The Role of Child and Youth Care Practitioners
in the
Treatment Planning Process

Gail Kissoon
Mount Saint Vincent University

A thesis submitted to the Department of Child & Youth Study

in partial fulfillment

of the requirements for the degree of

Master of Arts (Child & Youth Study)

September, 2006

Copyright © (2006) by Gail Kissoon

DEDICATION

This research is dedicated to my parents who have provided me with unconditional love, have taught me to persevere against all odds and who have encouraged me to pursue my dreams.

ABSTRACT

Many professions, whether implicitly or explicitly, claim a higher status than they afford to child and youth care practitioners (Beker, 1976; VanderVen, 1991). However, child and youth care practitioners have also contributed to this nescient view in not understanding how profoundly they can affect the lives of others, or by not explaining the depths to their practice. Whether for these reasons or others, Beker (2005) feels that child and youth care practitioners are kept on the peripheral when it comes to treatment planning. Moreover, although considerable research has examined these workers' struggles to be seen as credible practitioners, minimal research has examined a child and youth care practitioner's role in treatment planning. Thus, the purpose of this qualitative research was to explore the role of child and youth care practitioners within the treatment planning process, their knowledge of and comfort with the process, and the areas in which they feel capable or might want or need additional training. Data were gathered through structured interviews from eleven purposefully selected child and youth care practitioners with diverse backgrounds, though the majority had experience working in settings such as schools, group homes, day treatment and private practice. Modified grounded theory from qualitative methodology was used to analyze the data. Research questions were broken down into three topic areas, general role, treatment plan role, and perceptions of child and youth care practitioners. Results emerged around four interconnected themes: giving the client primacy of focus, marginalization of the child and youth care practitioner, a child and youth care practitioner's desire for change, and dynamicism of treatment plans. In a client-centred approach, the child and youth care practitioner maintains the child as the focus of treatment, though other environmental

factors are taken into account and worked with, when possible, and there is a sense of closeness to the client that other professionals may not have due to role constraints. Secondly, marginalization restricts access to and input into treatment plans. The third theme, desire for change, speaks to empowerment of the children and youth and giving credence to the child and youth care profession. Lastly, is a focus on the treatment plan itself and on the understanding that it is a working document that must be permitted to change and grow according to the changing needs of, and demands on, the client. However, a meta-theme emerges upon review of results. This theme is one suggesting that structures and practices of power that are exerted on child and youth care practitioners in their contact with other professionals, parallels those exerted on their clients. The following questions arise: Where would full membership of the child and youth care practitioner in the society of other professionals leave the relationship between the child and youth care practitioner and the client? Where would it leave the client?

ACKNOWLEDGEMENTS

The amount of people that have gone into supporting my pursuit of this degree and completion of this paper is substantial and countless.

From family thru to friends,
From my thesis supervisor thru to my thesis advisory committee,
From acquaintances thru to colleagues,
From other professors thru to other professionals,
…
From the bottom of my heart, thru to the depths of my soul
I cannot thank you all enough,
But know I am aware of my blessings.

TABLE OF CONTENTS

Page

Dedication ii

Abstract iii

Acknowledgements v

List of Tables viii

Chapters:

I.Introduction 1
Rationale 3
Significance of the Study 4
Research Questions 5
Terms Defined 6

II. Literature Review 7
Roles and Responsibilities of Child and Youth Care Practitioners 9
Distinction of Roles 9
Training 12
Treatment Plans 17
Perceptions of a Practitioner's Role 21
Devaluation of the Child Care Field 25
Allied Professionals' Perspectives 28
Compensation 32
Summary 33

III. Method 38
Qualitative Research 38
Participants 40
Measures 40
Demographic Information 40
Interview Schedule 41
Procedure 41
Data Analysis 43
Research Questions 44
Ethical Concerns 45
Limitations of the Study 45

IV. Results 47
Participants' Background 47

Findings to Research Questions ... 51
General Role ... 51
Treatment Plan Role ... 54
Perceptions of CYCPs ... 69

V.Discussion ... 75
Findings ... 75
Implications/Recommendations ... 83
Future Research ... 83
Clients ... 84
Child and Youth Care Practitioners ... 85
Policy Planning ... 85

VI. References ... 86

VII. Appendices ... 91
Appendix A: Needs Assessment ... 91
Appendix B: Letter to Participants ... 93
Appendix C: Consent Agreement ... 95
Appendix D: Letter of Informed Consent ... 96
Appendix E: Interview Questions ... 98

LIST OF TABLES

Table 4-1: Summary of Demographic Information on Participants..........................49

Table 4-2: Settings Child and Youth Care Practitioners have been Employed In……………………………………………………….50

Treatment can only be successfully accomplished in settings where there is an appropriately coordinated team approach. "Without organisation and clear delineation of authority and responsibility, and without coordination of the various skills of the team, child care practice becomes a pot-pourri of benevolent intention and masquerading professionalism which seldom addresses the task effectively."(Harper, 1986, p 5)

CHAPTER I

INTRODUCTION

According to much of the literature, there has been much growth in the child and youth care field. For example, Jerome Beker states "Residential child care workers …are increasingly taking more active, central roles in institutional programs…".(Beker, 2001, p356). However, there remains in the literature an awareness of the need for more growth. As Cavaliere (2004) noted, "More money must immediately get into the hands of child and youth care workers" (p376) so that effectiveness and professionalism can be maximized (Christiansen, 1996; Lochhead, 2001; Stuck, 1994). As well, it may be asserted that there are still professions who underestimate the significance of child and youth care practitioners (CYCPs), especially in terms of their contribution to the overall welfare of children and youth.

> In many cases, child care has been developed within existing fields as a lower status, custodially-oriented "second class citizen" rather than as a full partner in the child rearing or treatment enterprise. It seems doubtful that this situation will change significantly, even in such fields as social work which have belatedly laid claim to child care with promises of full recognition. (Beker, 1976, p15)

Workers in professions that co-exist in common environments with CYCPs, for example, workers in schools, such as psychologists and social workers, may implicitly and even explicitly in action, claim higher status. For example, a CYCP can be 'bumped' from a room because of the 'confidentiality needed' for a psychological assessment. "Even

though child care workers are increasingly better educated … there are as already stated still too many discrepancies between the status of child care workers and other disciplines" (VanderVen, 1991, p. 289). The genesis of this nescient view cannot be placed entirely with other professions like psychology. Child and youth care practitioners have also contributed to such sentiments. Personal experience, as well as research, suggests that CYC workers ‘live down to’ a role. Such acceptance of a lesser role contributes to this view, making it difficult for CYC workers to articulate, let alone advocate for, recognition of their ultimate value and possible role in programming and assessment of youth.

The confusion surrounding the profession of CYC worker speaks to the need to explore the role of CYC workers across various settings. This information needs to be collected, collated, and disseminated so that others are aware of the differing skills and services that CYCPs may offer both clients and the other professions.

It might be asserted that people, such as CYCPs, assume roles, and perform actions, that profoundly affect others throughout their lives without understanding their full level of importance or impact on others (Tucker, Strange, Cordeaux, Moules, & Torrance, 1999). As Fewster (2005, p. 6) points out, “The radical nature of our role is not to ensure accountability to some prescribed standard but to promote the more complex and demanding principle of self- responsibility. Beyond this, we can make no claim on the outcomes”. However, the perceptions CYCs have of themselves affect how they act as well as the clients with whom they act.

Negative external perceptions of a child and youth care practitioners seem to be especially evident in the area of treatment planning. Beker (2005) states, "when it comes to treatment planning, child care workers are kept in the peripheral". CYCPs might be but in actuality, are rarely consulted about, let alone asked to play an active role in, the determination of a direction of focus for the youth. Typically, their role is 'appointed'.

Being told what to do and how to do it in addition to knowing one is seen as tangential to planning may quickly lead CYC workers to feel disenfranchised. This feeling of being on the outside of what may be viewed as a homogeneous and uniform understanding on the part of an in-group of professionals, can make a CYCP feel marginalized from the team, Yet a team approach is advocated and considered necessary to help a client in care. Feelings of being treated unfairly and disrespectfully, coupled with being given inadequate financial compensation impacts the CYCP's work and sense of self-worth.

Given the exclusion of CYCPs from the assessment and program planning process, the proposed research will explore how CYC practitioners might be considered equal partners in the assessment and development of treatment processes for clients with whom they work.

Rationale

Considerable current research (Anglin, 2001; Beker, 2001, Cavaliere, 2004; Lochhead, 2001; Thomas, 2001) relates how child and youth care practitioners (CYCP) have struggled to be seen as credible workers whose level of significance parallels that of other professionals within the social service sectors such as social workers and

psychologists. Despite this dissonance, the CYCPs are seeking ways of finding equality. Being equal partners in the assessment and treatment planning process is one of those avenues. Given that CYCPs work consistently and directly with children/youth, and play a secondary role to the parent/guardian, they need participation in case planning and mutual respect from other professions.

Developing credibility also entails that CYCP take ownership of their own issues and to some extent try to effect change rather than allow their work to be "co-opted and trivialized" as suggested by Phelan (2003) and Lochhead (2001).

Citing the seminal works of experts in the child and youth care field (Brendtro; Krueger; Maier; Redl; Wineman; etc.), Thomas (2004) stressed the importance of developing leaders who could look well beyond their stressors, and find ways for CYCPs to move forward. A treatment plan process sets the course for how the worker and/or team will support the child/youth. Therefore, being a part of a plan from the beginning sets a tone of acceptance and value. The CYCPs can meet this challenge by ensuring that actual practice resonates with standards of practice for which they are accountable.

Significance of the Study

This research could result in child and youth care professionals viewing themselves and their role in a different manner. Understanding of some of the environmental factors affecting child and youth care practitioners should encourage growth and professionalism. Workers could use the knowledge gain through this study as a stepping stone to increase awareness of job responsibilities and agencies standards and guidelines. Child and youth care practitioners do not need to succumb to the narrow

perspective delineated by others but should rise above and work within and beyond their scope. For example, treatment plans are highly underdeveloped yet valuable tools exist and should be used by workers as they set the framework for the direction of those with whom and for whom they work.

By conducting interviews with several child and youth care practitioners working in a variety of settings, the hope is to determine their understanding and perceptions of the treatment planning process, their knowledge of and comfort with the process, and the areas in which they feel capable or want additional training. Perhaps many of them may realize that they lack the tools or underlying information needed to develop dexterous plans that guide their work. Perhaps the research will reveal the disheartened feelings workers possess that have unknowingly governed some of their practice by transference and /or countertransference of feelings of despair, but are now willing to be more proactive towards change. In using the coined phrase 'knowledge is power', the hope is that workers develop acuity to their practice and will funnel more conceptually based frameworks that will cultivate not only their work but their credibility as well.

As a worker in the field, I hope to assist myself and others, through focusing on the issues of credibility that impact CYCPs, and then offering the consideration of the role of treatment plans in ameliorating these issues as they arise in their practice within a panoply of settings as a "practical step".

Research Questions

1) How do child and youth care practitioners (CYCPs) describe the child and youth care field?

2) How did CYCPs describe the treatment plans including their development and data gathering process?
3) How did participants describe their role in the treatment planning process?
4) How did participants describe their role when implementing treatment plans?
5) How did participants feel they were perceived by others, such as families, youth, peers, and other professionals?
6) What are some of the things CYCPs can do to effect positive changes in their roles and responsibilities and how they are perceived?

Terms Defined

For the purpose of this study, the following terms mean:

- **Child and youth care practitioner (CYCP)-** is primary coping agent in the total life space of the child/youth (Linton & Forster, 1988; Krueger &Stuart, 1999). These workers place high value on their interpersonal relationships with their clients (Anglin, 1999; Beker, 2001; Cavaliere, 2004), and focus on the individual strengths across social, emotional and behavioural domains. (Eisikovits & Beker, 2001; Schneider-Munoz & Beker, 2002).

- **Assess**- to use observation and communication skills; individual histories, where appropriate; and, relevant theoretical models to understand and articulate a individual's/family's behavioural, developmental, and social functioning within the presenting context. (Ministry of Training, Colleges, and Universities, 2000, p15)

- **Treatment Plan**- consists of an accurate assessment of the distance between the present situation of the youth/family and the desired situation or place (Phelan, 2003) that a collective group, including the client, would like the client to inhabit.

CHAPTER II

LITERATURE REVIEW

Although child and youth care practitioners have been described in unitary terms, for example, as "specialists in facilitating change" (Ministry of Training, Colleges and Universities, 2000, p 8), theirs is a multivariate reality. For example, according to Beker, "residential child care workers….serve mostly delinquent, dependent, retarded, and/or physically handicapped youngsters" (2001, p356). As well, Beker (2001) speaks of other realities for CYCPs, for example, the realities they encounter as day care workers and hospital workers. However, all realities centre on children and youth, and includes decisions and actions around defining their problems, as well as actions and constraints on action around developing their treatment plan. Some of the research has been conducted on the examination of the role of child and youth care practitioners (CYCPs) in treatment planning, state that "the limited role of group workers and their involvement in the development of a treatment plan" (Metselaar, Knorth, Noom, Van Yperen, and Konijn, 2004, p157) contributes to "quite a lot of traps … (such as)…lack of uniformity, lack of topicality…and limited role" (Metselaar et al, 2004, p157). Possibly, a disjuncture exists between the everyday practice of CYCPs, and what could be the practice, were skills in their possession recognized, validated, valued, and used in actual formal treatment planning.

Whether a child's 'history' is or is not provided, CYCPs use observation and common sense as valuable sources of informal assessment, planning, and guiding to enable them to gage the child's level of competencies and difficulties. However, the use of what might be termed unrecognized, almost 'subjugated', skills like observation and

common sense brings the CYCP profession under scrutiny. Concerns can arise over the validity of subjective judgement. A lack of acceptance that child and youth care practitioners are 'trained observers', who work directly with children and youth, and become their advocates in ways that give the clients themselves a voice, leads to the omission of important data in treatment planning. This in return affects the credibility of the profession and calls into question the primacy and expertise of CYCPs (Beker, 2001).

VanderVen (2002), states that "the future does not shape us, and we need not passively fold into whatever happens". VanderVen identifies opportunities for those in the child and youth care field, despite their feelings of marginalization, to raise their heads and their status, to expand the range of possibilities and actions, and thus, of outcomes for the client. Instead of remaining in the 'victim stance', CYCPs can, should, and indeed must, take their knowledge of the barriers and use it as a stepping stone on the road to affirmation of their credibility.

> We can certainly make the case that we-not unlike many of the young people in our care-have been unfairly used, inadequately compensated, and disrespected by more powerful people and groups, by the "system" if you will. But the notion that we have been (and are) oppressed, true or untrue, does not excuse our failure to assess our situation and do what we need to do to enhance it in the service of young people and ourselves (Beker, 2001, p329).

Although CYCPs are not always included in treatment planning for a number of reasons, they need not stand passively by. This paper constitutes one attempt to assist in the development of practices, standards, and guidelines that include primacy of input in treatment planning from those in actual practice of the CYC profession.

Roles and Responsibilities of Child and Youth Care Practitioners

The role of a child and youth care practitioner is so widely misunderstood that it becomes difficult for others to respect members of this profession. The general public have a 'common sense' appreciation, a 'knowledge' of, or 'understanding' about, what a psychologist 'does', what a social worker 'does', what a teacher 'does', or what a nurse 'does'. However, ask the general public what a CYCP does, and little descriptions, or explanations of roles and responsibilities, are on offer. What may be termed ironic is that a fluid 'take' on CYC practice, or no take at all, is perhaps a more suitable stance than a rigid one at this time, as the CYCP role is emergent and changing. CYC roles in many ways derive from, interact with, and contribute to, the practices of other professions, such as psychology, sociology, and teaching. Yet the CYCPs are not treated with the same respect from peers, as those in the social science professions listed above.

Distinction of Roles

In the area of human service professionals, it is important to be able to differentiate the child and youth care practitioner's profession from others (Anglin, 2001). After all, there are a variety of resources and services available for children and youth, but without knowing the services provided, the expectations for, and the actual roles of professionals, it is difficult to determine who or what service should be accessed.

