Evaluative Case Study of the Clinical Processes in a Jamaican Place of Safety

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Abstract

The lack of enforced regulations and clarity regarding the mandate of Places of Safety in Jamaica results in varying quality in the standards of care, staff burnout and children having long terms of stay. This study examined actual clinical processes practiced in Places of Safety in Jamaica to assess cases, make referrals and improve residents' critical clinical/behavioural issues. The case study method was used, focussing on staff perception. The final evaluation was based on the Child Development Agency's 2010 *Guidance and Standards of Care for Residential Child Care Facilities*. A major finding of this study was that Places of Safety faced significant challenges in meeting the therapeutic requirements—though limited—of the Standards of Care. These included lack of funding, timeliness of services and limited access to clinical staff from their supervisory agency. Staff showed remarkable commitment to residents, but felt that transitional and counselling processes needed improvement.

Keywords: institutionalization, alternative care for children, programme evaluation.

Introduction

Currently there are varying strategies being adopted by childcare stakeholders to improve national systems in the Caribbean. Yet there is little research to inform context specific strategies. The closure of the Alpha Boys' Home in Jamaica, and the St. Michael's School for Boys in Trinidad reignited discussions on residential child care and institutionalization (Francis, 2014; "St. Michael's", 2018). Data on child institutionalism is limited in the region, as most countries have abandoned large Residential Child Care Facilities (RCCFs), choosing instead group homes, varied family settings or the provision of support for families (Johnson & Rhodes, 2007). While it is noted that the child protection system in many Caribbean States include alternative family settings such as foster care and adoption, a larger number of children are removed from their families and housed in large Child Care Facilities, reminiscent of the colonial past. The issue of institutionalization in the Caribbean and its impact on

children and staff therefore must be addressed. The discussion on RCCFs in the Caribbean requires further exploration for the purposes of applied research.

Institutionalism is a psychosocial syndrome characterized by apathy, social withdrawal, internalizing the cultural norms of the institution and a diminished sense of identity (Johnson & Rhodes, 2007, p. 226). It occurs following prolonged exposure to several negative environmental, psychological and social circumstances in residential settings, rather than in response to a single identifiable trigger. Additionally, institutionalization is a process that affects both residents and staff. As staff implement the institution's programme, they grow to depend on its structure and routine (Johnson & Rhodes, 2007). The "cultural peer pressure" that staff may be exposed to may cause the continued replication and inheritance of detrimental attitudes and practices. Notwithstanding, children living in RCCFs bear the brunt of negative effects of institutionalization. While institutionalization primarily affects staff socially, studies have found that it causes children to develop physical, social, emotional and neurological impairment (Johnson & Rhodes, 2007).

Jamaica has made several steps towards improving children's quality of life. At the core of these steps is the amendment of the Child Care and Protection Act (2004), which includes standards to regulate RCCFs. The enforcement of these regulations by the Child Development Agency (CDA)—now called Child Protection and Family Services Agency—, the regulatory board for children in Jamaica, has resulted in the closure of a number of private and state RCCFs and entry points into state care, also known as Places of Safety (POS). Despite these and other positive steps to reduce the occurrence and impact of institutionalism in RCCFs, *A Policy to Amend the Child Care and Protection Act* (CDA, 2013) highlights gaps in the services provided to children, especially as it relates to state care. Stakeholders have called for improvement in, "assessment and integrated case management for wards entering the system" (CDA, 2013, p. 15).

As one examines entry points to state care, a noteworthy problem comes to fore - there is a lack of enforced regulations and legislative clarity on the mandate of POS in Jamaica. This results in varying quality in the standards of care, staff burnout and long periods of stay for children. This in turn may foster the negative bio-psycho-social effects associated with institutionalization.

Historical and Contemporary Responses to Alternative Child Care

In many ways, Caribbean welfare systems continue to reflect the economic and social constructs inherited from colonial predecessors. From the 1602 Poor Laws to the 1942 Beveridge Plan, welfare and care emphasized the provision of alms and medical care to indigents and the removal of children from poor families (Patton, 2014). Institutionalization then was seen as a remedy for the social ills children faced. However, the strategy came with negative side effects, which included children facing physical and sexual abuse, emotional trauma, neglect and forced child labour (Berridge et al., 2012; Tjelflaat & Bolstad, 2008).

Many nations have since moved away from those systems. Internationally, POS are used as short term means of emergency childcare or to smoothly transition into a longer–term care facility for children (United Nations General Assembly, 2009). The scarcity of recent data on RCCFs from America and the United Kingdom is noteworthy. In the United Kingdom, Berridge et al. (2012) found that residential care for children over the age of 12, similar to POS, was mainly used for: (a) children

with complex behavioural issues; (b) if foster care arrangements failed; (c) as transitional homes for older young people leaving the system; and (d) as a short-term secure place for antisocial adolescents, who may put themselves at risk (pp. 4–5). In most of these types of childcare facilities, activities and behaviour management is based on stated models of care or theories e.g., therapeutic crisis intervention and sanctuary model (Berridge et al., 2012). Many of the homes in the United Kingdom provide support in the form of outsourced assessment and psychotherapy (Berridge et al., 2012). In America, however, many facilities offer multidisciplinary treatment teams that engage residents in a variety of treatment modalities e.g., psychiatric assessment and adventure therapy (Walter, 2007, p. 10).

The Caribbean however appears to be making that transition at a slower rate. An examination of the models used in Jamaica, St. Lucia, Barbados and Trinidad and Tobago highlight the need for regional consistency and streamlining of social services offered. In Jamaica, oversight of the quality of care in POS resides with the CDA (directly or via monitoring/licensing private POS). While regulatory policies exist to guide RCCFs, there is need for clarity regarding the role and correct functioning of POS (CDA, 2013). The 2010 *Children's Homes Regulations* provide guidelines for orientation and referral, and states that homes should provide counselling for residents. However, the interplay of policy and practice issues is a recurring one, stakeholders often call for shorter placement times at POS, improved assessment and care plans aimed at family reintegration or long-term alternative care (CDA, 2013).

