et. al, 2006; Weaver, 1999).

These communities benefit from program ideologies that recognize native ways of knowing and being. However, even as indigenous children and families maintain their own cultural identity, they must also adapt and interface with the dominant mainstream culture; thus assessment and treatment should be designed to support bicultural adjustment concerns (Avery, 2009; Pumariega et al., 2005). Research on adaptive identity and coping emphasizes the protective value of a sense of self-respect and a connection to spirituality, friends, and peers, as well as the importance of developing therapeutic relationships that incorporate cultural values (Briggs, 2009). Without community solidarity, children will be more alienated as they grow up, and the cycles of poverty, violence and abuse will continue (Greenwood, 2006). Non-indigenous service providers working with native communities would benefit clients by focusing on a strength-based, holistic, systems perspective that includes spirituality in their treatment goals for children and their families (Limb & Hodge, 2010).

Populations with Diverse Abilities

Traditional service structures tend to segregate people with disabilities according to their impairments and demographic factors, and are ill

suited to supporting individuals whose needs fall into more than one category. Children with disabilities and their families require a range of services, and providers with a knowledge and understanding of various disabilities to facilitate joint strategic planning and delivery of care. Service providers are encouraged to move away from gate keeping and resource management to advocacy and support tasks. As well as the necessary knowledge and skills, children and families also value service providers who have a combination of human qualities which embrace independence, wellbeing, and choice. The support of a child and family advocate who ensures each child's needs and priorities are known and addressed is one method of delivering personalized services that help promote cognitive, physical and social-emotional development, as well as dignity and independence, in children with disabilities (Capital Area Human Services District, 2001).

Personalized services models are well developed in the service delivery arena for adults with developmental and physical disabilities. The objectives of these adult-directed models, with their focus on high standards of care, dignity, and maximum choice and control, can offer something to the management of personalized services for young people in general. (Social Care Institute for Excellence, 2010)

Populations of Diverse Sexual Orientation

Despite changes in social attitudes, there is still great risk in "coming out" for a gay or lesbian child due to the cultural stigma associated with homosexuality. Family members and close support systems also fear the cultural stigma attached to having a homosexual member; this can exacerbate the lack of support or result in outright rejection of gay or lesbian family members (Moore & Moore, 2000). Adolescents face the potential of rejection from their families, on whom they depend financially, emotionally, and legally. When few role models and peer groups are available to offer support, individuals of diverse sexual orientations can experience extreme isolation. In residential settings, residents who are openly gay are often not accepted, and when they are, their sexuality is looked upon as a problem area. Gay and lesbian youth in residential care do not need to be treated specially; they need to be provided with equal opportunities for growth, self-actualization, and quality care (Moore & Moore, 2000).

Finding ways to incorporate an individual's sexual orientation into service delivery is complicated by the young person's right to equal treatment, respect for their privacy, and the avoidance of any discrimination based on sexual orientation or gender identity.

> Family members and close support systems also fear the cultural stigma attached to having a homosexual member; this can exacerbate the lack of support or result in outright rejection of gay or lesbian family members.

Ensuring that service plans address these needs is essential, but may be complicated by family and community attitudes and fears. A personalized service approach considers the following when working with populations of diverse sexual orientations:

- Service providers need to understand and get to know a young person beyond the "sexual" aspect of his/her homosexuality or gender identity, considering the whole person with various needs and strengths.

- Personalization embeds the consideration of difference due to sexual orientation in the organizational approach to service delivery, not in individualized service planning.

- Staff training to improve attitudes and interventions with young people

- Policies and practices provide a safe, caring, and supportive environment for youth dealing with issues of sexuality and identity.

- Service providers must have clear discrimination and harassment protocols and procedures, including investigation protocols (Findlay, 2000).

Evaluating Delivery of Services to Diverse Populations

Given the pervasive effects of culture on human behaviour, accounting for all cultural variables in care systems is a difficult to impossible task. However, an understanding of the cultural variables that affect service utilization and interventions is essential to determine the relevance of a particular therapeutic intervention, and evaluations must be tailored to reveal relevance. The following considerations apply when evaluating services for diverse populations:

- Evaluators must ensure they have a good understanding of program evaluation models and methods that transcends particular cultures. It is important to identify characteristics of culturally sensitive interventions that can be evaluated and replicated to ensure future dissemination and use of effective approaches.

- Researchers need to involve and collaborate with the community and informed people from the target cultures, including service recipients, service providers, funding representatives and other professionals. This collaboration should influence the basic design, choice of

instruments, methods, and the process of program evaluation for the population.

- Planned evaluations should be tested in a pilot project, and feedback sought from all stakeholders in order to revise and strengthen the plan.

- Plans should be developed that account for cultural influences in data analysis and interpretation.

Members of the target population, as well as other diverse groups, should provide feedback on the data analysis and findings; findings should be revised in accordance with the feedback (Epstein, Kutask & Duchnowski, 2005; Wells, Merritt & Briggs, 2009). Young people and families who had their voices and choices heard in the design phases of policy, programs and research, reported overall satisfaction with service (Lee & Farrell, 2006; Scott, Munson & White, 2009; Surgeon General, 2001; Owens et al., 2008; Wells, Merritt & Briggs., 2009).

Concluding Considerations

Understanding diversity along the lines of equity, bias, power relations, and institutional oppression is critical for service providers to remain relevant and accountable to the unique needs of children, youth, and families in a global society. They must understand the organizational culture, and be sensitive to the culture of children and families. Networking with communities that reflect the diversity of the service users, and establishing program, administrative and governance structures that reflect the voices of diverse groups, benefits young people and families. Working partnerships are an essential component to providing quality personalized services and achieve successful outcomes. Along with opportunities for developing independence, clients benefit from service providers focusing on reducing risk by adapting the physical environment, and developing clear procedures and management guidelines through the training and effective supervision of staff (Creative Support, 2008).

Educational programs often prepare service providers with a knowledge base of the history, experiences, and general characteristics of diverse groups of people; however, no one is ever fully competent in cultural understanding. Open communication and the inclusion of children's voices are necessary for understanding diversity within groups and value conflicts within the therapeutic alliance, and for gathering feedback and gaining community ownership of interventions (Backlar &Cutler, 2002; Weaver, 1999; Wells, Merritt & Briggs., 2009).

Networking with communities that reflect the diversity of the service users, and establishing program, administrative and governance structures that reflect the voices of diverse groups, benefits young people and families.

Service providers must have an awareness of self and of their own value systems and biases, and how these affect interactions with children and families receiving care (Backlar & Cutler, 2002; Epstein, Kutash & Duchnowski, 2004; Garfat, 2003). It is important to understand these diverse contexts in order to facilitate the development of service plans that reflect the voices and choices of children and families through collaborative partnerships with young people and families. The child's physical and cognitive abilities, health, gender, sexual orientation, and religion also require consideration in the development of an effective personalized plan. The significance of culture has been overlooked or underestimated as an important variable in therapeutic relationships. In order to fully attend to diversity, service providers and researchers need to view children and their families as experts on their own life experiences (Davis, 2009; Bellefeuille, McGrath & Jamieson, 2008; Steiker, 2008).

Outcomes

The goal of personalized services should be to achieve outcomes that reflect the unique needs of each individual versus the high level needs and requirements of the program. Key factors to be considered are:

- Outcome research in residential care settings has been limited by the difficulty of designing studies with control groups and implementing standardized measurement tools. Despite these limitations, the literature and public policy encourage agencies to move toward the determination of outcomes of service, which may negate the concept of personalized service delivery. Numerous reviews conclude only that:

  - youth with externalizing behavioral problems seem to make more progress

  - behavior-modification components and family-focused components in the treatment interventions seem to achieve results;

  - residential care seems to achieve better results than treatment at home with the same (very) problematic group;

  - specific training aimed at the social-cognitive and social-emotional skills of youths can strengthen a treatment effect and prepare young people for community reintegration;

  - discharge planning must begin at the onset of care and focus on establishing supports and eliminating barriers;

  - effective treatment programs are committed to monitoring outcome measurements and making adaptations as needed through a revised treatment plan, if prescribed outcomes are not indicating improvement.

- The limited personalization of services and placement decisions fuelled by which residential program has an opening at the time rather than by the program's fit with the child's needs impact outcomes prior to the child or youth even being placed in the residential program.