According to Anglin (1999), child and youth care practice is focussed on the growth and development of children and youth. This is not to discount other variables (i.e. - school, family, peers, etc) often affecting a child or youth's life, as Anglin (1999 goes on to state that care is concerned with the totality of a child's functioning, and then, that it includes all of these variables in a broad focus, rather than excluding some, as, for

example, according to Anglin (1999), do physicians who are concerned with physical health primarily, and probation officers, with criminal behaviour. However, when working 'with' the client, the child is always the centre, and both the subject and the object of focus. A key marker of difference between the child and youth care practitioner and other professionals, for example, social workers, is the collaborative support offered by the child and youth care practitioner to the child or youth. CYCPs are not 'about' deferring treatment until a full psycho-educational assessment has been conducted, or referring the client elsewhere. Their accountability is first to the child, and then, to the family and community (Samjee, Makan, Pierre, Myeza & MacKay, 1999). The child and youth care practitioner focuses on the developmental perspective of the child or youth (Anglin, 2001). Focus on developmental perspective enhances the client's perception of self. The child/youth works through his or her situation in a mindset he or she understands, yet with the support of someone (child and youth care practitioner) who guides them through the situation, while understanding where he or she 'is at', and then, by assisting the child to work "towards the next step by building on existing strengths and abilities" (Anglin, 1999, p145).

Perhaps more than professionals in other human service disciplines, such as social work, psychology, or sub-fields of them, like behavioural therapy, the child and youth care worker engages with the child or youth on way may be termed a personal level. For example, the child and youth care practitioner focuses on direct care and works jointly with the child or youth to persevere within the setting in which he or she is experiencing the most difficulty, "we work in residential centres, schools, hospitals, family homes, day care, on the streets, etc." (Anglin, 2001). As previously stated, the CYCP becomes, in

many ways, the voice of the child/youth, thus adding an additional component to the treatment planning process. Rather than making a diagnosis and referring the child or youth to another social service professional, to problem-solve on a basis of that diagnosis, the child and youth care practitioner engages the child or youth, in a joint venture, to 'take on' the problem. As well, many more facets of the life of a child are seen when work is conducted "at all hours", and in settings which range from schools, through hospitals, to the streets (Anglin, 1999)

Distinct from behavioural clinicians, and other professionals, child and youth care practitioners examine the historical patterns of behaviour as an integral source of information, and have "developed a social competence perspective rather than a pathology-based orientation to child development" (Anglin,1999, p145). The child and youth care profession gives new meaning to the term 'front-line work'. "We work 'at the coal face … at all hours" (Anglin, 2001). Often the child and youth care practitioner endures the brunt of problems, or more specifically the reactions of the child or youth to them, because the child and youth care practitioner serves as that 'significant adult' (Samjee, Makan, Pierre, Myeza, & MacKay, 1999) who tucks clients into bed at night, and who bears direct and compassionate witness to the pain that is endured by the child or youth. Often child and youth care practitioners are the 'secondary caregivers', beyond the family, who serve to provide the anchor for that young person, as well as, to encourage them to develop more effective interpersonal skills and relationships. Through their team approach, their interactive style, and their therapeutic measures, child and youth care practitioners enable children/youth to develop their self-confidence.

Training

Although the role of the CYCP differs from the roles informed by the guidelines and actual practices inherent in other disciplines, it incorporates aspects of training that are similar to those found in other disciplines. As Beker states, "we are specialists in terms of the settings in which we work, but there is a broad generic practice base which we (i.e., "other professionals") share…. (having)…in common … a developmental or mental health orientation to our work" (Beker, 2001, p357). The CYCPs, by the nature of the shared principles of training, and of resulting orientations, could contribute extensively to the treatment plan of those with whom they care for. A CYCP's emphasis may be placed with working through problematic areas and with helping the child within the realm of his/her developmental level and capabilities, as "families, communities, and organizations are important concerns for child and youth care professionals…(but are primarily)…viewed as contexts for the care of children….(and) development (remains) the very heart of the matter". (Beker, 2001, p145). However, aspects of an ecological perspective, as an example, may also be taken into consideration, as programming should encompass micro-mezzo- and macro life spheres (Beker & Maier, 2001). Yet a CYCP, while keeping an awareness of, for example, his ecological situation, or his pathology, still focuses on helping foster empowerment for that client by encouraging him to identify and reflect on his strengths, and to develop his skills, in order to better manage his situation, rather than, as would other professions, more situational and broader-sphere aspects of need.

CYCPs also look to normalize, rather than to 'problematize', behaviour. A CYCP benefits, as does the client, from understanding the meaning brought to an interaction, the

atmosphere in which an interaction occurs, and the nature of the interaction (Krueger and Stuart, 1999). When actions and interactions are viewed through such lenses, they are *understood* as making sense of, and in, their context, and can be seen and appreciated as *normal* actions, as actions that *make sense*, rather than as specimens of pathological behaviour.

This aspect of the work, practice, and focus for the CYC is crucial as they work with children and youth who often feel ostracized by their peers or society for the behaviours in which they display. By a CYCP's normalizing, to a degree, (but not minimizing the potential consequences of) many acting-out behaviours, and expressions of overwhelming affect, children/youth are provided with support in understanding that they are not alone in the battles they have to work through, and that all people have areas of development to work on. Given this fact, it may be seen as surprising, even intriguing, that, when it comes to programming for clientele, the majority of CYCPs are kept on the margins for decision-making. In many instances where the CYCP is not viewed as a professional of equal standing, marginalization of the worker mimics that of the child.

Differing points of view, and directions of argumentation, exist in the literature as to whether or not child and youth care practitioners receive proper training to engage in the development of treatment plans. Some authors (Griff, 1993) assert that, although this profession encompasses numerous roles, it is nonetheless, at least in part, highly undervalued partly because of types and levels of training that differ from those who most undervalue the CYCPs. The majority of CYCPs graduate with a college diploma from a three-year program. However, the minimum requirement for teachers is a three-year degree in any discipline, followed by one year of focussed training at the faculty of

education. This means a teacher can enter the profession with only one more year of training, training focused on curriculum delivery, rather than on aspects of children's learning or coping 'styles', in other than sweeping categories (like 'visual learner') and be seen as more credible than a CYC. Into the 'one-more-year category also falls an entry-level social worker, as a social worker's minimum requirement is four, and sometimes even three, years of training. There is, as suggested by these examples, strong support for the notion that training at the college level and university level, plus 'one more' year, enables others to practice with the mindset that they may be, and be perceived by others as being, more knowledgeable, certifiable and credible professionals. Interestingly, when a CYCP attains a Bachelor of Arts degree in Child and Youth Care, their degree is still viewed as less credible than a teacher's, or a social worker's. For example, in Ontario a child and youth care practitioner could not necessarily attain a position in certain agencies, for example, a position as a Family Service Worker, if they do not have a social work degree. Some agencies maintain clear distinctions between the two credentials and are opposed, to a degree that approaches the vehement, to permitting a CYCP to enter a position that entails more than having the 'child' as the focus. Such a position ignores the fact that, in a CYCPs training, knowledge of family work and dynamics is a component of the curriculum. The knowledge that they bring to their practice, that has been, and continues to be, gained through "doing, feeling, thinking about, and reflecting on their activity (Krueger and Stuart, 1999, p198) " is subjugated, undervalued and ignored. Often agencies will not even provide the opportunity for an interview to the individual holding the CYC degree, although the position is presented as requiring expertise in 'working with' and 'understanding' children, rather than

approaches, modes, and methods of care. If there is a hire, according to Krueger (2005), the employed CYCPs are “vastly (under)recognized for what they do… (and are)..at the margins …called in only as tokens”.

Social service professionals, whether because they lack understanding of the CYCPs role and/or of their specific areas of focus and levels of expertise, forget that a CYCP as well as the child/youth, needs roots, just as other individuals do in order to develop their own identity. However, the irony is that both children/youth and the CYCP are placed at the bottom of society’s hierarchy. Neither children/youth, nor members of the CYCP profession, are taken seriously, and members of both groups can end up being treated more like a commodity. By failing to take into account the value of not just the CYCP’s profession, but also the skills these workers possess, like examining the totality of the child’s functioning, those who put together treatment plans for the child/youth are limiting their scope. Incorporating feedback from a CYCP can provide that underlying knowledge of the child/youth or can provide clarity of perception of the problems and of vision of best avenues of address, for example, provision of useful and precise information about the environmental factors influencing the child’s performance or functioning, especially as at CYCP is often tasked with working within the child’s environment or milieu. As well, when a treatment plan requires ratification, CYCP “workers can change or adjust an (planned) activity to meet the needs of the youth based on their assessment of the meaning, required skill level, atmosphere, and anticipated outcome” (Krueger, 2005, pP197).

The goal of the child and youth care practitioner is to develop a positive and nurturing bond with the child or youth. This helps to the worker and the ‘worked-with’ to

collaboratively examine those environments that cause tremendous stress to the client and which therefore negatively impact his or her ability to function in a more socially acceptable manner. Direct work with the child/youth in their environment can broaden the scope of a treatment plan, because a CYCP is skilled at not just advocating on the child's behalf, but also, he or she is in the best position to seek and obtain input from the child/youth him or her self that can be used in determination of direction of the plan. As well, input is needed from those who know the child in a dynamic way, i.e., those who live with, and in many ways in, the life of the child on a daily basis. The workers who are doing this benefit from a diachronic series of exposures, rather than a synchronic one-time assessment. The work to be done "cannot be effectively standardized … because its success is a function of the practitioner's interpersonal sensitivity and skills …where the need is determined in part by the dynamic and often unpredictable responses of all those involved" (Eisikovitz and Beker, 2001, p418).

Because of this closeness in working within the child's surroundings, CYCPs highly value the level of intense relationships, and/or bonds, they form with children and youth. The resultant "feeling for and …understanding of the systematic essence of their client's lives" enables the "tolerance for uncertainty, the courage to act on inevitably incomplete knowledge…are all essential" (Beker and Maier, 2001, p383).

The 'custodial' role, or stance, of a CYCP facilitates trust building, which is, for many children/youth in their purview, an extremely difficult task and process to work through. The lack of support and acknowledgment that these workers receive, in essence helps them to identify more with the client, in terms of appreciating the fact, and not without associated feelings, that, in many cases, one may need to rely solely on his/her

self to get through situations. Developing this type of ‘solidarity’ and even identification, and then to come, in part to terms with it, can assist the CYCP to help the child feel more ‘normal’ than ‘outcast’, like some workers who may not have come to terms do, within this environment.

Treatment Plans

Treatment for any client, should involve a compilation of information from differing perspectives. The perspectives differ, and are as severally important as they are jointly, when those involved range from the client, through members of, and the unit of, the family, to each of the professional staff members. The plans drafted from these viewpoints “give insight into the care process, the treatment goals, specific treatment methods and an evaluation schedule” (Metselaar, Knorth, Noom, Yperen, and Konijn, 2004, p153), and help to link the client’s present level of functioning to the desired outcome (Phelan, 2003). Treatment plans are meant to be dynamic convictions of belief and value systems that support a client’s journey towards change (Phelan, 2004; Krueger, 1990). Their essence should reflect an ecological perspective of the client’s functioning. For example, information should be incorporated from areas of how the child/youth functions with his/her parents or peers, at school, or within the larger community, to name a few. The treatment plan then collates data to ‘map’ behaviours, and responsibilities, with consistent support of facilitating change as the goal. In these plans, each person connected to the child/youth, such as parents, teachers, or social service workers, along with the child/youth, can then work consistently, and with, rather than for example, ‘on’ each other, towards a common goal or mission. This aids in holding everyone accountable to the plan. In addition, by having treatment plans periodically

reviewed one can determine whether necessary changes are required. Suitability and practicality of models and approaches can also be monitored for assessment of present and/or future use within the field (Krueger, 1990).

Currently, treatment planning is often developed without the support or input from the CYCP. As Beker (2005) has explored, many child and youth care practitioners do not play central roles when it comes to the development of a client's treatment plan. There are those that are the exceptions to the rule, but more often than not, other members of multidisciplinary teams or supervisors make decisions. This is not the choice of the particular child and youth care practitioner, but comes about because other professionals, often social workers or psychotherapists, or administrators, assume the role (unless they are employed in a treatment-based facility) of often primary, and usually sole, decision makers. This is surprising as it is the child and youth care practitioner who usually performs frontline duties and guides the child/youth through his/her process of change. The philosophy of a CYCP, as an "interactive process" is to guide the child or youth to react, change, grow and develop (Rose, 2001). Without the input of the CYCP towards the treatment plan, valuable information could be missing. The leapfrogging of possible input from the CYCP, in the service of treatment planning, reflects the lack of value, as well as of credibility, associated with the CYCP. Gannon (2001) speaks to the importance of including the CYCP. He stresses that, when workers are included in the treatment planning process, they are more inclined, and able, to grasp a better understanding on the need for interventions at all levels. This gives staff both the knowledge to effect, and the confidence that they will be successful at, helping the

child/youth achieve his/her goals, as well as, providing the staff with ongoing individual motivation and empowerment. Gannon (1994) states,

> Staff members will generally be committed to a treatment plan if they have been party to its development. The same is true for the child. We have learned that treatment is not something that we 'do' to a child, but a process which we will go through with the child, together" (p64).

He explains that, when a worker is included in a process, he or she develops more of an understanding of the child's/youth's needs, and is more apt to abide by it, As well, they develop drive to achieve success. This also holds true for children and youth, in that when they are given a say in what course or courses of action is to be implemented within the treatment plan and, in turn, perceive their voice to be heard, they become more compliant and willing to engage in the process, as well as, in the actions themselves..

When other professionals do not a share common vision, and fail to see the value of each other's profession, gaps form within the service, and the functionality of the treatment plan is compromised considerably. Harper (1986) states, "without coordination of the various skills of the team …child care practice becomes a pot-pourri of benevolent intention…which seldom addresses the task effectively" (p5). Gannon (1994) states that "staff members will generally be committed to a plan if they have been party to its development" (p64). Phelan (The Treatment Plan) writes that "every treatment plan … (has to detail)…what behaviours the helper will engage in to do the job required". A worker's input into what she or she can do would seem seminal. Such considerations when taken into account, and when not done so, affect not only child and youth care practitioners, but impact on the child/youth, their parents, and, the achievement of goals, as well The initial strategies can become distorted, with differing goals, and differing

ideas of which have been, and which have not been, met suddenly placed on the table, and thus there can ensue unrecognized shifts in strategies that verge, at times, on the reactive and arbitrary.

A lack of unified vision, and of commonality of ideas, strategies, and goals, can be a major hindrance, especially when dealing with time allotments per child. Such allotments are set out for the CYCP. With the day-to-day pressures of trying to provide service and support for the individual with whom they work, the worker now experiences additional stress because of governed time frames. This can then lead even further to the amendment of the original goals and visions. The CYCP is now faced with a 'domino' effect, as each child under their care in turn suffers because of the underlying lack of structure, direction and the receipt of conflicting messages from different workers.

In situations where there is not a multidisciplinary team, CYCPs are expected to implement treatment decisions based on limited information (Browning, 1999), making it necessary for all professionals to collaborate and integrate their knowledge if they are to reach higher degrees of success, clarity and direction for children and youth. The focus of child and youth care practitioners is on their direct care work. Determining the best treatment plan can be delayed without substantial information, and without a clear knowledge of the subject of scrutiny.

Using common sense alone as an evaluative measure, rather than using input from a CYCP, to aid in the development of a treatment plan can pose serious problems.

> Relying on common sense can be misconstrued in diagnosis and treatment and gives an impression of preciseness where none exists. Consequently, counsellors may not be effectively addressing the concerns of their clients, nor providing counselling that appropriately affects levels of self-esteem (Guindon, 2002, p205).

Some influencing variables, which common sense in isolation may not take into sufficient account, are cultural background, education, environment, socioeconomic status, and experience. Although common grounds can be found, these variables are in many ways independent of each other, and one cannot be predicted from the existence of another. Thus, with atomistic variables, a blanket approach cannot sufficiently cover contingencies, or allow for appropriate planning in all instances. This is important to realize as individual situations vary, not only for each child/youth, but also for each CYC, or, for example, each psychologist However, if CYCPs use common sense, as an adjunct to their other knowledge and skill sets, from areas such as behavioural functioning for example, they come up with more valid assessment than with one or two elements in isolation.