Barbados has similar difficulties in its childcare system as there is a lack of legislative clarity about the differentiation of a POS and RCCFs (Prevention of Cruelty to Children Act, 1998, p. 3). In St. Lucia, however, their POS—The Transit Home—has a more structured and clearly defined mandate. This Transit Home ,however, only accommodates cases that may be considered to be extreme to complex, with the view of providing assessment and therapeutic treatment for a maximum of one year (New Beginnings Transit Home, 2011).

In Trinidad and Tobago, POS refer both to Reception Centres and Community Residences (Children's Authority Act, 2000). These are both clearly defined in the country’s suite of Children’s legislation. However, for this study, the Reception Centres may be explored as the point of entry into the child care system. These are temporary facilities, maximum 3 months stay, equipped with a full cadre of clinical staff who carry out assessments, develop and implement treatment plans for residents, and make recommendations for residents' longer-term placement (Children's Authority Act, 2000, pp. 15–16). However, as with all Caribbean states, questions surround whether the legislated system and its provisions for children’s clinical care, line up with what is practiced on the ground.

Institutionalism

Psychological institutionalism is described by Bettelheim and Sylvester (1948) as, “a deficiency disease in the emotional sense [due to the] absence of meaningful continuous interpersonal relationships" (p.191). Characteristics associated with this syndrome are, "apathy, lethargy, passivity, and the muting of self-initiative... social withdrawal and isolation, an internalization of the norms of institutional culture, and a diminished sense of self-worth and personal value" (Johnson & Rhodes, 2007, p. 226). Institutionalization may result in children experiencing stunted physical growth,

sustained socio-emotional deficits and impairment of the development of neural circuitry of the brain (Johnson & Rhodes, 2007). Therefore, the effects of institutionalism can: (a) cause further harm to children deemed in need of care and protection; (b) make family reintegration difficult, due to impaired social intelligence and competences; and (c) decrease the possibility of residents transitioning out of state care, via adoption or foster care, due to socio-emotional challenges that potential caregivers may not be able to cope with.

Institutionalization affects both residents and staff. Early studies describe staff as, "victims of the system" and implied that it was impossible to find staff who could withstand the process of institutionalization (Martin, 1955, p. 1190). They too may display some of the symptoms of institutionalism, namely submissiveness, reduced self-initiative and reliance on institutional structure (Johnson & Rhodes, 2007, p. 226). The cultural peer pressure staff may be exposed to can result in the continued replication and inheritance of attitudes and practices that may not be in the best interest of residents. This concept of cultural peer pressure causing the muting of self was seen in a study done in Canada with former staff of residential psychiatric wards, where staff was praised for efficiency—which was in part judged by detachment—, and penalized for, "caring too much about the patients" (Dooley, 2012, p. 109).

Causal factors of institutionalism vary, but fall under four models: the predisposition, total institution, asylum and symptoms.

- **predisposition model**: posits that only certain persons in an institution develop institutionalism (Wirt, 1999). It attributes the syndrome to a person's personality —including their early life experiences and worldview—and its exposure to an institution's environment (Wing, 1962; Wirt, 1999).
- **total institution model:** contrasts the predisposition model by implying that all children who are placed at RCCFs, despite their level of resilience, are at risk of developing institutionalism. It emphasizes the destructive characteristics of institutional life and how it mutes self-identity and motivation (Wirt, 1999, p. 262). Goffman (1958) described the core features of total institutions as: (a) all aspects of life are in the same place and under the same authority; (b) activities are done in group settings and each participant is treated alike; (c) rigidity of a tight schedule enforced through formal rules and a group of officials; and (c) the contents of the activities work towards achieving the official goal of the institution (p.43).
- **asylum model:** suggests that residents rationally view the institution as a sanctuary in comparison to the hardships they may experience outside the institution. Persons who experience difficulties and abuse outside the institution, may find a residential facility attractive and seek refuge there (Johnson & Rhodes, 2007; Rosenblatt & Mayer, 1974). In the resident's eyes, complying with the norms and demands of the institution is not a pathological adaptation, but a logical and small requirement for asylum (Wirt, 1999). This may also apply to staff, who, in the face of a restricted economy and job scarcity, may comply with the institution’s status quo to ensure job security.
- **symptoms model:** views institutionalism and its related symptoms as the side effects of medication, the results of years of treatment or symptoms of other alternative psychoses, despite the various settings persons may be in (Johnson & Rhodes, 2007). Earlier studies

attributed the symptoms of institutionalism to the actual process or cycle of the illness that individuals experienced (Wirt, 1999).

The normalization model of institutionalism is most current, and suggests that the factors that give rise to institutionalism are: individual vulnerability, conditions of the institution, resident's perceptions of the institution's environment, resident's perceived time in care and the actual time spent in care (Johnson & Rhodes, 2007, p. 227). This model was developed in an effort to deter institutionalization. Its main aim is for the provision of a safe living space that resembles the average family unit and helps create a sense of stability to the resident. This model recommends that RCCFs, "should be small (i.e., designed for no more than six to eight residents)... integrated into the community... residents should work and/or receive services away from the facility... [and] services should be adapted so that residents can experience a sense of permanence and security in their living arrangement" (Johnson & Rhodes, 2007, p. 229).

Theoretical framework

The General Systems Theory and the concept of Institutionalization were used as the theoretical and conceptual lens for this study. General systems theory provides a framework for exploring and understanding the dynamic and complex nature of human bio-psycho-social and cultural exchanges (Laszlo & Krippner, 1998). Specifically, it aids in defining systems and subsystems in the POS, understanding the nature of these systems and their interactions, and understanding the behaviour of people in the various systems (e.g., residents, POS staff, CDA staff).

Institutionalization refers to a process that is typically seen in large residential homes, whereby residents become emotionally inept, resulting from poor and inconsistent interpersonal relationships (Bettelheim & Sylvester, 1948, p. 191). A key feature of institutionalization is the acceptance and perpetuation of the norms and practices of the institution's culture, at the cost of self-initiative (Johnson & Rhodes, 2007; Martin, 1955). This perpetuating of norms and practices may apply to the staff's perception of their roles, view of residents, and staff motivation, all of which may directly impact the quality of services delivered.

