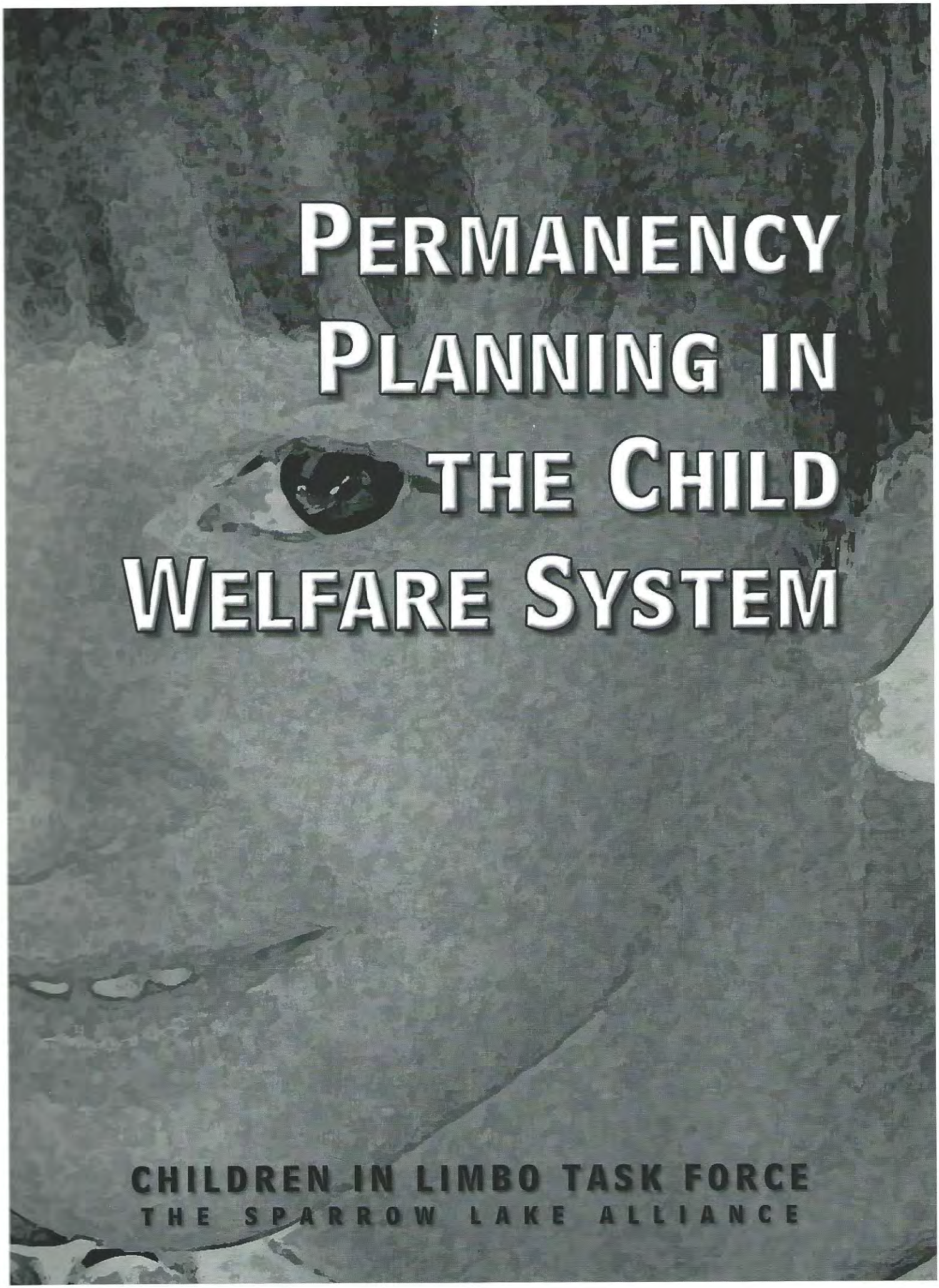
PERMANENCY PLANNING IN THE CHILD WELFARE SYSTEM
CHILDREN IN LIMBO TASK FORCE
THE SPARROW LAKE ALLIANCE

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Published by the
Sparrow Lake Alliance
January 2002

Permanency Planning in Child Welfare is available from:

The Canadian Resource Centre on Children and Youth (CRCCY)
75 Albert Street – Suite 209
Ottawa, ON K1P 5E7

Telephone: (613) 235-4412, Extension 24
FAX: (613) 235-7616
E-mail: crccy@cwlc.ca

National Library of Canada Cataloguing in Publication Data

Permanency planning in the child welfare system.

Includes bibliographical references.
ISBN 0-9698650-2-3

1. Child welfare—Planning. I. Sparrow Lake Alliance. Children in Limbo Task Force.

HV713.P47 2002 362.7 C2001-904239-6

ACKNOWLEDGEMENTS

The Children in Limbo Task Force extends grateful thanks to:

Our Editor, **Beth Herst**, whose hard work and dedication brought the document together;

The ***Children's Aid Society of Toronto*** for graciously hosting our meetings throughout our many years of existence as a Task Force of the Sparrow Lake Alliance;

The ***Shoniker Clinic*** for providing photocopies of the minutes and documents of the *Children in Limbo Task Force;*

Lynda Brown, *Shoniker Clinic*, for her secretarial services;

Liz Manson, *Hospital for Sick Children*, whose ready encouragement and assistance was instrumental in the completion of the project.

The Sparrow Lake Alliance would like to express deep appreciation to the following organizations whose generous financial support made possible the preparation and printing of this publication:

Dr. Marshall Korenblum and ***The Toba Korenblum Fund for Children;***

Hope for Children Foundation and the ***Children's Aid Foundation.***

HOPE *for* CHILDREN FOUNDATION
Serving the Catholic Children's Aid Society of Toronto

Children's Aid FOUNDATION

Cover design: **P. Colleran,** ***Surph Inc.***

DEDICATION

This book is dedicated to the memory of **Paul David Steinhauer**.

Paul's vision and initiative brought the contributors together as the *Children in Limbo Task Force* of the Sparrow Lake Alliance. The Alliance, founded by Paul in 1989, is a voluntary coalition of Ontario professionals who work with children. This *Task Force* – and the Alliance – represent Paul's goal: to bring together people from all sectors and disciplines, who would inspire, support, teach and learn from each other, and who are committed to working towards ensuring a better life for all of Ontario's – and Canada's – children, youth and families.

Paul's contribution to this publication is immeasurable. The material he contributed himself is essential. His comments at the meetings of the *Task Force* were always clear, informed, and encouraging.

All of us who worked with Paul on this project are deeply saddened and we know that children have lost a skilled clinician, a tireless advocate and a compassionate friend.

Paul died without having seen the finished work. Those of us left to complete the book hope that he would have approved and that his loving and creative spirit will be found in its pages.

OVERVIEW

INTRODUCTION

James R. Wilkes

This book is intended to promote optimal care and management of children in the child welfare system. It is directed primarily at the front-line and supervisory staff of Child Protective Services (CPS). It could also serve as a resource for lawyers, judges, social workers, psychiatrists, psychologists, teachers, child and youth workers, and other professionals who work with children in the child welfare system.

Underlying the material are two important principles of competent child welfare practice: the need for timely and thorough planning and the need to provide continuity of care. Some of the suggestions and principles set forth may be difficult or even impossible to implement with available services and funding. Such material is in no way intended to undermine or criticize child welfare professionals; rather, it is intended to provide information that can be used to advocate for further education and training of child welfare staff, and for the establishment of adequate and available resources in the community.

It is recognized that the policies governing child welfare practice are continually evolving; what is written here may have to be adapted to ongoing legislative or policy changes. It is also understood that the emphasis on the education and practices of child welfare practitioners must strike a balance between the necessity to adhere to existing legislative and administrative policies on the one hand, and the provision of humane, informed, and sensitive care on the other. While the focus of this publication is on the latter, there is no intention to diminish the importance of the former; rather, the intention is to provide a balance at a time when legislative and administrative considerations seem to be dominating child welfare practice.

Much of the material that is presented here comes from child welfare experience in the province of Ontario. It is understood, however, that the issues raised are not unique to Ontario, but have wide application. With this in mind, the aim has been to keep the discussion broad and to promote the general issues that lie behind the particular examples.

This publication deals with children who, because of abuse, or neglect, or both, have been taken from their homes by the CPS and placed in alternative care of some kind. In 1996, the Limbo Task Force of the Sparrow Lake Alliance published *Children in Limbo*, which looked at the plight of children who lack continuity in their care and drift through placements and caregivers. That publication dealt with the precursors and causes of limbo and suggested measures for its prevention and treatment. It also described the emotional difficulties and functional deficits that children suffer as a result of being in limbo. As that work was nearing completion, it became clear that there was a need for another document that dealt with the fundamental principle important in preventing limbo; namely, the early provision of a permanent plan.

The term *permanent* has to be understood in relative terms, because life is always changing. And this is particularly so with children who are subjected to change in the persons and circumstances around them, as well as change in their own interests, affections, and capacities resulting from their growth and development. An attitude to planning that does not take this into account is likely to result in a child being constrained in a plan that is inhibiting and potentially harmful. For example, an access arrangement that may be suitable for a child of five or six may not be suitable for a child of 13 or 14. It is also important that a child be able to form an emotional attachment to a permanent primary caregiver by being freed from the emotional pull of ordered access with a non-nurturing caregiver. If child welfare agencies and the courts are to be sensitive to the best interests of children, they must be open to the necessity of adapting to children's changing and developing emotional and relationship needs.

Planning for children in care is complex and involves sorting through a number of factors and issues. It is intended that this publication will help all those interested in planning for children in care to understand the process more thoroughly so that, in the end, such children will be planned for more effectively. When the complexity of competent planning is not recognized, the way is open for a number of well-meaning but potentially harmful initiatives from the legislative and therapeutic sectors.

The document begins with an overview of the issues surrounding permanency planning. It then goes on to discuss the various issues in more depth. A single subject cannot be understood properly without making reference to the important influences that bear on it. With the range of material covered in the document, overlap was unavoidable. There has been an attempt to edit the material so that extensive discussion and elaboration of issues occur in one place only.

The introductory section provides a planning flow chart with an accompanying glossary that show how children move in the child welfare system. At the different stages in the process, a case can be managed with varying degrees of competence. This is simplified under the headings "Functional Process" and "Dysfunctional Process". Under each heading of the flow chart glossary are the title and page number of papers pertaining to that particular subject. Planning requires that decisions be made bearing in mind a number of factors; these are summarized as "Factors Affecting Planning". The introductory section concludes with "Extending Options in Permanency Planning", which gives an overview of the current child welfare situation, and sets out various options that need to be explored to help expedite permanency planning.

While the document deals with children in care, it was felt important to include material on how best to maintain the child at home and so prevent the slide into limbo. The paper "When Should Children be Taken into Care?" looks at the actual decision process. Often a permanent plan for a child is delayed because of futile efforts to reunite parent and child. The need for proficiency and the importance of speeding up the decision process have led some children's aid societies to an over-reliance on risk assessment tools. A discussion of the potential problems involved in such over-reliance is outlined in the section "Use of Risk Assessment Tools". An important aspect of planning and caring for a child is the adequate and timely sharing of information with the child. This subject is covered in the paper "Truth or Consequences".

A critical aspect of child welfare practice is the use by the biological parents and family of contact and access with the child in care. Contact and access can be helpful or destructive to the welfare of children, and much depends on how thoroughly the various issues involved have been explored before the access and contact plan was formed. The section "The Use of Access" has a brief introduction on access variables and principles. A more thorough discussion of the use of access, along with considerations for decisions in access planning, are covered in the paper "The Role of Access in Permanency Planning".

The matter of adoption with access remains a controversial practice. Rather than coming down on one side or the other, the publication tries to address the salient issues. "Adoption and the Issue of Access or Contact" introduces these issues. Three papers from different perspectives help to flesh out the discussion. The paper "Adoption with Access" shows the advantages of open adoption for particular children. The practice of mediation has been gaining in importance and is highlighted in the paper "Using Mediation as an Effective Technique to Achieve Success in Open Adoptions". The paper entitled "Access and the Changing Face of Adoption" speaks to current aspects of adoption practices.

The section "Placement Out of the Family Home" has a brief introduction and contains papers entitled "Foster Care" and "Staff-Operated Settings". The unfortunate outcome of many children in limbo is that they become attachment-resistant. Such children pose significant problems for their caregivers, and they consume an inordinate amount of professional time and expertise. A therapeutic approach to these children is described in "The Recognition, Prevention, and Management of Attachment Disorders Within the Child Welfare System".

In the section "Youth Transition to Independence", the importance of educational and vocational planning for youth is stressed. The necessity of maintaining support and care for youth past the age of 16 is made clear.