Perceptions of a Child and Youth Care Practitioner's Role

Review of the literature suggests there are misconceptions about the roles of child and youth care practitioners (Ricks and Charlesworth, 1982). As an example, CYCPs can find themselves used as a human 'dumping ground' in a variety of settings, such as schools, group homes and day care programs. This can result in the child/youth, being placed with the CYCP prior to the CYCP having any knowledge or background on that individual, as the unstated goal is containment, rather than assisting transition from one set of skills, and one set of circumstances, to another, so there is no need for history, as there's little planning for future, and therefore, consideration of the distance needed to travel to get from the past to the future goal. This leaves no room for early screening in relation to a child/youth's suitability for the service to be provided or the agency that is to provide it. This in turn places more responsibility, can result in increased caseload, and

add to the stress on the CYCP. Increased caseload, more and broader responsibilities, and added stress in turn affect the time spent with each child/youth. Again, this pushes CYCPs to resort to their individual common sense, observations, and expertise to guide the child/youth through to a process of change, and , as each worker is different, and there is little expressed common ground or premise, such a turn of events may lead to inconsistencies between workers as there are no set guidelines to follow.

Another form of unfair use deals with work experience in school settings. Many CYCPs have been exposed to teachers feeling that their hands are tied when it comes to providing adequate education to a class that is comprised of high risk, low functioning, or inattentive students. Complaints about the lack of resources to accommodate the individuals with whom they work are often made by teachers and CYCPs. Depending upon the particular school board's philosophy of special education, a teacher can find his or her self in an 'integrated' setting, working with students at a level far from the norm of the regular class, or working with students with a melange of difficulties stemming from physical to behavioural problems.

In the teacher training programmes, candidates are extensively trained in the delivery of the curriculum. However, they are only given brief overviews of how to work with students with special needs. With experience, some of them learn how to balance the curriculum and meet the needs of their 'special' students. However, other teachers do not fully buy into their responsibility to teach to a spectrum of needs and styles, feeling that there is a universal mandate, a universal curriculum, and a universal mode of ensuring universal outcome, and resent and ignore movement across such a grain. Other teachers can lose faith in their abilities to cope and manage the behaviours within the

classroom, as a result of inexperience, in tandem with little training in behaviour and its management, and consequently quickly lose patience when required deal with these children/youth. Factors like these can push a teacher to seek outside assistance, not to successfully manage the student in the classroom, but rather, to manage the classroom without the student in it, through removing the troubled student(s), who 'end up' in the care of a CYCP.

In schools with segregated classrooms, students who are unable to control their behaviours are given an alternate program to assist them in learning and dealing with their troubles. With so many behavioural and learning difficulties in the classroom, the teachers feel that it has become too difficult to just 'teach' the curriculum in a manner that conforms with the strictures of the Ministry, the Board, the principal, and the parents. They feel inadequately prepared to manage various behavioural or emotional issues. Their role becomes that of a 'bouncer', or 'guard', who spends most of their teaching time 'managing' various behaviours or mental health issues. Other students miss out on learning as the teacher is pre-occupied. Teachers, at the peak of their frustration, have been heard to say, "if only that child were not here today, things would run a lot smoother within the class, and the other students would be able to learn". It is at this point that they, the teachers lose sight of any perspective that considers that those challenging behavioural tendencies are anyone's desire to have, including the student who presents them. As well, teachers can fail, at that point, to understand that the issue is not about students not wanting to learn, but, rather, that they are having trouble learning in the type of environment placing them in places on them. By having set treatment plans

in place, these challenges could be avoided at an earlier stage within the school year, thereby allowing all students and teachers to benefit.

Another example occurs when some children and youth require more movement, more breaks, more individualized time, or customized time. Teachers then find it difficult to accommodate all of the additional needs ‘on top of’ their daily teaching requirements. A teacher who is over-burdened, taxed, frustrated, and at wits end can easily forget that these children and youth are just as human as are hard-working teachers, and that they, the students, did not ask to have the difficulties. It is at these times that it is difficult for the teacher to demonstrate either the insight or the compassion necessary to assist them in their times of difficulty. As a result, students suffer once again due to a lack of individual time allotment as some students end up receiving more of the teacher’s attention than others for wrong, rather than right-minded, reasons.

In other settings, like group homes or other, usually non-treatment, facilitates, there is a similar attitude or pattern displayed. Once again, the child/youth is ‘dropped off’, with little to no background history. Children have been temporarily placed in care for the purpose of detention, whether they have upcoming court hearings, have recently been charged, or have been deemed in need of protection. In addition, children can sometimes end up being placed in care because their parents may feel that they are unable to manage their troubled child. At such a point, the parents, being frustrated, overwhelmed, and exhausted, might contact CAS, as a last means, for support. In the worse case scenario, some parents may simply abandon their child(ren).

Concerning day care programs, a general perception seems to be that such facilities are to provide daily activities and not necessarily to be regulators of behaviour.

Parents have viewed day cares as time fillers instead of a therapeutic or treatment-based milieu. Such a view, when held, leaves the CYCP with a role that is subsumed under the public perception of him or her as a 'glorified babysitter'. It seems that people forget that gone are, or at least they should be, the days when 'children should be seen but not heard'. Children cannot be held solely responsible for the behaviours they display or their lack of understanding as to why they act the way they do. What these children need is consistent, integrated, and uniform guidance around how to better themselves. Thus, it is not 'just' the role of the CYCP to provide that development of understanding and growth, but a task, and a mission, that should, and must result, from collaboration among all service providers. The use of treatment plans provides more guided and focused thinking and programming when all stakeholders have input. It also, when done correctly, can narrow the effects of differing points of view, and clearly delineate the responsibilities of each person supporting the client, as well as the client's responsibility for his or her behaviour, and, ultimately, outcome.

Devaluation of the Child Care Field

Linton and Forster (1988) assert that child and youth care practitioners sit at the "bottom level" of the American Mental Health hierarchy. In working with children experiencing varying difficulties, child and youth care practitioners can find themselves, and their chances of succeeding, impeded in several ways.

Roush (1996) delineates several of the ways that juvenile care workers are hampered in detention facilities. He speaks of a lack of understanding of, or training in, detention and corrections practice, adolescent development, human behaviour, principles of behaviour modification, program goals, program rules, problem solving, and

interactional skills. He goes on to state that the consequently weak observational skills, lack of training in behaviour modification principles, and even a lack of genuine concern for the residents, results in a lack of expectation of positive performance, a lack found in the CYCP, as well as in others in the setting. As well, there is a lack of recognition of the active contribution of the worker when such a lowering of expectation, and success occurs.

Modlin (2005) states that, until two years ago, "there were no education programs for child and youth care in Newfoundland and Labrador. Those who became employed as child and youth care workers, therefore, came from other disciplines, with psychology, sociology, and education being the most prevalent. Some agencies required a degree in the social sciences; others required two years of post-secondary education in a related field." She goes on to state that "Individuals who currently work in the field became child and youth care workers only after gaining employment as such". She states that, in consequence, "there are organizations that are doing child and youth care, and employing child and youth care workers (by a different name), and they don't know it (or refuse to acknowledge it). There are also organizations that knowingly employ child and youth care workers, but they do not identify with the field, thus encouraging a "preponderance of marginal over excellent workers" (Linton & Forster, 1988, p1). They do their own thing, in their own way. Then, there are the individual staff who may work in enlightened agencies, but choose to remain uninvolved with, and unaware of, the bigger child and youth care world out there".

In addition, in her call for minimal standards in the field of child and youth care, Modlin (2005) states that, as well as the field in general not being fully recognized by others, there is little respect for what they are doing in the minds of the workers themselves, and little of the mutual support that could build it, as there is no common language, little shared knowledge, and a lack of shared perception and understanding.

As well, inadequate compensation hinders the rewards that a worker could receive, and, quite possibly the value of the CYC perceived by the client, leading to a loss of authority and diminishment of expectation of success. With CYCPs working frontline, with sparse inter-team dialogue, little recognition is expressed by other team members for the nature and extent of difficulties that CYCPs have to address on a daily basis. These workers are often denigrated, verbally threatened, and/or physically abused (i.e.-kicked, punched, spit on) by clients. Although support would be of great assistance, if expressed by a parent, a supervisor, or even the community at large, it is seldom received. Monetary reward is what is left as the primary source of recognition, and when it is felt to be lower than a CYCP's training and performance of their task warrants, the CYCP, along with the child, can feel the effects. Other forms of recognition such as verbal praise and support from administration, recognition which could go a long way towards motivating a CYCP, and which could mitigate the high rate of turnover that results, in great part, from, for example, staff burn out, as the worker might feel less alone and more part of a team.

> There continues to be problems with a clear definition, cohesion, and structure in the field, with viable career ladders and with appropriate salaries, support and respect.… high turnover and the inability of the field to retain highly educated and skilled workers—has a significant impact on the maintenance of the lack of recognition afforded to the field. (Lochhead, 2001,p74-76)

By being a team member, a CYCP is able to obtain the forms of support needed to alleviate stressful circumstances involving this type of job. The key goal, for presumably all members of a treatment team, should be to consider that support given to a worker is, in turn, ultimately supportive to the child/youth in his/her care, so that both are enabled to a greater extent, and the goals outlined in plans of action are more readily met.

Allied Professionals' Perspectives

If the essence of a treatment plan is to successfully reflect an ecological perspective of the client's functioning, factors like location and time allowance must be included in setting up a plan. Because a treatment plan allocates, in part, responsibilities to all who are involved with the client, the plan must set standards and guidelines that can be met by all, if performance is truly to be held accountable. Difficulties can arise when input from all those to be involved in effecting desired changes is neither sought nor taken seriously into account.

Settings can differ not just in distribution of resources, physical layouts, and staffing allocations, but also in time frames permitted. A high acuity residential treatment centre in a large urban hospital may not have a year to treat a child/youth, if there is pressure to admit and demit candidates for treatment quickly, because of the numbers involved regarding catchments and populations to be served.

A school board is often subject to time constraints of a more formal sort, as the 'school year' consists of a ten-month period, with breaks up to two weeks at mid-point, and other off time totalling another half month. Those who work in a school setting as teachers, are used to, and may benefit from, the cycling (term one, term two, term three)

that seems almost natural. However, the situations of the child/youth that is in the care of a CYCP may not necessarily ameliorate at ‘break-time’. In fact, the opposite can be the case, with the most pressured time being at, for example, Christmas. As well, the kinds of changes that are needed may take more than a school year to effect.

Stein states, “Transference and countertransference can be identified dynamically as the same phenomenon: They both refer to how human beings use one another for unconscious purposes” (1985, p2). For Stein, transference takes place in any clinical relationship, and concerns “the patient’s displacement and exteriorizing of internal issues onto the clinician; (and) countertransference denotes the reverse” (1985, p 2). Mann-Feder supports this notion by stating,

> Our perceptions of our own competency may be at issue when the youth in our care are defiant or noncompliant. There is a real risk that our needs for control may, at times, dominate over our needs to connect. At the same time, we need to be aware of our own issues with attachment and how this can play out with the young people in our care. (2003, pp13-14)

The relationship between a CYCP and their clients might be regarded as a clinical relationship and, as such, might be looked at through such a lens.

Writing about physicians, Stein looks at how they defend themselves against the anxiety associated with patient care. Looking at the defences against anxiety, of a CYCP who must meet the standards of a treatment plan which conforms to expectations that are fuelled by the length of the school year, and not by the increasing intensity, for example, of family pressures at break times, when support from the CYCP may be most needed, is important in order to get another perspective on the need to include the CYCP in the setting up of a treatment plan for which, in great part, they will be responsible in terms of

implementation. Doing so might result in treatment planning that takes the realities and needs inherent in the tasks that face a CYCP, in this case, for purposes of example, in a school setting, more into account.

One hundred years ago, Osler (1906) argued for the importance of self-awareness in medicine. His arguments might currently apply to any of us who work with, and hope for change from, others.

The pressures of tasks that face, in this example, child and youth care practitioners working in a school setting, can lead to the use of unconscious defences. For example, a CYCP in a school setting may be asked to come up with a behaviour plan for a child whose behaviour is disruptive in a classroom. The expectations of the teacher, or the school administrator, may include that there will be changes in the child's behaviour that the teacher will be able to see and, as well, that such changes should hopefully occur within a 'reasonable time'. However, The CYCP may have little time to go over such a plan with a teacher, and a teacher may not be able to implement the plan as intended, when time constraints allow for only brief explanations. For example, if a plan included a 'token economy', the teacher may choose the entire week as the period of time in which behaviour is to be judged, and rewards received through cashing in tokens, when, for that child, a day, or an afternoon, may be a better and more realistic span.

A CYCP may however be unsure about the period of time a child may need at the beginning. Stein (1985) asserts that physicians may feel helplessness in the face of an ambiguous situation, like whether the length of a treatment course is the most appropriate. He states that they may find feeling helpless, when they are supposed to feel

helpful, unacceptable and may thus psychologically locate these unacceptable parts of themselves in another person ‘out there’ who may be seen as a more suitable recipient.

A worker who faces the constraints that come with particular settings, may also develop painful feelings of helplessness, and may psychologically locate them, to rid themselves of anxiety, in the child who is the subject of the behaviour plan.

The child may become ‘viewed as having failed to respond in timely fashion to the plan. The pressured CYCP may decide that *the child is resistant*, is *refusing* to make the step needed to gain the skills *at the rate expected*. The CYCP may unconsciously feel that more time is needed than expected by the teacher for a plan to take effect and helpless to state their feeling of the need to extend the time frame when talking to a stressed out teacher. The CYCP cannot then afford to consciously wish for more time and may allow themselves only to feel that the child needs to respond more quickly, needs to hurry up. Needs that do not belong to, and do not serve, the child. What is *being denied, through countertransference, is the CYCPs own wish to slacken the pace of treatment*. This wish is consciously unacceptable, because there is no time allowed to change the pace.

Taking more realistic considerations of what is possible in certain time frames, might lessen uncomfortable and contradictory feelings to a CYCP in a school setting, might result then in less ‘countertransference’ of attributes like ‘resistant’ to the child, and thus afford more possibility for change in the individual.

Other difficulties and unrealistic goals may occur in other settings where CYCPs find themselves, like youth facilities. These can lead to other uncomfortable feelings, which need to be warded off through ‘countertransference’. The effects of ‘countertransference’ need to be taken into account, through more attention to what may be possible, and what may not, when constructing a treatment plan.

Compensation

Although touched upon above, the issue of inadequate compensation warrants more extensive coverage. Being perceived as a member of the team, but somehow one of lesser value, by the treatment team of professionals also means, but is not limited to, receiving inadequate compensation (Gaughan & Gharabaghi,1999). Often within the CYCP profession, workers receive the lowest pay according to the hierarchy in place, which may be structured with regard to education, for example, a Master's degree rated as higher than a Bachelor's, regardless of specialization, and a professional degree rated higher than a degree leading to work in an unregulated field, as the field CYCP. Even when a worker has increased their level of training to one matching another profession, like social work or psychology, in terms of years of study or broadening of fields of focus or areas of specialization (like courses in art or play therapy), often, what is the case is that the CYCP will still be placed in a different and lower category level than the other professions. One would think it is discouragement that there are a minute number of university-based training programs for these workers.

Nominal compensation is so minimal in many agencies (Neugerbauer, 1992).that CYCPs are indirectly forced to acquire an additional job to survive. The effects of this practice can be reflected back to show a huge quandary over how much of themselves in

the end can a CYCPs truly provide. When a CYCP has to spread his or her self so thin to compensate for low salaries, let alone while also battling long and inconvenient working hours, they cannot truly meet the taxing demands of the job.

Another area in examining inadequate compensation is that in many social service agencies there is a lack of funding and insufficient resources (Gaughan & Gharabaghi, 1999). For an era that is suppose to find more value in the children and with the numerous cut-backs that continue to plague this world it is surprising that we, society, has made it thus far and that the population continues to grow as opposed to deteriorate. But then are we using the resources that we do have wisely?

