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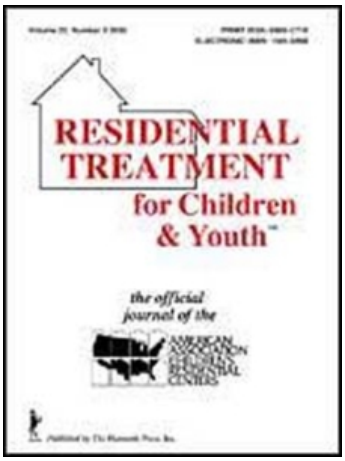

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Private Service, Public Rights: The Private Children's Residential Group Care Sector in Ontario, Canada

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Private Service, Public Rights: The Private Children's Residential Group Care Sector in Ontario, Canada

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This article explores the core themes and issues of private residential service delivery for children and youth in Ontario, with a specific focus on staffed group care within this sector. Such exploration highlights the juxtaposition of the public rights of children with the private world of service provision. Based on twenty interviews with owners of private residential care facilities and an examination of government and professional writing and reports about residential care in Ontario, there is no obvious reason to dismiss or be critical of private residential care. However, both private and public residential care in Ontario are under-regulated, resulting in significant variations in terms of organizational structures, the quality of staffing and training, accountability and transparency, and ultimately, the efficacy of specific residential services.

KEYWORDS residential care, group homes, private children's services, regulation and licensing, child welfare, children's mental health, professional association, accreditation of children's services

This article explores the core themes and issues of private residential service delivery for children and youth in Ontario, with a specific focus on staffed group care within this sector. Such exploration highlights the juxtaposition of the public rights of children with the private world of service provision. The private residential sector has grown steadily over the past 20 years; however, it is now experiencing some major challenges, which are driven

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by changes to the child welfare system that provides virtually all placements and, therefore, all funds for this sector. These challenges are also driven by an often negative public and professional perception about how this sector operates, its motivation for providing services, and its competence within an evolving culture of evidence based practice and outcome-driven program funding and evaluation standards. In some cases, questions about the integrity and the ethical standards within this sector have also been raised, exacerbated by significant incidents, including at least two client deaths, over the past few years.

Ontario is Canada's most populous province with just over 11 million residents. The province's child protection system is regulated by the Ministry of Children and Youth Services, and implemented by 53 Children's Aid Societies mandated through the *Ontario Child and Family Services Act*. Children and youth brought into state care as a result of protection issues are placed by Children's Aid Societies in a range of residential care placements. Historically, options for residential care were limited to faith based orphanages and in some cases, private family homes associated with the church (Rock, 2005). Over the course of the twentieth century, residential care options became secularized and publicly funded, so that particularly in the second half of the twentieth century, children and youth in state care were typically placed in either foster homes operated and regulated by the Children's Aid Societies or in residential treatment programs. The need for more institutional and professionally staffed placements in Ontario gave rise to a rapid expansion of private residential operators throughout the 1980s and 1990s, and by the end of the twentieth century, about 14% of the children's residential care system was operated by private sector enterprises. Today there are approximately 30,000 children and youth in state care in Ontario, and an estimated 4,000 live in privately operated foster homes or group homes. Well over 50% of children and youth placed in staffed group care are so placed within the private sector (Ontario Association of Residences Treating Youth [OARTY], 2008).

The analysis is set against a socio-political and cultural context of a country that holds public services as a core value. Unlike in the United States, on-going debates about privatization of health care systems, for example, have consistently been resolved in favor of maintaining and even investing in the public system instead of turning to the private sector in the hopes of achieving greater efficiencies. In the children's services sector, on the other hand, public debate has been limited and private services have been proliferating rapidly. Within the child welfare system specifically, the only functions that continue to unfold within the exclusive realm of the public sector are those related to child protection investigations and related court proceedings. Caring for children in the care of the state, on the other hand, has quietly but to a significant degree moved into the private sector.

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OBJECTIVES AND METHODOLOGY

The objectives of this article are to gain a better understanding of the core themes and issues entailed in private sector residential care. Specifically, the focus of the analysis reflects two themes. First, the sector is examined in relation to ethics, transparency and accountability. Second, the analysis seeks to deconstruct the organizational structures of private sector operators in order to determine the degree to which this sector has developed a solid foundation for the provision of residential care for children and youth in state care.

To this end, the research unfolded in two stages. First, a review of secondary material was undertaken with a focus on government policies and regulations with respect to children's residential care, as well as a review of residential service system models through academic and professional analyses. Second, interviews were conducted with owners/operators of private residential service providers. While the interviewees were primarily owners and operators of these services, many of the interviews also included senior management personnel in the areas of human resources and financial services. Collectively, a total of 20 private residential operators were interviewed representing nearly 600 beds, 800 staff, and 97 program sites.