- Placement spaces that are considered interchangeable and service providers that lack a clear definition of how their program, treatment focus and potential outcomes relate

to the needs of the clients make it difficult for young people and families to choose in an informed manner.

•   In the move toward a personalized services model, further research is required to discover how to balance personalized services -- the adaptation of service delivery to fit with client lives -- with designing programs that capture concrete outcomes and demonstrate effectiveness.

Outcomes of Personalized Services for Residential Care

Jessica Sauve-Griffin

The goal of personalized services should be to achieve outcomes that reflect the unique needs of each individual versus the high level needs and requirements of the program. Although we know that parental engagement and child characteristics have a direct linkage to treatment outcomes (Bettmann & Jasperson, 2009), there is limited literature available that speaks to outcomes of personalized services in residential care. Rather, the research speaks to individual variables that affect overall outcomes in residential care, or to program-related outcomes (Kufeldt, Simard & Vachon, 2000). Gaining an understanding of these variables will assist residential care agencies in moving towards an outcome-based personalized service delivery model. Outcome research in residential care settings has also been limited by the difficulty of designing studies with control groups. Consequently, it is a challenge to demonstrate service effectiveness in the residential care system using outcome measures (Hair, 2005). This section will review the research on outcomes in residential care related to the core concepts of personalized services, and address individual, family, program and system level outcomes.

> The goal of personalized services should be to achieve outcomes that reflect the unique needs of each individual versus the high level needs and requirements of the program.

Role of Individual Characteristics in Outcomes

Programs that are not individualized to the client's unique needs and family context are unlikely to be effective (Barth, 2005)and individual characteristics present a multitude of variables that influence successful outcomes in treatment (Bettmann & Jasperson, 2009). Barth (2005) identified four principles of individualized service delivery in a study with juvenile offenders in residential care;

1. Human Service: Did treatment occur?

2. Risk: Was there a process for assessing low and high risk? And was the distinction made?

3. Need: Was treatment and programming matched to individual characteristics and needs?

4. Responsivity: Was treatment and programming delivered in a manner that incorporated the clients learning style and abilities?

Medical professionals have begun to move toward a personalized services model -- the focus is to determine whether treatment is working for each individual -- versus a global intervention based on diagnoses. Within the global intervention model, the medical professional seeks to assess whether a specific treatment is working for a specific individual (Warren, Nelson & Burlingame, 2009). The personalized services model would go one step further and encourage consultation with the individual to see whether they felt the treatment was working for them. Within youth mental health services, outcomes related to symptom reduction and behavioural change can be measured, but it is also critical to determine whether the young person notices a change and if the treatment is thought to be working. It is also valuable, following intervention, to measure outcomes tied to a change in family functioning, or a change in how an individual functions within their social milieu. Individual qualities moderate the perceived severity of symptoms, and therefore should direct treatment focus and monitoring of outcomes (Bettmann & Jasperson, 2009).

The adult treatment setting also offers some insight into the personalized services model. In this setting, there are measurement tools that can be applied to identify to the clinician when the client is not meeting outcome-related factors such as their readiness for change, the therapeutic relationship or the individual's support network. An assessment of these factors is completed by the clinician and the patient; following this, treatment can be adjusted accordingly (Warren, et. al., 2009).

Family Influences on Outcomes

Research supports family involvement as a vital component of effective interventions (Nickerson, Brooks, Colby, Rickert & Salamone, 2006). In fact, Matares, McGinnis & Moira (2005) found that the involvement of families has a stronger impact on outcomes than the treatment itself. Cunningham, Duffee, Huang, Steinke & Naccarato (2004) recommend a further exploration of the connection between family engagement and outcomes in residential care as measured by reunification, recidivism, and future placements. Part of the rationale of involving families is to learn about the child's uniqueness and the environmental influences that can aggravate or inspire them (Barth, 2007). In a personalized services model, it is critical to honour the strengths, cultures, traditions and expertise that the family can offer to ensure that the uniqueness of each client is considered (Turchi, Berhane, Bethell, Pomponio, Antonelli & Minkowitz, 2009; Barth, Greeson, Guo, Green, Hurley & Sisson,

2007). To date, "… the residential and inpatient outcome literature largely ignores variables of race and ethnicity in considering outcome" (Bettmann & Jasperson, 2009, p. 173). This is an important component to consider and integrate into any outcome measurement tools for personalized services in residential care. The family and community must be involved in defining what outcomes are appropriate according to their cultural norms.

Integrating family involvement during service provision can lead to outcomes that include an increased likelihood of family reunification and stability following discharge (Nickerson, et. al. 2006). When families are involved, there is a stronger likelihood that youth will attain their goals, complete their programs and maintain gains following discharge. A growing body of research indicates that any short-term gains from residential treatment are often challenged after discharge because of a lack of family involvement, inadequate teaching of adaptive skills and problems with after-care planning (Barth et. al., 2007); all of these issues would be resolved in a personalized service model.

Family involvement has been identified as a predictor of positive outcomes after residential treatment. The outcomes included increased social competence, academic success, self esteem and increased functioning in the home setting, all of which can lead to enhanced educational and employment opportunities (Hair, 2005). Factors that contributed to ongoing stability after discharge included ongoing parental contact and involvement; shorter periods of stay in the residence (8 months or less); and the availability of supportive aftercare services (Hair, 2005).

Program Outcomes

Quality services are provided when residential care agencies focus more on the children and their needs than that of the program (Roca et. al., 2009). The movement towards a personalized services model will challenge residential care agencies to develop a predictable and reliable system for measuring the delivery and outcomes of personalized services in a residential care setting.

"In a world that has long understood that the best outcomes are likely when a good assessment is followed by services tailored to that assessment, residential care is not achieving this basic standard of care" (Barth, 2005, p. 158). Data collection is difficult in residential care settings; therefore, obtaining outcome data is a challenge (Hair, 2005). Agency and systemic barriers may also

limit the measurement of outcomes of service effectiveness. From a residential care perspective, there are no standardized measurement tools to assess the outcomes of personalized care at a program level (Wells, Merritt & Briggs, 2009). Despite these limitations, the literature indicates that it is important for agencies to move toward the determination of outcomes of service. The American Association of Children's Residential Care (AACRC) (2009c) encourages residential care agencies to embrace this challenge. Numerous reviews, including a meta-analysis on the outcomes of residential care (Hair, 2005; Knorth, Harder, Zandberg & Kendrick, 2008; Magellan Health Services Children's Services Task Force, 2008) conclude that:

- youth with externalizing behavioral problems seem to make more progress than youth with internalizing problems;

- the staff of a residential program seems to be more critical in assessing behavioral progress than youth themselves and their parents;

- behavior-modification components, and family-focused components in the treatment interventions, seem to achieve results;

- residential care seems to achieve better results than treatment at home with the same (very) problematic group;

- specific training, aimed at the social-cognitive and social-emotional skills of youths, can generate a significant strengthening of a treatment effect;

- when families are involved, residential care placements are shorter;

- discharge planning that begins at the onset of care, and that focuses on establishing supports and eliminating barriers, leads to successful residential programs;

- the teaching of skills that prepare youth for community reintegration is essential;

- effective treatment programs are committed to monitoring outcome measurements and making adaptations as needed through a revised treatment plan, if prescribed outcomes are not indicating improvement.

The limited diversity in program delivery in residential settings fails to take into account the individual characteristics and needs of each child (Barth, 2005; Libby, Coen, Price, Silverman, & Orton, 2005). The limited personalization of services can have

an impact on outcomes prior to the child or youth being placed in a residential care setting. Placement decisions are generally fueled by which residential program has an opening at that time, rather than being determined by the program's fit with the child's needs (Bates, English & Kouidou-Giles, 1997). The child welfare system should ensure that residential care agencies do not treat their placement spaces as interchangeable (Libby, et. al., 2005). As well, service providers should have a clear definition of how their program, treatment focus and potential outcomes (Bates et al., 1997; Knorth, et. al., 2008) relate to the needs of the clients, and this should be made available to clients. While "… clearer program definitions and clinical hypotheses would allow placement decisions to be based on the match between the program's characteristics and the child's problems" (Bates, et. al., 1997, p. 12) in the move toward a personalized services model, further research is required to discover how to balance personalized services -- the adaptation of service delivery to fit with client lives -- with designing programs that capture concrete outcomes and demonstrate effectiveness.