This question takes us back to the initial issue at hand, which is examining the effect of treatment planning towards a child and youth care practitioner's performance. Perhaps if agencies used their CYCPs more wisely by listening to what they have to say about the clientele they work with, more efficient treatment plans could be developed.

Summary

When a child and youth care practitioner meets a new client, their primary (primary in both the sense of first and in the sense of foremost) function is to assess his or her needs. Comprehensive and accurate assessment enables the CYCP to formulate a plan of action or a treatment plan. Such a plan would work for the child/youth given their present level of coping, needed direction of growth, and motivation. For such a plan to be effective, it needs to suit all parties involved, not just the child/youth.

However, what often happens in some agencies is that a child/youth goes through an intake process, the goal of which is to determine the individual's suitability for a particular program or setting. However, as mentioned earlier in this paper, in settings like

group homes, schools or detention centres, there is little room for screening a child/youth's suitability based on needs, capabilities, and goals specific to the child/youth and/or program/agency they are connecting with. Identification of psychological and social needs is seen as, and treated as, secondary to a basic hierarchy of needs, for example, shelter, leaving placement, in this case, to be based on availability of space in the service concerned. Nonetheless, once the initial intake is completed and the client is transferred to a physically appropriate program setting, they are then placed with a worker in that setting who must decide on the plan of action.

According to factors, like de facto recognition of experience and capabilities by administrators or other staff, determining what course of action will be taken for the child/youth becomes a matter under the discretion of the particular CYCP. This process can be time consuming and costly to the agency. A standardized approach in developing a treatment plan would assist workers in being more efficient with their time and in turn save on expenses. It would also afford more credibility to the child and youth care profession as their assessments are deemed subjective when workers are known to use their observational skills and common sense.

> We will need to depend on our own professional judgments and those of our colleagues, using more systematic, "objective" approaches where we can. Most important, it is essential that we identify for ourselves and of others why we propose to do what we do, and that we develop and convincingly integrated web of construct validity that will permit us to proceed with confidence and integrity where we cannot adduce systematic evaluative techniques and findings.
> (Beker & Maier, 2001, p384)

Treatment plans not only outline the client's struggles, but specifically delineate, assign responsibility for, and amplify focus on, the goals and objectives in helping children/youth work through their problems and become more successful. Having all

parties involved, including child and youth care practitioners, and developing some commonalities of practice, aides in providing direction for caregivers and the client in terms of treatment. This is not to say that all children/youth fit into a 'box' for treatment, but only that specific focus, and broader participation in choosing where and how to focus, through input into a treatment plan, will assist the CYCP in pinpointing what action needs to taken, and then, in taking it.

The time frame might also be shortened, which has fiscal benefit to the agency involved, and quicker relief and skill-building for the client. As specific questions can be asked, and specific answers given, answers that can point in specific directions, and eliminate at least some of the trial and error that sometimes occurs could be seen to be useful. By using treatment plans more consistently, child and youth care practitioners can be helped to eliminate unnecessary actions, as well as, narrow their enterprise to more focused programming more quickly. In addition, treatment plans can identify specific and clear needs, and whether they are met can be established through setting up pre and post measures of success.

Through participation in a screening process, the CYCP will come to a better understanding of the client's needs using guidelines that may be, and would be perceived by others in the field to be, more objective. Without the aid of treatment plans much is left up to individual interpretation and, therefore, depending on the experience of the CYCP, direction of treatment, and ultimate results, can vary. On the other hand, with consensually obtained, and viewed as 'harder', data, data produced as a result of collaborative efforts and consistency of practices, treatment plans can then be fine-tuned

when needed, in the areas specific to what is known, and specified, about the client's individual needs and personality.

The use of treatment plans by a child and youth care practitioner assists radically in the establishment of a shared vision with other professionals, as it can be seen, discussed, and revised. A treatment plan would likely therefore enhance the perception of the greater community of the skills and role of these workers. It would also give workers an opportunity to develop a viably consistent framework to function under. The result would be a transfer of training (Schneider-Munoz & Beker, 2002) through appeal to a more balanced and well-rounded format. As a group, the CYCPs would be able to discuss and connect to one another more easily facilitating sharing of skills, knowledge and expertise that would in turn boost morale. This shared knowledge would assist in building commonality of practice in the field.

Credibility in a field of practice is often a function of whether a field of human study, and related practices, is known to utilize measuring tools and devices. Yalom (2002) tells of the fact that unconscious determinant theory, specifically psychodynamic practice and therapy, has all but disappeared from the curricula of psychiatric training facilities. This tool can assist CYCPs in perceiving themselves, along with, as mentioned, being perceived, as on a par with their para-professionals, with heightened respect from their clients, the family, and the greater community.

VanderVen states, "Given the ever escalating sources of information and the speed of their transition, we may need a way of managing them" (2002, p185). With the ongoing threat of government cut backs, additional staffing does not seem likely. Presently, many agencies have a waiting list for a client to be seen and/or serviced by a

CYCP, and depending on the geographical area, this waiting list can be extensive. This substantial time frame demonstrates a need for the CYCP to be able to effectively manage their work with their clientele. Furthermore, unless society is made more aware of the role of a child and youth care practitioner, their position within the system will continue to go relatively unnoticed, resulting in improper use, further cutbacks in funding, and continued lack of recognition. This is not only limited to the public in general but also to the CYCPs, whose drive and commitment to the field diminishes with the ongoing battle of not being just seen, but also heard.

Unfair use of child and youth care practitioner's skills and time; diminished respect for CYCPs and by extension, their clients; inadequate recognition of what they can and do in regards to assisting individual growth; exclusion from providing input; recognition in law; and ability to engage in consensual practice with uniform, positive and predictable outcomes, would be assisted through development and implementation of effective screening and planning procedures.

However, what would be of incontrovertible worth, and what motivates me to attempt this project, is the benefit that would accrue to our clients.

CHAPTER III

METHOD

Qualitative Research

Qualitative research is a process of gathering data with focus on people's descriptions of social phenomena, intimate relationships and situational constraints (Rubin & Babbie, 2005; Denzin & Lincoln, 1994). In the field of child and youth care, this type of research can be viewed as a literary genre, as it reveals 'a story' of people's experiences, attitudes and perceptions. Its naturalistic investigation is often inductive, emergent and flexible (Frankel & Devers, 2000), and the researcher elicits first-hand information from the participant. Doing so allows hypotheses to be generated from the embryonic analysis of the collected data. Although researchers are concerned with the deeper meanings of human occurrence, they must work to preserve the participant's perspective, through the combined use of ontology, epistemology and methodology. This approach constitutes a basic set of beliefs that guide one's actions.

Qualitative research allows those engaged in it to learn about their topic, through explorations of information based on social constructionism and symbolic interactionism Berger & Luckmann (1966) state, when speaking of social constructionism, that "the formation of the self … must … be understood in relation to both the ongoing organismic development and the social process in which the natural and the human environment are mediated through the significant others (p59). Blumer (1969), when speaking of symbolic interactionism states:

> … the peculiar and distinctive character of interaction as it takes place between human beings. The peculiarity consists in the fact that human beings interpret or "define" each other's actions instead of merely reacting to each other's actions. Their "response"

> is not made directly to the actions of one another but instead is based on the meaning which they attach to such actions. Thus, human interaction is mediated by the use of symbols, by interpretation, or by ascertaining the meaning of one another's actions. (p180).

Child and youth care practitioners recognize, and then utilize, symbolic interactions with the children and youth with whom they work, to develop an understanding of their clients' environment. The 'stories' of the clients, and even those of the workers, are not merely anecdotal. Life history researchers are gathering of reality, based on the premise that discerning and understanding meaning, and recognizing contexts, can lead to an understanding of behaviour. In essence, behaviour and what may underlie it, may best be understood by what is gleaned from day-to-day occurrences, rather than, for example, from formalized setting up of structured yes/no situations, where what is to be known is reached through measurement (How many 'yes's', for example) rather than, as in qualitative research, through discernment, leading not to measurement, but rather to, evaluation of what is going on. When it comes to child and youth care work, the foundation of this profession accentuates the importance of relationships, an emphasis that dovetails with social constructionism.

Small sample size is often associated with qualitative research (Baum, 2000), as this approach relies heavily on depth, rather than on breadth, and detail in, rather than a survey of, participants' responses. Participants were purposefully selected (Ezzy, 2002) according to research aims and objectives, and according to the experience they have that relates to the topic of examining the role of the CYCP in the treatment planning process.

For the purpose of this study, an examination was conducted on the role of child and youth care practitioners in developing, and in not developing, treatment plans for

their clientele, and the value of these plans in guiding practice. The CYCPs' credibility, and how fellow professionals perceive them, was also examined. It was the hope that selected participants were able to articulate, display a degree of insight, and be comfortable with looking at both themselves and their profession. For the purpose of this study, research was collected through in-depth interviews. Analysis of data was a result of "emerging thematic identification and interpretation" (Tuckett, 2004, p56).

Participants

Eleven child and youth care practitioners across North America were interviewed. Being that this research focused on purposive samples, participants were required to have:

a) worked directly in the child and youth care field over five years, and
b) developed, or used, treatment plans in their place of employment.

This time and exposure factors were important as it generally takes time for a worker to develop his or her sense of purpose and identity within an agency. Often, those entering the field of child and youth work, at an early stage, simply coexist with those around them and mutely struggle to identify their purpose in terms that are more specific than general ones, like 'being there to help others'. In addition, it takes time to develop an understanding of one's strengths within the field, as well as, to label individual counselling styles and theoretical models in which they fall under. The child and youth care participants were drawn from different types of agencies that use CYCPs such as hospitals, shelters, treatment facilities, schools, and so forth.

Measures

Demographic Information:

Each participant was asked to complete a demographic form (Appendix A), that highlighted the participant's gender, number of years working as a child and youth care practitioner, his/her level of training within the CYC field, the type of agencies s/he has worked in, and his/her involvement in assessment and the treatment planning process. Contextualizing this data assisted in clarifying the complexities of symbols and meanings provided throughout the course of the interview.

Interview Schedule:

Given the purpose of examining the role of CYCPs in the treatment planning process, the tool of interviewing (considered an egalitarian approach) seemed most appropriate in that its process helps to investigate human experiences and perceptions (Beale, Cole, Hillege, McMaster, and Nagy, 2004). In this case, the use of interviews would allow for insight and exploration on such areas as who(m) is involved in treatment planning and what role, if any the CYCP played in developing that plan, etc. Although there are three types of interviews, structured, semi-structured, and unstructured, that could be employed; this study utilized structured interviews consisting of predetermined questions that will be directed to each participant. (See Appendix B)

Procedure

Upon receiving approval from Mount Saint Vincent University's Research Ethics Board, the researcher arranged that child and youth care practitioners were able to view a call for participants on the International Child and Youth Care Network (Notice in Appendix C). A general outline of the purpose of this study was provided and a request to participate, contingent on meeting two basic criteria, was included. The criteria were:

1) That s/he must have worked at least 5 years as a child and youth care practitioner, and

2) That s/he has been exposed to the use of treatment plans.

Interested recipients were then encouraged to respond via email and/or to provide a contact phone number. Those who responded, and met the criteria stated above, were contacted either by e-mail or by phone. During this contact, the research project was outlined, including researcher and participant responsibilities and rights.

Respondents were informed that only eleven participants were chosen, and others contacted and thanked for their interest and willingness to participate. Selected participants were contacted by phone and interviews were arranged at a time and place that best conformed to participants' needs. Due to the distance of some participants, telephone interviews were conducted as opposed to face-to-face interviews. Prior to commencing the interview, the researcher reminded each participant of his/her rights and that, as their participation was voluntary, they may withdraw at any time without penalty. Confidentiality was discussed, and clarity provided, when needed, about the fact that, as per the consent form, no distinguishing personal information was to be documented. Informed consent letters (Appendix D) were reviewed and signed by participants and the Demographic Survey (Appendix E) completed.

Although each participant was expected to sign a consent form, s/he was also asked to provide verbal consent on tape, as each interview was audio-taped, numerically coded (to ensure confidentiality), then later transcribed. The researcher posed the interview questions, and used only non-directive cues. Upon completion of the interviews, the audio- tapes were transcribed. Participants were encouraged to review their transcripts, and were able to request changes to ensure what they read reflected their

perspectives. Tapes were destroyed after they were transcribed. A summary of findings will be shared with all participants through their e-mail addresses.

Data Analysis

The analysis of the data was done using qualitative measures in order to learn about a particular aspect of the social world, and then, to contribute to new understandings that could be used by those in, and those effected by, the social world under scrutiny.

Interviews from a small sample size (Baum, 2000) from purposefully selected participants (Ezzy, 2002) were transcribed and each transcript was thoroughly reviewed through the use of the grounded theory approach. The method of analytic coding was used, in which data from interviews was collected, broken down, examined, compared, conceptualized, and categorized so that what was relevant would be allowed to emerge. Statements made were compared to allow phenomena that were similar to be seen and named as such. Then the phenomena so named were grouped in larger concepts in order to reduce the number of units with which to work. Such grouping constitutes what is described above as categorizing. Finally the categories were pulled together and more abstract groups of concepts or subcategories were formed. In sum, analysis of data was a result of "emerging thematic identification and interpretation" (Tuckett, 2004, p56).

Of the several ways of approaching the process of open coding, for example, line by line, paragraph by paragraph, or interview by interview transcripts compared in their entirety, the researcher utilized the approach of open coding through examining the responses of each question asked in each interview by means of combining related questions into one of three research topics, and several subtopics, which in combination,

addressed all questions asked of participants and enabled all answers to them to come under scrutiny.

For example, the first two interview questions "Based on your knowledge and experience, how would you describe the Child and Youth Care Field?" and "What do you feel are some of the positive and negative aspects of being a Child and Youth Care Practitioner?" were combined into the one research topic of 'General Role' and examined based on how child and youth care practitioners describe the child and youth care field. Some research topics, like the one concerned with description of treatment plans, were further broken into subtopics. See below for further breakdown of each of the interview questions into research topics and subtopics.

Research Questions

General Role

1. How do child and youth care practitioners describe the child and youth care field? (*interview questions 1 and 2*)

Treatment Plan Role

2. How did CYCPs describe the treatment plans including their development and data gathering process? (*interview questions 3-5*)
3. How did participants describe their role in the treatment planning process? (*interview questions 6 a-e*)
4. How did participants describe their role when implementing treatment plans? (*interview questions 7a and b*)

Perceptions of CYCPs

5. How did participants feel they were perceived by others, such as families, youth, peers, and other professionals? (*interview questions 8-10*)
6. What are some of the things CYCPs can do to effect positive changes in their roles and responsibilities and how they are perceived? (*interview question 11*)

Ethical Concerns

No personal identification in terms of name, address or place of employment were present in the thesis or subsequent presentation or publication, thus alleviating concerns that could arise over who would view information and whether this would pose any conflicts with their employer. Group findings and individual quotes provided were used, but with no identifying information. Simply, participants were sharing only their own opinions and interpretations of their issues. This topic was not one likely to cause distress; therefore, participants should have seen no harm in participating.

Limitations of the Study

As with many qualitative research projects, the number of participants always arises as an area of concern and questions may be raised as to whether a smaller sample is truly a representation of the general population. However, in attempting to draw information (hopefully from cases that are rich in content, with workers having been employed in varying types of agencies, and possessing considerable work experience), hope that this research may be transferable may be a reasonable posture . Transferability will be a reflection of commonalities in practices that are recognized and respected by others.

Another limitation is concerned with the lack of research already done on this topic. Although treatment planning has been studied, study of components of this type of planning, and of methods of contribution to its development, are quite limited in the literature.

Advancing both a collective approach to treatment planning, as well as, a recognition that input into treatment planning benefits all involved in a child's welfare, including the child, is a goal. However, although child and youth care has come a long way in terms of expectations that people hold towards this discipline, this research will only provide a contribution to, but not complete, the task of ensuring that growth of the profession, and of the children and youth in the charge of those working in it, are best served.