The interviews included three separate foci. First, interviewees were asked about their perceptions of the state of children's residential services in Ontario, and the role of private sector initiative within these services. Second, interviewees were asked to specify mechanisms for accountability, transparency, and ethics within their services. And finally, interviewees were asked a series of questions about their organizational structures and processes.

Some of the major themes from government documents and the literature with respect to residential services for children in Ontario are outlined in the following sections. This will be followed by a summary of the core patterns and themes from the interviews. The last section of the article provides some discussion and analysis of private sector initiative in children's residential services, and particularly in staffed group care, in Ontario.

PUBLIC SECTOR AND ACADEMIC APPROACHES TO RESIDENTIAL CARE

The literature on residential care is rich and very extensive, and covers myriad geographic contexts, including North America, Israel, South Africa, Australia, and the United Kingdom. Over the course of the past 50 years, academics have produced studies about specific residential care programs, best practices within residential care, and outcome studies seeking to produce evidence for program effectiveness. Classic works such as those by Bettelheim (1974), Trieschman, Whittaker, and Bendtro (1969), and Maier (1987) are complemented by more recent literature (Anglin, 2004; Becker and Eisikovits, 1991;

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Beedell, 2007; Durrant, 1993; Kendrick, 2008; Krueger, 1998; Milligan & Stevens, 2006; Northrup, 1994). In addition to the more common focus on the work that unfolds within residential care, some literature also covers its organizational and administrative features (Arieli, 1997; Bertolino & Thomson, 1999; France, 1993; Hicks, 2007).

Literature on residential care generally covers a number of core themes, which include the centrality of relationships (Anglin, 2004; Garfat, 2008; Gharabaghi, 2005), the importance of creativity and child-centered program planning (VanderVen, 2003), issues related to the developmental process of children and youth (Maier, 1987), and in some instances, issues related to the development and growth of the residential child and youth care practitioner (Stuart & Sanders, 2008). What is generally less covered is the context in which residential care is being delivered, and notably the distinction between public and private residential service delivery.

Within professional circles, and particularly within government ministries, the focus of discussion and contemplation has been more on the context of service delivery than on the substance of how services are most effectively delivered (Lyons, 2004; Whittaker, 2000). From the governmental perspective, the core issues to be considered relate to economic efficiencies in relation to outcomes and public accountability and transparency. In Ontario, residential care has generally been under attack for the past five to eight years (Bay Consulting, 2006; Finlay, 2007). Most recently, considerable attention has been on what appear to be lackluster outcomes of all forms of out-of-home placements, and particularly of all types of institutional placements, including group homes, residential treatment centers, and custody facilities. As a result, the Ministry responsible for all of these services has announced its intention to reduce the use of residential care significantly over the coming years, affecting all sectors. Particular emphasis is currently being placed on staffed group care, which is seen as especially ineffective, counter to the values related to family-based care, and comparatively very, very expensive (Bay Consulting; Ministry of Children and Youth Services [MCYS], 2007).

One of the key steps in the government's approach to reducing residential group care has been a comprehensive review of all residential services in the province. This review provided, for the first time, a clear picture of the relative size and scope of private residential care in the province; as such, it has created a starting point for considering the role of the private sector within residential service delivery for children and youth in a more systematic manner (Bay Consulting, 2006).

RULES AND REGULATIONS FOR PRIVATE RESIDENTIAL CARE

The private residential care sector includes both for profit and not for profit organizations that operate group care and foster care placements for children

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and youth. Based on data from the residential services review carried out by the Ministry of Children and Youth Services, Stuart & Sanders (2008) estimated that there are 90 private enterprises operating staffed residential group care programs in Ontario. Whereas some of these private enterprises might only operate a single program, others might operate as many as eight or ten, and in one case fourteen individual programs. It is likely, therefore, that there are over 300 staffed residential programs operated within the private sector in Ontario with a combined bed capacity of nearly 2000 (Bay Consulting, 2006; Stuart & Saunders, 2008). Private enterprises operate both fully staffed group homes and staff supported foster care, and several operate parent model group homes. About a third of these enterprises also operate traditional foster care that is very similar to the internal foster care resource held by the public Children's Aid Societies (CASs) (OARTY, 2008).

Private enterprises (PEs) receive no direct government funding. Virtually all of their income is derived from per diem placements from within the Child Welfare system. In some cases, PEs specialize in services to children and youth with developmental challenges, and these agencies receive per diem placements both from the Child Welfare system as well as the Developmental Services system. In a few cases, PEs are involved in residential youth justice initiatives as well, and therefore receive per diem payments or transfer payments through those channels too.