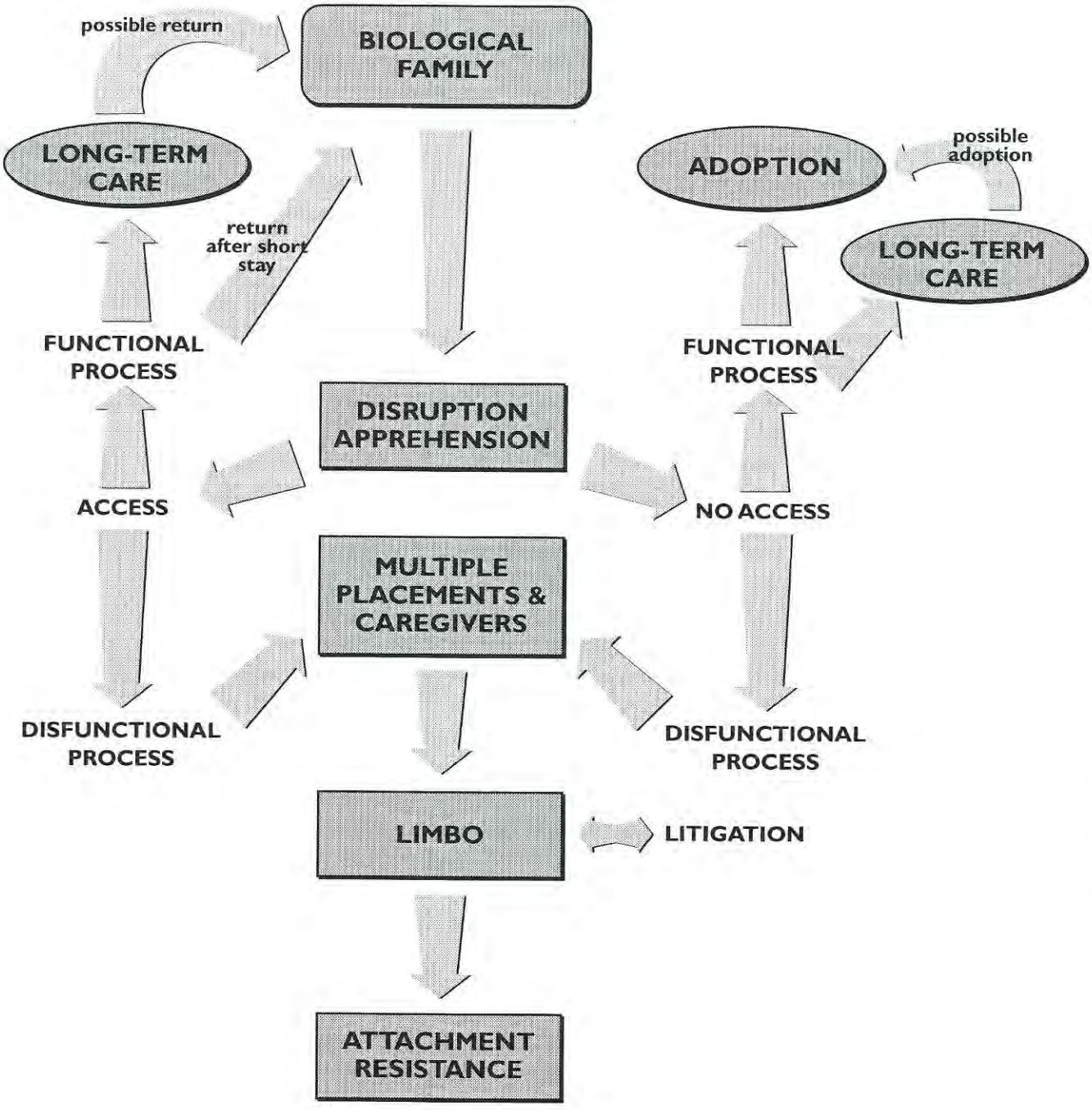
In the interest of uniformity the term **foster caregiver** is used instead of foster parent. The term **CPS worker** is used as the inclusive term and replaces CAS Social Worker and Protection Worker.

Throughout the document the terminology cites the **Child Welfare System** as the inclusive term.

Within this system are:

1. Child Protective Services (CPS) – also known as Children's Aid Society (CAS)
2. Family Court System
3. Children's Mental Health Services

PLANNING FLOW CHART



Developed by the Limbo Task Force, Sparrow Lake Alliance

GLOSSARY

Biological Family

Where possible, while bearing in mind the safety and well-being of children, child welfare staff work to maintain children with their families.

Disruption and Apprehension

When the function of the home is disrupted to the point that it cannot adequately care for a child, then the decision is made to bring the child into the care and protection of the child welfare agency. The family may or may not be in agreement with the decision.

Reference: "When Should Children be Taken into Care?" (pp. 27-32); "The Use of Risk Assessment Tools" (pp. 33-39)

Access or No Access

The decisions made around access are of crucial importance. These decisions are not only about whether or not to permit access and the frequency and duration of access, if permitted, but also how best to manage access to obtain the casework objective.

Reference: "The Role of Access in Permanency Planning" (pp. 59-88)

Functional Process

Thorough and timely assessment; carefully planned casework; clear and timely decision-making; open communication and cooperation between the family, child welfare staff, and mental health professionals; sensitive conflict resolution; well-planned access visits; clear explanation of issues to the child; and child-focused court proceedings.

Reference: "Factors Affecting Planning" (pp. 10-14); "Truth or Consequences" (pp. 40-54)

Dysfunctional Process

Inadequate assessment and understanding of the issues involved; reactive decision-making; drifting casework; failure to explain issues adequately to the child; vague or confusing access planning; conflict and hostility between the family, child welfare staff, and mental health professionals; delayed and adversarial court proceedings.

Return Home

The commonest outcome of children coming into care is to be returned home in less than six months. Where there has been a dysfunctional process, it is quite likely that there will be further disruption, increasing the likelihood of the child returning to care and drifting into limbo.

Adoption

The plan of choice when access has been terminated and there is a suitable substitute parent-figure available who is willing to adopt the child. If the child has formed a strong emotional attachment to a substitute parent-figure, the child should not be moved.

Reference: "Adoption and the Issue of Access or Contact" (pp. 90-92); "Adoption with Access" (pp. 93-100); "Using Mediation as an Effective Technique to Achieve Success in Open Adoptions" (pp. 101-122); "Access and the Changing Face of Adoption" (pp. 123-129)

Long-Term Care

The child is in care for an extended period of time, which in some cases will extend to the age of majority. Ideally, the child is returned home or adopted when it becomes possible and is in the child's best interest.

Reference: "Foster Care" (pp. 132-136); "Staff-Operated Settings" (pp. 137-143); "Youth Transition to Independence" (pp.173-184)

Limbo

The situation into which children drift when there has been ongoing discontinuity in their care. Limbo usually involves lengthy and emotionally taxing court proceedings. Children who are caught in limbo suffer life-long deficits in social and emotional functioning.

See separate publication: Sparrow Lake Alliance (1996). *Children in Limbo*. Toronto: Author.

Attachment Resistance

Limbo contributes to the development of attachment difficulties in children. Such children are particularly difficult to plan for. Their behaviour is difficult to manage, and they tend to exhaust their caregivers, making them vulnerable to further moves.

Reference: "The Recognition, Prevention, and Management of Attachment Disorders within the Child Welfare System" (pp. 144-171)

FACTORS AFFECTING PLANNING

James R.Wilkes

This chapter is a brief introduction to the various factors that have to be considered in planning for children. Many of the issues touched on are dealt with more fully in the body of the book.

I. **CHILD**
1. age
2. emotional health and behaviour
3. capacity to attach
4. significant attachment figures
5. need for specialized care

II. **BIOLOGICAL PARENTS**
1. parenting capacity
2. cooperation with what is in the child's best interest
3. working with treatment settings
4. working with foster home

III. **SUBSTITUTE PARENTS**
1. capacity to hold and help child
2. willingness to commit to long-term placement

IV. **AVAILABLE SUPPORT SERVICES**
1. financial
2. therapeutic

V. **COURT SYSTEM**
1. awareness of emotional and developmental needs of children
2. limits of court adjudication
3. opportunity for mediation
4. evidence of parenting capacity

VI. **POSSIBLE PLACEMENTS**
1. remain at home with support
2. home of relative or friend
3. adoption
4. foster care
5. specialized foster care
6. parent-operated group home
7. staff-operated group home
8. residential treatment setting
9. hospital
10. correction facility

INTRODUCTION

Planning for the care of a child whose emotional and/or developmental needs are not being met is a complicated task. Not only does it require judgement on what the child ideally needs, but it also requires knowledge about what can actually be provided. Each case will be different from the next. The mental health, coping skills, and relationship qualities of the family members will differ in each situation and will have to be assessed. The availability of support services and adequate substitute homes will differ depending on where the family lives.

Inadequate planning leads a child into limbo. It leads to the likelihood of a child moving from one failed placement to another. It leads to dissatisfaction as well and increases the possibility of litigation.

Good planning is thorough and prompt. Unfortunately, the pivotal decision to move a child from his or her home for the first time is often done with little or no planning. The first move is the most important because it sets the stage for the child's future. Proper planning at this stage should work toward seeking the cooperation and allegiance of the biological parents and not alienating them. It should also establish realistic estimates for length of stay. The energy of the most experienced staff is important at the beginning, not when the child has fallen into limbo and become a major problem. The goal is to avoid a child drifting in care because of a series of short-term "reflex" decisions.

FACTORS TO BE CONSIDERED

Child

Age

The first year of life is crucial for the mental health of a child. During the first year, a child's brain undergoes a complex development. If the child does not receive adequate care, the brain development will be impaired. Furthermore, high levels of stress cause the secretion of hormones that are neurotoxic. The implication of these facts for child welfare personnel is significant. An infant must not be left in a situation of high stress and/or neglect. Time is precious and delay can be devastating. At the same time, infancy is the period in which the child develops permanent attachment with parents, so that separating a child from parents at this age can have life-long consequences. If separation is necessary, every effort should be expended to have frequent contact (preferably daily) between child and parent. If the decision is to separate the child permanently, the sooner this can be done, and the child permanently placed, the better.

Age is also a factor in how the child is informed of the plan that is undertaken. Adequate records must be kept so that the younger child can be helped to understand the thinking behind the plan when the child becomes old enough to understand. All children have to be assisted in understanding the decisions behind the plan or else they can be left with a high sense of vulnerability and an underlying sense of impotence.

Emotional Health and Behaviour
The planning decisions relating to emotional health and behaviour are whether the child can be managed in a home setting and what the needs for treatment and support services are.

Capacity for Attachment
This is really a category that belongs under emotional health, but its importance requires a heading of its own. If a child has difficulty with attachment, and this is not adequately dealt with, then the child is likely to have a number of failed placements. Attachment and separation issues are often intermingled. Unless a child has the opportunity to process the past and deal with attachment and separation issues, the child will not be emotionally free to develop close and trusting relationships (see "The Recognition, Prevention, and Management of Attachment Disorders within the Child Welfare System," pp. 144-171).

Close Attachment Figures
An important element in planning is to look at all the important attachment figures in a child's life and to be sure that the child's relationship with each one of them has been considered in the planning. Unfortunately, if a child has to be moved, there will be disruption of these relationships, but the more thoroughly these relationships have been considered and factored into the plan, the less the disruption will be. Issues to be looked at would include distance away of the placement, frequency and nature of contact and visits, and the degree of involvement of major figures in the plans for the child.

Need for Specialized Services
If a child requires hospitalization or high-tech assessment and investigation, it often means a move out of area. It is important to maintain connection with attachment figures and to establish liaison with those services that will be following up.

Biological Parents

Parenting Capacity
An adequate parenting capacity assessment is an essential component in the planning process. All too often, such an assessment is overlooked or undertaken long after important decisions have been made and the child is already on a course leading to limbo.

Cooperation with What is in the Child's Best Interest
The capacity to put the needs of the child first is an important component of parenting. A parent who persistently looks at the child as a possession, and who spends more energy competing with staff or substitute parents than understanding the needs of the child, is not likely to be an effective parent. When such is the case, the parent cannot be part of the planning team.

Working with Treatment Settings
It is a positive sign when parents are able to work effectively with treatment settings. This means that the parents seek to understand their child's problem behaviour rather than criticize it, that they genuinely seek to learn how best to help their child and are willing to look at how they may

have contributed to the difficulties, and that they keep appointments. Parents who are unable to work effectively with treatment settings and simply regard such settings as a place to "fix" their child are not likely to be able to parent their child adequately.

Working with Foster Homes
When parents are able to work cooperatively with foster homes, it is much more likely that the child will be able to return home than it is in situations in which parents are critical of the foster home and seek to undermine it.

Substitute Parents

Capacity to Hold and Help Child
A major problem in child welfare is the child who drifts in care as the child is moved from one failed setting to another. Emotionally disturbed children can put excessive demands on a family, and it is important that substitute parents have adequate support and training. A key strength is the capacity to develop strategies for living with the child rather than working to change the child. Attempts to change the child are seen as rejection by the child, and the usual outcome is frequent power struggles and angry exchanges.

Willingness to Commit to Long-Term Placement
In situations where it is likely that the child is not going to return home, it is important to try to place in a home that offers the possibility of the child staying on a long-term basis. A child will suffer feelings of rejection if the child becomes attached to a home and then has to be moved.

Available Support Services

Financial
There are children who could be kept at home if there were the means to provide the necessary nutrition, transportation, recreation, and relief. The state provides funds for substitute parents.

Therapeutic
The availability of competent and accessible therapeutic services can be important in maintaining a child at home or preventing a placement breakdown.