CHAPTER IV

RESULTS

The results section consists of findings that emerged from the qualitative analysis of the data, which resulted when participants answered the questions listed in Appendices A and B. This section will be divided into two areas. The first will examine the background/demographics of each participant, using not only their narratives but also comparative tables. Table 4-1 summarizes the demographic information on each of the participants, whereas Table 4-2 illustrates the different experiences brought forth from the participants that helped in the description of their work and role in treatment planning. The second area will review responses from these participants to each of the research questions. The research data was coded using a grounded theory, constant-comparative approach. All questions of all interviews and all statements of participants were incorporated and integrated in findings derived from consideration of the three research question topics and sub-topics.

Participants' Background

Eleven child and youth care practitioners participated in this research. Of those participants, 9 are female and 2 are male (See Table 4.1). All participants had over 5 years of experience, with a range of 5-29 and a mean of 16.6 years. Two of the participants held no direct training within a child and youth care worker type program, but held training in related fields such as human services and psychology, and all but two participants held additional training above their principal education. Beyond this data, 82% of the participants stated that they were in the process of furthering their education

beyond that which is outlined in Table 4.1, and of those individuals, one third of them were pursuing their undergrad degree in child and youth care.

There was a great deal of variation in experiences presented by the participants (See Table 4.1). The four most predominant settings that a worker had experience in were schools, group homes, day treatment and private practice. Within the school setting, 82% had experience there, followed by 64% having worked in a group home and the final two most worked in settings were day treatment and private practice with a tie of 55% of participants.

On the Demographics Form (See Appendix A), participants were also asked to highlight their involvement in the treatment planning process. Although expansion of this question is highlighted in more depth in the next section, several preliminary similarities emerged outright. The two most prevalent elements were that 100% of the participants identified using "observation" as a tool for information gathering and that every participant identified that it was his or her role or desire was to gather the child's or youth's input for goal development. Several participants expressed their involvement as 'consulting with a team of professionals' or having "discussions with the client, family, co-workers, doctor". In addition, the final emerging theme was not only to develop the plan, but also to also assess and review its effectiveness and suitability for the client.

Table 4-1: Summary of Demographic Information on Participants

Participants	Gender	Years of Experience	Training	Additional Training
1.	F	29	Certification Diploma	-Autism Intervenor
2.	F	20	Diploma	-MST Therapist (Multisystemic Therapist) -Life Skills Coach -CBT Training (Cognitive Behavioural Therapy)
3.	F	10	Diploma	-None
4.	F	23	Diploma	-Play Therapy -Trauma Assessment -Life Skills Coach
5.	F	26	Diploma	-BA in Psychology -Behaviour Analyst
6.	M	21	Diploma	-Certification in Solution Focussed Therapy -Certification in Brief Therapy -Certification in Narrative Therapy - CBT Training (Cognitive Behavioural Therapy)
7.	F	18	Diploma	-Certificate in Family Therapy
8.	F	5	Masters Degree	-NVCI (Non-violent crisis intervention)
9.	F	15	Diploma	-Crisis intervention
10.	M	11	None	-Diploma in Human Services -Diploma in Counselling -Diploma in Addictions Counselling -BA in Community Services -Suicide Intervention -CPI -Systematic Training in Effective Parenting -Sexuality for the Disabled
11.	F	5	None	-BA in Psychology

Table 4-2: Settings Child and Youth Care Practitioners have been Employed In

PARTICIPANTS	**TYPES OF SETTING WORKED IN**												
	Child Protection/Welfare	**Day Treatment**	**Group Home**	**Hospital**	**In-Home Consultation**	**Mental Health Agency**	**Private Practice**	**Residential Treatment**	**School**	**Sexual Abuse Treatment Program**	**Shelter**	**Social Services Department**	**Social Rehabilitation for Psychiatric Adults**
1.	✓		✓				✓	✓	✓				
2.		✓	✓	✓	✓				✓				
3.		✓			✓		✓		✓				
4.		✓	✓		✓		✓		✓		✓		✓
5.	✓					✓	✓			✓		✓	
6.				✓			✓		✓				
7.		✓	✓						✓				
8.		✓	✓	✓									
9.		✓	✓	✓					✓				
10.			✓				✓		✓		✓		
11.				✓									

Findings to Research Questions

General Role

<u>Research Question # 1:</u> How did participants describe the child and youth care field?

When interviewing child and youth care practitioners presented their views and perspectives based on both their knowledge and experience, on the child and youth care field. Participants' responses fell within three broad categories: client related, practice, and perceptions of the field.

With regard to client related, participants viewed children as the focus of their work. They noted that one of their main roles was to have an impact on the child rather than just follow a plan. For example, participants stated;

> "I describe the field as working with children and any kinds of personal issues that they may have"
>
> "To impact upon children through direct counselling and through manipulation of the environment"
>
> "To help them learn their skills."

Child and youth care practitioners also realized that the child does not exist in a vacuum and acknowledged the role of others and the environment when working with children. They noted the dynamic interactions that take place and the need to address these underlying issues. There is a span broader than that of a unitary child, thus interaction should encompass an ecological approach. Even if the child is not the direct recipient of service but was the one for whom efforts were expended, participants expressed the importance of examining other venues that could or are affecting the child:

"family, school, peer group."

"looking at family dynamics"

"impact upon the child … through manipulation of the environment".

The second theme that emerged took in child and youth care practitioners' perceptions of their evolving field. They noted that there was a shift in practice involving a change of focus from care to treatment. One participant stated that "the field has become … more treatment focused versus care focused." Another spoke of "looking at … dynamics … helping children with any issues … and providing counselling".

Participants described their work as a diachronic appreciation of problems coupled with diachronic application of solutions. One participant states that they have the luxury of working in a "long term mode" rather than just having to do a quick "get in and get out". Another speaks of the feedback that accrues, and the progress that can be seen, with "day to day involvement". Related themes included that the job allows child and youth care practitioners to be more current, and in the right place at the right time. Thus one participant states

> "we're able to come up with real life scenarios rather than … making an appointment and talking of how your week's been" and goes on to state that they are "able to spend a lot more time with the people in real life".

There were consistent indicators of a theme of effectiveness, related to the implications of relevance touched on in the previous paragraph. One participant terms the work an "incredibly effective mode of intervening"". Rather than being too specific, another states, child and youth care practitioners are more in a position to "cover everything", a

range, they go on to state they feel "is great" and constitutes a "nice thing about our field". Another states that the work is "not just scribed as one kind of intervention".

Significantly, participants stated that change, growth, expansion, acceptance and development were descriptors that characterized their field. For example, they stated:

> "I feel the role is not only being enhanced, but growing, and, because we're growing, we're also learning".
>
> "becoming more accepted within schools and within other facilities".

Participants also consistently noted that child and youth care work involved being part of a team and that people were always seeking their opinion. However, another worker felt that being part of a team was a negative phenomenon wherein the role of the child and youth care practitioner "is scripted by other professionals" and one in which "the (other team members) who are making the decisions are not the people who are working in the front line…(but are)…people with a different agenda".

A final theme that emerged dealt with participants' views on how they are valued and perceived. They addressed the lack of authority, lack of validation, lack of credibility, and lack of financial recognition for their profession: The use of the quasi-modal *should* in many responses implies a theme of injustice. Some participants noted that these perceptions exist both externally and within the field itself. Participant used phrase such as those that follow to describe how they feel they are perceived;

> "not being seen at the level of professionalism that…we should be seen at"
>
> "that experience…knowledge…are not seen to be where… (they) should".

> "in a group home they seem less trained and less educated (than) a child and youth yare practitioner in a hospital setting".

> "the field is hierarchical".

Related to the theme of general lack of validation is **l**ack of financial or other recognition of worth. One child and youth care worker speaks of gender and age skewing of the child and youth care practitioner work force as a consequence of low financial compensation as males generally feel compelled to work at higher-paying jobs in order to retain the status of patriarch, in terms of financial support, of a nuclear family. Age bias, they noted, was evident as older people who may need to pay mortgages cannot afford to work in the profession. Thus, as one participant states, that the clients miss out on getting "practitioners that are both male and female at different stages of their own life development so that they can bring that to the field". Another statement illustrates the theme that child and youth care practitioners are often seen in deficit, that they are "not a social worker". As well their skill set, their experience, and their knowledge are seen as less by clients and other workers than what "others of the health team profession possess". Practitioner describes

> "facilities where child and youth care practitioners are underpaid and under-acknowledged and really don't seem to get a lot of recognition".

Treatment Plan Role

<u>Research Question # 2:</u> How did participants describe treatment plans including their development and data gathering process?

The responses concerning treatment plans including their development and data gathering process reflected two major themes, that of a treatment plan as it manifests in actual document form and that of communication issues regarding what goes into a plan.

The first theme suggests that a treatment plan is a document that functions not only as a guide but also as an actual map, in that there are directions in which to aim and distances to travel as a child and youth care practitioner.

One participant called a treatment plan "the driving force where you want to go" and extended the metaphor with "you can *run* through the forest and you can hit the tree … (or)…you can *manoeuvre*…*through* the forest". Another states that "you can *move* from the information … to … (setting a goal) … (and can) …revise … if things don't continue to *follow'*. Yet another speaks to the treatment plan as a facilitator of step by step understanding and step by step remedy, a way of "sequential understanding".

The treatment plan is a foundation for the concrete exposition of ideas and the concrete setting of visible, even measurable, goals - " I think the plan helps people who are working with the youth..(it)… gives them a focus so that we're all on the same page, as opposed to individual ideas that others may have."

The idea of a treatment plan as an instrument that assists in assuring the validity of problem definition and congruency of scope and of judgement of the efficacy of treatment efforts, is related to that of a treatment plan as an enabler of consensual understanding of problem areas and of setting of goals.

Thus, the initial information is gathered and goals get set. With treatment plans, this means structuring what the focus of the plan is (where do you want to go and what are the goals), followed by what should happen (objectives in meeting those goals), and by whom (responsibilities get laid out):

> "you can *move* from the information … to … (setting a goal) … (and can) … revise … if things don't continue to *follow'*.
>
> "I think it externalizes the thinking process and by externalizing it, it

provides it with structure and organization so that you can move from the information that you have to making conclusions that are valid conclusions if not always correct. It also gives you the ability to revise those conclusions if things don't continue to follow up with what you would expect".

"a way to see where you're at and where the child is and then with the goals – seeing how they're changing and if the goals are in fact working… and then moving on from there – so reassessing and developing new goals and new strategies."

"come up with a more effective way of coping with things"

The ideas of treatment plan as enabler of assessment of where you are at, and of action to accordingly take, can also be found. As one participant states, "So if there had been concerns, issues, goals set out, the treatment plan would be like an action list of things you want to do to address some of the issues that are concerning to the clients and to yourself". Another describes a treatment plan as a document whose "function is to assess the situation, come up with needs and goals that need to be met from that assessment and then come up with the strategies". The idea of the treatment plan as an indicator of where you are at, and where you might need to go, is joined by that of a treatment plan as a record of where you were coming from as you move along. As one participant states, a treatment plan is an enabler of "seeing where you are at…(at the beginning)…a built-in base line". Another terms it a way "to find out what the client needs and what they want or what they're lacking".

Thus the treatment plan is a facilitator of step by step understanding and step by step remedy. One participant calls it a way of "sequential understanding".

In brief, a treatment plan must be what it is – flexible. The complexity of a client's life rarely accounts for a smooth journey. Often, other disruptions occur, thus

forcing the child and those involved to ‘go with the flow’, which might mean revamping the plan to its entirety or to revise certain aspects of that plan.

> ‘if a client comes…and…doesn’t feel they’re ready to make friends and instead they want to talk about why they feel so crappy, then the goal is going to change”

One participant stated that a treatment plan is “like a day to day thing”. Another stated that “sometimes the referring agent has invented a treatment plan but once I am working with a child or an adolescent they may determine their own treatment goals so it varies with the initial referring goals”. As well, the same participant states that ‘if a client comes…and…doesn’t feel they’re ready to make friends and instead they want to talk about why they feel so crappy, then the goal is going to change”.

Thus the treatment plan document is seen by child and youth care practitioners not as a static inscription in stone but rather as the start of a work in progress. There is provision in a treatment plan of a way to ensure the opportunity for, and enable extensive, follow up, according to the responses of those interviewed. Similarly, there is recognition of a need for, and an opportunity to implement, revision. One participant states “I think it externalizes the thinking process and by externalizing it, it provides it with structure and organization so that you can move from the information that you have to making conclusions that are valid conclusions if not always correct. It also gives you the ability to revise those conclusions if things don’t continue to follow up with what you would expect”. Another states that a treatment plan is “a way to see where you’re at and where the child is and then with the goals – seeing how they’re changing and if the goals are in fact working…and then moving on from there – so reassessing and developing new goals and new strategies.”

The second theme in data gathering and treatment plan development is communication. Participants felt a treatment plan is crucial role in communication because it aligns thinking and makes for a more efficient and effective plan when everyone is not only working together but also sharing and communicating their ideas.

> "I think the plan helps people who are working with the youth..(it)… gives them a focus so that we're all on the same page, as opposed to individual ideas that others may have."

It also can be seen as an agent of unification of team members. One participant stated that s/he usually "goes over his/her findings with the client to see if they're congruent with their experience …so it's like agreeing on what we've decided to target". Another participant stated "I think that the purpose is to gather with other members of a disciplinary team to put together the best possible plan". One described the building of a treatment plan as a "personal consultative process where people seek out the people they feel are going to be helpful to them". Another participant stated "we come together as a group and decide on goals and how we're going to…put them in place".

One of the most salient modes of ensuring alignment of goals and hopes, and thus effectiveness, is seen as coming through client input and the treatment plan is thus viewed as primary agent of affecting input from those whose situations and the skills to cope with and change them when required, it is set up to address. One participant states "I believe a treatment plan has to involve the person who it's for". Another responds to query about their perception of the role a treatment plan can play in assisting the client through stating " People can say 'well I want the child to be over here', well you can want what you want, but when you don't have collaboration with the client (you cannot

succeed…but when you do)…you can use your treatment plan as part of developing your alliance, and assessing the validity of your concern, assessing if (the motivation of the client) needs to shift…and who needs to participate in treatment".

In this one statement, with several parts of it echoed in statements by other participants, are the important ideas of developing an alliance between child and youth care practitioner and client, ensuring that what the child and youth care practitioner is concerned about is congruent with the needs and *concerns* of the client (i.e., validity), examination of motivation, and deciding scope of consideration and of need for change or action.

The themes of broad input through consultation with many of the workers in a setting and broad outcome through ecological rather than solely client-focussed emphases are salient in the statements of Child and Youth Care Practitioners. Participant statements that support this observation include "I meet with family, youth, teachers, to get their desired outcomes … and decide on goals … and how we are going to put them into place", "I'm the one incorporating everyone's thoughts", "kids are … involved in the treatment plan", "the child or youth is always involved, and their families", and "with everybody's input, we'll determine a plan of action". As well, one child and youth care practitioner stated that "we spend the first month in assessment phase, reviewing dynamics. Then we agree on what to target" and another, that "we discuss what we see in the child that may need to be worked on"

Another prevalent theme is the description of a treatment plan as a way to assist in mutuality and to place emphasis on effective coping skill building rather than on client deficit. One participant asserted that "one of the big aspects that I always explain to my

clients is that I'm not here solely about changing you… (but rather I'm about)… making you more effective in day to day life" and states "I've noticed that people really buy into that idea and feel less put down like they don't get the sense of 'you're doing this wrong'". Another says a treatment plan is a way to work with the prospect that "maybe we can come up with a more effective way of coping with things and that's it in a nut shell."

Not all participants paint rosy pictures. There is evidence of some restriction of scope in the setting up of a treatment plan so that one respondent felt that the scope of a treatment plan was "not (wide) to the degree that I think there should be. … It doesn't extend into the community or home setting".