Current Study

Studying the clinical processes used in POS may contribute to the development of a best practice model of residential childcare in the Caribbean. The results can be helpful for policy and programme planners, as well as practitioners in the related helping professions. Therefore, this study sought to identify and evaluate the clinical processes used in a POS in Jamaica to assess cases, make referrals and improve residents' critical psychological/behavioural issues. The study aimed to determine the effectiveness of the clinical processes used and compare them against the requirements of CDA's 2010 *Guidance and Standards of Care for Residential Child Care Facilities* (SOCs). Consideration was also given to current regional best practices and international guidelines on the alternative care of children. The study also explored staff's view of the effectiveness of the clinical processes used, and sought to understand the various factors that influenced what was actually practiced. The research questions were therefore:

1. What clinical processes are residents exposed to when they stay at POS in Jamaica?
2. How effective are the processes used by POS in Jamaica to assess, treat and refer residents?
3. How do staff perceive the effectiveness of these processes?

Method

While the purpose of this study was to evaluate the clinical processes of a particular POS, it was hoped that the findings could also provide insight into institutionalism and residential childcare processes in Jamaica. Therefore, a mix of intrinsic and instrumental case study design was used. The following operational definitions were used to frame the study:

- **place of safety:** state–run, temporary, child care facility. This statutory institution is "time-limited", during which efforts are made to address critical case issues and behaviours before transitioning to long-term placement such as family reintegration or alternative residential care (McLean et al., 2011, p. 5).
- **child and adolescent**: Persons under 18 who are deemed by law or relevant policy in need of care and protection.
- **resident**: child placed at a POS on a Care and Protection Order. Children deemed to be "out of control" or who have been temporarily placed at the POS due to commission of a criminal offence were excluded from this study.
- **critical clinical/behavioural issues**: This includes but is not limited to psychological and behavioural issues that directly relate to the child's physical health and ability to function at a basic level of societal normality (e.g., clinical depression, self-mutilation and suicidal ideation, anorexia, high risk sexual behaviour, violent outbursts etc.).
- **effectiveness**: The ability to meet the assessment, treatment and referral criteria set out in the SOCs (CDA, 2010) and uphold the ethos of the United Nations' *Guidelines on the Alternative Care of Children* (2009).

Participants

The study focused on the Nokia Home[1]—a state-run POS selected by the CDA—located in an urban centre in Jamaica. Children in this institution are deemed to be in need of care and protection and/or are awaiting a court hearing. At the time of the study, 49 children were being cared for at the POS by 40 members of staff. The residents, aged 0–13 years, were not included as the study focused on staff's perspectives.

Using an opportunistic sampling approach, participants comprised eight staff members from the POS and CDA, as others from the agencies were not willing to participate. Of the eight participants, four were caregivers and managers who were involved in some of the clinical processes being studied. The managers had worked there for less than a year, while the caregivers averaged 6 years at the POS. The ages of these core participants ranged from 35 to 50 years. Auxiliary staff of the POS—i.e.,

[1] Name changed to uphold confidentiality.

attendant, laundry staff—was also included to provide context about processes like orientation and referral. One of these was auxiliary staff had been at the POS for 8 years. The other three participants worked with the CDA, providing psychotherapeutic services to residents of RCCFs. It was felt that they could provide useful information that would corroborate some of the other participant's claims.

Procedure

In-depth interviews were the primary source of data collection for the study, seeking to elicit the actual occurrences of the clinical processes in the home; the role the particular participant plays in these processes; and staff's perspectives of what was actually done in the home. A semi-structured observation guide was also used to verify if the basic physical and task requirements of CDA's SOCs (2010) were met; and aid in the evaluation of the core clinical activities, by observing what was normally done with/for the residents and the contexts in which clinical modalities were delivered.

A desk review was also done including the POS' activity schedule, their report book, CDA's SOCs (2010), examples of standardized psychological tests used, the Child Justice Guidelines (Office of the Children's Advocate, 2013), annual reports from CDA, and CDA's 10-year highlights (2014). With the exception of the annual reports, all other files were viewed under supervision at the POS.

Non-participatory observations of staff engaging in some of the clinical processes were not possible due to confidentiality concerns. However, direct observation of residents in group settings was permitted.

The main ethical issue of this study surrounded confidentiality regarding staff and residents. As this study involved a particular POS, there was a measure of risk that participants could be identified. Additionally, staff opinions could be seen as negative by some, or highlight gaps in the various parts of the system. It was important, therefore, to reduce the possibility of victimization by implementing strict measures to ensure confidentiality and de-identification of the data gathered.

Data Analysis

A thematic analysis of the data, and subsequent process evaluation of the actual clinical activities in the POS—assessment, treatment and referral—was done. Process evaluation is a specific activity that falls within the wider context of programme evaluation. It involves analyzing the effectiveness of programme operations and implementation (Abdul Latiff Jameel Poverty Action Lab, 2014). Since the intention of the study ultimately was to possibly improve the procedures used in the home, the evaluation was formative in nature. This differs from a summative evaluation which is more concerned about the ultimate success or failure of a programme (Grinnell, 1997, p. 571). The evaluation therefore followed a model suggested by Saunders et al. (2005) and explored fidelity, dose delivered, reach and context (see Table 1).

Table 1
Definitions of Parameters for the Process Evaluation

Component	Parameter Definition
Fidelity	This refers to the quality. It explored how well what was actually accomplished reflects the intent and ethos of the planned/required procedures.
Dose delivered	It explored the extent to which the required procedures were actually delivered or provided to the residents. It included the materials/strategies used, time spent doing them and how they actually should be done
Reach	It explored the participation rate of the priority audience (i.e., residents presenting with critical clinical/behavioural issues). This sought to ensure that persons who were supposed to benefit from the clinical processes actually were exposed to them.
Context	Exploring context was necessary as several factors affect the ability of organizations to effectively deliver planned services. This includes surrounding social systems, wider political environment, character/personality of persons delivering and engaging in the processes, existing partnerships and access to resources.