Court System

Awareness of the Emotional and Developmental Needs of Children

1. Sufficient weight needs to be placed on the importance to the child of significant attachment figures and not just on the importance of the biological parents.
2. The first two years in a child's life are crucial to the child's development: infants should not be allowed to drift into litigation limbo.
3. Access plans should be flexible enough to allow for change in plans as the child grows and develops.

Limits of Court Adjudication

Difficulties with the adjudication procedure may include:

1. Transaction issues (financial costs, delay perpetuating limbo, and emotional costs)
2. Process issues (participation of the parties in both the fact-finding and decision-making process)
3. Outcome issues (the imposition of a "remedy" from a predetermined and limited range of options)

Opportunity for Mediation

Mediation offers the parties the possibility of reaching agreement by facilitating negotiations that focus primarily on interests rather than positions. In planning for children, the possibility of mediation ought to be considered before proceeding to litigation.

Evidence of Parenting Capacity

The past history of parenting is one of the best predictors of future parenting capacity, but this is often not admitted as evidence or given sufficient weight. A psychiatric or psychological assessment of a parent, without the assessor seeing the parent with the child, is of little or no use in assessing parenting capacity.

EXTENDING OPTIONS IN PERMANENCY PLANNING

Gail Aitken

The summary points of this article are the urgency of action: first, to implement the considerable knowledge we have about permanency planning for children in care; second, to extend the options for obtaining appropriate long-term placements; and third, to allocate the resources necessary to do permanency planning well. Too many Canadian children who are permanent or Crown wards are languishing in "limbo" without stable homes and families. Too many children who come into protective custody already badly scarred from devastating experiences in their early years are being further damaged as a result of disrupted care. It is crucial to prevent the attachment disorders that too frequently result from the instability in their lives and the lack of opportunity to relate positively and consistently to at least one parental figure (see Steinhauer et al., "The Recognition, Prevention, and Management of Attachment Disorders", pp. 144-171). We need to develop and extend options in permanency planning in order that more children in society's care can have as healthy an experience as possible.

For the purpose of providing some demographics to illustrate the need and potential to extend permanency planning options, the data in this paper are largely from Ontario, Canada, with some references to other jurisdictions. However, the issues discussed seem to relate to many areas of this country and others.

OVERVIEW OF THE CURRENT SITUATION

The current situation indicates that the professional concerns about children "in limbo" that have been voiced for more than a decade persist (Aitken, 1995; Children in Limbo Task Force, 1996). According to the Ontario Association of Children's Aid Societies (OACAS), on September 30, 2000, there were 14,268 children in substitute care in Ontario, up from 11,260 children on December 31, 1997 (OACAS, March 2001). Of these 14,000, 40%, or more than 6000 children, were Crown wards who needed effective permanency planning and stable long-term placements.

Recently, in most regions of Ontario, as in other parts of Canada, the number of children in care has been rising significantly. Frequently, the growing number of apprehensions is attributed to greater worker vigilance as a consequence of the 1997 Coroner's inquests and recent legislative amendments (Revised Statutes of Ontario, Child and Family Services Act, September 1, 2000). A particular amendment leading to the increased number of apprehensions is the inclusion of neglect as the justification for bringing children into care (Ontario Child and Family Services Act, September 2000, Sect. 37 (2c)). However, the dire circumstances of the children apprehended indicate that workers are not at all equivocal about their need for protection. In Ontario, the number of children in care has increased by 45% since January 1, 1995 (OACAS, February 2001). Further research is important to assess shifts in reasons for apprehensions and

bases for Crown wardship since the mid-nineties. Certainly, in Ontario, the increase in children in care has been disproportionate to the increase in child population.

Despite larger infusions of provincial money during the past several years, the intensity of demands in the child protection system has mounted enormously, and resources are woefully inadequate. Workload pressures and the shortage of good placement options have meant that children who become permanent wards still experience numerous destructive shifts in placements as well as a confusing rotation of workers. Some evidence is contained in the 1999 Ontario Crown Ward Review (Province of Ontario Ministry of Community and Social Services, 2000). Of the children reviewed that year, 1,135, or 42%, had remained in the same placement since becoming Crown wards, 21% had had one placement change, while 37% had had two or more shifts. For many, placement disruptions were affected by changes in worker assignments, with only 19% having one worker, 38% having two workers, and 43% having three or more workers. The long-term damage to these children, who often seem to be batted about like balls on a bedraggled, under-resourced inter-agency playing field, is immeasurable, and the long-term social costs, many intangible, are huge. The instability of placements is reflected in the 1999 Ontario Crown ward Review referred to above. This report indicates that the average placement length at the time of permanent wardship for children under 7 years was 33.6 months, compared with 21 months for children aged 7 to 12 years (the largest group), and about 11 months for those over 12 years of age. Obviously, even in jurisdictions where differences in placement stability among age groups are less marked, the message is clear: the younger the child at the time of placement, the greater the likelihood of stability.

It is important to stress that the provincial or Crown wards for whom child welfare authorities are responsible, are generally not infants. Also, in Ontario, licensed adoption agents handle a very large proportion of the adoptions that do occur and the majority of adoptions of infants. It is the children well beyond infancy who have diminished prospects for adoption. To illustrate: a 1999 provincial survey revealed that while 638 Crown wards were between 0 and 5 years, 1,987 were between 6 and 12 years, and over 3,000 were between 13 and 17 years (OACAS, March 2001). Of the children reviewed in 1999, 58% of whom were males, the average age at the time of their becoming permanent or Crown wards was 7.8 years. Of these, 73% were identified as having special needs, that is they were children who were medically, emotionally, or physically challenged, or were of mixed racial background, or were members of a sibling group. They presented caregivers with extremely complex challenges, particularly since more than half of these children were known to have experienced either sexual or physical abuse. Many had also suffered from psychological abuse, which is more difficult to assess, and presented behavioural problems.

Various options need to be explored for potential means to expedite permanency planning including:

- Increasing the availability of adoption subsidies;
- Reviewing and defining practices regarding contact or access between birth parents and children with a view to avoiding impracticable court-ordered arrangements;

- Encouraging agency-mediated contact arrangements negotiated between the appropriate parties to apply either during alternative care arrangements or after adoption;
- Extending fostering with a view to adoption programs, also known as parallel or concurrent planning;
- Developing and extending post-adoption services;
- Creating a designated or assigned guardianship option that would provide children past the toddler stage with a permanent placement offering greater stability than long-term foster care.

What follows is some elaboration of these options.

THE NEED TO EXPAND THE USE OF ADOPTION SUBSIDIES

A strong case can be made for promoting permanent placements through extending the use of adoption subsidies. Since a very large proportion of provincial or Crown wards have physical, emotional, or mental disabilities needing ongoing attention, the quest for permanent placements is hampered by considerable uncertainty about future medical and educational needs. Although adoption may be the desired objective for many of these children, it is obvious that foster caregivers and other prospective adopters will be deterred from taking that very big step if financial resources and other supportive services available to foster children are unavailable after adoption. In some circumstances, foster caregivers and other adoption applicants who may be quite suitable adoptive families are without the income to provide for a child with special needs. Yet, a loving family of modest means and reasonable expectations may be very appropriate for such a child.

The hesitation to adopt special needs children is intensified in the current political climate where government-insured health care is being hotly debated within provincial government forums and in the media. Certainly, extending the availability of adoption subsidies would enhance the prospects for adoption of many more children. However, because regional child welfare authorities exercise their considerable discretion about how scarce resources are used, subsidies are not consistently available throughout Canada.

Ontario agencies mirror this inconsistent use of subsidy to facilitate adoptions. A major reason for this is that the current provincial funding formula for Children's Aid Societies does not include adoption subsidy as an activity that is volume-based. The resulting problem is that this essentially caps the use of subsidy, rather than creating an incentive to use it extensively to secure permanent placements. Agencies deciding to allocate extensive resources to adoption subsidy do so because they regard this as a top priority amongst many competing claims for scarce resources.

The variation in agency priorities and financial circumstances is reflected in a report of an Ontario adoption survey responded to by 41 of 50 quasi-private Children's Aid Societies. This

recorded that there were 731 children on adoption probation, with 616 children known to have been placed where the family received an adoption subsidy (OACAS, 2001 [Adoption Statistics September 2000]). Although data are incomplete and inadequate, the Ontario picture is of approximately 52 CASs, each determining its own policies and practices regarding adoption subsidy, with no strong correlation between agency size and the extent of subsidization of adoption.

The largest agency in the province, the Children's Aid Society of Toronto (CAST), has a strong commitment to using subsidy to secure permanent placements. Currently, CAST is allocating 1.25 million dollars annually to subsidize over 200 children. Children of all ages, sometimes in sibling groups, are subsidized not only for special needs, but also frequently for daily maintenance costs. This is the case with many multiply-handicapped children who are not covered by any insurance program for required services and treatments. Sometimes subsidization is for short-term transition expenses, such as daycare costs. Another of this agency's very progressive measures is to enter into open-ended subsidies to allow families whose high-risk child may be progressing well at the time of adoption to request help from the agency later if they encounter expensive special needs. This potential support is important to adoptive families who see access to publicly funded services becoming increasingly limited (N. Dale, personal communication, October 13, 2001).

Many small or mid-sized Ontario Children's Aid Societies usually grant subsidies only for special needs. Certain progressive agencies, such as the Family and Children's Services of Guelph and Wellington County provide some maintenance costs, especially to facilitate the adoption of older sibling groups (Personal interviews with officials of the agency, July, 2001). Other agencies, largely due to budgetary constraints, have chosen not to subsidize adoptions.

By contrast, in British Columbia in recent years, adoption subsidies, including allocations for monthly maintenance, are common, and respite care costs for people adopting handicapped children are also assumed by the province. Subsidization is regarded as a major tool in that province's current campaign to promote adoption, a campaign that has resulted in an increase in adoption homes available.

A case sometimes made against subsidized adoption is that it really is not different from foster care and that children might feel resentful that their adoptive parents have to be paid to accept them as family members. This does not seem to be a substantial argument, particularly as so many of these children requiring families have expensive health care or educational costs. In fact, it seems less like bribery than fulfilling the state's responsibility *in loco parentis* – sharing the costs of caring for dependent people. Despite the financial pressures, some agencies are recognizing this; for example, an Ontario review of 59 children on adoption probation, with an average age of seven years, revealed that 56% of them received an adoption subsidy (Province of Ontario Ministry of Community and Social Services, 2000, p.21). As three-quarters of the children reviewed were described as having special needs, this seems entirely appropriate. Considering the child's need for security and stability, the psychological difference for the child between being fostered and being legally adopted may be vast. Given the condition of children who become Crown wards, it seems important to direct more resources to subsidize adoption and

even to helping loving families of modest means cope with the costs of accepting another person to feed and clothe.

To obtain permanent placements there should be greater emphasis on adoption subsidy to promote kinship care and adoption by relatives. Respondents to an Ontario adoption survey mentioned above indicated that, of the 731 children, there were only 70 kinship care placements, including placements of aboriginal children with family or band members. The Saskatchewan government has developed a policy that the "extended family should be considered the priority resource for children who cannot be cared for by their parents" (Saskatchewan Children's Advocate Office, April 2000). Much can be done to promote this in practice, however, and to expand the number of adoptions by selectively and judiciously extending the use of subsidy to facilitate permanent placements with relatives other than the birth parents, as well as with non-relatives. Also, by now, the wisdom and importance of helping native agencies to place Aboriginal children within their own bands seems established and selective subsidization is a means of doing this.

ACCESS ORDERS

Much controversy still exists around access of birth family members to a child not only after permanent or Crown wardship, but also after adoption. As has been pointed out, issues of access have changed permanency planning practice immensely in the past two decades (see Osmond, Perlman, Dale, and Palmer, "The Role of Access in Permanency Planning", pp. 59-88). Also, as Paul Steinhauer, Nancy Dale, and James Wilkes suggest, contact between birth parents, siblings, and other close relatives may be highly appropriate for some older children after adoption (see the chapters in this volume: "Adoption and the Issue of Access or Contact", pp. 90-92; "Adoptions with Access", pp. 93-100, and "Access and the Changing Face of Adoption", pp. 123-129). However, during recent years the percentage of Crown wards having access orders has rapidly increased. In 1999, the courts in 76% of cases sanctioned some degree of contact between Crown wards and birth family members, and access was exercised in a high percentage of those cases. As a numerical example, in the month of March 2000 alone, permanent or Crown wardship with access was ordered for 21 children under age 6 from 9 CASs, and 92 children over 6 years from 30 CASs. However, although a large proportion of children is of school age when they become permanent wards, "No Access" orders are still common but inconsistently applied. Surprisingly, in numerous other instances, the permanent wardship order is silent on access. Yet, currently, by the Ontario Child and Family Services Act, the contact or access that may have occurred during permanent wardship is to be discontinued after adoption (R.S.O. (September 2000) Ch.11, Part 7, Sects.143, 160). Despite this legislative prohibition, it is often impracticable, impossible, or undesirable to prevent a child from having some contact.