The per diem rates of PEs are set through a "rate review process" tightly controlled by the Ministry of Children and Youth Services. Rate agreements typically take into consideration the intensity of service offered by the operator, the degree of psychological and/or psychiatric services included, and other professional services and programs that might enrich the experience of the children or youth placed there. Very notably, the rate review process does not take into consideration staff salaries or capital expenses of any kind, and it does not make allowances for cost of living increases. Any increase in the per diem rate of a PE must be linked to service enhancements.

All residential care providers from all sectors (both public and private) are subject to an annual licensing process. This typically involves a site visit by a licensing specialist, employed directly by the funding Ministry, who examines administrative aspects, clinical recordings, and policies and procedures as presented by the licensee. The licensing specialist also checks the physical condition of the facility and ensures that specific safety-related measures are in place (fire drills, cleared emergency exits, water safety checks if property operates on a well, etc.). Site visits are scheduled well in advance, and surprise visits are rare and usually only in response to significant complaints from clients (and sometimes at the behest of the Child Advocate's office). Agencies operating more than one residential facility must maintain a license for each facility separately, although all facilities

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operated by the same agency may be governed by a single set of policies and procedures.

PEs receive their referrals directly from CASs who typically have specialized placement workers to carry out this process. Referrals might be emergency-based or not; in many cases, placement is required immediately, but in some cases, placement may be desirable within the next 30 to 60 days, which makes pre-planning possible. PEs are under no obligation to accept referrals from any CAS, and most do regularly reject referrals. Common reasons for rejection include poor match with the client group already in the placement, specific types of behaviors, and insufficient or unclear referral information.

All children or youth placed with a PE are connected to a social worker from their CAS, and case management typically remains the exclusive domain of the CAS worker, although planning meetings would generally involve representatives from the PE as well. Recent research by Stuart & Saunders (2008) suggests that some case management functions are carried out by the front line staff within residential programs; however, final case responsibility, and all major case management decision-making rests with the social worker from the CAS. Discharge decisions are typically also made by the CAS, although in some cases, a PE may request an unplanned discharge due to behavioral challenges on the part of the client that impact the safety or well-being of other clients in the placement. On paper, the same process applies to CAS placements in public residential treatment centers operated within the Children's Mental Health sector, however, in practice, one might argue that these centers maintain much greater control over case management than PEs. Stuart & Saunders' research confirms that even front line workers within the public treatment sector have far greater involvement in case management than do their counterparts in the PEs.

There is no mandatory participation in central associations or organizing systems that applies to PEs, nor is there a mandatory accreditation process (some PEs have completed third party accreditation on a voluntary basis). In fact, while approximately 75 PEs do belong to an association (Ontario Association of Residences Treating Youth [OARTY]), at least an equal number do not belong to any association, or alternatively, have affiliation with other "association-like" organizations (e.g., Ontario Association of Child, Youth and Young Parent Centres, Foster Care Operators' Association of Ontario). To the extent that OARTY is the largest centralized association of PEs, it is notable that it has, in recent years, undertaken significant efforts to improve the organizational standards amongst its members and to advocate for more extensive accountability, transparency, and consistency primarily through its endorsement of third party accreditation. In fact, one of the stated goals of OARTY is to have all of its members subject to third party accreditation by 2012 (OARTY, 2008).

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The previous outline of the rules and regulations pursuant to private enterprises offering residential services to children and youth in Ontario serves to provide a reference point for considering the perspectives of the Owners/Operators of PEs on the state of the residential care system. Overall, we can summarize the basic characteristics of PEs in Ontario as follows:

- many diverse operators with limited centralized organization or systems coordination;
- Financial structures that depend almost entirely on the placement decisions of CASs;
- minimal legislative or regulatory requirements other than those regulating residential care in general; and
- the majority of children and youth living in group care situations under the auspices of the child welfare system are placed with a PE.

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PRIVATE ENTERPRISE PERCEPTIONS OF THE RESIDENTIAL SERVICES SYSTEM IN ONTARIO

Owners and operators of private residential group care programs in Ontario articulate their perceptions of the residential services system at least partly in response to the often critical comments about their services from the public sector. As indicated, public perceptions about the private sector range from favorable to extremely critical, with some voices even calling for an end to private residential service provision. The recently initiated child welfare transformation process in Ontario explicitly aims to reduce the reliance on residential group care in general and private residential group care, in particular by increasing foster care placements where necessary and kinship care placements where possible. At the government and public child welfare agency level, residential group care has now been firmly articulated as an option of last resort, only to be accessed when other, seemingly less intrusive service options, have either failed or not been available (Frensch & Cameron, 2002; MCYS, 2007).