Note. Components and definitions cited from "Developing a Process-Evaluation Plan for Assessing Health Promotion Program Implementation: A How-To Guide," by R. Saunders, M. Evans, and P. Joshi, 2005, *Health Promotion Practice*, pp. 136-141 (https://doi.org/10.1177/1524839904273387).

Initially, the evaluation was based on the operational definitions of effective assessment, treatment and referral derived from CDAs SOCs (2010). Another level of comparison was subsequently done, based on regional and international best practice models of care for children. In essence, analysis in this study involved comparing the actual clinical processes—in terms of their fidelity, dose delivered, reach and context—with the ideal clinical processes of POS' locally, regionally and internationally.

The element of research bias was minimal in this study. Since the study sought to evaluate based on already existing standards, guidelines and requirements, the opinion of the researcher was minimal. On the other hand, this also presented a limitation of the study as the evaluation of the POS processes was limited to the requirements of those standards. Therefore, if, as is being argued, the standards are archaic and flawed, determining how truly effective the clinical practices of the POS are may also be limited.

Results

The findings will be presented based on the research questions and represents the amalgamation of the various views of participants, observations of the researcher and documents reviewed.

Research Question 1: What Clinical Processes are Residents Exposed to When They Stay at POS in Jamaica?

Residents of POS are exposed to informal and formal assessment from lay and professional therapists. Clinical care is primarily outsourced to a Child Guidance Clinic. One member of staff said, "As soon as you pick up anything unusual...if there is a problem, we go to the doctor. We would tell them and they would refer us to Child Guidance Clinic or counselling or whatever." A member of the clinical team at CDA reporting on children at POS stated that, “as a general routine, no. You're not assessed." Ideally, if the child presents with behavioural problems this is to be reported to the children's officer for the POS or the child's individual children's officer, who would then either directly assess the child and address the matter, or refer the child to the regional clinical psychologist from CDA.

According to one of the participants who works closely with a Guidance Clinic, the child undergoes, "a full battery of psychological evaluations.” These evaluations include standardized tests that are primarily US-based. If a resident is formally assessed, a treatment and care plan is then developed outlining recommendations for the child's optimal psychosocial development. Therapeutic treatment for critical behavioural issues would then be delivered adopting a range of age-appropriate techniques. Commenting about therapy offered at Guidance Clinics, one of the participants—a clinician—reported that, "although some of the clients really need the long-term therapy…we can't afford to with the case load."

A child stays at a POS on average for 4 years. Residents, however, may transition out of the POS by virtue of their age or legal judgment. In some cases, residents and staff are given 1 weeks’ notice or same, but sometimes no notice is given. With a sense of sadness, one particular staff member said, "some of the time they just go to court and that's it. They just don't come back." Nonetheless, some staff members maintain a close relationship with former residents and continue to follow up on their progress long after they leave. When asked about a former resident, a participant said she was like a godmother to the former resident. She shared, “Probably before my own children call me, that child would call me and tell me what happened in school or what they did that day."

Research Question 2: How Effective are the Processes Used by POS in Jamaica to Assess, Treat and Refer Residents?

At this reporting stage, an area was determined to be "effective" if the procedure(s) outlined in the 2010 SOCs was implemented well, in terms of its fidelity, dose delivered, reach and context (see Table 1). The process evaluation is first presented narratively. A summary of the evaluation is then presented in Table 2 based on each evaluation component.

Assessment

Requirement. "[Code 4.6]: Staff should be trained to recognize special needs (including mental disabilities) and direct to Children's Officers" (CDA, 2010, p.7).

***Findings based on evaluation components*.**

- **fidelity:** The intent of the 2010 SOCs are unfortunately not clear in this regard. The term *recognition* implies a measure of assessment that would be done. *Special needs* however is defined as, "mental or physical." Mental needs, may or may not include psychological/emotional needs. The intent of what staff should be trained to recognize is therefore unclear. Staff generally hold the view that the children's officer is overworked and has little contact with the home. If special needs are recognized, they therefore do not contact the children's officer but direct the case to the Guidance Clinic. Nonetheless, this reflects the intent of the required procedure.
- **dose:** This requirement is partially fulfilled as intended. The requirement suggests that staff would be adequately trained to conduct front-line assessment of children for mental health challenges. However, assessment done by staff depends on the level of training each individual has received. While the staff receive ongoing training from CDA, different members have been exposed to different training by virtue of their time at the POS. Additionally, while the entire compliment of staff should be able to conduct these assessments, some support staff see it as a job only for, "the caregivers. That is not my responsibility."
- **reach:** According to staff, residents with critical physical or mental needs are identified by staff. It should be noted however, that residents with critical behavioural issues should also be considered a part of the priority audience, as these tend to have mental and emotional foundations. However, these residents may be excluded based on the limited wording of the requirement. Despite the limitation of a refined definition of "mental special needs" staff still refer residents who may present with complex behavioural issues to the Guidance Clinic for assessment.
- **context:** A number of contextual factors have resulted in the way the POS chooses to implement this requirement. It is widely felt that the limited financial resources of the CDA continue to be a root cause of many of the assessment issues. The current compliment of clinical staff have large caseloads, which do not always permit psychological or psychosocial assessments of residents to be done. However, at the time of the study, the new management of the POS emphasized the need for psychosocial care of residents. Additionally, CDA was seeking to improve the resources available to clinical staff with the purchase of psychological diagnostic tools.

Treatment

Requirements.

- "[Code 1.9] A written plan of care by the Manager with the Case Officer should be formulated and thereafter be implemented. This plan should be reviewed regularly" (CDA, 2010, p.5).

- "[Code 4.4] The Home should provide counselling services for children, their parents, guardians and relatives" (CDA, 2010, p.7).
- "[Code 6.4] The Home should ensure psychological care is provided to the children" (CDA, 2010, p.9).
- "[Code 6.6] Children with special needs should have access to regular on-going therapy and services based on their needs" (CDA, 2010, p.9).
- "[Code 6.8] Staff must be trained & equipped to deal with special needs children, especially children with suicidal and self-destructive behaviour" (CDA, 2010, p.9).