The heated controversy around the issue of access between the birth family and child during permanent wardship is even more intense regarding "open" adoption. In jurisdictions such as Ontario, where private adoptions exist and are effected for a high proportion of the adoptions of infants and toddlers that do take place, extra-legal contact between birth mothers and adoptive families has been common for many years in most private adoptions. Provincial documents

acknowledge that court ordered access is a legislative barrier to adoption (Ontario Ministry of Community and Social Services, 2000, p. 9). For many years child welfare experts, such as Marvin Bernstein and others, have outlined ways in which the extent and degree of contact between birth family members and permanent wards and adoptees can be enshrined in provincial child welfare legislation to provide guidelines and protection for the parties concerned (e.g., Bernstein, Caldwell, Clark, & Zisman, 1992).

Other Canadian jurisdictions have recently modified the barriers for ongoing contact between children and their families of origin. In British Columbia, current legislation regarding continuing custody or permanent wardship leaves it to birth family members to apply to the courts for access to the child (Province of British Columbia, *Child and Community Services Act,* Sect. 56). Arrangements are negotiated between the birth family and foster parents, with the region's social work staff mediating (Province of British Columbia Ministry for Children and Families, 2001). If the child moves to adoption probation status, application can be made to continue the access arrangements that applied during continuing custody, and these are often approved. Apparently, due to a spirit of cooperation and good faith, perhaps a result of minimizing the adversarial court process and facilitating birth parents' satisfaction, officials there consider this approach to be successful. In Saskatchewan, too, contact between adopted children and their birth families has also been accepted as generally appropriate, in keeping with current needs, providing some required controls are retained (personal interviews, Saskatchewan government officials, October 16, 2001).

For too long in Ontario, social workers and lawyers have been dealing with problems relating to skirting the law. At this point, considering the changes that have occurred in family structure, the profile of children in care, information technology, and population mobility, it is inappropriate to cling to practices that may have been relevant in the mid-twentieth century. Rather than ignoring this controversial issue, it seems time to remedy inconsistencies between the legislation and good practice, and to develop appropriate guidelines and standards for contact or access.

MEDIATION COUNSELING

In the child's best interests, it is accepted as essential to reduce delays in achieving permanent placements by avoiding protracted adversarial court processes. It seems almost unnecessary to mention the potential savings for both the courts and child protection agencies if permanent wardship, when necessary, is attained speedily. Most important, however, are the benefits to the children who are spared the anguish of unnecessarily prolonged "litigation limbo". Contact between children and birth family members may be entirely appropriate for many children during Crown wardship, and "open" adoption may be the best option for children beyond the toddler stage. However, the necessary skills and resources must be made available for prompt and effective mediation counseling, whenever practicable, as soon as children who are assessed as likely to become permanent wards come into care (see Bernstein, "Using Mediation as an Effective Technique to Achieve Success in Open Adoptions", pp. 101-122).

In Ontario, at this time, skilled mediation counseling is not available at every child protection agency, or even in every community. Yet, trained and experienced child protection staff are required to lead these crucial team processes. As just one example of progressive practice, in Ontario's Wellington agency, where mediation counseling is a high priority, specialized senior social work staff members are assigned the task, generally prior to placement. They find that mediation counseling is empowering to the birth parents, including many with limited potential. The negative effects of coercion are reduced, and volatile or potentially volatile situations can be defused (personal communication with agency officials, July 2001).

Mediation counseling can be viewed as expensive, and, in the short run it is, as is the whole process of comprehensive permanency planning. However, as administrators at the Family and Children's Services of Guelph and Wellington County have determined, savings can be achieved through improved placement choices and a greater number of adoptions, as well as through fewer litigious processes and less staff time in court. To enhance further the mediation process and the likelihood of a successful permanent placement, it seems almost unnecessary to stress that many of these very vulnerable young people should participate in their permanency planning to the degree suitable to their age and circumstances (see Wilkes and Milne, "Truth or Consequences", pp. 40-54).

FOSTERING WITH A VIEW TO ADOPTION

Another technique to promote adoptions that stick is to institute 'fostering with a view to adoption' programs. This approach, used with success around the mid-20th century by some agencies but quickly abandoned, largely because of legal complexities, has recently gained currency. As just one example, staff at the Guelph and Wellington agency mentioned above are enthusiastic about their "parallel planning program" which involves placing some of the children assessed as likely to become permanent wards with adoption applicants. Families selected are those who seem to have the potential to cope with a child's particular needs. Children are then placed with prospective adoptive parents in what are called "flexible resource homes" or "flexible resource families", people who can cope with the tentativeness of fostering the child with the intention to adopt when feasible. This process can be accompanied by mediation counseling of the birth parents and often with their involvement in placement decisions. It can be effective in reducing the number of placements the child experiences in the initial year or so in care, and shortening the time between taking the child into care and gaining permanent wardship. It can enhance the bonding process between the child and the adoptive parents, and reduce the likelihood of adoption breakdown.

Perhaps an even more radical approach to permanency planning is used at Family and Children's Services of St. Thomas and Elgin in Ontario (personal interview, agency officials, August 2001). There all children under six years of age who seem to have little chance of returning home are considered for a concurrent planning program. Two options are developed simultaneously: one being their return home and the other being their prompt placement in a foster home with prospective adopters. This agency has for several years had a foster/adopt program in which all

potential adoptive parents must foster the child for a period of time prior to the adoption probation period. Prospective adopters must attend a foster-care pre-service training program before a home-study is conducted. In some instances, the six-month adoption probation is reduced in view of the fostering period. The agency does not have an alternative adoption service. One consequence of the St. Thomas-Elgin foster/adopt program has been a low incidence of adoption breakdown. There the philosophy is to have the prospective adopters bear most of the risk, rather than the child.

With similar objectives, the British Columbia Ministry of Child and Family Development currently strongly endorses what is referred to there as "concurrent planning". This involves attempting, when taking a child into care, to find a long-term placement with potential adopters. It is consistent with their thrust to promote adoption and find families quickly to avoid the devastating impacts on children of protracted periods of uncertainty and rootlessness (Province of British Columbia Ministry of Child and Family Development, 2001).

Although fostering by potential adopters may be considered presumptive, it has the advantage of facilitating recent legislative changes that reduce the time that children can be temporary wards (e.g. R.S.O., *Child and Family Services Act* (2000), Ch. 11, 70). It also has the advantage of stimulating effective permanency planning by trying to ensure that the first family placement has long-term potential. Because the emphasis from the outset is to evaluate long-term prospects, the child and the prospective adoptive family have an opportunity to test the situation. Given the ages and circumstances of most children for whom adoption homes are sought, it seems entirely appropriate to have a period of fostering before a permanent commitment is made. Fostering with a view to adoption seems to imply that the perspectives of all the parties involved are of concern and allows for variable periods of adjustment before the adoption probation period begins. For the well-being of both the children and the potential adopters, it is important, of course, to minimize the potential for adoption breakdown and all the attendant feelings of failure and rejection that occur when an adoption commitment is made at the outset of a placement.

POST-ADOPTION SERVICES

Currently, in many jurisdictions, few post-adoption services are available. Where they are, it is generally assumed that the request for services will come from adoptive parents, usually in crisis situations only. Again, given the ages and circumstances of most permanent wards available for adoption, it seems wise to assure adoption applicants that it is expected that support may be requested, not only during a preliminary fostering period, or during adoption probation, but also later as the need arises. Given the complex situations of many families who may be coping with concerns about their child's various disabilities as well as issues around contact with the birth family, regular post-adoption counseling could be considered routine. In Ontario, although some of the larger agencies run groups for adoptive parents, such programs are few. Groups for adoptees of latency age or more are almost non-existent, yet seem essential as these children need help in dealing with identity issues and concerns around access to birth family members. To prevent problems from fomenting and to avoid adoption breakdown, it seems crucial to fund

adequately post-adoption services for both individuals and groups and to ensure accessibility. In B.C., where Child Protective Services are funded and administered by the province, the government is sufficiently convinced of their importance and cost-effectiveness that it is currently funding two non-government agencies to run post-adoption programs. This has also been done by child welfare authorities in England where it was thought that, to avoid the stigma that may be attached to major child protection agencies, it was appropriate to establish these programs at distinct locations with their own administration. Certainly, to promote and preserve the adoptions of children and youth in care, it is essential to ensure that high-quality post-adoption services are generally accessible.

THE NEED FOR A LONG-TERM FOSTER-GUARDIANSHIP OPTION

For numerous permanent wards needing homes and families, adoption in the classical manner with rejection of identification with the birth family is simply not an option. In some instances, particularly for children of school age, beneficial contact with birth family members adds sufficient complexity to deter adoption. Sometimes serious, even terminal, health problems of a birth parent, prevent their assuming responsibility for the care of their children, but they would readily co-operate in finding a suitable permanent home. In these circumstances, often children beyond infancy should maintain ties with siblings or grandparents, but need long-term alternative fostering. If a child's medical condition leaves future costs uncertain, given the scarcity of resources available for adopted children in some jurisdictions currently, foster caregivers may be reluctant to move to adopt a child to whom they are very committed. Yet, for both the child and the long-term foster caregivers, it can be important to develop a status reflecting the stability of the permanent parenting role.

A status intermediate between foster and adoptive parent seems to be required. A designated guardianship role could reduce the confusion often displayed by children who are permanent wards in the "limbo" of foster care. Their anxiety is often intense, as they wonder which adult is really in charge: the foster caregiver, the social worker, possibly the birth parent, or some other unknown officials of the agency or courts. Also, a designated guardianship status would give tried and true foster caregivers with commitment greater recognition and clarity about their role. A designated or assigned guardianship status would eliminate the necessity for involving the worker in day-to-day decisions regarding the child, but still leave the parenting figures with the agency's support as necessary. Officially, the province would be the legal guardian until the child reached the age of majority. The children, certainly those of school age, would be able to retain the birth family name, and thereby gain a sense of loyalty, but they might also gain a reassuring sense of the foster family's long-term commitment.

An intermediate status between fostering and adoption has been considered in various places, such as England during the early 1990s, but the complexity of dealing with how the state could maintain its status as legal guardian has generally been an impediment to developing it. In Canada, Saskatchewan is making advances toward developing an appropriate process for

assigning guardianship to tried and true foster caregivers, although this has not as yet been incorporated in the Saskatchewan Child and Family Services Act (personal communications, officials of the Saskatchewan government, October 2001). Considering the circumstances of many older children in care and their need for stability and support throughout their transition into adulthood, it is important to undertake the challenge to develop ways of enhancing long-term fostering (see Milne, "Youth Transition to Independence", pp. 174-184). It is important now to establish interdisciplinary task forces to examine how a permanent placement such as designated guardianship could be developed as an alternative to adoption.

INTEGRATED EFFORT TO REDUCE THE LENGTH OF LIMBO PERIOD AND PROVIDE FAMILIES FOR CHILDREN IN CARE

It is crucial that various measures be meshed to improve permanency planning. These include modifying child welfare legislation and policy, streamlining agency and court processes to facilitate placements, and improving the qualifications of judges, lawyers, and child welfare professionals for their decision-making roles. Social work education must focus on developing practitioners with expertise in permanency planning, workers competent to find and weigh the choices available to gain stability for children in their care. Also, concerted media campaigns are needed to increase public awareness of the various ways they can assume the parenting role for children in care. Adoption, particularly adoption in the classical sense, with all its attendant restrictions and secrecy, is only one option on the continuum of choices available to provide children with the permanent placements they urgently need.

No single measure will have great impact on finding permanent homes for children in care. Many of the steps suggested here are controversial, but controversy should be encouraged and some of it resolved by reforming policy and practice. Effective comprehensive permanency planning is expensive in the short run. However, in its absence, the long-term tangible and intangible costs of the devastating effects on thousands of children in state care are huge and immoral.

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II. Removing the Child from Home

WHEN SHOULD CHILDREN BE TAKEN INTO CARE?

Paul D. Steinhauer

[Note: This chapter was prepared for publication by the editor.]

When are children best protected by removing them from their natural families and placing them in substitute families? And when are they best served by working with them within their natural families?

There is always a risk involved in removing children from their natural families to take them into care. That must be balanced against the risk of not apprehending children, when the failure to do so has the effect of lengthening their exposure to neglect and abuse. To minimize the risk involved in an unnecessary separation, and to avoid unnecessary and inappropriate intrusion into the life of the family, children should be apprehended only as a last resort, and only when three conditions are met:

1. The safety and/or the development of the child are so compromised by chronic neglect and/or physical, emotional, or sexual abuse within the family that the child's current adjustment and future development have either already been damaged or are at serious and ongoing risk.

2. There is clear evidence that the parents lack the capacity to improve their parenting at least to a level capable of supporting normal development, assuming that the best help and supports that are reasonable are available within a time-frame that is appropriate to the age, basic needs, and time sense of the child.

3. The risk of not taking a child into care - that is, of leaving that child to remain within a family that is continuing to constitute a threat to his or her safety or ongoing development - is greater than the risks involved in apprehension.