Outcomes from Looking After Children (LAC) & Wraparound Initiatives

In the realm of child welfare services, residential agencies in many jurisdictions have used the Looking After Children (LAC) framework to identify individual strengths and needs, and to inform Plans of Care (Champion & Wise, 2009; Kufeldt, 2000; Ontario Association of Children's Aid Societies, 2006). Looking After Children, as a case planning tool:

- empowers clients to participate in their service delivery;
- increases the service providers knowledge of the child or youth in care;
- increases collaborative opportunities;
- clarifies goal setting; and
- measures the capacity to obtain long term goals. (Kufeldt, 2000)

All of the foregoing should be fundamental to personalized service and proponents of the LAC framework insist that monitoring children's developmental progress, and the conditions in care under which pre-placement difficulties are likely to manifest, can help service providers to understand unmet needs and to adapt policy and program delivery in order to promote healthy developmental outcomes and long-term life chances (Champion & Wise, 2009).

The Wraparound model has also been applied to personalized services in residential care. The Wraparound "…philosophy provides guidance for establishing a continuum of services and supports for youth and families and procedures for integrating them in an individualized and family driven manner" (Suter & Bruns, 2009, p. 336). The focus of this model is on the development of a collaborative process with the clients and families, where traditional and non-traditional approaches can be applied based on client need. Jones & Lansdverk (2006) report on a successful residential educational model that is based on Wraparound and utilizes a team to provide individualized guidance for each youth. Wraparound has been demonstrated " to achieve a broad range of outcomes such as improved mental health, reduced juvenile recidivism rates, more successful permanency outcomes, improved school achievement and attendance, and retention in less restrictive educational settings" (Suter & Bruns, 2009, p. 337). Youth involved in probation, special education, child welfare and residential settings where the Wraparound model was applied, demonstrated a "… significant reduction in functional impairment during a 6-month period for youth referred to Wraparound services" (Cox, Baker, & Wong, 2010, p. 4) as assessed by the Child and Adolescent Functional Assessment Scale (CAFAS).

Wraparound has been demonstrated " to achieve a broad range of outcomes.."

Individualized service models reflecting the Wraparound philosophy can also reduce the overall cost to the system. A longitudinal quasi-experiential study, with youth residing in inpatient or residential care who were diagnosed with a severe emotional disturbance revealed that participation in the Wraparound process resulted in fewer days in care (Cox, et. al., 2010). In studies with juvenile offenders, the Wraparound model resulted in fewer absences from school, less running away, decreased recidivism and less time in juvenile facilities. In residential care, a move toward increased community involvement is likely "… to enhance their motivation to address emotional or behavioral difficulties and foster their connection to peers and adults in their receiving neighborhoods" (Cox, et. al., 2010, p. 11). These are outcomes of the Wraparound model.

Despite the ability to demonstrate a variety of enhanced outcomes for young people who participate in Wraparound, the literature offers minimal evidence about to the characteristics of youth and families who are treated most successfully with a high-fidelity Wraparound process. Even less is known about the relative importance of the various elements of the approach in contributing to positive outcomes for children and families (Cox, et. al., 2010). In other words, we know it works but what the individual and program factors are that contribute to making it work remain a mystery.
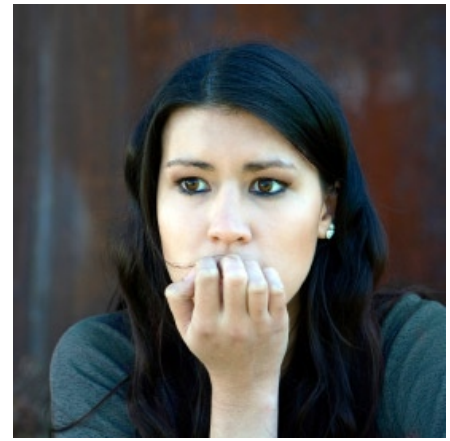
Concluding Questions

With evaluative data becoming critical in determining the effectiveness and securing continued funding for programs, "gathering data is not necessarily a luxury . . . it may be critical for an agency's survival" (Gilman & Huebner, 2004, p. 8). The implementation of standardized measures will help service providers understand each youth's individual needs; however, the appropriate measure, as it relates to personalized services in residential care, requires further research (Butler, et. al., 2009). The development and implementation of standardized empirically based assessment methods including tools such as the Strengths and Difficulties Questionnaire (SDQ) (Marquis & Flynn, 2008), the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, Xue & Wotring, 2004) and LAC (Champion & Wise, 2009; Kufeldt, 2000; Marquis & Flynn, 2008) provide general program outcome measurements in the context of personalized service delivery. The testing and use of these tools with families of diverse backgrounds is limited, and the purpose of the tools varies. Some can be used in residential care to increase the identification and guide treatment of behavoural and emotional problems (Marquis & Flynn, 2008) and others are designed to personalize the case management process but not necessarily to assess concrete outcomes from residential treatment. In most cases, they provide an opportunity for service users to voice their true experiences and "… carers expressed relief that difficulties were finally out in the open" (Whyte & Campbell, 2008, p. 200). Whatever the tool, the focus should be on showing "an empirical relation between outcomes on the one hand and well-described interventions for children and youth on the other; and then we may get a real insight on what makes the difference in effective residential child and youth care" (Knorth, et. al., 2008, p. 137). In determining the outcomes of personalized services in residential care, it is important to also ensure that measures are in place to assess client voice and choice, and the relational elements and cultural context at the individual, family, program and system level. Further research is required to determine the definitive outcomes of personalized services, and the specific measurement tools that are appropriate to capture this data.

Tools & Protocols

In order to make the principles of personalized services a meaningful priority to all young people and families receiving service, organizations require tools and protocols that incorporate and prioritize the principles throughout the service. Tools and protocols for personalization can be found in the models previously described.

There are four stages of planning common to the service models reviewed (**Integrated Case Management**, **Systems of Care**, **Wraparound** and **Every Child Matters**). These stages include:

- engagement and team preparation;

- team-based planning;

- implementation and review; and

- transition and evaluation.

Throughout the planning process personalization of services requires that service providers negotiate the tensions between their roles as agency representatives, and their roles as advocates for the young person and family. Constantly mindful of how they use their discretionary power to negotiate complex processes during service provision, and what implications their discretionary practices have for user choice and personalized service responses, providers have developed protocols to ensure:

- that child and family decision-making is encouraged through graduated participation and increasing responsibility;

- that the planning focuses on the strengths and priorities of the young person and family and celebrates achievement and positive change

- that meetings are easily accessible for young person and family and conducted in a manner that addresses least contentious issues first; keeps discussions practical and concrete; and assists the young person to formulate the agenda. Preparation is offered before and after meetings;

- that funding for transportation and childcare is provided;

- that community members and advocates are included;

- that there is a balance between respecting the privacy of young people and sharing necessary information.

Four stages of planning:

1. Engagment & team preparation;
2. Team based planning;
3. Implementation & review; and
4. Transition & evaluation

Specific tools such as meeting agendas, common assessment frameworks, participant guides, and training and certification programs have developed around the initiatives and models that take a personalized service delivery approach. These tools provide consistency within the initiative and ensure that the set of principles and values that form the foundation for the service delivery approach are both understood and implemented.

Tools & Protocols Towards Personalization

Tamara Este

In order to make the principles of personalized services a meaningful priority to all young people and families receiving service, mental health, juvenile justice, and child welfare organizations need to develop tools and protocols that incorporate and prioritize the principles throughout the entirety of service. This synthesis considers tools and protocols that focus on the principles of voice, choice, relationships and cultural context and identifies how these tools and protocols support the implementation of personalized service goals. Tools and protocols for personalization can be found in models such as:

- Integrated Case Management (ICM);

- Systems of Care;

- Wraparound;

- and Every Child Matters (ECM).

There are unique aspects to each of these models that will be outlined later in this paper; first, it is useful to review the strategies and planning protocols that all models have in common.

Strategies

Personalization of services requires that service providers negotiate the tensions between their roles as agency representatives, and their roles as advocates for the child and family. Service providers much be constantly mindful of how they use their discretionary power to negotiate complex processes during service provision, and what implications their discretionary practices have for user choice and personalized service responses. (Foster, Harris, Jackson, Morgan, Glendinning, 2006). There are a number of common foundations in a personalized services approach including:

- child/family participation;

- response to diversity, in particular cultural differences;

- integration of residential care with community services;

- and protecting the privacy of young people and families.