Findings based on evaluation components.

- **fidelity**: Case officers could not be contacted during the study to verify if care plans were reviewed. However, the term *regularly* is quite vague and left up to the interpretation of managers and case officers. However, it should be noted that the POS does not provide counselling and psychological care directly, this is outsourced to the Guidance Clinic. Additionally, care staff from the POS are consistently provided with training from CDA to recognize and deal with self-destructive behaviour. Despite the lack of information on reviews of care plans, it is felt that what is actually implemented upholds the spirit of the requirements.
- **dose:** According to staff only a few parents, less than 10, regularly visit their children at the POS. For those that do, they receive lay-counselling from staff. This includes listening, encouraging and providing parenting advice when applicable. Likewise, staff provide informal psychological care for residents when advised by external clinical staff. Responses to children with behavioural problems were shared, " Sometimes we would just have to put them away from the others... we may even talk to them or try give them a little time out if they not responding to it [counselling]."
- **reach:** While the SOCs call for counselling services to be extended to family members, for the purposes of this study, the residents with critical psycho/behavioural issues make up the priority audience. At the time of the study psychological care was being provided mainly to the priority audience. It is important to note however, that these residents were referred to the Guidance Clinic based on staff's informal assessment.
- **context:** While resource constraints prevent formal psychological care from being provided directly at the POS, they continue to take advantage of external resources. The wider Jamaican context of financial instability should be noted, as it is felt that additional clinical staff are not hired and more in-depth training not provided, because the State cannot afford it.

Referral

Requirements.

- "[Code 10.2] The Home should ensure the provision of necessary support and preparation for children's next placement" (CDA, 2010. p.11).
- "[Code 4.16] Ensure a child is advised and consulted when there is a change in designated Agency" (CDA, 2010. p.8).

- "[Code 10.4] Basic living requirements are established before child leaves care" (CDA, 2010. p.11).

Findings based on evaluation components.

- **fidelity:** While children receive basic physical requirements on transitioning out of the POS, psycho/emotional preparation is not standardized, and is largely based on the judgement of the caregivers. This is, in part, due to the haphazard way staff is informed of some of the residents' departure.
- **dose:** For children who transition out of the POS because of their age, staff would begin to talk to them about leaving. Most times this would take place approximately two weeks before their departure. However, in many cases where children transition out of the POS by court order, staff are informed late or not at all about the residents' move. Ideally, residents' case officers would inform the POS of upcoming court dates or possible moves to other care arrangements. This would allow staff to begin to prepare children for the possibility of their departure.
- **reach:** This component with regard to referral cannot be determined in this study. This is because the priority audience of this study are residents of the POS. The policy of the POS is that all residents are given care packages of basic food, clothes and toiletries when leaving. However, this is only done in cases where the POS has prior knowledge of the resident leaving. Some of the residents, in addition to the care packages, are prepared fairly well for transitioning. Staff help these residents to emotionally prepare for their next placement by talking with them about what they should expect. Some residents however are not prepared at all.
- **context:** The main contextual factor that affects the implementation of effective referral is the legal system. Even if communication between children officers and the POS are improved, judges decide whether or not a resident will leave the POS immediately. This ultimately affects whether a POS can holistically prepare residents for departure

Table 2

Results of the Process Evaluation

Evaluation Component	Clinical Process		
	Assessment	Treatment	Referral
Fidelity (Implementation reflects the requirement's intent)	Good	Good	Fair
Dose Delivered (Requirement is done how it should be done)	Fair	Fair	Poor
Reach (Participation rate of priority audience)	Good	Good	-

Evaluation Component	Clinical Process		
	Assessment	Treatment	Referral
Context (Factors that affect implementation)	Fair	Poor	Fair

Note. Very Good= Excellent practices and systems that can be modelled by other similar institutions; Good= Solid practices and systems in place. Some room for improvement exists; Fair= There is much room for improvement in the practices and systems being used; Poor= Immediate action is needed to improve the practices and systems being used

Research Question 3: How do Staff Perceive the Effectiveness of These Processes?

Seven out of the eight participants felt that the clinical processes of the POS being explored in this study—assessment, treatment and referral—were not very effective. The eighth participant abstained from responding to this question, saying, "is not mi responsible, so mi nuh think mi supposed to answer." In analyzing the respondents' views of the actual clinical practices of the home, the following themes arose:

Staffing

One of the subjects that elicited the most emotional responses from the staff of the POS was that of staffing. Most participants, when asked if there was anything they would do to improve the clinical services provided at the POS, started by commenting about staffing. Generally, there were three issues they spoke about- clinical staff being overworked, the need for therapeutic staff working on site, and the general need for more staff at the POS.

According to the CDA (2014), there are four psychologists who each cover one region (p.3). According to the 2008 Annual Report, the staff served 1126 clients (CDA, 2008. p.42). This amounts to an average of 281 active cases per psychologist. Staff at the POS empathize with the social workers, saying that their work expectations were “ridiculous.” One shared, “Yuh cyaan ask a children officer who have 20-odd case who's dealing with children outside, to come here and do some counselling. I don't think any officer should be having 200, all 300 case. Foolishness dat!"

Length of Time for Care

Staff was also concerned about the length of time it took for a child to get the psychological help they needed. Reiterating the desire to have clinical staff working at the POS, one participant disliked the fact that residents' appointments at the Guidance Clinic were often far apart. “That child might very well move on,” another respondent added, "and then the treatment might not follow up. Because it depends on where the child goes." Clinical staff also raised this issue as a concern and felt that if the authorities invested more into upgrading the clinical services at CDA, the waiting time for clinical care may be reduced.

Physical Welfare Focus

Participants made sure to mention that the children at the home were well taken care of. However, no reference was made to residents' psycho/emotional wellbeing. One staff member said, "I always tell my children that they [residents] are better cared for than them at home. Yes, they eat regularly, and they take shower regularly." Other participants also agreed that the psychological care of the residents was neglected, stating, "I think that is an area that wasn't really being addressed-observing children, seeing the different types of behaviour, and then start addressing the behaviour."