Taking a child into care is like starting a war. It is easy to fire the first shot, but even easier to lose control over the process that has been started by the apprehension. There is always risk involved in bringing a child into care, and especially into a child welfare system that, after years of under-funding and over-extension, may lack the resources to meet the child's particular and often considerable needs at an adequate level. At the very least, apprehension risks disrupting the child's existing attachment relationships, which usually provide the basis of whatever sense of security the child has. This may precipitate a sense of loss and a separation reaction that the child may not be able to resolve successfully. There is the added risk that the child will not find, within a tolerable period of time, an adequate replacement family able to provide the nurture, stimulation, structure, security, and permanence so badly needed in order for normal development to proceed. This is a particular risk in view of the dearth of foster families and the lack of resources in the child welfare system in Canada today. Caseloads are often so large and specialized training, supervision, and morale in such short supply that the rate of burnout of both

workers and foster caregivers is predictably high. As a result, it is probably no longer realistic to expect that children will routinely receive the quality and continuity of surrogate parenting that all children deserve if taken into care.

Apprehension, therefore, should be undertaken only when failure to apprehend is associated with even greater risk to current safety or future development. These risks are aggravated, at least in most Canadian provinces, by legislation that often gives a higher priority to the rights of parents and families than to the needs of children. This bias is further magnified by a legal system frequently insensitive to the effect of multiple delays on the needs and best interests of children. These delays so prolong the decision-making process that it frequently takes several years before effective permanency planning can even begin. Yet the longer that children remain in limbo - i.e. lacking continuity with their major caregivers and confused about family relationships, parental authority, past history, and, especially, future plans - the greater the risk that they will lose hope and become resistant to all attachments.

For all these reasons, and because the state should intrude on the family only when nothing less will protect the safety and development of children, every effort should be made to support a family to meet the needs of its children before ever removing its children from the family. While such a policy has traditionally informed practice within child welfare, the last two decades have seen an increasing emphasis on the use of "family preservation models" or "wrap-around services". In these services, a massive, short-term infusion of resources is applied to families whose children are at risk for coming into care in order to avoid apprehensions wherever possible. The theoretical rationale for such services is to try to alleviate the overwhelming, multiple, coexisting problems and stresses often related to poverty and disadvantage that aggravate the family's psychological and interpersonal problems and result in the neglect, conflict, and abuse so common in these families. Such families, too, are not infrequently receiving services simultaneously from many professionals and agencies whose advice and interventions may be uncoordinated or even contradictory.

Family preservation models attempt to engage and empower families to function and to regain control over their lives through the provision of a prompt, intensive, home-based, and around-the-clock service - some offering over 100 hours within a period of weeks. The goal is to provide a coherent mix of services tailored to the particular needs of family members and the family as a unit. The rationale is that if the client families receive the help they need at the time, in the way, and to the extent that they require it, then: (a) the excessive pressures on the family will be relieved sufficiently to lessen significantly familial distress and dysfunction that are being aggravated by intolerable stress levels; and (b) the existing crisis can be used productively to allow the family members to regain control of their lives and to help them develop newer and better methods of coping, problem-solving, and parenting for the future. Because of the levels of time and energy that such programs require, their workers have extremely small caseloads (between three to six) and are assigned to families in teams. For such programs to succeed, their workers must have prompt and ready access to a wide range of practical and professional resources and community services provided by cooperating agencies and treatment centres. Workers in such programs are expected to juggle their personal schedules in order to meet their clients' needs and demands.

It should be noted, however, that not all neglect and abuse can be eliminated by wrap-around programs of this sort. The Homebuilders program, one of the earliest and best-known family preservation programs, accepted only families in which at least one parent was willing to participate, while neither parent opposed the goal of placement diversion (Kinney, Madsen, Fleming & Haapala, 1977). These criteria excluded many of the most disorganized, neglectful, and abusive families in a typical child welfare caseload. Problems in obtaining outcome studies that provide reasonable estimates of such programs' effectiveness and cost have been noted (Frankel, 1988; Cameron & Bidgood, 1990; Pecora, Fraser, & Haapala, 1990).

Recently there has been an increased - and not always realistic - emphasis on family preservation programs that has not always kept in balance both the strengths and limitations of such programs. So far, no family preservation program has been shown to be effective. That does not necessarily mean that they cannot be effective, rather that the studies of these programs have not been done carefully enough to demonstrate conclusively how effective they really are. In the meantime, until research provides more definitive information, here are some clinical issues to consider when using family preservation programs:

- Family preservation programs can provide a unique opportunity for in-depth assessment that can hasten permanency planning.
- Earlier intervention increases program effectiveness.
- The potential for rapid response to crisis adds to program effectiveness.
- The greater the level of support and the range of promptly available services, the more effective the program.
- Even with high-risk adolescents, such programs can decrease both entry rates and time spent in care.
- Documented physical and sexual abuse decreases program effectiveness.
- A randomized control group is needed to assess accurately the effectiveness of any given program.
- Although family preservation programs can be excellent, when workers terminate the intense services and the family loses the external motivation (i.e. immediate threat of apprehension), then often the family does not follow through. Many of these cases are reopened later. Sometimes families need ongoing, intensive support. Families should be weaned slowly off these programs so that services are more entrenched.

One essential component of family preservation and wrap-around programs should be the constant awareness that neglect and/or abuse may be continuing in spite of the program. Well-trained and experienced family preservation workers are often aware within a few weeks whether the program is working. Is the family truly utilizing the workers' assistance and potential for teaching? Are the workers being resentfully tolerated? Are they being used to take the children off the hands of parents who have no commitment to improving their parenting? Have the parents accepted their assistance only as a legal maneuver to convince the court that they are prepared to cooperate in order to have their children returned to their care? As a result, the decision about which is least detrimental - continuing family preservation or taking the children into care - requires ongoing monitoring and realistic evaluation (Steinhauer, 1991, pp.122-127).

Rather than being seen as a panacea for all families, family preservation should be targeted selectively towards families that meet the following criteria that suggest they have the capacity to improve their level of parenting:

- The family has a history of having functioned and raised its children successfully over an extended period, until an influx of major stresses (e.g. marital separation, catastrophic unemployment, mental illness, loss of housing) created a crisis that precipitated a sudden and clear decompensation from its previously adequate level of functioning.
- In the absence of the above, the family does not have a history of repeated and malicious physical or sexual abuse.
- If drug or alcohol abuse is present, the parents have succeeded in a program for substance abusers before beginning a parenting program.
- The family shows a reasonable potential for change in parenting capacity.

Assessing potential for change in parenting capacity:

1. The parents take some responsibility for the family problems, rather than denying them and/or blaming others for them. This may not be true initially, but unless the parents are able to behave as if they are taking responsibility within a period of weeks - even if they remain unable to acknowledge it verbally - their failure to do so is an indicator that they do not consider their parenting a problem and therefore are unlikely to change it substantially.

2. The parents desperately want the child returned and are both cognitively and emotionally open to learning new parenting techniques. However, while a teaching and supportive approach can often be extremely helpful, some parents are not open to learning about or are not capable of improving their parenting. For example, if their failure to improve attitude and skills is not due to a lack of knowledge, but rather to the interference of unresolved attachment issues, or to a rejection of societal values and norms regarding childrearing, then repeated exposure to parenting courses is a waste of time and scarce resources. Parenting courses will achieve nothing other than keeping children in limbo longer and/or prolonging their exposure to neglect and abuse.

3. The parents have a history in the past, from one or more attempts to engage them therapeutically, of successfully forming a therapeutic alliance and of making significant and sustained improvements in parenting. (It should be recognized in this regard that some mental health agencies place unreasonable demands on their clients that those with multiple problems are incapable of meeting. Such agencies repeatedly set up such parents for failure, and the resulting lack of compliance or termination may say more about the treatment centre than about the parents.) The longer the history of interventions in the past that have either proved unsuccessful or have produced only short-term gains that have since been lost, the more one would question the capacity for change with yet another therapeutic intervention.

4. The parents have a network of supportive friends or neighbours and have shown capacity to relate successfully to a number of societal institutions and authority figures (bosses at work; their children's teachers; the police; medical professionals; social assistance workers, etc.).

5. At least one parent or partner does *not* have a chronic psychiatric disorder - which includes a personality disorder - that is significantly undermining the child's development or safety. If the parents do have psychiatric disorders that are seriously undermining parenting, they are accepting treatment for those disorders and are capable of responding to the treatment.

The more of the above conditions that exist, the more likely it is that a family would benefit from a trial of family preservation to see if it can be helped to achieve a new level of equilibrium and parenting. The fewer of these conditions that are met, the less likely the family is to make significant and lasting gains in functioning and parenting from a family preservation approach. Any attempt at intensive family preservation should be seen as a trial, subject to careful, ongoing, realistic monitoring to determine within weeks whether the parents are indeed being helped by the intervention, or whether it is merely masking the existing parenting problems. Without such ongoing evaluation, and realistic job expectations for the worker, one risks perverting the concept of family preservation. The child is left too long in a family whose neglect and/or abuse are continuing to undermine and distort his or her development, even though important windows of opportunity necessary for normal development are closing. Too often, unfortunately, family preservation and community workers see their work as antagonistic to and incompatible with that of child welfare workers, whereas their work should be seen as complementary. If family preservation is successful, there is no need for apprehension. If it is not, failure to apprehend is likely to conspire with ongoing and damaging neglect and abuse.

It is important to define the task of family preservation workers so that they do everything possible to improve parenting but, at the same time, are encouraged to recognize and acknowledge when their efforts are not improving the parenting. Should the latter be the case, the thrust should shift to one of assessment of parenting capacity in order to determine realistically which is the lesser of the evils: apprehension and placement or continuation of the status quo. Failure to take such a position risks collusion with and extension of the developmentally corrosive effects of a family that is continuing to undermine normal development.

In closing, the author would emphasize the need for controlled research to shed light on the complex and important issues raised in this chapter.

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USE OF RISK ASSESSMENT TOOLS

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This section addresses the topic of risk assessment in the child protection field. The purpose of such risk assessment instruments is to assist social workers in predicting the future likelihood of an occurrence or recurrence of maltreatment to a child. The distinction should be made between risk assessment strategies used in child protection and those employed in child abuse prevention programs. A detailed discussion of the latter, while important, is beyond the scope of this paper. Such assessment has generally taken place in the context of research studies aimed at determining which families in the community are at risk for experiencing physical abuse and/or neglect (sexual abuse has not typically been the focus of such work). Methods of screening have generally included staff-administered checklists, self-administered questionnaires, or standardized interviews. Nevertheless, the principles of risk assessment used in the area of child abuse prevention have been helpful in considering measures to assist with investigations of child abuse and decision-making about child removal.

In order to protect children at risk of suffering from abuse or neglect at the hands of their caregivers, it is essential that protection concerns be identified and the degree of risk to a child be assessed as early as possible in the child's life. The longer a child is subjected to parental abuse and/or neglect, the more damaged he or she becomes at all levels of functioning, and the more difficult it becomes to implement an alternative permanent plan that will meet the child's needs. Thus, early identification and assessment of risk are key elements to ensuring effective permanency planning for children who are exposed to abusive or neglectful home environments.

Unfortunately, identifying and assessing the degree of risk to children at an early stage are two of the most significant challenges that child protection professionals face in their work with families. These are highly complex tasks that involve an analysis of numerous factors that may be having an impact on the family's functioning. Most importantly, identifying and assessing the level of risk to a child often requires the social worker to obtain detailed information about the child and his or her caregivers and to understand fully the family's difficulties. This process obviously takes time and, unfortunately, often results in the child remaining in limbo in situations where intervention should ideally occur at an earlier stage. In addition, the process of assessing the degree of risk to children is essentially a matter of clinical judgement, which is affected to a certain extent by the biases of the social worker involved with the family. One of the most significant criticisms which has been made regarding child protection practice has been the inconsistency in the diagnostic criteria applied by social workers in assessing the degree of risk to children in the care of their parents (Cicchinelli, 1995).

In recognition of the importance of assessing risk to children as early as possible, and of fostering consistency in decision-making regarding risk to children, many jurisdictions have introduced standardized risk assessment tools to be applied by child protection workers in their daily practice. The risk assessment tools used by the various jurisdictions vary greatly in terms of the structure of the instruments, their primary focus, the content of the tools, and the scope of

information that is used. For instance, some risk assessment instruments focus exclusively on risk assessment, while others include diagnostic, case planning, treatment monitoring, and case closure components. In addition, some models are investigative in nature, with the purpose of assisting social workers reaching decisions regarding specific courses of action, while others have the main purpose of assisting social workers in prioritizing the urgency of intervention with respect to a caseload of clients. The various risk assessment models used also vary in terms of the general nature of the information collected, with some focusing on open-ended information and others focusing on more specific and objective data (Murphy-Berman, 1994).

Risk assessment tools can be highly valuable resources for child protection workers in that they establish a standardized map of factors and areas to consider in assessing risk to a child, and they provide a concrete and rational means of organizing the worker's thoughts about a case. They can also serve as an effective training and supervision tool for entry-level social workers, since they outline the typical risk factors at play in child protection cases and require the workers to document whether they have considered those factors. Risk assessment instruments create a sense of accountability for how and why certain decisions are made by social workers that is appropriate in light of the seriousness of the issues involved in child welfare cases.