It is much too early into the child welfare transformation process to determine whether indeed these measures taken to reduce the reliance on residential group care will effectively reduce the number of children and youth residing in such programs. It is clear, however, that the intensity in which the new directions toward group care avoidance have been introduced by government and senior management at the agency level have had a tremendous impact on placement process and decisions, as well as the experiences of children and youth coming into contact with the child welfare system. The interviews that were conducted with the owners and operators of PEs clearly identify this trend of new activity, labeling it as uncertain, tentative, and perhaps more concerning, chaotic.

Without exception, all PE executives interviewed expressed grave concern about the manner in which the child welfare system is making placement decisions, utilizing private placement resources, and is collaborating with private placement providers. Descriptions of the system functionality varied from "concerning" to "chaotic" to "complete disarray." A common theme among interviewees was that there was virtually no regard, among either placing agencies or the Ministry governing the system, that private providers are being asked to do more with fewer resources.

Virtually everyone agreed that the profile of children and youth being referred to private placements has become increasingly complex and difficult to manage. One of the causes for this trend is that the recent child welfare transformation in Ontario has actively discouraged residential group care placements, and has demanded that all other types of placement options be attempted prior to accessing group care (Bay Consulting, 2006). As a result, according to PEs, the children and youth being referred to them have experienced multiple placement breakdowns in foster care and sometimes kinship care arrangements that may well have not been appropriate in the first place. While there is general support for family-based care for those children and youth that do not require the more intrusive/intensive group care model, the reality is that many children and youth do in fact require staffed group care. OARTY has noted a particular increase in the referrals for children and youth with Fetal Alcohol Spectrum Disorder (FASD) and Autism Spectrum Disorder (ASD) (2008). This is the case not necessarily because of their psychological disposition or psychiatric diagnoses, but simply because behaviorally they are too challenging to manage for any family (kin or foster) for any length of time. The placement breakdowns that occur in those settings set children and youth up to become mistrusting of any treatment interventions, resulting in much greater challenges to the group care placement once they do, in fact, end up there (McElroy & Small, 2008).

Compounding the challenges for PEs resulting from the current pressure to minimize group care placements is that placements are widely perceived as becoming shorter (there is only anecdotal evidence for this perception), with discharges to foster care, kinship care and even return to family taking place as soon as the PE is able to report increasingly positive behaviors on the part of the child or youth. This is seen as highly problematic, if not shortsighted. Children and youth "doing well" in their placements does not provide evidence of their capacity to maintain their gains in another setting. PEs argue that their work is relationship-based, and that the initial stages of behavioral improvements resulting from the imposition of external controls and structure need to be rendered sustainable over time through the relationship-based work of the staff. Without this process being allowed to unfold, it is not surprising that discharges from group care result in repeated placement breakdowns in less intensive settings, since the gains made by children and youth have not yet been rendered sustainable. One of the many undesirable

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side effects of multiple placement breakdowns is that children and youth become subject to a very large number of care givers over relatively short periods of time, which contradicts much of the research pertaining to resilience factors for children and youth (Ungar, 2002; 2004).

Inasmuch as PEs are often seen as questionably competent by public service providers, both within child welfare and the children's mental health sector, that perception is certainly reciprocated by the PEs with respect to their public counterparts. Having been reduced mostly to the observer role in terms of the decision-making processes about children and youth, PEs express dismay at a system that appears to be moving in all the wrong directions for far too many children and youth.

TRANSPARENCY AND ACCOUNTABILITY OF PRIVATE ENTERPRISES

PEs maintain that the level of their accountability and transparency by far exceeds that of residential group care providers in the public sector. They are particularly critical of CASs running their own group care programs, arguing that this constitutes a conflict of interest and essentially is the equivalent of "the police running jails." In Ontario, seven CASs operate their own group homes (25 individual programs) and sixteen CASs operate either group homes or staff-supported parent model homes that are licensed as group homes (46 individual programs). Virtually all PEs interviewed expressed concerns about the quality of care provided in CAS group homes, and many related worrisome stories about decrepit buildings, poorly trained staff, and approaches to care that were neither based on best practice nor on any evidence base. Several of the interviewees also pointed out that the per diem cost of CAS-operated group homes is substantially higher (in some cases, 100% higher) than that of private group homes. And yet, according to PEs, one never hears about what takes place in these group homes, and it appears that the only regulatory process checking up on them is the standard licensing process to which all group homes are subject.