Referral Dissatisfaction

Varying reports were made by the participants regarding how much notice is given to them and residents. While for some being given late notice did not bother them, others were concerned that some children were not given enough time to prepare psychologically to leave the POS. "I think there is some inadequacy in how preparation is done," said one respondent.

Discussion

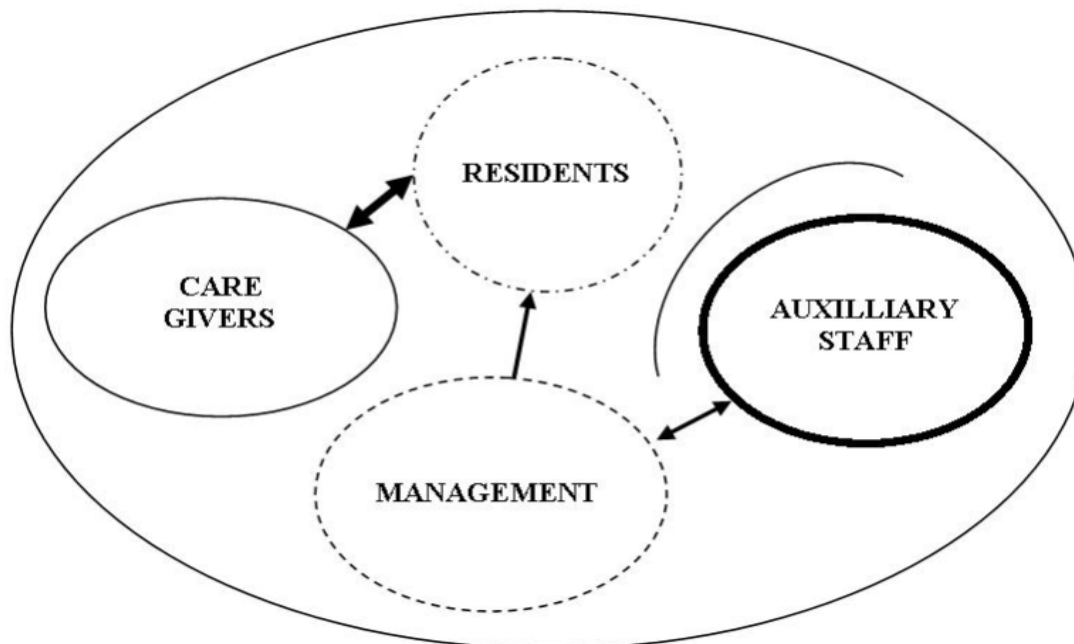
Research Question 1: What Clinical Processes are Residents Exposed to When They Stay at POS in Jamaica?

The POS bore several markers of a total institution, however, it can be said that most of the participants showed no signs of being institutionalized. Most of the participants from the POS showed high levels of self-initiative, and appeared to genuinely be more concerned with caring for the residents than controlling them. This was remarkable as the physical environment, job requirements and even the language of the SOCs can lead one to focus mainly on attending to the physical needs of residents, ignoring their psychological health.

Perhaps the POS' move towards ensuring residents have access to the psychological care they need, was a result of the changing legislative environment and political attention related to child care. Since the SOCs were issued in 2010, there have been some progressive steps locally that emphasize the need to attend to the psychological needs of wards of the State, e.g., the 2013 Child Justice Guidelines.

Considering the issue from a systems perspective, the fact that staff did not appear to be fully aware of their identity as a subsystem, nor of the function of the other systems, internal and external to the POS, suggests that there may be an issue with boundaries.

Figure 1
Diagram showing relationships between the subsystems in the POS



The borders of the management subsystem and residents subsystem appear to be semi-permeable, allowing energy (represented by arrows) to pass to and from its system to the other subsystems in the POS (see Figure 1). This was evident from not only the way staff interacted freely with the managers, but also from the amiable references some of the participants made of both managers and residents. Conversely, the auxiliary staff subsystem appears to be a closed system that is cut off from the residents. While the caregivers subsystem appears to be closed as well, its borders are not as rigid as the auxiliary staff's, as they allow more energy reciprocation from the management and residents subsystems. Based on these borders, it stands to reason that auxiliary staff are at most risk of showing signs of institutionalism, on account of their social withdrawal from part of the POS community and the lack of meaningful interpersonal relationships with other staff members.

Research Question 2: How Effective are the Processes Used by POS in Jamaica to Assess, Treat and Refer Residents?

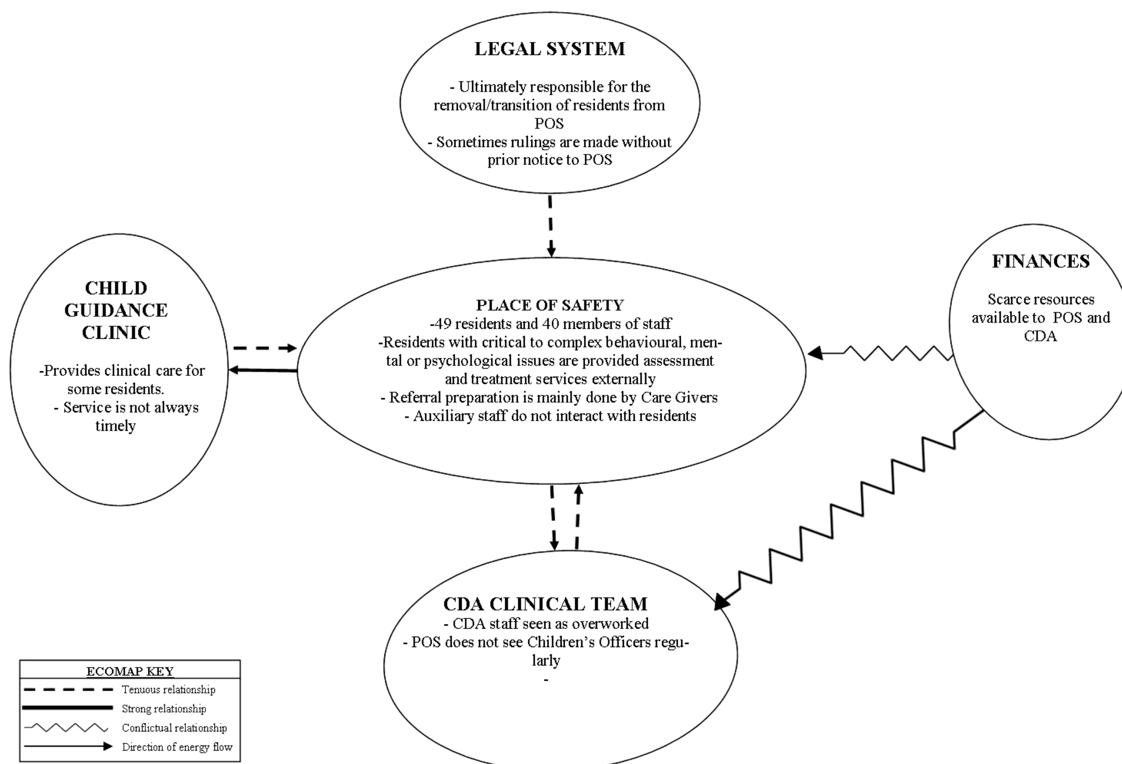
Based on the findings, the POS' efforts at ensuring residents with complex issues (priority audience) had access to professional therapeutic services was commendable. However, the findings also highlighted gaps in the actual delivery of the plans, called urgent attention to referral practices, and raised an alarm about deterrents from the wider system the POS was a part of.