As well as restriction of focus there is a varied ideas of restriction of who has input, how much input there can be, and what type of input is admissible. One child and youth care practitioner says that in the setting s/he works in, she is excluded from treatment plan formation stating, "typically, the social worker and psychiatrist… read from the notes and interactions with the child and they do the plan with the family and the child. So we're not included". In other settings, involvement can be more inclusive so that in one school setting, the plan formation results from input from "child and youth care practitioners (along with) with school personnel, although the input in this setting of the child and youth care practitioner does not receive primacy which is reserved for "primarily the teacher, and administrator". In other settings the child and youth care practitioner is included in, but names her/himself as lowest in, the pecking order, stating that the plan is a product of the "supervisor, team leader and child and youth care practitioner". Other treatment plans are more inclusive in their formation taking input

from "multidisciplinary (input from) school personnel and student services (who) could be psych staff, social worker, child and youth care practitioner, speech and language pathologists and child when appropriate, depending on age". Other settings permit a range of input voices but allow a child and youth care practitioner to have a hand, and voice, in treatment plan establishment in conjunction with "the doctor and the nurse". "In another place (the same participant) worked, it would have been the director, doctor and the school personnel". In still other settings, input to the plan is welcomed from "the family, parent and foster parent" but, in one school, the only one beside the child and youth care practitioner with an interest is "the teacher mostly".

Ideas regarding the types of information gathered vary. Some include global as well as environmental focus. Thus, referrals are accompanied, according to one participant, by material involving "global/environmental issues- social, emotional, community, environmental". As well, another participant speaks of expansion of consideration beyond the immediate present so that setting up a plan includes consideration of "history, relationships, medical info". In terms of present-focussed themes, one participant describes input as also consisting of "behavioural observations … and school-related academics". There is a theme of information being ecological, extending through genealogy, space, and time, so that, in one setting, consideration includes the "family composition, presenting problems, trauma, genetic, social economic history, how long the problem persisted , how has it persisted, how has it interfered with the child's functioning". The import of written input from licensed professionals is also a theme with submissions from psychiatrists.

Participants vary about actual sources and forms of input, for example, describing utilization of both formal and informal measures, although informal measures seem to take primacy in direct proportion to the weight allowed to the child and youth care practitioner in setting up the plan. One worker states s/he uses an "ABC format (antecedent, behaviour, consequence) … (and) …also the GOR (goal oriented recording). Another participant states s/he relies on an "informal plan… speaking with the child". Still another speaks to the use of data that is "informal… (and comprised of) observations and interactions with the family, with the peers, with teachers". In actuality observation, and reliance on what can be gleaned from it, is one of the most salient themes, with almost all participants referring to it. For only one example, one participant states "I use classroom and school yard observation". Such data may be gathered over time, with one participant stating, as one example, "in the first month I spend a lot of time with the clients".

There is a theme of relying on narratives for input, with several participants making statements about "consultations with parents, and school staff" or "information from the youth". Formal measures are usually derived from submissions by other professionals, so that there is a theme of rigour only from external sources rather than from child and youth care practitioners, such as "assessment from the psychiatrist", or "a psycho-educational assessment", and "documents from the Ontario Student Record". One participant states that s/he seeks formal assessment information from "social history, files from the Children's Aid Society, occupational assessments, any assessment that would assist me in understanding the past experiences that the child has had".

One child and youth care practitioner ‘breaks the mode’, and the theme of inverse variation between being a child and youth care practitioner and reliance on formal measures, in that s/he “use(s) measures like The “Beck Depression inventory, Beck Anxiety Inventory, The Johnson Session Rating Scale, and The Burns Manual” but states that s/he has to subjugate what has been gathered to a status of “in my background”, with declared assessment and input tools confined to “more subjective measures like “observation, narratives from the classroom teacher, narratives from family or friends, narratives from other care providers, and the narrative of the child in terms of what is going on for them”.

Research Question #3: How did participants describe their role in the treatment planning process?

Many participants saw their role in the treatment planning process as one of sharing in it. Others saw their role as more of one of taking direction from the plan as a fait acompli. One participant describes him/her self as “crucial- I gather information, I incorporate everybody’s thoughts, feelings, and desired outcomes … analyze process … and (decide) what we need to change that’s going to be do-able”. Others may not see themselves as totally indispensable, but nonetheless as highly valuable, as, for example, they “see and spend more time with the client … than others”. Nearly all felt they had much to offer when invited to the treatment planning table, for example, one would “bring … my observations and discussions I had with a client … (and) …would talk about how the unit was set up and make suggestions on how we could achieve individual goals”. Another sees him/her self in a collaborative but leading role where they “share observations with a possible hypothesis and case conceptualization … and discuss

options”. Others add unique perceptions as they “offer strategies, techniques, different ideas around what exactly is going on”. Still other participants would suggest further clarifications when they deem it needed, so that they would “assess student’s needs and request further assessment if necessary”, as well as, “identify what needs to be improved, then come up with strategies or ways to implement that change and to routinely reassess it”. One participant performs, as a source of input to the treatment plan, “a crisis assessment by finding out what the issues are” and another will “gather information to assist the psychiatrist in making an appropriate decision”. Another participant sees him/her self in a multitude of seminal roles varying from “historian (who will) gather pertinent information … (to) educator … and (finally to) secretary to produce a written paper in the end”.

A number of child and youth care practitioners felt that “gathering information” on “all areas that impact on clients … like emotional, behavioural, social, mental health functioning, familial”, or “looking at a holistic approach” was an important aspect of work they did that furthered the development of a plan of action. “For example, two workers from different backgrounds commented on the use of the “ABC model” as a tool that could guide some decision-making surrounding goal and plan development.

Those who felt they shared in the formation of treatment plans, such as described above, expressed that they accordingly felt good, satisfied, and integral for the most part. Comments about how participants feel include “satisfied (as I) get to spend a lot of time with clients “ along with “really good … integral … if it weren’t for the way I process the treatment plan, the treatment plan would be less effective or even non-existent.”

Those participants who expressed feelings that their training and expertise were recognized and valued appeared to feel that being invited, encouraged, or allowed to share derived from understandings of their worth. They saw themselves as valued by those with whom they worked, so that valuations of what they could contribute were positive:

> "awesome because I'm the clinical person"
>
> "important (as we) spend more time with clients in a natural setting"
>
> "we really have the information and we know what the set up is and the dynamics"
>
> " well-valued"
>
> "well-utilized".

Perceived competence varied in degree from high in all regards to high in merely some when it came to providing input and direction when treatment plans are being constructed. Some child and youth care practitioners felt "absolutely" capable and possessed of sufficient background:

"I think I do (have the competence through) training through school and my background in psychology and social work … and knowledge and expertise in treatment planning".

Another stated, "in terms of planning, assessing … I can do fairly well". Sometimes there was evidence of a theme of competence in one area but not in another "Somewhat-because I work in an educational setting, I focus on academics and that is not my area, but in terms of social, emotional behavioural … yes".

In spite of the positive themes of high valuation indicated above, a salient theme of discontent and high desire for changes was evident. Comments included (change is

needed because there should be a “shift to hear what the client wants as opposed to what is directed to be” and a movement to being evaluated by people who “know how to evaluate my work/practice”. Even the “title of my role, ‘care’, (was thought to be) limiting”, and other desired changes included being “given greater credence from a ‘care practice’ to a ‘professional practice’”, no longer being “told how things were going to be done”, getting “ plans that are more appropriate for the kids” and “more time with students” as well as “time to see how a process is carried out”.

The desire for changes was expressed, with varying degrees of depth and in varying directions, by those who felt that they shared in planning as well as by those who did not. One respondent expressed the opinion that changes were needed because not all provinces nor states either have or adhere to a standard practice of education or training upon hiring a worker to fulfill a child and youth practitioner’s role.

> “Being trained with the same information … consistency among delivery of service from similar settings … more sharing of information … would give a worker better understanding of what they are working with … and making a proper assessment.”

One comment involved workers having a “clearer defined theory base”, while another expanded this to state the need to have “more specific (theoretical) models to draw from” as a more professional method to guiding practice like through the use of the CBT (cognitive behavioural therapy) model.

Not surprisingly, those who were more marginalized, in that their comments expressed a theme that the treatment plan was more of a finished and final directive than a document they helped to construct felt more strongly about the need for change. .” One participant stated that s/he felt “initially helpful and positive”, s/he went on to state that “… however, I think we could be more integrated into the actual treatment planning

aspect". Another stated that s/he felt that "it would be nice if they would actually consult with us as child and youth care practitioners". Another felt that they currently experienced a fitting level of regard and a fitting role in planning but that they had been required to secure such status through arduous effort stating he/she was only "taken seriously … as a result of my pushing … and insisting".

<u>Research Question #4</u>: How did participants describe their role when implementing treatment plans?

The themes regarding the role of implementation of treatment plans by child and youth care participants broke mainly into active roles like providing input for purposes of feedback and revision, working as members or leaders of a team, and sharing in delivery and into more passive roles like taking direction from specifications in a plan or following plans as interpreted by others who monitored adherence to their vision.

In terms of input, one stated that his/her role entailed being the one who would "draw (the treatment plan) up … then present plan to the team, (and) summarize the logic and field any questions". In more dynamic and longitudinal terms, others presented what they could do in themes that portrayed their roles as changing through the life of the implementation of the plan, so that they could be "counselling … consulting … providing resources … and following up with parties to determine success".

At times, as team members, they saw themselves as general advisors to other professionals with different skill sets and different tasks, so that, some child and youth care practitioners saw themselves as unifying and clarifying forces, who ensured ideas were understood, so that they would "ensure (the) plan is specific and clear as possible … before it is implemented … meet with the team … and present the plan … get everyone to be doing the same thing" and "identifying what the treatment plan is and what the steps

are to be addressed in that plan and then identifying who can take what responsibility in what area … and what they need to be accountable for" or "gather(ing) information … review(ing) it and prioritiz(ing) …with other people what to put into place.

Others saw their role in plan implementation less in terms of clarification and more in terms of the theme that what they could and would do was more a matter of relationship and working with people than of crystallizing and ensuring adequate transmission of ideas, so that they would be "collaborative (and) offer guidance and consultation … (and would) work with youth in an individual capacity (and) help them to make sense of their struggles", or they might find themselves "strategizing with parents on how to handle the behaviours … getting the students involved in the process and talking to them about how things are working". On several occasions, responses indicated that child and youth care practitioners felt that they possessed valuable skills; that such skills could be taught and learned, and that such skills could bring about desired changes in clients. Thus, one participant stated that s/he saw the role as "making sure players have the skills and understand how to use them".

On a more negative note, some child and youth care practitioners on the other hand felt either left out ("I am advised of the situation and read up on notes from fellow child and youth care practitioners but am not given the plan because it is developed by the social worker") or without degrees of freedom to determine what they can do, other than to rigorously follow directions, to implement the plan ("the program support teacher oversees the plan so my role varies").

There is therefore a wide range of roles, expectations, and valuations of worth, both from self and from others, through implementation of treatment plans. Whatever

their contribution and in spite of constraints on it, a salient theme was one of extensive contribution to plan implementation:

> "I'm targeting what has been classified as a priority … everybody feels needs are being met" … "If the client feels their needs are being met then … I am making a valuable contribution" …
>
> "Value is determined by the client … and is met if you meet the motivation … and do it collaboratively"
>
> "We are the frontline … and we're the ones they get comfortable with"

At the same time, there is a desire for a more active, wider-ranging, and more important role in treatment plan implementation.

> "It is up to us to assess a situation … appropriately … but would still like more collaborative work done with other professionals"

Perceptions of CYCPs

<u>Research Question #5</u>: How did participants feel they were perceived by others, such as families, youth, peers, and other professionals?

The responses of participants to questions about perceptions they feel might be held, could be held, or should be held of them form varied themes. These themes break into positive ones and negative ones. Both positive and negative themes, i.e., themes of valuation and of devaluation in the perceptions felt to be held by others, vary among settings, among participants and, as well, among elements of response by a single participant.

The responses of several participants formed the theme that what they had to give was highly valued, with one stating "I get good feedback", another, that s/he feels "valued….(and that) …people seek out my opinion", and another respondent, that "I think we are highly regarded … perceived as being really good at counselling").

Positive valuation spanned settings so that “that “in a hospital setting it’s more appreciated”, and, in a treatment centre, being seen as true peers with interaction described as perceived as “collaborative … by psychiatrists, psychologists and health care professionals”.

As well there is a theme that child and youth care practitioners are seen as true advocates for the child, with one respondent stating parents feel that they are “functional … and useful…like that somebody is there to advocate for their child … palliative to them”.

Also to be found in examination of responses is a theme of positive valuation because of direct contact with clients, i.e., getting hands dirty with real contact and real-time acquaintance , so that one child and youth care practitioner states “It’s come a long way … more valued and respected …people see we are in the trenches and we do know the kids”.

As well, the theme of respect for, and recognition of training emerges. For example, one respondent states “some programs) require child and youth care worker training over a master’s degree in another profession … so I think that says a lot about the skills and training we bring”.

However, some responses were indicative of themes that were more negative. There was a theme of devaluation. Thus one participant states “(some are) seen as similar to education assistants … social worker’s assistants … and not as professionals but as warm bodies”. Another states “in school settings … we’re equated with education assistants”. The interview of one respondent led to him/her stating “at the beginning … people perceived us as high paid babysitters and didn’t understand the theory base we

came from" .. Sometimes, according to one respondent there is little change with exposure, in contrast to the previous respondent's statement that devaluation was most acute "in the beginning". Thus s/he states "(we are seen as) babysitters … (the general) perception of child and youth care practitioners is wrong and needs to be highlighted in a different way".

The themes of valuation and devaluation seemed linked with a theme of education in the replies of many participants wishing to be seen as "well educated men and women who are working with children and youth who need support … and knowledge about development" as well as "more valued and more professional with knowledge on all kinds of disorders and disabilities that children have".

In tandem with the theme of devaluation is the theme of marginalization. One respondent state s/he wished to be seen more as "part of a team … and providing… a valuable service". Other statements that indicate significant themes of marginalization include the responses ("told I 'don't have a say in this because you're the child and youth care practitioner", "in residential treatment … social workers have the final say", "at times we're 'othered' because of the lack of identity", "administration does not see our role as needing to meet as a team .. as something that is valued. There is no time for getting together with my peers and no time for clinical support", "(We're) not being given enough tools/resources to do programming for the kids, i.e., access to a computer, printer, laminator", "often (marginalized) in group homes … the downside is the child and youth care practitioners are the ones running the house which means shovelling driveways, fixing drywall, etc.", "in in-patient programs (the perception is) we just maintain (the clients)" … and finally .. "because of the high value on education, a

certificate, diploma and degree all carry different weights", "roles are marginalized in the school board because you are just meant to deal with the behaviour and not a broader based spectrum even if you have the ability to".

One respondent fits the themes of marginalization and devaluation into a singular phrase. S/he states that child and youth care practitioners are often seen, and used, as "cheap labour".

In sum, these themes of alienation and devaluation share more than negativity, they share the feeling that perceptions of child and youth care practitioners could be more accurate, could be better, and, as well, that estimates of what they do and the consequent impact could be higher, with participants stating that in a more ideal world they would wish that they be seen as more professional and that people would "take what we say and put it into practice".

Research Question #6: What are some things that child and youth care practitioners can do to effect positive changes in a) their roles and responsibilities and b) how they are perceived?

Responses to questions organized around consideration in terms of this research question yield themes of being proactive, advocating for their profession and for the rights of their clients, effecting change, taking a lead, increasing professionalism, securing recognition of the profession, securing credential when needed and respect for credential once secured. Lastly, change can be effected through uniting.

The most salient themes are the themes of being proactive and of advocacy. The child and youth care practitioner can and should be a viable and significant agent of positive change through arguing their case. There is no shortage of statements about what changes in behaviour a child and youth care practitioner can unilaterally implement that

might result in changes in his/her role. For example, the role of passive consultant, with what they have to say solely as a product of speaking only when or after spoken to, can be addressed by “speaking up more”, “showing (and) explaining their skills”, and “speaking clearly in meetings”.

As well they can and should “embrace larger roles”, “head their own campaign”, “present conferences”, “write papers”, “do assessments”, “take more of a front seat role”, “ (advocate for) a tier system… that a worker moves up from”.

There is a theme of the self as agent of raising the perceived value of his/her contributions, so that, one participant expressed that s/he would “explain our role and case conceptualizations as opposed to minimizing our work”, and another, that s/he would “publish articles … (and) … share knowledge”.

There is also a theme of recognition for the quality and level of work that child and youth care practitioners do through educating others so that these practitioners can and should “show how they work” and “share knowledge”, terming their practice based on knowledge rather than untutored belief.