Transparency

The principal governmental initiative designed to ensure transparency in residential group care is the licensing process. PEs are somewhat critical of the licensing process, because it primarily focuses on written case records and on safety-related issues pertaining to the physical plant. It does not, however, focus on the process of caring or on the quality of programming, and most PEs feel that they do an as effective or more effective job in these areas than their public counterparts in Child Welfare and Children's Mental Health (CMH). In addition, PEs expressed their concern about inconsistencies

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in the licensing process depending on the particular focus within the regional offices responsible for licensing, which can vary considerably. In many cases, PEs also pointed out that there are major variations in the degree to which licensing is carried out in a thorough manner that depend, primarily, on the specific individual doing the site visits. While some PEs reported that their licensing specialist were "very picky and took a long time to conduct their site visits," others reported that their licensing specialist completed the site visit in "a couple of hours," and spent most of this time "chatting with the manager and touring the house."

Many PEs expressed support for the concept of Third Party Accreditation (several had already achieved this), arguing that this process is more focused on quality of care issues and more informed about evidence bases and best practices in residential care than the licensing process. Third Party Accreditation is in fact promoted by the largest PE association in the province, OARTY. The emphasis is on *Third Party*, and PEs argue that while most of the CAS sector and much of the CMH sector are also accredited, it is not a Third Party but peer based process. The emphasis on Third Party Accreditation adds credibility to the PE sector, however, this must also be kept in perspective; currently, only a very small number of PEs have actually initiated/completed this process, with many complaining about the costs involved in doing so. In addition, while members of OARTY are being heavily pressured to pursue accreditation, many PEs are not in fact members of OARTY or any other association of relevance, and none of those are currently pursuing any form of accreditation.

Transparency, however, does not end with accreditation. Most PEs make considerable efforts to be connected in their neighborhoods and communities, frequently with much more concrete and regular initiatives than their public counterparts. In fact, while many CMH centers operate their residential treatment programs on private grounds (a campus environment) or in rural settings, most PEs operate their programs in houses that are well integrated into their neighborhoods, although many also operate in rural areas that are well removed from any community scrutiny. Nevertheless, PEs have typically been quite proactive in getting the children and youth involved in community-based activities, and because of limitations in their physical infrastructure, often rely on community-based facilities for recreational outings and extracurricular activities. Perhaps more so than is the case in CMH centers, children and youth placed in PEs are connected to a wide range of community-based treatment services, including medical doctors, psychologists, and in some cases, psychiatrists. In CMH centers, professionals, who are employed by the CMH, provide most of these services.

Accountability

Accountability mechanisms in residential care in Ontario are weak regardless of the sector. Even the licensing process, which is the government's

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primary method of ensuring accountability among residential providers, has few provisions for actually enforcing the rules it monitors. Where violations of licensing standards are found to exist, conditional licenses are issued that require addressing the violations in a given time frame, typically six months. If any violations have not been addressed, however, the license still is not necessarily withdrawn, but instead, another conditional license is issued for an additional six months. Barring any major violations, residential care programs can, theoretically at least, carry on their business notwithstanding such violation for an indefinite period of time.

Still, most PEs argue that they must be accountable to their customers in order to stay in business. They point to the fact that customers (placing CASs) have choices about which care provider to choose, and therefore the need to account for one's actions is in fact greater in the private sector than in the public sector. There is truth to this point of view; certainly in the public sector, both CASs and in most cases CMH centers (except in larger urban areas, where there are often several CMH providers with residential treatment facilities) have a monopoly on service. On the other hand, many of the PEs also acknowledge that placing CASs are typically desperate to access their beds, and in many cases have very little knowledge about the specific type of service provided there. If that is truly the case, then the argument that the competition for beds is related to the degree of accountability of the PE holds very little weight.

Certainly with respect to accountability, PEs are not able to really lay greater or lesser claim to high standards than the public sectors. In reality, accountability continues to be a major concern throughout the residential care system in Ontario. Perhaps one area in which PEs will have to do some soul searching relates to their position vis-à-vis each other. Nearly half of the 20 PEs interviewed confessed to being aware of another PE operating with very poor standards in terms of quality of service and organizational integrity. However all of these PEs also acknowledged that they had done nothing to address these issues with the other PE, and they had not reported their concerns to any of the placing agencies or the Ministry itself. In a business environment, the risks of reporting each other were simply too great.