Although the use of risk assessment in child protection is becoming increasingly common and has many advantages, there are several unresolved aspects regarding its application (McCurdy, 1995). While many studies have identified factors associated with one or more types of child maltreatment, few have identified risk indicators that actually predict abusive or neglectful behaviours. The task of analyzing the effectiveness of risk assessment is a complex one requiring an examination of numerous factors, including:

- the psychometric properties of the risk assessment instruments, particularly reliability and validity;
- the state of our current knowledge about the occurrence and recurrence of child abuse and the correlation between the two;
- the degree to which the instrument forms the basis of decision-making;
- practical considerations regarding the implementation of the instrument, including the reasons for which the instrument is used, the skill of the person using it, and the time constraints under which the tool is applied;
- the feasibility of the instrument.

The most important point that must be emphasized at this stage in the use of risk assessment tools is that these instruments cannot be viewed as a panacea. There is a widespread myth that a risk assessment model somehow automatically improves a social worker's ability to determine future risk of maltreatment towards a child. While a common model of assessment across child welfare agencies may be helpful in ensuring consistency, it does not necessarily imply accuracy. Risk assessment strategies that serve as a guide to information gathering need to be differentiated from those instruments that are considered the basis for decision-making without adequate evaluation. The use of risk assessment tools is a relatively new phenomenon, and there has been an urgency to implement mandatory use of risk assessment models, frequently without adequate

assessment of the actual instrument. Although many jurisdictions, including Ontario, describe these instruments as "work in progress", the reality is that these tools are already being utilized by child welfare workers, and the assessments themselves are being introduced in court proceedings. In other words, the results of these risk assessments are already having an impact on the lives of children and their families. Unfortunately, the evidence for the effectiveness of these tools and models has lagged behind.

It is useful to review the basic features of validity and reliability, two of the most important psychometric properties of any instrument or scale. Validity addresses whether an instrument is really measuring what it is intended to measure; any source of bias threatens the validity of a measurement. Reliability is the consistency with which an assessment can be reproduced. Both concepts are important in measuring risk. For example, a scale could be highly reliable when used by two different workers (inter-rater reliability), but have low validity in predicting future risk. Similarly, an instrument could have excellent predictive validity when used by one person, but not by others (low inter-rater reliability).

A number of studies in recent years have focused on the predictive validity of risk assessment tools, i.e. the degree to which the instrument is capable of distinguishing between individuals who are likely to maltreat their children in the future and those who are unlikely to do so. In assessing the predictive validity of a given tool, it is necessary to examine its sensitivity (the probability of correctly identifying people who will maltreat in the future), specificity (the rate of correctly identifying people who are unlikely to maltreat in the future), and misclassification rates. The last item, which includes false-positive and false-negative rates, must be considered against the prevalence of child abuse. Ideally, a risk assessment tool would be evaluated prospectively by following a group of clients over time to estimate the sensitivity and specificity, as well as the reciprocal of these estimates: false negatives (misses) and false positives (false alarms) respectively (Agonthonos-Georgopoulou & Brown, 1997). Leventhal (1988) has reviewed prospective studies assessing child abuse risk; he reported that the positive predictive accuracy was less than 50% in nine out of eleven studies. Without considering all of these issues, the accuracy of the risk assessment model is unknown. For example, even with a high prevalence rate of an event such as physical abuse in the child welfare population, screening with an instrument whose sensitivity is 80% and specificity 90% still results in a high number of false-positive predictions.

The majority of risk assessment instruments have been assessed among high-risk families in the community; there is even less information about prediction of recurrence of child maltreatment (which is often the issue facing child protection workers). To date, the studies relating to risk assessment tools do not paint an optimistic picture of the predictive validity of the instruments that have been assessed (Lyons, Doueck, & Wodarski, 1996, p. 148). With up to 50% false positives when used in the general population, it is clear that child welfare professionals cannot rely exclusively on risk assessment instruments for predictive purposes and that the use of risk scales may in fact result in more harm than good in some cases. False-negative results present less of a problem than false-positives when risk scales are used in families already known to the child welfare system, as ongoing monitoring may occur in those situations. High false-positive rates are of serious concern, however, as they lead to a sizable number of people and families

who do not go on to commit abuse being identified as being "at risk for child maltreatment". Such misclassification stigmatizes people and may increase levels of stress, thereby potentially undermining parenting and arguably placing the children at greater risk than before the risk assessment instrument was applied. As highlighted by Wald and Woolverton (1990), there are major ethical concerns raised by using risk assessment tools for decision-making in child protection, given the inadequate information about the predictive accuracy of such instruments.

In assessing the usefulness and effectiveness of risk assessment models, it is also essential to appreciate our current state of knowledge about correlates of maltreatment recurrence for the various types of maltreatment, and whether the same variables predict both occurrence and recurrence of maltreatment (Lyons, Doueck, & Wodarski, p. 144). Presently, there is a surprising dearth of research in these areas. In one review of risk assessment models, Marks and McDonald found that only 50% of the 88 variables commonly relied upon as factors predictive of maltreatment had actually been empirically validated (as cited in Lyons, Doueck, & Wodarski, p. 144). There is an urgent need for more study in these areas for the sake of child welfare practice in general, and more specifically in order to assess the effectiveness of risk assessment tools that are being used by child protection professionals.

The value of risk assessment scales to child protection professionals depends not only on the validity and reliability of the scales, but also on a number of factors relating to the implementation of the tools. One concern regarding the introduction of standardized risk assessment instruments is that these tools may be seen as supplanting rather than complementing the social worker's clinical judgement. This perception may arise not only among social work professionals, but also among other professionals who review the risk scales, such as lawyers and judges involved in child protection court cases. Risk assessment tools typically outline a number of specific risk factors and require the user to give a specific rating to each of those risk factors. While this exercise may assist the social worker in organizing his or her thoughts and concerns, it also fosters the notion that there is much more precision in assessing risk to children than actually exists in practice. In reality, the weight to be accorded to each risk factor and the overall risk rating given to a case are essentially matters of professional judgement. In addition, there may be important dynamics or special circumstances at work in a family that are not adequately reflected, or not reflected at all, in the risk scale. Each child protection case is unique, and a neatly packaged list of risk factors does not necessarily capture the full essence of a family's functioning. Another danger inherent in using risk scales is that they may narrow the focus of vision to risk within the family, without giving sufficient consideration to the family's strengths and supports, or to changes in the individual or family dynamics.

Risk assessment instruments are simply tools to assist child protection professionals in the exercise of their clinical judgement and are not intended to replace that judgement. This message must be clearly conveyed to child protection workers and other professionals involved in the field, especially legal professionals. Otherwise, a tool that is intended to assist social workers in making decisions and to complement professional judgement may in reality become a tool for limiting the scope of professional judgement and attacking the credibility of social workers in their clinical decision-making. Furthermore, the tool may come to be viewed as a means of obviating the need for effective education, supervision, and training of child protection

professionals. The point that must be stressed in this regard is that risk assessment instruments are only as effective as the social worker using them; in the absence of sound clinical training, judgement, assessment skills, and supervision, such tools will become major sources of liability rather than assets.

The usefulness of risk scales will also be dependent to a certain extent on the guidance and support that are provided to the child protection professionals using them. Most importantly, it is essential that clear guidelines and policies be implemented regarding the use of the risk assessment instrument, particularly when the tool should be completed, and the involvement of supervisors in the process. In the absence of such guidelines, risk scales may not be completed as often as expected, or may be used simply to document decisions after the fact rather than as an aid in the decision-making process. These problems may also arise if social workers are not accorded sufficient time to complete the risk assessment properly. These tools typically require several hours to complete, and have a significant impact on the workload of social workers. Moreover, it is expected that caseload numbers for child protection workers will increase as the use of comprehensive risk assessment tools becomes more widespread. Accordingly, a decision to introduce a risk assessment tool must be accompanied by a clear commitment to assess the resource implications of implementing the tool and to allocate any necessary additional resources to ensure the proper use of the instrument. In the absence of sufficient resources to support the use of risk assessment tools, there is a significant risk that the tools will simply be used to prioritize cases that are considered high risk rather than to improve the level of service to all children involved with the child welfare agency.

Social workers using risk assessment tools also require appropriate guidance and support regarding the relevance and use of these instruments in the context of legal proceedings. Risk assessment tools represent a movement towards a more formalized and sophisticated approach to the investigation and management of child protection cases. They require social workers to document the factors and considerations that underlie the basis for their judgements and decision-making. Once introduced, these tools become pivotal components of case management decision-making. As such, risk assessment tools are highly relevant for the purposes of court proceedings.

One point that is often overlooked by child protection professionals in developing risk assessment instruments is the need to ensure that the models are consistent with the principles of the legislation governing child protection practice. Child welfare agencies do not operate in a vacuum; the nature and scope of their activities are governed by the relevant child protection legislation. Accordingly, any significant inconsistencies between risk assessment models and the legislation governing child protection practice have potentially serious legal implications from both a jurisdictional and liability perspective and may expose social workers to serious challenges in the context of legal proceedings. For instance, if a risk assessment tool directs the social worker to consider factors that do not fall within the scope of the protection grounds outlined in the applicable child welfare legislation, the social worker and child welfare agency may be challenged for exceeding their jurisdiction and acting overzealously. On the other hand, if the tool does not include factors that the legislation requires child welfare agencies to consider, and social workers rely too heavily on the tool in making case management decisions, child

welfare agencies may be challenged for failing to discharge their statutory obligations to protect children.

Child protection professionals must also be prepared for the fact that the use of risk assessment tools that require the enumeration of specific risk factors and the formal documentation of specific risk ratings will undoubtedly invite more intense scrutiny of every aspect of the social worker's decision-making, particularly in the context of legal proceedings. In addition, the credibility of the worker's assessment will now be based in part on the quality of the assessment tool and not just the social worker's professional experience and judgement. Accordingly, it is essential for social workers to be fully trained regarding the development of the tool being used and its psychometric properties, so that they can address these matters in court proceedings if necessary. Furthermore, although risk assessment tools are not intended to replace general professional judgement, there is likely to be a tendency in practice to restrict the focus in court proceedings to the risk factors and ratings outlined in the tool. In cases where a social worker's assessment is based in part on factors not included in the risk assessment tool, the social worker will be placed in the challenging position of having to convince the court of the reasons for a course of action and that general clinical judgement still has a role in conducting risk assessments. The role of counsel for child protection agencies in properly preparing social workers for these new challenges created by risk assessment tools will be crucial, and it is therefore important that legal professionals be fully trained in all aspects of the risk assessment model as well.

Overall, risk assessment models may have the potential to improve child protection practice, but only if they are properly implemented and the instruments are validated on the basis of an empirical foundation. Cicchinelli advocates starting with reserving the use of the term "risk assessment" for predicting future events using currently available information (1995). He emphasizes that to be useful, a risk model must include factors that a worker can actually measure with some degree of certainty. Until empirical evidence is available for the predictive validity of risk assessment tools, they should be thought of as ways to organize case material to inform clinical judgement. At this point, any greater emphasis on these instruments is premature.

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TRUTH OR CONSEQUENCES

James R.Wilkes and Cheryl Milne

I) INTRODUCTION

The central person in the child welfare system is, of course, the child. While this may be self-evident, it is unfortunately often overlooked in casework practice. Child Protective Services (CPS) staff can be caught up in such things as the rules and regulations of practice, the need to comply with recording demands, and the possibility of having to defend their practices in court; so it is understandable that their energy can be taken away from sensitively engaging the child in the casework issues.

This chapter is directed toward helping staff engage children in information sharing, decision-making, and planning. The first two sections deal with the rationale for sharing information, first from the clinical perspective, and second from the legal one. There continues to be uncertainty and disagreement over what rights children have to access information, particularly when their parents may not wish such information disclosed to them. The final two sections deal with how to share information with children and involve them in the planning process.

II) INFORMATION SHARING: WHY SHOULD WE TELL THE CHILD?

A) Introduction

There is no general agreement on how much a child should know about potentially sensitive issues. Western culture is becoming more open in giving children important information that used to be kept away from them. Issues such as adoption, parental illness, and suicide of a family member are examples of areas that are more open to the involvement of children than they used to be.

From the clinical perspective, the consensus is that a child should be given important information unless there is a strong reason against it. This represents a shift in emphasis away from protecting children from potentially stressful information towards helping children understand and deal with the information.

Clinically, it is known that children often blame themselves for family breakdown. Therapists commonly have to work with children to help them understand that the principal problem was with the parents or the result of such things as the harshness of poverty or discrimination. In this way, the child is helped to see that what happened was not the child's fault. In order for this approach to be successful, the issues have to be discussed with the appropriate degree of openness.

The literature on family secrets does not deal directly with child welfare cases, but nevertheless is relevant to child welfare practice. Working with the presumption that the information that a parent is trying to prevent the child from knowing is a "protective family secret", the literature indicates that withholding important family information from a child can be detrimental at a wide range of levels.

Peggy Papp posits that it is difficult for parents to keep disclosures away from children in order to protect themselves or the children; although the event itself may not be revealed, the intensity of the feelings around it are difficult to disguise. She explains that the very act of keeping a secret generates anxiety in the parent who must be constantly on guard against disclosure. As well, the parent may well avoid particular subjects and distort information. It is likely that a child will sense that something is "off" and that certain areas of discussion are not to be raised. She states: "When children sense information is being withheld they become confused and anxious, they lose their sense of trust and often end up blaming themselves" (Papp, 1993, p. 66).