This synthesis considers tools and protocols that focus on the principles of voice, choice, relationships and cultural context and identifies how these tools and protocols support the implementation of personalized service goals.

Child/Family Participation

Child voice and choice are essential and recurring principles in the models used for integrated individualized care. The level of participation is determined by factors relating to the child, caregivers, service providers and the service context. Neglecting to focus on child voice and participation will give service providers permission to impose their own service agendas based on what they think is best for the family; thus, the needs and assets of young people and families will not be addressed adequately. Strategies that promote child and family participation include:

Strategies that promote child and family participation include encouraging child and family decision-making...

- encouraging child and family decision-making;

- providing briefings and debriefings before and after meetings;

- creating an open, trusting and respectful relationship;

- keeping the number of people at meetings to a minimum;

- addressing the least contentious issues first;

- keeping discussions practical and concrete;

- increasing child and family participation as they are ready to take on more responsibility;

- encouraging the child to formulate the agenda and choose support persons;

- providing funding for transportation and childcare to facilitate participation;

- holding meetings in locations comfortable for the child and family;

- focusing on the strengths and priorities of the young person and family and celebrating every achievement and positive change. (Debicki, 2009; Every Child Matters, 2010a; Ministry of Children and Family Development(MCFD), 2006; Rutman, Hubberstey, Hume & Tate, 2005; SAMHSA, n.d.)

Response to Diversity

Linguistic and cultural differences may constitute a barrier to the full participation of the child and family, and service providers may fail to fully appreciate skills and contributions of the young person and the family. Barriers with respect to culture and diversity create disparities in access and service utilization for certain groups.

Therefore, personalized service should be culturally responsive. Representatives from cultural communities with whom the child has an open, trusting relationship should be included in planning and consulted regarding community expectations.

The child's abilities, health, gender, sexual orientation, and religion require consideration in the development of an effective personalized plan. Adaptations that enhance participation in planning and in implementation need to be considered and implemented. In addition, service providers can suggest that the young person and family involve community advocates or leaders in the plan (MCFD, 2006).

Integration of Residential Care with Community-based Services

With the advent and expansion of the "system of care" philosophy and practices, there have been significant tensions between community- and residentially-based service providers. Community-based providers voiced concern that their residential colleagues kept young people too long and failed to demonstrate the effectiveness of their services. Residential providers stated that their community-based colleagues did not collaboratively support their efforts, assist with discharge planning or provide intensive service options as necessary follow-up. Furthermore, families and youth often expressed mixed reactions and opinions about both sets of providers, asking that all providers become more family-driven and child-guided, and encouraging them to create a more integrated array of services (Building Bridges Initiative, 2009).

A continuum-of-care and personalized approach leads to enhanced placement stability. It offers more consistent, targeted therapeutic interventions, leads to the establishment of better attachments and social functioning, and in turn stabilizes behaviours that contribute to placement breakdowns. Child and Family Teams (CFT) bring together the expertise of residential treatment and community-based providers, and capitalize on the strengths of the youth and family as part of a long-term recovery-oriented plan. Such partnerships are improving efforts to ensure that treatment is family-driven and youth-guided through practices such as:

- implementing CFTs;

- hiring family and youth advocates;

- developing youth and family advisory councils;

- providing education and support to increase self-advocacy skills;

- integrating cultural and linguistic competence;

- and implementing trauma-informed care, thus reducing the need for restraint and seclusion (Building Bridges Initiative, n.d.; Building Bridges Initiative, 2009).

Protecting Privacy of Young people and Families

Information sharing is essential for effective intervention, for safeguarding and promoting child welfare and for wider public protection. However, service providers must reflect on the mechanisms for information sharing and communication within the service context and personalized plan, to ensure everyone is comfortable and knows what to expect.

Finding a balance between respecting the privacy of young people, and sharing necessary information during the personalized planning process, is a delicate task. The best interests of the young person must be at the forefront when making decisions, and only the information necessary to develop a care plan should be shared, with explicit permission of the young person and family.

Safety planning is a key activity during the Team Planning phase within the Wraparound and System of Care programs. Service providers must clearly explain the importance and benefits of signed consent to share information, and the circumstances when personal information may be disclosed in the absence of consent. Every Child Matters provides specific resources in this area (Debicki, 2009; Every Child Matters, 2010a; MCFD, 2006; Rutman et al., 2005).

Planning Protocols

Basically, there are four stages of planning common to the service models reviewed; Integrated Case Management, Systems of Care, Wraparound and Every Child Matters. These stages include: engagement and team preparation, team-based planning, implementation and review, and transition and evaluation.

Engagement and Team Preparation

Trust and shared vision among the family and team members are established. The tone is set for teamwork and team interactions that are consistent with the principles of a personalized service model of care, particularly through initial conversations about strengths, needs, culture and other aspects of difference. This phase provides an opportunity to begin to shift the family's orientation to one in which they understand they are an integral part of the process and their preferences are prioritized. The activities of this phase should be completed relatively quickly (within 1-2 weeks if possible), so that the team can begin meeting and establish ownership of the process as quickly as possible.

Team-Based Planning

Team trust and mutual respect are built while the team creates an initial plan of care. During this phase in particular, the young person and family should feel, that they are heard. It is important to plan for success by:

- encouraging the young person to identify their priorities;

- choosing areas of priorities that are less complex rather than more complex;

- choosing areas where there is likely to be general agreement about the desired outcomes or goals;

- choosing areas where an immediate impact is likely to be felt; and

- choosing areas that will support the immediate health and safety of the young person.

Once measurable goals are established, the team begins to identify strategies and activities for each of the priorities, the people who will be responsible and the timelines. The service plan should incorporate any case planning that has already happened between the young person and individual service providers to ensure that all members are aware of one another's planning, and to provide opportunities to improve the coordination of services.

Implementation & Review

Appointments to review the plan and monitor progress can be made with the young person, family and the team as needed. The team should stay connected since these individuals represent the young person's support network. Regular team meetings help keep all team members informed, and provide opportunities to measure progress, review issues of confidentially, make changes to the plan when it is not working or circumstances have changed, and prevent crises in the life of the young person. When deciding how often the team should meet, the team should consider:

- wishes of the child and family;
- stage of planning;
- life circumstances;
- setbacks;
- milestones;
- and changes to the team.

When additional services are required, such as the need for a specialized assessment, residential placement, consultation with a specialist, or the need for financial assistance, it is important for service providers to help the relevant organization understand the child's need, and the relationship of the requested service to existing supports.

All participants of the personalized plan should evaluate the process they have shared, from their perspectives, and provide suggestions or comments either about the way service was conducted, or about the effectiveness of the process.

Transition & Evaluation

Plans are made for a purposeful transition out of the formal service arrangement to a mix of formal and natural supports in the community. The focus on transition is continual, and the preparation for transition is apparent even during the initial engagement activities (Substance Abuse & Mental Health Services Administration - SAMHSA, n.d). The transferring and closing of a file occurs with the consensus of all team members, and forms part of the case record. Team members should support the child and family in making appropriate contacts in the new community, if they so desire.

All participants of the personalized plan should evaluate the process they have shared, from their perspectives, and provide suggestions or comments either about the way service was conducted, or about the effectiveness of the process. The evaluations help strengthen the understanding and practice of personalized service, and help

ensure that young people and families are growing and developing in healthy ways (MCFD, 2006; Rutman, et al., 2005).

Personalized Service Delivery Tools

Integrated Case Management (ICM)

Integrated Case Management (ICM), implemented as a policy directive from the Ministry of Children and Family Development (MCFD) in British Columbia, is a team approach used to create and implement a personalized service plan for young people and families. With the ICM model, an integrated case coordinator is chosen who may be the young person, a family member, or a professional support person. The coordinator may function alone or with support from another team member. Depending on the needs and skills of the young person/family and other team members, the role of the ICM case coordinator may be primarily administrative or supportive. One key responsibility is the documentation of the process using a consistent format that considers the child's health, education, identity, family and social relationships, social presentation, emotional and behavioural development and self-care skills (MCFD, 2006; Hubberstey, 2001; Rutman et al., 2005) . ICM is supported by a User's Manual, (MCFD, 2006) which includes an assessment format based on the eight domains of the Looking After Children (Kufeldt, 2000); a suggested recording format; and sample meeting agendas. There is also a participant's manual (Tate, Hubbersty, Hume, & Rutman, 1999a) and an instructor's manual (Tate, Hubbersty, Hume, & Rutman, 1999b) for training practitioners in implementing ICM.