Ethics in Private Residential Care

PEs are often accused of making profits on the backs of the most vulnerable, children and youth in Ontario. All interviewees firmly reject this claim. Their perspective is that money is spent in both the private and public sector to benefit those individuals providing the service. In the public sector, senior managers of CMH centers and CASs are paid top salaries with extensive benefits, and at times, scandalous privileges (free gym memberships, car leases, etc.) (Auditor General of Ontario, 2006). Staff, too, are paid significantly more in the (often unionized) public sector than in the private sector. A front line

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position in a CAS-operated group home, for example, can have an annual salary as high as $55,000, often with double the vacation and sick time allowances than what would be typical in the private sector. With respect to the profit issue, interviewees repeatedly pointed to the fact that they are able to provide a needed service for children and youth at substantially lower cost than the public sector. They maintain that the quality of their service easily and very favorably compares to that of CMH centers and especially CASs. As further evidence, they cite the fact that it is CASs who place children and youth in PE group homes, and they keep doing so with regularity and frequently very positive feedback.

On the other hand, PEs, because of the per diem structure of their revenue, do make decisions that favor the financial needs of the business over the service needs of children and youth. This is most apparent in the speed at which beds are filled, allowing for minimal time for clients to adjust to the departure of a peer or to prepare for the arrival of new client. It is also apparent in the compromises around matching clients often made by PEs in order to fill a bed. Most PEs argue, however, that the design of their programs is, in fact, to focus on the needs of clients, and that the need to sometimes compromise a "best practice" comes about specifically because of the new trend on the part of child welfare to avoid placement in group care. Unlike CMH centers or CASs, who are not immediately impacted financially, PEs cannot afford to maintain empty beds for any period of time as the financial impact is immediate and significant. Very notably, several of the interviewees nevertheless did maintain the preeminence of service integrity and took the financial losses of empty beds resulting from service considerations out of their profit margin. It should also be noted that neither CMH centers nor CAS operated group homes give much consideration to allowing for separation time when clients are discharged. CMH centers frequently have the luxury of operating with empty beds, however, CASs typically operate at full and sometimes in excess of full capacity most of the time. The need for beds generally overrides best practices with respect to admission processes.

In terms of the day to day incorporation of ethics in PE services, the issues are as lamentable as they are in the public sector. Most of the interviewees were unable to produce any specific statement on ethics, none had provided any specific training for their staff related to ethics, and only one had somewhat of a process in place to weigh the ethical consequences of decision-making on a regular basis. It should be emphasized, however, that this virtual absence of "active ethics" in PEs is very much mirrored in the public sectors as well. One characteristic unique to PEs is the number of organizations that are faith-based, resulting in value-systems that reflect the religious orientation of the organizations. Most of these PEs do in fact spent considerable time orienting their staff to these values, but they do not, typically, provide training that reflects any type of "universal" ethics.

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ORGANIZATIONAL STANDARDS

Whereas organizational standards with respect to program organization and human resources do not, in and of themselves, provide any evidence for positive outcomes for children or youth, they do say something about the organizational culture and the degree of program sophistication sought after by the organization. For this reason, part of the interviews with PEs conducted for this article involved a focus on issues related to recruitment and staffing qualifications, compensation structures, training, and professional development. In very general terms, it is fair to summarize the organizational standards of PEs as "'extremely varied," with some maintaining very high standards in most areas, such as recruitment, staffing qualifications, and training, while others appear to have rather limited standards.

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Recruitment and Staffing Qualifications

Residential group care providers of all sectors throughout Ontario face many challenges with respect to human resource management. Residential care is very staffing intensive, and because of the intensity of the job, staff turnover rates tend to be higher than in other service sectors. Further complicating matters is that residential care is a twenty-four hour operation, and it is not always easy to recruit staff willing to work shifts on weekends and during overnight hours. Therefore, most residential service providers hire full time staff who work primarily during the week, part time staff, who often work on weekends, and causal or relief staff, who fill in when the regular staff need some time off, are sick, or on vacation.

On average, a community-based group care program with six to ten beds requires a staffing team of fifteen workers (full time, part time, and casual). PEs that operate multiple programs therefore become mass recruiters of child and youth workers, some employing as many as one hundred to one hundred and fifty staff. OARTY estimates that in 2007, its 80 member agencies collectively employed approximately 1,700 full time equivalents (2008). For some PEs, this has not posed major challenges because their operations are closely linked with community colleges that graduate child and youth workers. For others, however, no such colleges exist in their geographic region, resulting in major challenges in terms of adequately staffing the programs.

Public service providers such as CAS or CMH centers typically are much more successful in their recruitment efforts for qualified staff. This is partly the case because their funding structures allow for significantly more competitive compensation packages, with salary levels that frequently are 50% to 75% higher than they are in the private sector. This results in considerable variations in terms of the human resource capacity of PEs. While some are able to maintain relatively consistent teams of qualified child and youth workers,

others have minimal hiring criteria and often are unable to maintain any sort of consistency within their teams. And while some PEs are able to maintain very low staff turnover rates, others are hiring almost on a continuous basis, with staff turnover rates approaching 100% during some years.