In addition, the literature and clinical reports indicate that in the face of secrets children resort to searching for a way to explain the inexplicable and create private beliefs, myths, and fantasies. Papp contends that these often get acted out through symptomatic behaviour. She states that the tensions and conflicts produced by secrets remain unresolvable as long as the information necessary for their resolution remains inaccessible. She further states that if the information is causing the parent significant distress, the child will experience the distress without having the tools to decode and deal with it.

Other authors have also written about the negative effect of keeping family secrets. Baran and Pannor contend that "whenever a family is living with a secret, the fear of revelation of that secret is a specter that haunts those holding the information, ultimately straining their relationship" (1989, p. 153). Donovan and McIntyre argue that non-disclosure of "protective secrets" can affect a child's cognitive functioning and academic performance. They conclude: "It is very difficult to develop the cognitive blinders necessary for secret-keeping without having the process generalize to other areas, especially those related to knowing and telling" (1990, p. 185).

B) **Information Sharing in Child Welfare**

The literature regarding secrets strengthens the argument that children should have access to relevant information. This in turn has direct bearing on CPS practice. Casework decisions in child welfare are often complicated and difficult. At times, such decisions require planning conferences that may take several hours of senior staff and consultant time. Often, there have been preceding assessments of the child and/or parents, and this material is relied upon for help in making the casework decision. Decisions are made about such important things as whether to take a child into care, length of stay in care, arrangements for access, changes required before a child can be returned home, and the necessity of changing the child's placement. In most such decision-making meetings, the question that is not addressed is "How do we explain this to the child?". An important part of any decision-making process is to decide who is going to give the

child the information and how to go about doing it. As important as this is, it is frequently not done.

The discussion will now look at some of the reasons why telling the child is avoided, give examples of difficulties that arise when a child is not adequately informed, and suggest principles of how to go about giving the child information.

C) **Resistance to Telling the Child**

i) *Trying to protect the child from stressful information.*
Staff often avoid raising issues with a child because they know the material will be unpleasant or hurtful to the child. An adoption worker made this quite plain when she said that she prefers dealing with the placement of infants because she did not have to tell them what she was doing. Such an attitude may well be based on compassion and sensitivity, but the problem is that when children are not informed and helped to understand important events and circumstances in their lives, they lose the opportunity to integrate them into their sense of identity, and they develop a confused sense of themselves.

It is also important to remember that withholding certain information from a child can serve to reinforce negative societal stereotypes. For example, if the fact that the child's mother has schizophrenia is withheld, the child may interpret this as a message that such an illness should not be discussed and is something to be ashamed of.

ii) *Concern about giving information that might seem critical of a parent or family member.*
Important information about the parents is often withheld from the child, and at times this may be at the request of the parents themselves. The parent may be addicted to drugs, or in jail, and somehow this is presented to the child in some euphemistic fashion: "Your mother isn't well and needs to be in hospital for a while and afterwards she will need some rest. When she is feeling better, we will talk about you going back home." "Your father has had to go away to work and he won't come back home for a long time." Again, while working to keep a positive impression of a parent in the child's mind can be well intentioned, it frequently leads to the child feeling that the parent's absence is somehow the fault of the child: "If I were good and loveable my parent would be here taking care of me".

iii) *The complexities of information sharing lead to avoidance.*
Among the factors involved in giving a child information are: the child's cognitive capacity, the child's willingness to listen, the trust level between the child and the person(s) giving the information, the quality of the presentation, and the opportunity for ongoing questioning and explanation. The recognition of the complexity of the task can be sufficiently daunting that it is avoided or unduly delayed (see "How Do We Tell the Child?" below).

iv) *Not sure of where things are heading so best not to say anything.*
There are a number of variables that can have an impact on casework plans, making it difficult to plan with strong predictability. Variables such as how a judge will decide, whether a parent or

child will respond to treatment or cooperate with the agencies' suggestions and decisions, and administrative and clinical delays make it difficult to establish a permanent plan with concrete arrangements and dates. Therefore, there is a tendency simply to take the attitude of waiting and seeing how things develop. The child is told that things will be explained once they become clear, or given token reassurance that everyone is working to have things turn out in the best possible way. In such circumstances, the child's world becomes increasingly vague and capricious. At the very least, the process in which the child is involved should be explained to the child. It would be far better if the variables were explained to the child, even though people may seem powerless to change them.

v) *Remain ambivalent about the casework decision so don't want to explain it.*
At times, it seems that every possible plan has flaws or uncertainties, yet not to decide and to leave things as they are is also destructive. The worker may be dissatisfied with the decision and feel angry, guilty, or inadequate. In such circumstances there is a reluctance to explain why other alternatives were not undertaken; they are simply left out and the child is given a one-dimensional version of the situation. The child may be told the decision in a way that masks the worker's feelings by conveying a sense of authoritativeness and certitude. The difficulty is that the child is not able to process the real situation and moves into a false and superficial existence. It would be far better to explain how difficult it was to come to a decision and why this direction was decided upon and certain others were not.

vi) *Not wanting to stir up difficulties.*
The worker may be dealing with resistant parents and feel that they will become more resistant or hostile if their child is made aware of how the parents contribute to the current difficulties. The child is unlikely to raise the issue on his or her own, so it is easy for the worker to avoid the issue, and hope that things can work out. The result of such avoidance is that the child is prevented from dealing with the real issues. This not only impedes the child's emotional development, but also makes it more difficult to resolve the family problems.

vii) *Staff's and foster caregivers' feelings impede a clear presentation of the situation.*
The circumstances and events in the lives of children in care can elicit strong feelings in those who look after them. These feelings can be stirred up when talking to the child about the real situation. There may then be a tendency to avoid or perhaps water down the truth.

D) **Case Material**

The following are actual case materials that illustrate the complexities of information sharing with children and the negative impact of withholding information from them.

Case 1

A mother tells her family physician that she witnessed her husband (the children's father) sexually abusing one of the children who appeared to be sleeping. The physician telephoned the CPS. There was an investigation, and her husband was charged and removed from the home. He argued that he was drunk and therefore not guilty. The mother refused the physician's suggestion that she and the children undergo counseling.

Five months later, the physician telephoned the clinic requesting therapeutic help. The mother was now requesting help. The physician reported that the family "was a mess." The children were having numerous problems: the oldest was not eating properly, all of them were angry, their behaviour was difficult and disruptive, their school marks were dropping, all of them were sad, and the children were blaming the mother for their father being absent from home.

The clinic worker telephoned the mother who explained that she had not told the children about their father's behaviour and why he was out of the home. She stated that the children were confused and that she herself was distressed and didn't know how to tell them. The clinic worker asked the mother to have the CPS worker call.

The CPS worker telephoned and explained that she had agreed with the mother to work at the mother's pace and delay telling the children what had happened. The CPS worker was reluctant to break the secrecy and wanted clinic service in place before the children were told. The clinic worker advised the CPS worker that the children must be told before therapy could proceed.

A month later the CPS worker telephoned to say that the secret was out: the children had suspected something and seemed relieved. One child said, "I was wanting Mom to tell me". The children all wanted to talk to someone, and they agreed that the whole family needed help. After a period in therapy, the oldest child disclosed sexual abuse by the father.

In this case, the caseworker's decision to go along with the mother's request not to tell what happened left the children confused and angry, and it also delayed the obtaining of therapy. The prolonged secrecy had reinforced the oldest child's reluctance to disclose.

Case 2

A ten-year-old boy lived with his father and stepmother. His biological mother had been in hospital for drug rehabilitation, and the boy had visits with her at the hospital over a period of six months. Prior to her hospitalization, the boy's father had accused her of inappropriate sexual behaviour with the boy, but this was not substantiated. On her return home, visits were arranged so that the boy visited his mother at her home, during the day, every other Saturday. These visits had been going on for a month when the boy told his father that his mother had bathed with him twice during one visit. The father informed CPS, and the CPS worker interviewed the boy at the CPS office without his father or stepmother present. The worker then informed the father that visits to the mother were to be stopped. The CPS worker did not explain anything to the child.

The following week, the child had an appointment with his therapist at the clinic. The father reported that the boy was upset because he had not visited his mother. The father and stepmother were not sure how to explain it to the boy.

The child's therapist telephoned the CPS to request that the worker explain the decision to the child. Two days later, the worker returned the therapist's call and by that time had come to the opinion that the concerns were unsubstantiated and the visits could be reinstated. Regarding the issue of telling the child the initial decision, the worker said: "Oh, I thought the father would explain it".

This case illustrates a situation in which the caseworker had not even considered the issue of explaining his decision to the child. It shows how such an oversight can be distressing to the child.

Case 3

A nine-year-old girl in a staff-operated residential setting was having visits with her mother every other Saturday, during the day. Occasionally, the mother would miss visits, saying she had car trouble. She also took her daughter to see her own parents who were alcoholics and frequently fought. On one such visit, the girl witnessed a fight between them. Her mother was told by the CPS not to take her daughter to see the grandparents, and the mother agreed that it was not a good place for her daughter. Nevertheless, she continued to take her there on occasion. One Saturday, the mother called to say she couldn't make the visit because of car trouble. A few hours later she turned up in a borrowed car. During the following week, the CPS had been unable to contact the mother and decided that visits with her should be stopped until things could be sorted out. The CPS worker informed the residential setting staff of the decision, and the staff asked what the child should be told. The worker puzzled over this, then suggested that, when the day came for the visit, the child should be told that the mother had car trouble.

This case illustrates a situation in which the truth was deliberately avoided by substituting an explanation more palatable to the child. To support this girl's positive view of her mother untruthfully when, in fact, there were very real concerns over her parenting capacity, prevented

the child from processing what was really going on. It also meant that a later decision to curtail visits or to keep the girl in permanent care would seem unreasonable to the child. In such a situation, the girl will lose trust and drift further into limbo.

Case 4

An eight-year-old boy had been in a staff-operated setting for ten months. His parents had said that their son's behaviour was out of control, and they refused to care for him. In an assessment interview at a mental health clinic, the boy stated that he was in care because of his bad behaviour. Left out of the child's understanding was the fact that the father was an alcoholic and was frequently abusive to his wife. The CPS was requesting that the couple seek help around the problem-drinking and marital problems, but the parents were refusing to acknowledge that there was an alcohol or marital problem. None of this was told to the boy.

In this situation, the boy is left feeling that the whole problem is his. He does not have the real facts so he cannot be helped to gain understanding of the development of his difficulties. The truth is that even if his behaviour were to improve dramatically, there was the strong possibility that his parents would not demonstrate adequate parenting capacity. The CPS would then be in the position of having to tell the child that even though he had worked so hard and had changed his behaviour he still could not go home. To keep such information away from this boy prevents him from dealing with reality and thwarts the development of his identity. In such a situation, the longer he is kept away from his parents, the more he will lose trust in his caregivers, the lower his self-esteem will be, and the less receptive he will become to the true story.

Case 5

At the request of a foster caregiver, a psychiatrist was asked to see three foster children who had been in the foster home for two years. Their behaviour was difficult, and they had not shown sufficient signs of settling in the home. The history was that the children had been in their own home at the time that their mother had beaten to death the youngest child who was a year-and-a-half-old at the time. The children had heard the child's screams and the sounds of the beating. They were apprehended by CPS and placed in care. The foster caregivers were told not to talk to the children about what had happened or what the children had heard, because the prosecuting lawyer had said they could be called as witnesses and their testimony should not be contaminated.

In this situation, because the caregivers followed the lawyer's directive, the children were deprived of the emotional support necessary to help them deal with such a devastating event. In actual fact, it has been shown that if a listener adopts a neutral and non-directive approach to what a child is saying, then there is a better chance for the child to retain the information accurately. If the children had been able to talk about what had happened, they would have benefited emotionally, as well as been more credible witnesses.

III) INFORMATION SHARING AND THE LAW

A key question in the child welfare system is, "Does a child have a right to access as much information as is available regarding why he or she was removed from the birth family, especially in the event that the parent does not want the information revealed to the child?".

Legislation governing the disclosure of information to children is inconsistent or non-existent in some jurisdictions. The vague nature of many of the legislated provisions governing disclosure of information requires further contextualization in order to look to other guiding principles for the legal determination of whether or not information is to be shared. The two most relevant are the principle of the best interests of the child and the children's rights approach.

A) Best Interests of the Child

The leading and firmly established legal principle for a case approach is the best interests of the child. This standard used in Canada is also the standard of many areas of the world. The United Nations' *Convention on the Rights of the Child* chose the best interests of the child as the primary consideration in all actions concerning children.

The difficulty with the criterion of the best interests of the child being the fundamental criterion governing legal decisions concerning children and information sharing is rooted in the larger debate surrounding the use of this criterion in all spheres of children and the law. The lack of clarity has been widely noted and criticized.

Deleury and Cloutier ask: "Are decisions made in the name of the best interests of the child always concordant with the arguments advanced to justify them? Does the perception of this criterion depend upon the perspective with which we approach the subject? If so, to what extent? What are the approaches and the methods of evaluation involved in this definition? In other words what are the principal characteristics of this concept of the best interests of the child?"(1988, p. 212).