Systems of Care

The United States Department of Health and Human Services supports the development of community-based **Systems of Care** -- coordinated networks of community-based services and supports -- for young people with mental health needs and their families. Families and young people work in partnership with public and private organizations so that services and supports are effective, build on the strengths of individuals, and address each person's cultural and linguistic needs. A system of care aims to help young people and families function better at home, in school, and in the community, throughout life. The Building Bridges Initiative has focused on the continuum of residential to community-based services within the systems of care approach and offers a self-assessment

tool for quality assurance (described in the accompanying Quality Assurance paper). Members of the initiative who endorse the approach may have developed specific tools to assist their work, but the **Systems of Care** approach operates primarily as a philosophy with a set of associated protocols to be adapted with existing tools for case planning and service delivery (Building Bridges Initiative, n.d; Building Buidges, 2009) .

The Common Assessment Framework (CAF) is an integrated model for improving outcomes by ensuring that all service providers and sectors are working together and communicating effectively.

Wraparound

Wraparound is a child- and family-driven intervention that is individualized or personalized to each child's needs, as well as a system-level intervention. A facilitator works in partnership with the child, family, and other support persons, to identify strengths, cultural factors and priorities guiding participants through a highly structured, intense and frequent planning process toward a comprehensive personalized plan, one that addresses the top child and family priorities by developing strategies and activities that build on strengths and resources within the family and the community. In essence, the team "wraps" services and supports around the child and family. Any needs that are beyond the resources of the family and team are communicated within the team and a Community Mobilization Team, who act as "community connectors", to find and acquire the necessary informal and formal resources.

A certificate program on the **Wraparound** principles is available; the Wraparound Evaluation and Research Team (WERT) website (Wraparound Fidelity Index, n.d.) was created to facilitate the dissemination of the Wraparound Fidelity Index (WFI). As well, the National Wraparound Initiative website provides access to tools that can be used to accomplish the activities that comprise the Wraparound process (National Wraparound Initiative, 2007b). Additionally, service providers and programs have submitted tools that describe the skills needed for people who play key roles in implementing the **Wraparound** process. These tools include job descriptions, as well as descriptions of skill sets and competencies (National Wraparound Initiative, 2007a).

Every Child Matters

The Every Child Matters: Change for Children programme has developed The Common Assessment Framework (CAF) for children and youth, an integrated model for improving outcomes by building

children's services with all service providers and sectors working together and communicating effectively. The Common Assessment Framework for Children and Young People: A Guide for Practitioners (2006) outlines specific tools and processes that have helped embed integration more fully across children's services (Children's Workforce Development Council, 2010b). Guidance, training and support materials on information sharing are also available online (Every Child Matters, 2010c.ContactPoint is a contact list of those who work with children (Every Child Matters, 2010b). The National eCAF is being developed to support service providers who use the CAF to assess a child's additional needs and determine how they will be met (Every Child Matters, 2010d.

There are various resources available in the United Kingdom which are part of the move toward personalisation and the delivery of integrated services, such as the Children's Workforce Development Council (Children's Workforce Development Council, 2010c).. The council has developed tool kits and processes for implementation (Children's Workforce Development Council, 2010a). Refreshing the Common Core of Skills and Knowledge outlines required knowledge and skill of service providers (Children's Workforce Development Council, 2008) and Champion Children is a framework for those who are leading and managing integrated models of care (Every Child Matters, 2006).

Conclusion

Tools and protocols for the provision of personalized service value participation by placing young people and families at the center of services, and help ensure they have a voice in decision making and how service is delivered. Wrapping service around young people as opposed to young people and families adapting their lives around programs requires that care systems move towards more collaborative partnerships and multidisciplinary models of working together. Tailoring services around individual needs and working in partnerships with communities and service sectors will enable service providers to respond more effectively to diversity and cultural differences. Tools and Protocols for personalization in this paper reflect existing principles of individualization and client-centered care demonstrated by Integrated Case Management (ICM), Systems of Care, Wraparound and Every Child Matters (ECM) service models. These tools and protocols will help service providers adapt their service delivery models to assess and support young people and families in a way that respects their priorities and builds on their strengths. The models value the principles of personalization by

focusing on voice, choice, relationships and cultural context while working in partnership with young people and their families. Newly developed tools and protocols can be combined with existing tools (Looking After Children; Case Management Protocols) to truly enable an appreciation of both client and service provider differences and the service delivery contexts that reflect multiple jurisdictions and philosophical approaches.

Quality Assurance

Quality assurance processes such as client involvement, agency accreditation, specific tools for the fidelity of personalized services, performance indicators, and program evaluation methods ensure that guiding principles are in place, with specific mechanisms to ensure a standard of personalized service delivery. Quality assurance in personalized services must take a different approach in consideration of the following factors:

- For the "personalized" quality of the service to be maintained overall, there must be significant changes to ensure that parents and young people are involved on advisory committees, governing boards, in quality reviews and as advocates for service. Leading examples of these changes can be found nationally, provincially and locally in Youth Councils and advisory committees at the Mental Health Commission of Canada (MHCC); The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (Children's Hospital of Eastern Ontario); Children's Mental Health Ontario (CMHO); Ontario Association of Children's Aid Societies; and Youth Net (YN/RA) in Ottawa.

- Accreditation bodies have incorporated standards for quality assurance and quality improvement that are consistent with expectations for personalized service such as the involvement of young people and families, participation in of a continuum of care, continuity of care, and participation with community partners. How essential these standards are to accreditation and even whether accreditation is required within a particular jurisdiction affect the comprehensive implementation of personalized services.

- Programs that follow specific models of personalized service delivery, such as Wraparound and the Building Bridges Initiative, have developed quality assurance tools for self assessment and fidelity measurement. These tools merit additional investigation as part of developing quality assurance processes for personalized service delivery.

- Program evaluation to this point has focused on outcomes for young people and client satisfaction measures. More recent work is recognizing the importance of both qualitative and quantitative data, including exit interviews, assessment of staff and leadership values, examination of ongoing staff training, etc. in the determination of program outcomes.

Quality assurance tools for personalized and individualized service delivery models are just beginning to emerge and must be examined relative to their ability to help organizations ensure that practices reflective of the basic principles of personalized service delivery and continuity of care are included throughout the entire service experience.

- Quality assurance tools for personalized and individualized service delivery models are just beginning to emerge and must be examined relative to their ability to help organizations ensure that practices reflective of the basic principles of personalized service delivery and continuity of care are included throughout the entire service experience. These tools for organizational self-reflection and self-assessment encourage formative evaluation and quality improvement processes internal to the organization All of these tools are relatively new, are focused for the most part on a single organization, and are designed to be used as part of a formative evaluation process on the road to changing the culture and service delivery orientation of the organization.

Quality Assurance Protocols for Personalized Services in Residential Care

Andrea Fournier

Service providers, funders and service users (young people and families) are all stakeholders in quality assurance for residential care. Assuring the quality of personalized services requires that guiding principles be in place, with specific mechanisms to ensure a standard of service delivery. Quality assurance processes such as client involvement; agency accreditation; specific tools for the fidelity of personalized services; performance indicators; and program evaluation methods are examined in relation to personalized services in residential care.

Client Involvement in Quality Assurance

A paradigm shift is required to move away from the traditional model of residential care to a personalized model, one where the child and family are co-producing treatment strategies with the residential agency suited to their specific needs (McPherson, 2007). Barth (2005) notes that residential care, like almost all educational and health services, is best when it is individualized to the child's learning style and situation in the family context. This allows clients and families, as experts, to collaboratively direct the process of services they receive (Pumariega et al., 2005; Barth, Greeson, Guo, Green, Hurley & Sisson, 2007). For the "personalized" quality of the service to be maintained overall, there must be significant changes, so that parents and clients are involved on Boards, in quality reviews and as advocates for service (American Association Children's Residential Centers (AACRC), 2009a). Residential care serves as a "powerful intervention with great capacity to impact the lives of young people and families. When marshalled and focused appropriately on the individual needs of each child and the family, this impact can be, and often is, enormously potent" (AACRC), 2009b, p. 238). The impact on programs and services when parents and clients are actively involved in quality assurance can be equally potent. The Federation of Families for Children's Mental Health is a partnership founded on a family-driven care model of working together in which "power, resources, authority, responsibility, and control (emphasis added) [are shared] with families and youth" (AACRC, 2009a, p. 232).