The pre-service qualifications of staff in the private sector vary much more so than those in the public sector. While nearly 50% of front line staff in group care programs operated by CMH centers and CAS are child and youth workers with child and youth care diplomas or degrees that is only the case for approximately 30% in the private sector. Similarly, the percentage of staff with no post-secondary qualifications is significantly higher in the private sector than in the public sector, where this is becoming quite rare (Stuart & Sanders, 2008).

Compensation Structures

PEs have no mechanism to increase their funding base outside of increasing the per diems they charge to CAS. The rate review process that governs such increases does not include provisions for increases in compensation for staff. As a result, PEs typically are not able to offer competitive compensation packages for their staff compared to the public sectors. Whereas salaries are frequently a mere 50% to 75% of salaries in the public sector, extended health care benefits often are not offered at all, and even vacation and sick time benefits are minimal.

Without cost of living increases to their funding base, it is not surprising that PEs are unable to compete with their public counterparts in terms of material compensation of staff. On the other hand, it is also difficult to fully understand the extent of variation in these packages across PEs. Hourly salaries for PEs with similar bed capacities and similar or even identical per diems vary from $10 to $17. Such variations have not been fully explained by the PEs, pointing to a lack of transparency in this regard.

Training and Professional Development

Training and professional development is costly in a residential care context, because in addition to the costs associated with the training event itself, there are staffing replacement costs to consider. While a staff member attends training, someone still has to work the shift that staff member would otherwise have worked. Largely as a result of the costs involved, training and professional development throughout the residential sectors, public and private, is a significantly underdeveloped area, resulting in the Ontario Association of Children's Aid Societies releasing a public letter expressing grave concern (OACAS, 2007).

Among the 20 PEs explored for this article, in the best case scenario that applied to 5 organizations, PEs provide a range of in-service and

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external training and learning opportunities with direct relevance to residential care. These agencies pay their staff's time and the cost of the training event itself, and put considerable thought into the competencies and skills required to do the job. Training events might include attachment theory, relational work, issues related to Self, a wide range of emotional and psychological pathologies, as well as, team building and systems-related issues. In addition, these PEs ensure that their staff have access to recent literature. In many cases, they require or at least encourage membership in the Ontario Association of Child and Youth Counselors (OACYC), and also send at least some of their staff to local, regional, national, and even international conferences related directly to child and youth care practice or specifically to residential care.

Six of the PEs explored provide some training and professional development opportunities, but in most cases, these opportunities are related directly to specific client profiles currently in the program. These PEs also provide some training opportunities that relate to the agency's value systems as well as to team building. They do not typically, however, provide training or learning opportunities related to some of the core elements of child and youth care practice, such as relational work, sense of Self, or even ethics. Moreover, most of these agencies either pay only for the cost of the training event but not for the cost of the staff's time, or they pay only partially for the staff's time.

In a worst case scenario, applying to the remaining nine agencies explored, there simply is no additional training provided, or it is so sporadic and offered to only a very limited number of staff, that it is not likely to have an impact on the work. These agencies do not pay for the staff time in training, and sometimes only cost share the cost of the training event itself. Leaders within those agencies responded with comments such as "we don't have time for training," "we tried training but didn't learn anything," and "there is no training available in our region."

It should be pointed out that training and professional development is also a concern in the public residential systems. While CMHs and CASs invest significantly more money in training than do PEs, much of it is focused on clinical pathologies and systems issues rather than skills required to work with the day to day reality and experiences of children and youth in residential care.

CHALLENGES AND PROSPECTS FOR PEs

When asked to identify the two most urgent challenges facing their sector, all 20 PEs responded with the same two core issues. First and foremost, the degree of partnership within the residential care system in Ontario is limited, and PEs very much find themselves on the margins of this system. This

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is a major concern, given that the lives of children and youth living in a PE are primarily influenced by that environment. The marginalization of PEs in processes such as case planning, system development, and placement decision-making is reflected in the experience of children and youth placed there. This is clearly not a positive characteristic of the residential service system. OARTY (2005) identified this problem very clearly in its report entitled *Partners in Care*.

The second most important issue cited by most of the PEs relates to human resource issues, which in turn relate also to financial systems. Most PEs are encountering major challenges in the recruitment of qualified staff, and in many cases are drawing on human resources that are significantly under-qualified. Combined with the challenges associated with in-service training and professional development, this creates some very weak foundations for service to children and youth. PEs are critical of the financial system in place to pay for their services, arguing that it is the way in which per diem rates are determined that limit their ability to remain competitive in the recruitment of staff.