The evaluative component of Dose Delivered received one of the poorest ratings. In part, some of the requirements were not done due to assumptions made about children's officers' caseloads, a lack of capability of staff, and in most other cases the contextual factors prevented the requirements from being accomplished in the manner it should be.

The contextual factors that affect the POS ability to effectively deliver relevant therapeutic services, even as prescribed by the 2010 SOCs can be understood better by adopting a systems approach. Figure 2 shows that the POS may be thought of as a system under stress.

Figure 2

Ecomap of the POS in relation to other systems and contextual factors



Tenuous or conflicting relationships are shared with all of the systems with which it interacts. There is no identifiable system that the POS has a completely strong relationship. While the POS shares a strong relationship with the Guidance Clinic, it is one-sided. Due to long waiting periods, the relationship with the clinic is not one that is entirely in the best interest of the POS. Likewise, the ecomap helps one to see the impact the economic environment has on both CDA and the POS. On several occasions during the study, staff expressed how limited funding prevented both CDA from expanding its service capacity, likewise for the POS.

It is the opinion of the researcher however, that there appears to be an over-reliance on the profession of psychology to provide clinical care. According to the participant representing CDA's clinical staff, the system of therapeutic care was designed to emphasize the role of the social worker as the first tier of therapeutic care. Psychologists then would engage clients with more complex psycho/emotional issues. This is also echoed in the United Nations' *Guidelines on the Alternative Care of Children* (2009), as emphasis is placed on the role of professional social workers in assessment and support. While both professions have different lens from which they work, they work best together.

While resources are limited, it is felt that if greater emphasis is placed on providing social workers with psychosocial assessment and behaviour modification tools, the psychologists and Guidance Clinic may be freed to focus on the complex cases. Ultimately this may reduce the caseload of clinical staff and improve the quality of care.

How do staff perceive the effectiveness of these processes?

The findings showed that despite the culture of the home, staff were dissatisfied with the way therapeutic care was delivered to residents. The issues and concerns that were highlighted by staff varied, and showed that in some areas, staff had an intricate understanding of the problems often associated with residential child care.

It is felt that the concerns raised about staffing are valid ones. The current caseloads, staff to resident ratios and diminished presence of clinical staff at the POS are notably different from what is practiced in more developed countries. For example, in the US state of Alabama, the Minimum Standards of Child Placing Agencies specify that professional staff case-loads should not exceed 18 traditional foster care cases, 8 therapeutic foster care cases and 40 adoptive and resource cases (Department of Human Resources, 2002, p.25). This caseload greatly differs from the estimated caseloads of the average social worker and psychologist working under CDA. This in turn can affect the quality of work, result in staff burn out and ultimately further put clients at risk.

Conclusion

The POS studied has shown remarkable instances of resilience in the face of resource constraints. It is believed that the commitment to residents is, in a great way, responsible for staff seeking to find other ways to provide genuine care, as opposed to solely controlling residents. The study suggests that this commitment, born from training and meaningful interaction with the residents, helps prevent staff from developing socio/emotional symptoms associated with institutionalism.

Implications for Social Work Practice

This study has highlighted the need for social workers to play a greater role in Jamaican child welfare system. It is important that programme administrators adopt a truly multi-disciplinary approach to therapeutic care. Inherent in this is the need for social workers to fully utilise their therapeutic skills. Reducing the role of social workers solely to that of case managers, is a waste of potential and resources available to the State. Social workers then must empower themselves, and advocate for themselves- urging administrators to allow them to function in their clinical/medical role, instead of relegating them to case management.

Recommendations

In his classical work *Rethink*, journalist Gordon Rattray Taylor (1972) wrote “the future cannot be, must not be, simply an extension of the past: a radical rethinking of the whole system is needed" (p.9). Likewise, the child welfare system in Jamaica requires radical ideas and new strategies if it is to be deemed truly effective. The following recommendations are therefore offered:

Short Term

- **expand research**: This study should be expanded to include a larger cohort of participants (residents and staff), as well as other POS'.

Medium Term

- **improve policies regarding POS**: CDA's 2010 SOC's should be updated to define a POS', be more specific in terms of time frames within which residents' cases are reviewed, and the period of time a child should stay in the POS.
- **assign qualified Clinical Social Workers to RCCFs**: Psychosocial screening does not have to be done only by clinical psychologists. It is recommended that every RCCF be staffed with one residential social worker for every 20 residents at most.
- **mandatory psycho/educational assessment**: The state should ensure every child who is placed in a POS undergoes a psycho/educational assessment. This should be done in conjunction with the resident's medical examination within the first month of their arrival at the POS.