The use of advisory boards is a viable method of quality assurance when they review outcome data and make recommendations to

improve services (Blewitt, 2009). Wattie (2003) suggests that, along with feedback from the funders, accreditation and placement agencies would benefit from independent advisory groups with separate chairpersons. "Such a group is necessary to assist in the complex and demanding task of assessing the current patchwork of services for young people and working toward a new provincial organization to build effective and useful linkages across the system" (Wattie, 2003, para. 18). However, although advisory boards are a valuable tool, there is limited information on the efficacy of this service protocol in residential care.

Parents have important voices on advisory committees and Boards, because they recognize the need for a variety of services to help their families, and they "offer critical input into strategic planning and resource allocation and have a powerful influence on policy makers" (AACRC, 2009a, p. 234). It is important also to recognize the voices of young people as valuable feedback, and to include them on advisory committees to evaluate the efficacy and quality of services. The Mental Health Commission of Canada (MHCC) recently formed a Youth Advisory Committee:

It is important also to recognize the voices of young people as valuable feedback, and to include them on advisory committees to evaluate the efficacy and quality of services.

> The group is made up of 17-25 year olds who have lived experience of mental health problems or illnesses. The Youth Council will advise the Commission about matters relating to youth and mental health. Individual members will have the opportunity to join MHCC project teams, working groups and other committees. The committee is now working on projects to: develop a Canadian vision for child and youth mental health; support the delivery of evidence-based mental health services for children and youth within the school setting; make the child and youth segment a central part of the national anti-stigma campaign; identify, understand and promote effective strategies to address and defeat self-stigma experienced by children and youth; develop an index of current local, national and international knowledge exchange initiatives related to child and youth mental health and establish a Canadian consortium for knowledge exchange in child and youth mental health; systematically compile, review, and synthesize material for the knowledge exchange related to child and youth mental health to meet the needs of various end users. (n.d., Children and Youth, para. 4)

Focus groups that enable young people to have open discussions can influence the way agencies provide client-focused services (Pereira, 2007; YouthNet, n.d.). The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (Children's Hospital of Eastern Ontario), in partnership with Children's Mental Health Ontario (CMHO), uses focus groups as a way to hear young people's thoughts and opinions, share personal stories and discuss what young people want from service providers (Pereira, 2007). The focus groups even "made recommendations that included the development of resources for professionals and a resource guide for healthcare providers, co-written by young women and clinicians…" (Pereira, 2007, p.50, 51). Youth Net (YN/RA) in Ottawa uses a model developed by young people; for young people. A "youth helping youth" format where facilitators are older youth who are young enough to remember what it's like to be an adolescent, but who are old enough to have had some life experience. (Pereira, 2007, p. 53

Including young people and families in the process for personalized service models in residential care adheres to the values of the quality assurance frameworks typically used and discussed in the next section, and enables clients' voices in service provision.

Accreditation Standards and Quality of Personalized Services

Developing a standard framework for quality assurance is an important step in creating a foundation for personalized services in residential care. Ideally, standards for personalization would be transparent and woven into all levels of service delivery. An integral process in creating personalized quality assured services is "setting standards that are clear, realistic, reliable and understood in the same way by everyone and [that are] not subject to distortion or misinterpretation" (AACRC, 2009c, p. 242).

A standard framework would be most effective if it included indicators and evaluation methods to support and infuse personalized services in residential care (AACRC, 2009c). Determining a set of indicators ensures that there is evidence available for quality improvement, sustains valuable feedback, and identifies outcomes to validate personalized services (AACRC, 2009c). The AACRC (2009c) suggests the following framework to categorize indicators for both performance monitoring and outcomes assessment:

- practice/process indicators;

Ideally, standards for personalization would be transparent and woven into all levels of service delivery.

- functional outcomes;

- perception of care;

- organizational indicators.

Organizational and practice indicators are explored in further detail in the **Performance Indicator** section, and functional outcomes in the **Evaluation Strategies** section of this paper.

Ensuring that residential care agencies become accredited is one approach to standardization and validation of personalized care in residential treatment. While residential facilities do not require accreditation in order to receive a licence to operate in Ontario, as they do in some other provinces; accreditation adds credibility to assurances of quality care delivery and many agencies pursue it (Children's Aid Society, 2008). In Ontario, the Ontario Association of Children's Aid Societies (OACAS) and CMHO offer different accreditation programs, which include residential standards, for their memberships and the Ontario Association of Residences Treating Youth (OARTY) (2005) proposed a residential care model that includes having residential care agencies become accredited. There is broad support for the importance of accreditation to build on the transparency and credibility of agencies and the various types of care provided (OARTY, 2005). International accreditation bodies, such as the Council on Accreditation (COA) and the Commission on Accreditation of Rehabilitation Facilities (CARF), offer quality assurance standards relating to areas such as client rights, service delivery, ongoing quality improvement and governance which reflect the principles of personalized service delivery.

In their revision of their accreditation standards, CMHO (2007) concurs with the core principles of personalized care:

> *At the heart of the new accreditation program standards framework is the belief that clients are central to all of the work of children's mental health providers and that accreditation will ultimately benefit them. Thus, the framework is founded on three accreditation program values: children's mental health entitlement, respect for the dignity and diversity of children, youth and families and accountability. (p. 14)*

Accreditation is a process that complements personalized services as a way of ensuring that the individualized needs of young people, and families are being met.

Other standards of performance related to personalized services include:

- annual reviews and inspections by Ministry funders, child welfare agencies and accrediting agencies (Ministry of Children and Youth Services, 2009; OACAS, 2009; CMHO, 2009; CAO, 2008);

- training and skills development for staff and parents (Residential Forum, 2009; Barth et al., 2007; NBPG, 2002);

- consistent family involvement (AACRC, 2009c);

- ongoing staff retention and recruitment activities (Hartje, Evans, Killiam & Brown, 2008; Colton & Roberts, 2007; Connor, McIntyre, Miller, Brown, Bluestone, Daunais, & LeBeau, 2003);

- and staff memberships in professional organizations (Ontario Association of Child and Youth Counsellors, 2009; The Association for Child and Youth Care Practice, Inc, 2010).

When core principles and values are evident in both client service delivery, and the treatment of staff and families by the organization, one can assume that personalized service has been adopted as a core construct in service delivery.

These types of indicators signal that the core principles and values of personalized services are incorporated in the organizational structures. When core principles and values are evident in both client service delivery, and the treatment of staff and families by the organization, one can assume that personalized service has been adopted as a core construct in service delivery (Smith, 2007).

Performance Indicators

The literature suggests developing target indicators that help determine the degree of adherence to standards, measure outcomes and identify gaps in personalized service (NBPG, 2002; AACRC, 2009c). Examples of organizational indicators to be measured in relation to providing quality personalized services would include:

- offering choice and access to a variety of services;

- staff retention;

- job satisfaction;

- work environment;

- fiscal performance;

- safety programs.

"These important dimensions of performance directly affect the quality of care, and can be correlated with practice and functional indicators, and the perception of care" (AACRC, 2009c, p. 244, 245). Examples of practice indicators to be used as benchmarks in programs using a personalized services model, as recommended by the AACRC (2009c), include monitoring:

- dimensions of family and youth involvement;

- youth participation in treatment;

- parent contact;

- continuum of care factors such as access to services and supports;

- participation of community partners;

- continuity of care;

- timeliness and comprehensiveness of diagnostic assessments;

- discharge planning;

- activities/ practices sub-grouped by life domains (i.e., emotional, psychological, physical, social, academic, medical, nutritional, legal, spiritual, cultural, vocational). (p. 244, 245).

Tools for Quality Assurance in Personalized Services

There are tools available for quality assurance implementation and evaluation that can be adopted into practice guidelines for agencies developing personalized service delivery approaches (Helen Sanderson Associates, n.d.). Several tools have been developed to guide the implementation of specific programs and ensure that the program is following the core principles of personalized service delivery. While not yet tested beyond these specific programs, these tools do provide examples of quality assurance and fidelity monitoring that is specific to the personalization of service delivery; rather than more generic quality of care and service. Reviewed here are the Building Bridges Initiative quality assurance tools for personalized services; the Matrix and the Self-Assessment Tool (S.A.T) and the Wraparound Fidelity Assessment System.