Advocacy extends beyond the self to the client as the rights, and futures of CYCP and client are expressed as being linked. Several child and youth care practitioners presented the theme that one road to change was through speaking on behalf of the client, so that they would “advocate on the child’s behalf” and “speak up on behalf of kids”.

There is a theme of leadership. For example one speaks of taking leadership in the formation of treatment plans stating s/he would “develop plans and show how they

work". Another, that s/he would lead others to an appreciation of what s/he does and how it counts by "present(ing) workshops".

There are statements that speak to the theme of recognition of the credential secured and the securing of greater credential. One respondent states that s/he would ensure that Child and Youth Care Practitioners "don't lose sight of our roots and the value behind the practical application we received through college training".

Other statements yield a theme of securing greater credential in that participants would "get supervision", "be members of an association", "lobby to be credited", and "strive for higher education".

A salient theme is that of seeing education as having major, and both intrinsic and extrinsic, value ("seeking higher education", "working towards degrees", "strive for higher education", "don't assume we know it all", "consult with other disciplines", "provide supervision and consultation to one another", "get supervision", "be certified in doing more formal assessment testing to come up with concrete diagnoses or something like that rather than waiting for another agency or professional to provide those answers", "come together in a setting to advocate and educate one another", "standards need to be clearer in terms of education", and "increase level of education from college to university".

CHAPTER V

DISCUSSION

The discussion chapter is divided into two segments. The first part consists of the emerging themes and issues that were extrapolated from the study. The second section focuses on possible directions for future research and various recommendations to be considered regarding child and youth care practitioners, their concept of self, the perceptions of them held by others, and what directions they themselves see, and might be seen by others, could be important in regard to their current and possible roles in the construction and implementation of treatment plans.

Findings

The primary aim of this study was to explore how child and youth care practitioners are viewed by others, such as the clients, and by other members of treatment teams, as well as, how they may view themselves, in relation to the assessment and development of treatment processes for clients with whom they work.

Another major goal of the investigation was to explore in depth their understanding and perceptions of the treatment planning process, their knowledge of and comfort with the process, and the areas in which they feel capable or want additional training.

Several themes and patterns surfaced from the research. Some were supported by available literature and others appeared to be new areas that have not yet been widely studied and may need to be addressed in future research.

The themes that may bear, may even demand, further consideration arise through recognition and consideration of some implications of what was said in, through, and

surprisingly across, so many responses as to be almost choral, or, at least, consideration of what I have inferred from review of what was said.

There were four themes that were expressed with high frequency and reflected a degree of consistency in selection of a continuum along which to array various positions. For example 'being treated as a professional' could constitute an aspect of a continuum ('valued') and 'well respected for my knowledge of behaviour programs', a location along a continuum. These themes were often present in what was said by participants regardless of setting in which practitioners worked.

These themes, after being outlined below, will be considered from a viewpoint that there were some conditions of possibility, or even necessity, for such themes to emerge, and those of impossibility for other themes, or at least restricted possibility for alternative themes, to arise.

The four major foci that appeared consistently in cross-reading of responses to research questions will be briefly looked at below.

The first may be termed giving the client primacy of focus (Veeran, 2004; Ungar, 2005) and appears in responses that centre on feeling closer to the child than other professionals with whom the child comes in contact, having real life rather than remote access to the client, advocacy as a prime element of a child and youth care practitioners role, and having more alignment with a child's goals thus being able to work with, and for, goals which a child can live with.

The second theme is one of seeing their practice as often met with restriction, devaluation, and marginalization. Restrictions include controlled access to inputting into plan formation, a narrow range degrees of freedom regarding plan implementation

strategy, tacit and explicit devaluation, for example, being evaluated by those with no real knowledge of the work being done, and marginalization, for example, being barred from actually seeing the plan, and limited to being told 'relevant' aspects.

The third consists of expression of a high desire for changes, ranging from giving the client voice in determinations of his/her actions (from problem definition to mode of address), though being given credence as professionals practicing a profession, to constructing plans that were more appropriate, through getting more time with kids, to getting time to see processes carried out.

The fourth involves a particular view of treatment plans as being active and dynamic entities, as changeable as feedback indicates they need be.

The first theme is centered on feeling closer to the child, having real life access. Being closer enables an assumption of understanding, of having more alignment with a child's goals , that in turn permits and encourages advocacy as a prime element of a child and youth care practitioners role, working towards goals that a child can live with, will want to, and will, attain.

The feelings of closeness, of having more real life contact, are expressed in terms of what child and youth care practitioners do and do not do and what other professionals do and do not do. What other professionals do and do not do are described as matters of possibly ungrounded practice, practice which leads to unrecognized distance between them and the client, distance that is not found between a child and youth care practitioner because they "come up with real life scenarios rather than … making an appointment and talking of how your week's been" and are "able to spend a lot more time with the people

in real life". Another child and youth care practitioner speaks of actually getting a kid to come out of a car rather than discussing whether it would be appropriate to come out.

Other professionals are seen as preferring the word to the action, the intention to the effect. But is it a matter of words, preferences, and effects, or something more? In a community setting, the roles that other professionals have regarding the children falling within their purview are dual in nature more often than not. A social worker may be providing treatment for a client, or for his/her family, but the nature of the treatment relationship is always impacted by the fact that the same social worker can and must summon the forces of discipline if he/she suspects child protection matters have arisen, and, in the case of a children's' aide worker, can initiate proceedings that can rupture a home. In a school setting, the dual role of the school social worker as treatment provider but also disciplinarian is extant in their dual role as social worker and truant officer. Teachers, even when most in their in loco parentis role, are also constrained by needs for discipline and accounting, as in truancy matters. A psychologist's role in varied settings involves, to varying degrees, aspects of judgement, classification, and even diagnosis, a word which entails distance as it bears the meaning of 'dual knowledge', where the client becomes known through 'diagnosis', becomes subject to separate and 'objective' knowledge, rather than enjoined in mutual relationship. The child and youth care practitioner, on the other hand, has little power to wield, can neither rupture a home, nor summon the law as a central part of their role, and has then, an unimpeded access to relationship, to real time shared experience, to action and effect in relation to clients.

The second theme, that of practice being met with restriction, devaluation, and marginalization supports the continuation of a relationship based on a different premise

than power, power that, as just discussed, can distance clients, acting as a wedge between a worker with a dual role involving power, like a social worker, and a client. Restrictions on the power of a child and youth care practitioner, including controlled access to inputting into plan formation, a narrow range degrees of freedom regarding plan implementation strategy, tacit and explicit devaluation, for example, being evaluated by those with no real knowledge of the work being done, and marginalization, for example, being barred from actually seeing the plan, and limited to being told 'relevant' aspects, isolate the child and youth care practitioner from other professionals and encourage the balance of everyday interaction to take place with the client, and thus ensure that a Child and youth care practitioner remains close to the client and in the position to have a real life narrative-based, experiential, and suitable, rather than paper, appreciation of their clients and of their needs.

Child and youth care practitioners see their knowledge of the client, their selection of goals, and their effectivity as more 'real'; thus expressions like 'real-life contact' are used several times.

Looking at the examples of changes wanted, appearing in the third theme, desire for change, such as giving the client voice, constructing plans that were more appropriate, getting more time with kids, to getting time to see processes carried out, suggests that the same underlying condition of possibility, that of power exerted upon clients as quite possibly the case when other workers were involved, rather than the case being, in large part, treating clients when child and youth care practitioners were the workers, appears to exist. Top-down unilateral decisions disempower those who are the passive recipients, and then the subject, of them. Statements then get made like "I believe a treatment plan

has to involve the person who it's for" and " People can say 'well I want the child to be over here', well you can want what you want, but when you don't have collaboration with the client…" and "assessing… who needs to participate in treatment".

The lack of power as a barrier between child and youth care practitioner and client constitutes a prime condition of possibility for the theme that the work then consists of developing an alliance (Hubble, Duncan, & Miller, 1999; Safran & Muran, 2000; Seita & Brendtro, 2002) between child and youth care practitioner and client, ensuring that what the child and youth care practitioner is concerned about is congruent with the needs and concerns of the client.

There are other power relations between workers in the more 'stringent' of the professions, like social work and psychology, and those who work as child and youth care practitioners, that act to distance these workers from other workers and ally them more with clients. The child and youth care practitioners are presumed to not have extensive or deep theoretical bases to their training, a perception that some practitioners address through continuing independent pursuit of coursework and skills training. Whether further training is pursued or not, workers are not presumed to be able to understand uninterrupted psychology reports, in my board, or be able to grasp, let alone wield, terms like 'borderline'. They thus are denied access to information and have therefore little place for input into decision making, on the basis of little 'approved', i.e., theoretical, rather than experiential, knowledge.

At times, this setting up of barriers comes from child and youth care practitioners as well. One of the most frequent themes, occurring in almost every interview transcript, was the theme that such valuations, or, perhaps more accurately, devaluations, are made

by the child and youth care practitioners themselves, and perceived as made by others as a function of lack of educational attainment. Valuation and devaluation seemed linked with education. Devaluation, estrangement, and alienation go hand in hand with themes of marginalization that come up in responses.

There is a definite power relationship, between those given, and those marginalized and thus denied, access to information, and freedom to effect and implement decisions. The child and youth care practitioner remains close to the client, close to the reality, and the treatment plan remains close to its makers, and thus far from where it needs to be.

The fourth theme appears to involve a particular view of treatment plans as being active and dynamic entities, as changeable as feedback indicates they need be.

However, this theme entails the belief that treatment plans are active and dynamic i.e. subject to change because they are necessarily so as they are either inaccurate being composed by those who know the child least and least know what would then be best (Metselaar, Knorth, Noom, Yperen, and Konijn, 2004; Phelan, 2004; Krueger, 1990).

A treatment plan that would suit the needs and interests of the client must fit the client (Berman, 1996; Krueger, 2005) and in order to do so, would need to be based on real time knowledge of the client. Such knowledge can be accessed through utilization of both formal and informal measures, with informal measures taking primacy when child and youth care practitioner input is allowed in setting up the plan. Observation, and reliance on what can be gleaned from it, is one of the most salient themes, with almost all participants referring to it. As well, there is the theme of relying on narratives for input.

When formal measures do come into play, they are usually derived from submissions by other professionals, so that there is a theme of rigour only from external sources rather than from child and youth care practitioners, such as “assessment from the psychiatrist”, or “a psycho-educational assessment”, and “documents from the Ontario Student Record”.

It is when the child and youth care practitioner, with, as they constantly expressed, their claiming of more real time knowledge of the child, knowledge bolstered by narrative and observation, is denied input; when planning is based on formal assessments, that treatment plans will require swift revision, and swifter account of feedback, as to what is and is not working.

In sum, what emerges from looking at the themes expressed by child and youth care practitioners, and then, at some reasons why these themes are prevalent, suggests that there is a great deal of knowledge of the client, and a great deal of ability to advocate for, and effect, what a client may really need and want, that results from the existence of power issues that separate other workers from the client (issues like truancy-enforcement roles), power issues that separate other workers from the child and youth care practitioner (issues such as rights to information), and structural marginalization, (like denial of input to treatment plans where it occurs). It is important to note, that these issues emerge from professionals with high and varied levels of experience and it would be interesting to note if any discrepancies in opinions would surface from professionals with less experience, for future research. However, such issues allow a different relationship to form with a client, one of closeness, and of advocacy in the client’s voice, that might not be in place for the client should child and youth care practitioners ‘gain’ the recognition, the

professional status, and access to the setting up of paper documents that, some of those interviewed claimed to want, if recognition comes with imbrication in relationships of power that drive a wedge between client and child and youth care practitioner.

Implications/Recommendations

Future Research

1. A possible concern with the current methodology, as is often the case with qualitative research, is the small sample size. Follow-up studies should look to replicate this study or funding should be sought for a large study.
2. Another suggestion that arises falls within the question of examining the perceptions of families, children, youth, peers, and other professionals towards the child and youth care profession. This question might look to encompass those 'other' individuals as opposed to asking solely the workers themselves to determine what perceptions people hold towards their profession, as opposed to considering those that are receiving service thus would have a better understanding, and to see whether perceptions are mirrored or differ in any way. Also, by asking individuals that are not connected to service, this might give a clearer picture of the true understanding and development of the field in its recognition, or lack there of.
3. Different methods could be used such as surveys, to reach more participants, as solely conducting interviews is restraining when factoring in accessibility to participants and coordinating time for interviews.
4. Future research could be broader in scope. More participants could be interviewed and the actual interview could provide participants with an

opportunity to explore treatment plans, procedures, and process indepth from multiple viewpoints.

5. Future research could be broader in scope also by omitting a 'minimum years of employment in the field', to determine whether responses will vary in interpretation of workers' roles and experiences and perceptions by others of their practice.
6. Researchers could obtain permission to be observers during treatment planning meetings, obviously respecting the confidentiality of participants and reporting only on the process. Such observations by an unbiased third party could provide insight into the procedures, roles, communications, interactions and other relevant aspects of the treatment planning process.
7. Future studies might look to conduct a document study to examine different treatment plans from different institutions, then compare and look for similarities/differences, which might then come up with a universal document.
8. Follow-up studies should look to have participants who are presently employed in group homes, as the participants of this study reflected on what it 'was like' while working in this type of setting and it would be helpful to know if this perception of marginalization still occurs to the depths it was perceived at in previous years.
9. Future studies should look to examine treatment plans in urban/rural settings as access to services/professionals varies

Clients

1. Examine role of others in treatment plans

2. Interview others regarding input into treatment plans and implementation
3. Interview child and youth care practitioners on the idea of a child-centred approach.

Child and Youth Care Practitioners

1. Call on child and youth care practitioners to be more reflective on their practice.
2. Encourage child and youth care practitioners to be more proactive - advocate, promote profession, become empowered
3. Note the importance of mentoring /sharing/support groups.
4. Need for ongoing professional development.
5. Child and youth care practitioners need to organize to gain recognition as a profession.

Policy and Planning

1. Need to define role/responsibilities/standards of practice.
2. Work with government and training institutes to advise on how to prepare people for child and youth care work.
3. Work toward developing national standards and credentials
4. Look at the need to invest more funding into supporting children/youth in crisis - current wages unacceptable - think of future and the impact of a lack of services and qualified professionals.
5. Develop "Best Practice Guidelines" for the child and youth care profession.

References

Alessi, N. E. (1993). Hope for the helpers: Beyond Therapeutic Nihilism. *Reclaiming Children and Youth*, *2*(2), 39-41.

Barnes, F. H. & Kelman, S. M. (1974). From slogans to concepts: A basis for change in child care work. *Child Care Quarterly 3*(1), 7-23.

Baum, F. (2000). *The new public health*. Oxford: Oxford University Press.

Beale, B., Cole, R., Hillege, S., and McMaster, R. (2004). Impact of in-depth interviews on the interviewer: Roller coaster ride. *Nursing and Health Sciences 6*, 141-147.

Beker, J. (2001). By way of thanks for warm recognition: Some personal and professional reflections on the field and its prospects for the future. *Child & Youth Care Forum*, *30* (6), 325-330.

Beker, J. (2001). Development of a professional identity for the child care worker. *Child & Youth Care Forum*, *30*(6), 345-354

Beker, J. (2001). The emergence of clinical youthwork as a profession: Implications for the youthwork field. *Child & Youth Care Forum*, *30* (6), 363-376.

Beker, J. (2001). Toward the unification of the child care field as a profession. *Child & Youth Care Forum*, *30* (6), 355-362.

Beker, J. and Maier, H. W. (2001). Emerging issues in child and youth care education: A platform for planning. *Child & Youth Care Forum*, *30* (6), 377-386.

Berman, P. (1996). If we are the good guys, why do we feel so bad? *Reclaiming Children and Youth*. *5*(2), 108-109.

Berger, P. L. and Luckmann, T. (1967). *Social construction of reality: A treatise in the sociology of knowledge*. University of Frankfurt.

Blumer, H. (1969). *Symbolic interactionism: Perspectives and methods*. Englewoods Cliffs, NJ Prentice Hall.