Long Term

- **convert large RCCFs:** In the spirit of deinstitutionalization, large RCCFs should be converted into short term therapeutic centres. While these centres will be residential, they should function as short-term child-friendly therapeutic environments. It is recommended that children be admitted for no more than 3 months, and that each centre facilitate a maximum of 30 children in the overnight facility. Coupled with the overnight facility, should be a drop-in centre where children in alternative living arrangements can receive psychological care. The facility should be staffed with a multidisciplinary team of clinical professionals, and feature play therapy rooms, adventure therapy facilities, and a dance/yoga studio.
- **group homes:** As large RCCFs are phased out, children in need of care and protection require a sustained sense of family throughout their life. The state is urged to move towards developing small group homes, and expanding the foster care programme to include therapeutic foster carers.

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References

Abdul Latiff Jameel Poverty Action Lab. (2014). *Process evaluation*. http://www.povertyactionlab.org/methodology/what-evaluation/process-evaluation

Bettelheim, B., & Sylvester, E. (1948). A therapeutic milieu. *American Journal of Orthopsychiatry, 18*(2), 191–206. https://doi.org/10.1111/j.1939-0025.1948.tb05078.x

Child Development Agency. (2008). *Annual report - 2007/08*. Ministry of Youth and Culture.

Child Development Agency. (2010). *Guidance and standards of care for residential child care facilities.* Ministry of Youth and Culture.

Child Development Agency. (2013). *A policy to amend the child care and protection act*. Ministry of Youth and Culture.

Child Development Agency. (2014). *The journey to create a nation fit for our children continues...highlights (2004-2014).* Ministry of Youth and Culture.

Children's Authority Act (Act No. 64 of 2000) Trinidad and Tobago. http://www.ttparliament.org/legislations/a2000-64.pdf

Berridge, D., Biehal, N., & Henry, L. (2012). *Living in children's residential homes* (Research Report DFE- RR201). University of Bristol. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/184079/DFE-RR201.pdf

Department of Human Resources. (2002). *Minimum standards for child-placing agencies*. State of Alabama Department of Human Resources.

Dooley, C. (2012). "The older staff, myself included, we were pretty institutionalized ourselves": Authority and insight in practitioner narratives of psychiatric deinstitutionalization in Prairie Canada. *Canadian Bulletin of Medical History, 29*(1), 101–123. https://doi.org/10.3138/cbmh.29.1.101

Francis, J. (2014, May 8). Holness wants church to take over children's homes. *The Gleaner.* http://jamaica-gleaner.com/gleaner/20140428/lead/lead7.html

Goffman, E. (1958). Characteristics of total institutions. *Symposium on Preventive and Social Psychiatry* (pp. 43–84). Walter Reed Army Institute of Research.

Grinnell, R. M. (1997). *Social work research & evaluation: Quantitative and qualitative approaches* (5th ed.). F.E. Peacock Publishers.

Johnson, M., & Rhodes, R. (2007). Institutionalization: A theory of human behaviour and the social environment. *Advances in Social Work, 8*(1), 219–236. https://doi.org/10.18060/143

Laszlo, A., & Krippner, S. (1998). Systems theories: Their origins, foundations and development. In J. Scott Jordan (Ed.), *Systems theories and a priori aspects of perception* (1st ed., Vol. 126, pp. 47–74). Elsevier Science B.V.

Martin, D. V. (1955). Institutionalisation. *The Lancet, 266*(6901), 1188–1190. https://doi.org/10.1016/S0140-6736(55)92918-4

McLean, S., Price-Robertson, R., & Robinson, E. (2011). *Therapeutic residential care in Australia: Taking stock and looking forward* (NCPC Issues No. 35). Australian Institute of Family Studies.

New Beginnings Transit Home. (2011). *Standard operating procedures.* Ministry of Health, Wellness, Human Services and Gender Relations.

Office of the Children's Advocate. (2013). *Child justice guidelines*. Office of the Children's Advocate.

Patton, W. W. (2014). *Child protective services- Historical overview, current system*. Education Encyclopedia– State University. http://education.stateuniversity.com/pages/1828/ChildProtectiveServices.html

Prevention of Cruelty to Children Act. (1998). Barbados. http://badaj.org/wp-content/uploads/2014/07/Prevention%20of%20Cruelty%20to%20Children%20Act.pdf

Rosenblatt, A., & Mayer, J. E. (1974). The recidivism of mental patients: A review of past studies. *American Journal of Orthopsychiatry, 44*(5), 697–706. https://doi.apa.org/doi/10.1111/j.1939-0025.1974.tb01148.x

Saunders, R. P., Evans, M. H., & Joshi, P. (2005). Developing a process-evaluation plan for assessing health promotion program implementation: A how-to guide. *Health Promotion Practice, 6*(2), 134–147. https://doi.org/10.1177/1524839904273387

St. Michael's school for boys closes, after 129 years (2018, May 2). *Trinidad Express Newspapers.* https://trinidadexpress.com/news/local/st-michaels-school-for-boys-closes-after-129-years/article_df669fc2-4e29-11e8-bbb1-eb46f85860ff.html#:~:text=The%20Office%20of%20the%20Prime,for%20Boys%20in%20Diego%20Martin.

Taylor, G. R. (1972). *Rethink.* Book Club Association

Tjelflaat, T., & Bolstad, T. (2008). Looking back to look ahead: Abuse and neglect of children in institutions. *IUC Journal of Social Work Theory & Practice,* (18). https://www.bemidjistate.edu/academics/publications/social_work_journal/index.htm

United Nations General Assembly. (2009). *United Nations Guidelines for Alternative Care of Children.* United Nations General Assembly.

Walter, U. M (2007). *Residential treatment: A review of national* literature (Best Practices in Children's Mental Health Report no.20). University of Kansas.

Wing, J. K. (1962). Institutionalism in mental hospitals. *British Journal of Social and Clinical Psychology, 1*(1), 38–51.

Wirt, G. L. (1999). Causes of institutionalism- Patient and staff perspectives. *Issues in Mental Health Nursing, 20*(3), 259–274. https://doi.org/10.1080/016128499248655