Building Bridges: The Matrix and Self-Assessment Tool

Building Bridges is a national initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA) which uses Systems of Care approaches to link residential care and community-based service delivery for young people and families. The initiative has developed two tools to assist residential programs to ensure that they are following the core principles of the initiative and implementing the necessary process and practices to support a more personalized delivery of services connecting residential and community service providers. (Building Bridges Initiative (BBI), 2009). The Matrix includes performance guidelines and indicators that could be used as benchmarks of experience in the field while the Self Assessment Tool (S.A.T.) operationalizes the content in the matrix and is designed to be completed by those directly involved with the residential program and identifies the principles and values that they are using. The S.A.T. measures performance indicators such as the degree of continuity, seamlessness, the integration of services and supports in local communities, and the extent to which known best practices are being utilized in both residential and community settings (BBI, 2009). These tools have been designed to point to specific best practices, not prescribe them and are not intended to replace existing monitoring mechanisms, but rather, augment them.

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The Wraparound Fidelity Assessment System

The Wraparound Fidelity Assessment System (WFAS) is an approach to assessing the quality of individualized care planning and management for young people with complex needs (WFAS, 2009). Fidelity measurement in the wraparound process is essential in supporting evidence-based practices. Stakeholder interviews, team observations, and document review are used within this system; independently or together. One goal of the WFAS is to enhance program delivery and to provide valuable data that can be used to guide quality assurance. The instruments have not been widely used or adopted to assess conformance to standards or to "certify" Wraparound initiatives however there has been some interest in adapting the tools for this purpose with the caution that communities must carefully examine their own practice models, local standards and requirements to determine if the tools are sufficiently aligned to be used to compliance or accreditation (WFAS, 2009).Initially designed as a program measurement tool, WFAS instruments can also prove useful in providing service providers with guidance regarding the quality of the intervention a family is receiving.

Evaluation Strategies

AACRC (2009c) suggests that evaluation methods specific to personalized services require assessing and reflecting on change in the child's level of functioning, either during a residential episode, or afterwards. The use of valid and reliable instruments that measure levels of functioning must be balanced with family and community expectations which identify meaningful functional outcomes. Quality of personalized services therefore requires the identification of community standards related to the "restrictiveness of living environment, school performance, legal involvement, peer relationships, [and] severity of illness..." (AACRC, 2009c, p. 245). This approach to evaluation necessitates a culture that values equally both quantitative and qualitative information. Such a culture requires careful work on the part of leadership to evoke, support, and sustain key norms and values related to quality improvement and continuous learning. It involves:

- including stakeholders, especially staff, parents, young people, and community partners, in indicator identification and system design;

- ensuring that indicators are supported by available evidence and that the data collected is relevant;

- establishing and sustaining cost-effective and efficient information systems;

- reinforcing data-driven process improvements; and

- using the products of performance measurement and benchmarking to provide timely feedback and to support staff in their work. (AACRC, 2009c, p. 243)

Data collection in the evaluation processes can include: direct observation; exit interviews with young people; interviews with the service provider; and review of clinical records (Nursing Best Practice Guidelines (2002). As a starting point for effective evaluation, these methods, paired with a series of key questions for young people and their families, can help determine if personalized services were provided, and identify areas for improvement. The AACRC suggests that boards of directors and management personnel begin an evaluation process by asking:

> *Do the staff of the organization act, speak, and interact in ways that truly welcome, support, affirm, and incorporate the perspectives and wishes of parents? Do parents have to be "invited" into the organization or is it a baseline assumption of staff that parents are*

reciprocal partners? Is the organization committed to redefining itself as providing an intervention within a community continuum rather than as a placement of last resort? Does the organization believe that sharing decision-making, leadership, and power with parents yields better outcomes for children and youth? Is the organization willing to implement training and other practices that culturally reinforce the importance of parents and families in day to day actions, discussions, and care planning? (2009a, p.235)

Once the qualitative responses have been reviewed, agencies can begin to use the data to evaluate their baseline, and decide the steps necessary to move forward with personalized services for young people, and families in residential care.

<mark>Conclusion</mark>

Implementing a quality assurance framework for personalized services requires organizations to recognize hear and use the voices of young people and families as invaluable tools in assuring quality personalized services and conducting thorough evaluations helps to determine the outcomes of the care delivered. Young people and families; funders; and service providers are all stakeholders in residential care, and success depends on the outcomes of quality personalized services. As the principles of personalized services are embraced in residential care, future considerations include:

- What type of accreditation will residential care agencies need for quality assurance in personalized service and who will create the framework by which accreditation occurs?

- Will this framework be infused with personalized service values and evaluate agency practices based on such?

- How will young people's voices be a part of the accreditation process in keeping with the principles of personalized services?"

Logistics & Human Resources Requirements

There is considerable evidence in the literature that personalized services for clients depend on the following:

- Agencies operating with personalized service policies will hire staff with the expectation that they will adopt the value base of this type of care and effectively provide treatment and resources reflecting these values. This entails Staff training to develop skills, knowledge and a value base.

- Organizational and managerial support for personalized values must exist throughout the organization and be represented in the managerial and supervisory relationships with staff as well as the organizational relationships with funding bodies.

- Providing personalized services requires staffing structures that encourage interdisciplinary teamwork within the organization and across different service sectors. Case managers become much more than just the coordinator of service; as an identified key contact for the family they can help obtain services in a more timely fashion, while minimizing or eliminating duplication. They act as both an advocate and coordinator of care, from point-of-intake until discharge, and through the follow-up phase. Young people and families form bonds with workers who offer continuity and consistency of care that affects the well-being of young people and has a large impact on their lives.

- Adequate funding is essential and cost effectiveness is relatively unknown at this point. Funding must address the costs of developing evaluation frameworks and interpreting the data as well as funding to enable young people and families to participate in program development.

- The logistics of integrating the values of personalized service delivery with community response and interagency collaboration is unknown.

Young people and families form bonds with workers who offer continuity and consistency of care that affects the well-being of young people and has a large impact on their lives.

Resource Considerations for Implementing Personalized Services in Residential Care

Andrea Fournier

Personalizing service in residential care is a complex task that requires a commitment to the core values and principles of personalized care on the part of the organization, the service providers and the funders. Since the literature on personalized services in residential care is limited, research from related areas has been used to identify the logistical and human resource considerations inherent in implementing this type of model. There is considerable evidence in the literature that personalized services for clients depend on the following:

- staff training to develop skills, knowledge and a value base;

- organizational and managerial support for personalized values;

- case management with qualified staff and caregiver continuity; and

- adequate funding.

These considerations will be explored in the paragraphs below.

Empowerment is essential to give young people a voice and a choice about the events that affect their daily lives in residential care, and is a key value facilitating growth and healing.

Agency Values

Personalized services are guided by the premise that clients are the experts of their own experiences, and based on this expertise, they decide the kind of care and the particular caregiver suitable to meet their needs (Nursing Best Practice Guidelines (NBPG), 2002). Empowerment is essential to give young people a voice and a choice about the events that affect their daily lives in residential care, and is a key value facilitating growth and healing (Strolin-Goltzman, Kollar & Trinkle, 2010; Bettman & Jasperson, 2009). Adopting a personalized service model requires a process of values clarification that must be cultivated throughout the agency. To provide consistent personalized care, it is essential for staff members to work from the same values paradigm.

Most researchers agree that care providers must be willing to embrace the shift, and organizations must facilitate this shift, for the values of personalized services to be used consistently by all

staff involved with a client. Training workshops, where values can be linked to actions, are one way to begin this paradigm shift (NBPG, 2002) however staff and management must work to breakdown preconceived notions of care and personal biases as well as develop cultural awareness and address interdisciplinary deficits in knowledge in order to promote new values and beliefs(Pumariega, Rogers, & Rothe, 2005).

> *It is often an empathy with social care values, and specifically the values embodied in good practice in the Residential Care segment of the care sector, that steer people into this area of work in the first instance, and influences retention as their career progresses. Staff need to be able to translate their understanding of those values into the way they relate to residents. Attitude and ways of working, trying to understand things from the residents` point of view is fundamentally important to the quality of care experienced by service users. There is, however, very little theoretical underpinning to support this, and values and attitudes are hard to quantify or measure….. Training, supervision, leadership and management and good practice must all keep core values at the heart of what they do, and help to create …a learning culture. (Residential Forum, 2010, Values Section, para. 2)*

Values cannot be imposed, as they require development, support and modelling to be ingrained in daily practice. Time, training and empowerment are essential for organizations to shift from their current operational methods to delivering personalized services to young people and families.