Browning, C. (1999). The child care worker: A vital member of the team. *CYC-Online, 7*. Retrieved October 24, 2003, from http://www.cyc-net.org/cyc-online/cycol-0899-teammember.html

Cavaliere, G. (2004). Cream city dreams: Reflections on professionalization of child and youth care workers in the U.S.. *Child & Youth Care Forum, 33*(6), 375-378.

Christiansen, M. (1996). We need a new profession—not just an upgraded direct care

worker: A response to Shealy. *Child & Youth Care Forum*, *25*(5), 305-309.

Clarke, L. (2004). The value of qualitative research. *Nursing Standard*, *18*(52), 41-44.

Eisikovits, Z. and Beker, J. (2001). Beyond professionalism: The child and youth care worker as craftsman. *Child & Youth Carer Forum*, *30*(6), 415-434.

Ezzy, D. (2002). *Qualitative analysis: Practice and innovation*. Crows Nest, New South Wales: Allen and Unwin.

Fewster, G. (2005). Free for a moment. *Relational Child & Youth Care Practice, 18*(1), 3-6.

Frankel, R. M. & Devers, K. J. (2002). *Study design in qualitative research: Developing questions and assessing resource needs*. Education for Health, *13*(2), 251-261.

Gannon, B. (1994) *Theories, approaches and principles of education and treatment*. Pretoria: University of South Africa, 64-66.

Gannon, B. (2001) Engaging with youth—making it happen. *CYC-Online*, 33. Retrieved October 24, 2003, from http://www.cyc-net.org/cyc-online/cycol-1001-engaging.html

Gaughan, P. & Gharabaghi, K. (1999) The prospects and dilemmas of child and youth work as a professional discipline. *Journal of Child and Youth Care*.13 (1), 3-5.

Glesne, C. (1999). *Becoming qualitative researchers.* New York, NY: Longman.

Gregory, D., Way, C., Hutchinson, T., Barrett, B., and Parfrey, P. (1998). Patients' Perceptions of their experiences with ESRD and hemodialysis treatment. *Qualitative Health Research*, *8*, 764-783.

Griff, M. (1993). Activity programming in the milieu setting: Commonalities in work with children and older adults. *Journal of Child and Youth Care,* 9(1), 11-18.

Guindon, M. H. (2002). Toward accountability in the use of the self-esteem construct. *Journal of Counselling and Development*, *80*, 204-214.

Harper, P. (1986) Principles of case management. *The Child Care Worker*, *4*(10), 5-8.

Hubble, M., Duncan, B., & Miller, S. (1999). The heart and soul of change. Washington, DC: American Psychological Association.

Krueger, M. (1990) Child and Youth Care Organizations. In Krueger, M & Powell, N. (Eds.) *Choices in Caring*. Washington: CWLA. 9-11.

Linton, T.E & Forster, M. (1988). The child and youth care workers: Who needs them?

The Journal of Child and Youth Care, 3(4), 1-10.

Lochhead, A. (2001). Reflecting on professionalization in child and youth care. *Child & Youth Care Forum*, *30*(2), 73-82.

Mann-Feder, V. R. (2003). Relatedness and control. *Relational Child and Youth Care Practice. 16*(3), 13-14.

Metselaar, J., Knorth, E. J., Noom, M. J., Van Yperen, T. A., and Konijn, C. (2004). Treatment planning for residential and non-residential care: A study on indication-for-treatment statements as input to the care process. *Child and Youth Care Forum*, *33*(3), 151-173.

Ministry of Training, Colleges and Universities (2000). *Child and youth worker program standard*. Toronto, ON: Ontario Ministry of Training, Colleges and Universities,

Modlin, H. (2005). Reading for child and youth care people. *CYC-Online,* 75. Retrieved December 6, 2005, from http://www.cyc-net.org/cyc-online/cycol-0405-modlin.html

Moustakas, C. (1994). *Phenomenological research methods.* Thousand Oaks, CA: Sage.

Neugerbauer, R.(1992). 12 reasons people love to work for you. *The Child and Youth Care Administrator*. *4*(2), 16-18.

Norcini, J.J., & Shea, J.A. (1997). The credibility and comparability of standards. *Applied Measurement in Education*, *10*(1), 39-59.

Osler, W. 1906 *Aequanimitas*. London: H. K. Lewis as cited in Stein, Howard, 1985 *The Psychodynamics of Medical Practice: Unconscious factors in Patient Care.* Berkeley, Los Angeles, London: University of California Press.

Phelan, J. (2003), Language and professional credibility. *CYC-Online*, *59*. Retrieved May 11, 2005, from http://www.cyc-net.org/cyc-online/cycol-1203-phelan.html

Phelan, J. (2004). The treatment plan. *CYC-Online*, *60*. Retrieved May 11, 2005, from http://www.cyc-net.org//cyc-online/cycol-0104-phelan.html

Ricks, F. & Charlesworth, J.(1982) Role and Function of Child Care Workers. *Journal of Child Care, 1*(1), 40-42.

Rose, L. (2001). On being a child and youth care worker. *CYC-Online, 27*. Retrieved October 24, 2003, from http://www.cyc-net.org/cyc-online/cycol-0401-rose.html

Roush, D. W. (1996). Desktop guide to good juvenile detention practice. US: National Juvenile Detention Association.

Safran, J., & Muran, 1. (2000). Negotiating the therapeutic alliance. New York: Guilford Press.

Samjee, Makan, Pierre, Myeza & MacKay (1999). Child Care Workers tell it like it is: What child care administrators need to know about work on the front line. *CYC- Online*, *7*. Retrieved October 24, 2004, from http://www.cyc-net.org//cyc-online/cycol-0899-admin.html

Schneider-Munoz, A. J. and Beker, J. (2002). Revisiting a classic, and one of our founding fathers. *Child & Youth Care Forum*, *31*(1), 45-60.

Seita, J., & Brendtro, L. (2002). Kids who outwit adults. Longmont, CC: Sopris West

Stein, H. (1985) *The Psychodynamics of medical practice: Unconscious factors in patient care.* Los Angeles: University of California Press.

Strauss,A. and Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory(2nd ed.).* Thousand Oaks, CA. Sage Publications.

Stuck, E.N. (1994). The future of child and youth care as a profession: Assessing administrator attitudes. *The Child and Youth Care Administrator, 5*(2), 13-17.

Thomas, D.C. (2004) Honoring our own: Mark Krueger, Tony Maciocia, Varda Mann-Feder, Karen Vanderven. *Journal of Child and Youth Care Work, 19*, 9-12.

Tucker, S., Strange, C., Cordeaux, C., Moules, T., and Torrance, N. (1999). Developing an interdisciplinary framework for the education and training of those working with children and young people. *Journal of Interprofessional Care*, *13*(3), 261-270.

Tuckett, A. (2004). Qualitative research sampling: The very real complexities. *Nurse Researcher*, *12*(1), 47-61.

Ungar,M. (2005). Resilience among children in child welfare, corrections, mental Health and educational settings: Recommendations for service. *Child and Youth Care Forum, 3*(6), 445-464.

VanderVen, K. (1991). Residential care, education and treatment in the United States. In M. Gottesman (Ed.), *Residential care: An international reader* (pp. 289—290). London: Whiting & Birch.

VanderVen, K. (2002). A gentle cosmopolitan leader affirms the future: The legacy of Meir Gottesmann. *Child & Youth Care Forum*, *31*(3), 183-190.

Veeran, V. (2004). Working with street children: A child-centred approach. *Child Care in*

Practice, 10(4), 359-366.

Verheij, F (2002). Working with the families of children in care. *International Journal of Child and Family Welfare*, *5*(4), 198-199.

Vishnevsky, T. and Beanlands, H. (2004). Interpreting research in nephrology nursing. *Nephrology Nursing, 31*(2), 234-238.

Yalom, I. (2002). *The gift of therapy: An open letter to a new generation of therapists and their patients, lying on the couch.* HarperCollins: New York.

Appendix A

Demographics of Participants

1. Gender: Male ☐ Female ☐

2. Number of years as a child and youth care practitioner: __________

3. What level of training do you hold within the CYC profession?
   Certification
   Diploma
   Degree(s):
   Other:

4. Do you possess any other training? If yes, explain

   ____

   ____

   ____

   ____

5. Titles held under the CYC paradigm:
   Child & Youth Counsellor ☐
   Child & Youth Worker ☐
   Child Care Worker ☐
   Youth Worker ☐
   Other(s):

   ____

   ____

   ____

   ____

6. Indicate the type(s) of agencies you have worked for:

   Day treatment ☐

- Group Home ☐
- Hospital ☐
- Private Practice ☐
- School ☐
- Shelter ☐
- Other(s):

____

____

____

____

7. Have you been involved in treatment planning? If yes, explain your involvement

____

____

____

____

Appendix B

Interview Questions

General Role

1. Based on your knowledge and experience, how would you describe the child and youth care (CYC) field?

2. What do you feel are some of the positive and negative aspects of being a child and youth care practitioner?

Treatment Plan Role

3. Describe the function of a treatment plan.

4. Is there a treatment planning process in place where you work?
    a. If yes, tell me about it.
    b. If no, how are plans typically developed where you are employed? (if necessary question whether their planning process includes meetings, assessment, use of a team, follow-up)

5.
    a. Who is responsible for developing the treatment plan where you work? Who is involved?
    b. What types of information is gathered and shared in developing the plan?
    c. Tell me about any formal or informal measures you use to assist in developing the treatment plan.

6.
    a. Tell me about your role in the development of the treatment plan.
    b. How do you feel about your role in the treatment planning process?
    c. Are there things you would like to change about your role in treatment? If yes, in what way?
    d. Do you feel you possess the knowledge and expertise to develop a treatment plan for your clients? Explain.
    e. What specific practices of treatment development can we draw upon to develop some commonalities across the CYC field?

7.
    a. Please share with me your role in implementing the treatment plan.
    b. Do you feel you make a valuable contribution towards the implementation of a client's treatment plan?

Perceptions of CYCPs

8. In your opinion, how do other professionals, families, youth and peers perceive CYCPs?

9. How do you feel CYCPs would like to be perceived?

10. In working as a child and youth care practitioner, have you experienced any marginalization? Explain your answer.

11. What are some things that CYCPs can do to effect positive changes in …
    a. their roles and responsibilities?
    b. how are they perceived?

Appendix C

Notice

Dear Child and Youth Care Practitioner,

My name is Gail Kissoon and I am a student enrolled in the Master of Arts (Child & Youth Study) program at Mount Saint Vincent University. As part of my Masters program, I am conducting research that explores the role and involvement of child and youth care practitioners in the treatment planning process for clients with whom they work. Information gathered during this study could inform current practice and be used to advocate for the greater involvement of child and youth care professionals in the treatment planning process.

I am requesting your participation in this research project. If you: 1) have worked at least 5 years as a child and youth care practitioner, and 2) have been exposed to the treatment planning process then you are eligible to participate.

Participants will be required to take part in a one-on-one interview dealing with their perceptions of the treatment planning process and their roles/responsibilities during and after this process. The interview should take approximately 40-60 minutes and will be audio-taped. Interviews will take place at a time and place that is convenient for you. Prior to the interview, you will be asked to complete a short demographic questionnaire to gather information on participants' gender, experience, and training and to sign an Informed Consent Form to ensure you are aware of your rights during the research process. A summary of the research findings will be shared with participants through their e-mail addresses after the thesis is completed.

Should you meet these requirements and be interested in participating in this study please contact me at [redacted] or ([redacted] Should you have any questions, comments or concerns about this study, please contact me or my thesis supervisor, Dr. Carmel French at (902) 457-6187 or carmel.french@msvu.ca. This research has met the ethical standards of the University Research Ethics Board at Mount Saint Vincent University. If you wish to speak with someone not directly involved with this study you may contact the University Research Ethics Board by phone at (902) 457-6350 or by email at research @msvu.ca.

Sincerely,
Gail Kissoon

Appendix D

Letter to Participants

(Letterhead)

Dear Child and Youth Care Practitioner,

Thank you for responding to my email and for your interest in participating in this research that explores the role of child and youth care practitioners in the treatment planning process. As previously mentioned, my name is Gail Kissoon and I am a graduate student enrolled in the Master of Arts (Child & Youth Study) program at Mount Saint Vincent University in Halifax, Nova Scotia. Information gathered during this study could inform current practice and be used to advocate for the greater involvement of child and youth care professionals in the treatment planning process.

You are being asked to participate in a one-on-one interview dealing with your perceptions of the treatment planning process and your roles/responsibilities during and after this process. The interview should take approximately 40-60 minutes and will be audio-taped. Interviews will take place at a time and place that is convenient for you (or via telephone at an appropriate time depending on the distance). Prior to the interview, you will be asked to complete a short demographic questionnaire to gather information on participants' gender, experience, and training and to sign an Informed Consent Form to ensure you are aware of your rights during the research process.

Please understand that participation in this study is completely voluntary, and you may decline to participate or withdraw at any time, without penalty. You may skip or decline to respond to any questions that you are uncomfortable answering. All information obtained in this study will be kept strictly confidential and not influence your employment status. The surveys and interviews will be numerically coded and destroyed after they have been transcribed. Once the transcription is complete, it will be e-mailed to you and you will have the opportunity to review it to determine if it reflects your perceptions and to suggest changes if necessary. All data will be stored in a locked file cabinet in the researchers office and electronic files will be password protected.

The results of this study will be presented as group data and no individual participants will be identified. Quotes from the interviews will be used in the thesis and may be used in future publications and presentations to illustrate themes arising from the data, however no name or identifying information will be reported. A summary of the research findings will be shared with participants through their e-mail addresses when the thesis is completed.

If you are still interested in participating, please let me know times and places you can meet for the interview (or appropriate times and dates, a telephone interview can be

conducted, because of the distance). This way a mutually convenient arrangement for the interview can be made. If you are more comfortable discussing the times and place for the interview, you can provide a contact phone number or call me at the phone number provided.

Should you have any questions, comments or concerns about this study, please contact me at (or or my thesis supervisor, Dr. Carmel French at (902) 457-6187 or carmel.french@msvu.ca. This research has met the ethical standards of the University Research Ethics Board at Mount Saint Vincent University. If you wish to speak with someone not directly involved with this study you may contact the University Research Ethics Board by phone at (902) 457-6350 or by email at research @msvu.ca.

Sincerely,

Gail Kissoon
Student, MA candidate

Dr. Carmel French
Associate Professor

Appendix E

Letter of Informed Consent

Letterhead

I, ___________________________________, am willing to participate in a study entitled "The Role of Child and Youth Care Practitioners in the Treatment Planning Process". This study is being carried out by Gail Kissoon as part of the requirements for her Master of Arts (Child and Youth Study) degree at Mount saint Vincent University in Halifax, Nova Scotia. Information gathered during this study could inform current practice and be used to advocate for the greater involvement of child and youth care professionals in the treatment planning process.

I have been informed that my time commitment for the individual interview will be approximately one hour. I am aware that the interview will be audio-taped and that once the interview has been transcribed it will be e-mailed to me and I can review it and suggest modifications. I have also been informed that all tapes will be destroyed after they are transcribed and that data will be stored in a locked file cabinet in the researchers office and electronic files password protected.

I understand that my participation in this research is entirely voluntary and that I can withdraw at any time without consequence. I understand that all information obtained in this study is confidential and that no participant will be identified.

I am aware that tapes will be coded to maintain anonymity. I also understand that quotes from interviews will be used in the thesis and future publications and presentations to illustrate themes arising from the data. However, no identifying information will be reported and my identity will not be revealed in any way.

I am aware that a copy of the research findings will be e-mailed to me when the thesis is completed.

If I have any questions, I can freely direct them to Gail Kissoon, student researcher, at [redacted] or [redacted] or to Dr. Carmel French, thesis supervisor, at (902) 457-6187 or carmel.french@msvu.ca. However if I wish to speak with someone not directly involved with this study I may contact the University Research Ethics Board by phone at (902) 457-6350 or by email at research @msvu.ca.

I have read the information provided above. I understand that by signing below that I am agreeing to participate in this research study and have received a copy of this consent form.

Name: ____

(please print)

Participant's Signature:____

Participant's E-mail Address ____________________________________

Date: ____

Researcher's Signature: _______________________________________