There are several additional challenges within the private residential care system that mirror challenges in the public system. Research and analysis of the services provided, their effectiveness, and their efficacy rank high among these. In reviewing the systems set up to do so, it is notable that in many PEs, data collection is significantly more advanced and sophisticated than it is in the public system (although in many other PEs, there is no research and no data collection to speak of). The use of such data, on the other hand, continues to be ambiguous and there are few coordinated and strategic initiatives to analyze data and apply the results to practice. This is potentially problematic, particularly given an on-going perception within the public system and even among government departments that private residential services are limited to "care and nurture approaches" to being with children and youth, whereas public systems, and particularly the CMH system, provide "treatment." Funding for the public system, therefore, always exceeds what is available to fund services in the private system, since the notion of treatment is typically held up as somehow more valuable and, perhaps, even more complex than notions of caring and nurture. The complete absence of evidence that treatment is "'better" than caring and nurture seems to faze no one, nor does the absence of any kind of common definition or even approach to what might constitute treatment. Several of the PEs pointed out during the interviews that many of their admissions were the direct result of a CMH center not being able to provide service to a child or youth as a result of behavior problems. This does raise some questions about where to place public resources—with the service that cannot or with the service that can.

Perhaps the greatest concern one can identify with private services, specifically in the context of staffed group care, relates to the enormous

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variations in terms of organizational structures and day to day operations that are, without a doubt, present. As mentioned previously, organizational structure does not, in and of itself, provide much insight into the quality of experiences children or youth might have while living in a group home. On the other hand, organizational structure does provide us with a foundation for confidence and trust in the efficacy and intentions of service providers. Whereas the private sector has made significant strides in terms of coordinating its services and standards pursuant to these services through its core association, OARTY, the fact that there are many providers who are not members of this association is problematic. In practice, PEs operate as their owners see fit.

The great strength of private enterprise is its flexibility and the transcendence of bureaucracy that often becomes debilitating within the public sector. In the context of residential group care, however, this does not mean that one can operate such programs strictly as a business or based primarily on business principles. The balance needed to achieve efficiency and a high quality of service requires some commitment to the principles and ethics of working, living, and being with children and youth, and where such commitment is breached, service providers must be willing to step forward and respond. This is not the case in either the public or the private residential services sector in Ontario, but getting there might actually be more feasible in the private sector.

Although service models vary significantly among PEs, many can at least claim success within the context of their stated mandate based on testimonials from children and youth themselves, comments from placing agencies, and complementary reviews from other, like-minded professionals. Certainly there are no indications within the organizational structures of PEs that would render them any less valuable than their public counterparts. In fact, within the context of a poorly regulated residential services system, PEs often provide children and youth with services and living conditions that at least have the appearance of higher standards than what is found in the public system. As a result of differing standards, however, the onus to remain vigilant must rest with the public child welfare system; PEs are an enormously useful service for children and youth, but some might also be harmful.

PRIVATE SERVICE IN AN INTERNATIONAL CONTEXT

Ontario is not unique in its mix of public and private residential services for children and youth. Certainly in the United States, residential services exist in both private and public organizations as well, and there is much greater variation in the types and the organizational contexts of residential services. These include group homes, treatment programs, private residential schools, and even private hospital programs specifically designed to address the needs of children and youth with severe psychiatric challenges. In Europe, too,

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private residential service exists, however, to a much lesser degree than it does in North America. The vast majority of placements, both in child welfare and in children's mental health, are aimed at public agencies that receive transfer-funding from government departments (Gilligan, 2009; Petrie, Boddy, Cameron, Wigfall & Simon, 2006; Sallnas, 2009). In the United Kingdom and in Ireland, private residential services are on the rise, but still constitute only a small part of the residential service system, and most of it relates to foster care (Bullock & McSherry, 2009). And even in South Africa, Israel and Brazil there are traces of private service provision, but again these are not significant components of the residential service systems in those countries (Dolev, Ben Rabi, & Zemach-Marom, 2009; Rizzini & Rizzini, 2009; Stout, 2009).

What is perhaps more notable when examining private services across the world are the commonalities in terms of challenges. In the US, in Europe, and in lesser-developed areas in South America, Asia, and Africa, service providers are struggling to find and retain qualified staff. They are having difficulties integrating their services with public service systems and governmental directions, and accountability is limited given weak regulatory infrastructure and government oversight. What sets the Ontario context apart, to some extent, is that these challenges are quite unnecessary. The material infrastructure and knowledge resources are readily available, and one can at least hope that in a country where public services are held as a fundamental social value, the capacity to regulate both public and private children's services will one day be utilized more fully.

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