Staffing Structures

Hiscock & Shuldhum (2008) highlight that leadership is one of the most important factors in providing quality care, setting the direction of the agency, developing values and ensuring services are provided at or above set standards. As residential care agencies consider adopting new frameworks for personalized services, competent supervision and reliable managerial support are essential to help staff members respond to the new and ongoing demands of the job (NBPG, 2002; Barth 2005; Oliver, 2008). Supervisors play a significant role in developing staff's skills and supporting them in the organization. The relationship staff members have with their

supervisors affects their level of job satisfaction, skills development, professional growth and the motivation to remain working at their current agency (Landsman, 2007). Having supervisors act as supportive role models for staff during the implementation of a personalized services model is paramount to successful implementation in residential care.

Providing personalized services requires working within an interdisciplinary team that can help clients obtain treatment from different service sectors. An effective way to coordinate services and treatment options for clients is by assigning a case manager (Zoffness, Garland, Brookman-Frazee & Roesch, 2009). Case managers become much more than just the coordinator of service, as an identified key contact for the family they can help obtain services in a more timely fashion, while minimizing or eliminating duplication (Reid & Brown, 2008). They act as both advocate and coordinator of care for a child and family, from point-of-intake until discharge, and through the follow-up phase, thus providing the foundation of care integral to the facilitation of personalized services (NBPG, 2002; Zoffness et al., 2009). Clients form bonds with workers; one designated staff person who offers continuity and consistency of care can affect a child's well-being and have a large impact on their life (Strolin-Goltzman et al., 2010).

In order to provide care through a personalized services model, staffing structures may need to be changed to accommodate family involvement (Barth, 2005). Barth, Greeson, Guo, Green, Hurley & Sisson (2007) cite one example of an in-home staffing structure for therapists that includes "caseloads of four to six families, with a robust training, supervision, and consultation structure (four therapists per supervisor; weekly team supervision and consultations; intensive initial and quarterly training coupled with weekly therapist development plans" (p. 161). This underlines the need for a staffing structure that allows time for the adequate development, training and supervision of staff members. At present, the Ministry of Children and Youth Services determines the minimum level of staffing required in residential care in Ontario; the average ratio of clients to staff is 7:2, with seven licensed children's beds per group home unit (OARTY, 2009), and two staff members on shift (Family Tree Youth Services, 2009, Residential Treatment Program, para. 3) on shift during the evening hours when the majority of routine activities take place. Current staffing structures may not be adequate to support the principles of personalized services in residential care, adding case management and family involvement to the daily management of young people's needs is challenging.

A common theme in the literature pertaining to various human service settings is that young people and families are the experts on their lives; respecting their ideas and wishes for service, and having them define their goals for service and treatment, are what makes personalized services effective (NBPG, 2002; Barth, 2005). Identifying young people and families as a key component of an organization or service can make the values of personalized services transparent by identifying the clients as the experts of their lived experience, with the ability to choose the care that is right for them. "Children placed out of home by public welfare agencies have a significant stake in employment practices and patterns within the child welfare system" (Strolin-Goltzman et al., 2010, p. 48).

"Children placed out of home by public welfare agencies have a significant stake in employment practices and patterns within the child welfare system"

Staff Retention

Effective personalized services for young people and their families requires continuity and consistency of the staff who provide the care. The recruitment and retention of qualified staff in residential care are important to meet the challenge of working with youth (Hartje, Evans, Killiam & Brown, 2008). High staff turnover is detrimental to young people because it can intensify their feelings of abandonment (Colton & Roberts, 2007), and impede their healing and growth, undermining "the educational and therapeutic mission of residential treatment" (Connor, McIntyre, Miller, Brown, Bluestone, Daunais, & LeBeau, 2003, p. 43). This can create instability in an environment where consistency is essential for appropriate intervention (Connor et al., 2003; Jones et al., 2007). Frequent turnover presents a significant challenge to program success because of the time it takes to develop relationships with young people, and supportive and cohesive relationships among staff members (Hartje et al., 2008, p. 29). By addressing the causes of employee turnover and implementing retention strategies, organizations can maintain a consistent staff team and provide personalized services with continuity of treatment for clients (Colton & Roberts, 2007).

Although salary and pay increases are fundamental in retaining staff, the motivation to remain working in residential care is not only about financial gain and work position status (Connor et al., 2003). Additional staff retention strategies include:

- increasing job satisfaction and organizational health with a positive work culture (Hodas, 2005; Hare, 2004; Strolin-| Goltzman et al., 2010; Krueger, 1996);

- training and professional development (Oliver, 2008; Mellin, 2009; Gharabaghi, 2009; Colton & Roberts; 2007; Reid & Brown, 2008; Connor et al, 2003; West, 1998);

- flexible work schedules (Reid & Brown, 2008);

- meaningful supervision (Krauss, 2005; Bowling, 2007; Senter & Martin, 2007);

- tuition reimbursement (Jones, Landsverk, & Roberts, 2007);

- support and encouragement of membership in a professional association (Gaughan & Gharabaghi, 1999);

- personalized workspace (Wells, 2007);and

- additional job responsibility and decision-making capacity (Stalker et al., 2007).

Many of these staff retention strategies are effectively built in to the implementation of personalized service delivery as residential staff will experience their own voice, choice, and satisfying relationships with supervisors and managers through the implementation of a personalized value set in the organization. Working within the principles of personalized services, listening to the voices of clients can be a valuable way to understand the impact of staff turnover on the lives of young people and families. The perspectives of service users can guide the actions needed to address staff turnover and simultaneously increase job satisfaction.

Funding

Systemic support will be required to ensure that agencies have the funding needed to deliver personalized services to young people and families. Funding approaches for residential care agencies may require re-evaluation as the agencies move toward a personalized service delivery model, and seek to avoid "waitlists, the inability to meet demand for services…and frustration [associated] with the accounting and reporting systems"(Reid & Brown, 2008, p. 338).

A funding shift is needed in order to provide personalized services to young people and families, with an adequate number of qualified professionals. Providing personalized services and empowering the client are attainable, but not easily so; operating in this manner requires substantial staff time and consumes many resources in its initial phases, thus increasing operational costs (Churchill, 2005; Butler, Little & Grimard, 2009). Additional costs include

but are not limited to: initial and ongoing training workshops, the implementation of staff-retention strategies and evaluation and monitoring methods.

Allotting adequate funding specifically for staffing is exceptionally important, as staff retention has a direct impact on an agency's ability to raise standards (Colton & Roberts, 2007; Reid & Brown, 2008). As well, high staff turnover creates a financial burden for agencies due to the costs associated with recruiting and training new employees (Ellet, Ellis, Westbrook, & Dews, 2007). According to Strolin-Goltzman et al. (2010), agency investment in staffing and staffing-related issues increases staff retention, and is directly related to healthy outcomes for young people.

Additional funding implications are found within the need to involve service in discussions about the future funding of social care and social services since they are the people most affected by these decisions (Beresford, 2010, p. 1). In order to obtain their opinions and have them join in developing programs, they must not only by empowered to use their voice, they must also be assisted to overcome the logistical barriers to participation. Reid & Brown (2008) suggest that, although coordinating funding streams from the Ministry can be complicated, personalized services in residential care may be justified by the streamlined process of managing client treatment, and the potential money that can be saved by coordinating treatment strategies while reducing the duplication of services (Reid & Brown, 2008).

Conclusion

Logistical and human resource issues are important considerations in the implementation of personalized services for young people and their families. Clients are the experts of their lived experiences, and giving them a voice and a choice of the services they need for healing is a key value. Agencies operating with personalized service policies will hire staff with the expectation that they will adopt the value base of this type of care, and effectively provide treatment and resources reflecting these values. Staffing structures, staff retention strategies and funding are all important elements to consider and plan for in moving towards this new model of service. Future logistical and human resource considerations not addressed in the literature include:

- how service providers may be affected by the successful implementation and delivery of personalized services which will reduce the need for residential care;

- the costs of developing evaluation frameworks and interpreting the data; and

- funding to enable young people and families to participate in program development;

- insight into the differences between individualised and personalized service delivery options; and

- the logistics of integrating the values of personalized service delivery with community response and interagency collaboration. How can you operate personalized services in the absence of co-operation from community-based recreation child protection agencies, juvenile justice and the after-school care or the daycare?

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