Bernard, Ward, and Knoppers echo the above observations. They state: "None of these statutes, however, define the meaning of best interest. It has been left to the courts to determine in each case what are the best interests of an individual child" (1992, p. 58). They have observed, however, that as a result of this lack of definition, in certain cases, the courts have relied on some indications provided by legislation as to how the principle should be interpreted. For example, the Ontario *Child and Family Services Act* (CFSA) lists a number of factors that the court must consider in making a determination of what is in the child's best interests. This is distinct from the Quebec *Civil Code* and the *Youth Protection Act*, which require consideration of both the interests of the child and his or her rights.

Barnhorst and Walter contend that the phrase "best interests of the child" is quite vague and, therefore, such a statement is of little help to decision makers. Further, it is open to a wide range of interpretation and value judgements (1991, p. 18). They contend that this vagueness tends to

support an interventionist approach, thereby giving courts and agencies broad discretion to intervene in the family. However, they point out that despite the focus on the best interests standard, there is a simultaneous focus on other principles that may not necessarily be congruent with the best interests standard and its interventionist bias. For example, they point to the concepts of permanency planning, the position of children in families, and family autonomy which are also enshrined in certain statutes. For example the CFSA states that "while parents often need help in caring for their children that help should give support to the autonomy and integrity of the family" (S.O. 1984, c. 55, s.1). Further, the clinical reasons for telling the child, described above, inform the best interests analysis and may in fact tip the balance in favour of sharing information with the child.

B) **The Rise of Children's Rights and Child Autonomy**

The issue of family autonomy considered in conjunction with the best interests standard is multifaceted. While traditionally any discussion of family autonomy would evoke the notion of children having no part in decision-making, there has been a notable rise in focus on children's rights and autonomy within the family in recent decades. Hence, it is important to consider the implications of this movement on the firmly established standard of best interests.

As explained by Colleen Sheppard, the idea of according equality rights to children is a relatively recent phenomenon (1992, p. 197). Even the most cursory historical analysis reveals that children were not accorded rights within the family. Rather, they were "subject to the unregulated, unscrutinized, unchallenged private power of their parents, especially their fathers"(Sheppard, p. 197). Beginning in the 1970s, children's rights became an issue of public concern. Consequently, there was extensive law reform in North America. Canadian provincial and federal laws now reflect the recognition of children's rights. Maureen Baker posits that four main concepts underlie and shape the socio-legal status of children in English speaking countries. They are: *patria potestas, parens patria,* best interests of the child, and child as person before the law (1995, p. 237).

Perhaps the most striking example of the validation of this movement can be found in the United Nations' *Convention on the Rights of the Child.* Article 12 states:

> 1. Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the children being given due weight in accordance with the age and maturity of the child.
>
> 2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of natural law.

Taken at face value, this article applied to the issue of information sharing could bolster the position that a child wishing to know the reasons for removal from the birth family should be

taken seriously. However, the *Convention* must be considered in context. Jane Fortin notes that the Convention provides a generous acknowledgement of children's entitlement to participate in decisions affecting them, recognizing that children mature at different rates; however, how children are to be heard is not clearly specified (1998). Other analysts such as Professor Steven Toope have remarked that "the participation of children in decisions affecting their own lives is a very difficult and controversial area where the present state of Canadian social and legal policy may not mesh with the requirements of the *Convention*" (1996, p. 37).

Both of these paradigms (children's rights versus best interests) are problematic if considered as opposite or even distinct approaches. A desirable view is expressed by Michael Freeman who acknowledges children both as rights-holders and as a group in need of protection, as follows:

> But ask also whether, and to what extent, we are prepared to encourage children to participate in decisions regarding their life choices. It is much easier to assume abilities and capacities are absent than to take cognizance of children's choices.
>
> If we are to make progress we have to recognize the moral integrity of children (Miller, 1987). We have to treat them as persons entitled to equal concern and respect and entitled to have both their present autonomy recognized and their capacity for future autonomy safeguarded. And this is to recognize that children, particularly younger children, need nurture, care and protection. Children must not, as Hafen (1977) put it, be abandoned to their rights (Freeman, 1992, p. 66).

If access to information by children is viewed as a legal right, then legislation is required to ensure a process for children to exercise this right. If it is an issue of the best interests of the child, then there remains the potential for conflict between the compelling clinical reasons for information sharing and the personal views of family or caregivers who believe that certain information is best withheld. Thus, the best solution is for legislation to clarify the elements of the child's best interests and to provide a process for the child's right to access important information about him or herself and his or her family.

C) **Privacy Rights**

The need for legislation is most clearly illustrated by the complexities that arise when family members, such as parents who do not want their children to know about their problems, assert their own privacy interests as a way to block information sharing. Can CPS workers share personal information about parents with their children? Can this be considered the child's personal information as well? The case examples above show the dilemmas that workers may find themselves in. Without clear guidelines for workers, the confusion can operate to frustrate what may clearly be in the child's best interests.

The heightened awareness of the privacy rights of individuals is a product of legal trends in sexual assault prosecutions. Recent amendments to the *Criminal Code of Canada* establish a process by which records held by therapists and child welfare agencies, among others, may be

disclosed to persons accused of sexual assault, including assaults against children. In the context of the litigation surrounding this issue, the right to privacy of the individuals named in these records has been highlighted for many agencies that heretofore had no consistent policies around disclosure. There is potential for the assertion of privacy rights to constitute a roadblock for the disclosure of information in a manner that is not in the best interests of children. The simplest answer to this potential legal problem would be to ensure that child welfare legislation facilitates the release of information to children.

IV) **HOW DO WE TELL THE CHILD?**

The clinical and legal principles support sharing information with children in order to include them in decision-making and assist them to adjust to the changes in their lives that are inherent in child welfare interventions. Whether one determines that it is the child's right to know, or that it is in the child's best interests, the worker must use clinical judgement (rather than legal procedure) to determine how best to convey the information. The following suggests some principles to guide the worker.

1) *Recognize the importance of the context of the sharing situation and make it as conducive to information sharing as possible.*
Children can be very sensitive to their surroundings and to the people present. It is quite possible that in a strange situation they will focus more energy on complying with the immediate expectations of what is going on than on trying to remember or understand what is being told to them. The context of a situation also involves the people present as well as the location and surroundings. The degree of trust a child has for the people present as well as the capacity of the principal caregiver to support the child later are the key issues (see 2 and 3 below). There is no ideal age or time to give a child difficult or unpleasant information.

2) *The information is to be given by someone the child trusts.*
It is difficult to process information adequately from a person who is unfamiliar or mistrusted. This is particularly true of children who lack an adult's capacity for abstraction and the adult capability of providing context and assigning weight and importance to the information that is given. If circumstances are such that information has to be given by an unfamiliar person then it is important to have someone present whom the child trusts (see 3 below).

3) *The child's current principal caregiver is present.*
The major issue for the child's mental health is not so much the actual information that is to be shared, as important as that is, but the opportunity for the child to be able to process that information. In this regard, the principal caregiver has an important role. Not only does the caregiver provide the child with support, but the caregiver also has the important function of asking questions on the child's behalf during the telling and then helping the child process and question the material over the days and weeks that follow. The distinct roles of the CPS worker and the foster caregiver or group home staff can be used to advantage (see Placement out of the Family Home: "Foster Care", below).

4) *Where possible have the parent(s) present.*
It is good practice to have the parent(s) present, especially if the information is about them. If this is not done, it makes it possible for the parent to contradict later what the child was told and cause the child to be confused (see 9 below).

5) *Be aware of the child's present concerns.*
It is important to have a sense of what the child is dealing with right now. If no attention is paid to the child's sense of what is going on and what is immediately important to the child, then what is being said is likely to be ignored or distorted.

6) *Be sensitive to the child's cognitive capacity and present the material accordingly.*
This does not mean that the more complex issues are withheld from the child. Important information that is beyond the child's understanding is to be put in the child's file and made available to the child when the child is capable of understanding. This is important at any age. Decisions made in a child's infancy are often poorly documented and the material sanitized so that it is impossible to retrieve the child's history for the child.

7) *Be sensitive to the child's desire to hear the information.*
Talking about something with a child also involves being aware of the child's receptivity. If it is apparent that the child does not want to hear, it is unwise to attempt to force the issue. Various measures may be undertaken when a child demonstrates reluctance. For example, the child may be told something to the effect that the caseworker feels that this information is important and that the worker feels the child should know, so it will be told to the foster caregiver and the child can ask about it when the child is ready. If the child is in therapy, the information could be given to the therapist.

8) *Ask for the child's opinion.*
It is always useful to ask a child for the child's opinion about what is happening and perhaps more importantly about what should be happening. It is important for the child to know that the child's opinion is respected, even though it is understood that at times it cannot be followed. Asking for the child's opinion allows the child to understand more fully what is going on as well as bolstering the child's sense of self. Once the child's opinion is sought it has to be taken seriously (see discussion on involving children in planning and decision-making below).

9) *Have the child present at meetings.*
A child will be able to process information more effectively if the child can be present at meetings where issues are being discussed. The decision as to whether or not a child should be present has to be carefully considered. The key considerations will be the child's emotional fragility and the amount of support the child has during and after the meeting. The child can benefit from hearing what goes on and witnessing even contentious interaction. The principal caregiver has two crucial tasks: first, he or she must remove the child if the situation becomes excessively unruly or contentious; and second, he or she must support the child in dealing with what was said and how people felt and behaved (see also 3 above).

10) *Use transition times creatively.*
Transition of a child from one placement to another or from one CPS social worker to another is a disruption in continuity of care. Nevertheless, the negative effect can be diminished by having a meeting or several meetings with the old and new staff present. At this meeting, the child's history including the time with the old staff or foster home can be reviewed. Such a meeting gives the child a sense that he is known and accepted.

11) *How are children best informed about a parent's wrongdoing?*
CPS staff can be faced with the difficult task of informing a child that a parent has committed a crime, e.g. murder, drug trafficking, assault etc. In such a situation, in addition to the principles listed above, the following suggestions may be of assistance:

> i) People giving the information must acknowledge to themselves, or process with others, their own emotional reaction to the parent's behaviour so that it influences the telling as little as possible and the presentation can be made as factual as possible.
>
> ii) Understand as much as possible what the child already knows about what has taken place. This includes understanding how the child experienced what the parent did. Where was the child at the time? Did the child hear or see anything?
>
> iii) Use a description of what took place rather than relying on the noun. Terms such as murderer, thief, prostitute, and drug trafficker carry a heavy load of criticism and do not help the child understand the situation. It is important not to misrepresent what happened; so the more information that the teller has about the event itself, including the reason for the parent's behaviour, the better. This is an example of how the presence of the parent could be beneficial.

When the core of the necessary information is set down it may sound stark and unfeeling. And it has to be understood that the information is given in a process of interaction with the child in which those involved are sensitive to the child's response to each item in the situation. It is also understood that the telling may take place over several sessions.

With the above being understood, the core of how a child might be told about a murder is as follows: "You know that your father has a bad temper and that when he drinks he really has trouble controlling it. Well, last night he got into a fight with a man who owed him some money, and he hit him and kicked him so much that the man died."

The core of how a child might be told about a theft is as follows: "Your mother didn't have enough money to do the things she needed to do. She wanted money so that she could buy food and pay the rent. She stole a purse, took the money, and used the person's credit cards."

The core of how a child might be told about prostitution is as follows: "Your mother needed money and she didn't have a job. She got money from men by doing things for them that most people think should only happen between people who are married."

In practice the clinician may want to inform a child about a parent but is constrained by the court.

The law is silent about when a child can be given information, especially if this has bearing on a case before the court. From the clinical perspective, however, the principle that children need information still applies. If relevant information is withheld at the order of the court, then the child should at least be told that there are things that are important to talk about, but this is not allowed by the court until the court proceedings are over, or until the court gives permission.

V) INVOLVING CHILDREN IN PLANNING

If children are overlooked in the matter of information sharing, they are even more overlooked when it comes to sharing in planning. As mentioned above, the more information available to a child, the better the child is able to understand and cope with what he or she is experiencing. Involving a child in planning adds to the child's understanding of what is going on and enhances the child's self esteem.

The general principles of information sharing also apply to the process of engaging a child in planning. In addition to the above material, it is important to emphasize certain key considerations.

1) The authority the child has in the planning process must be made clear, so that the child is not confused or misled by the process. This is particularly the case with children who are not accustomed to having their opinions sought and who might misconstrue what is taking place and expect compliance with their wishes. The child should not get the impression that the child alone has the power to make major decisions. It must be explained that the child's opinion will be considered but in the end the guardian will make the final decision. This is equally important in situations where the guardian agrees with the child, because if something goes wrong the child should not feel the guilt for the decision.

2) As with the matter of sharing information, the planning discussions should be with a trusted person and take place in a non-threatening and familiar atmosphere.

3) After a planning decision is made, there should be a discussion with the child dealing with the reasons for the particular decision. Part of the discussion will deal with the extent to which the decision was in compliance with the child's wishes. Where the decision did not comply with the child's wishes, the worker can acknowledge why the child wanted a particular course of action, but explain why the particular decision taken was felt to be in the child's best interests.

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III. The Use of Access

INTRODUCTION

Access between a child in care and members of the child's family of origin is of fundamental importance in planning. If access is handled well, it is likely that the outcome for the child will be beneficial. The converse is also true: where access is simply ordered as a matter of course and without relevance to the long-term plan, the child is much more likely to end up in limbo.

Access should always be planned in the child's best interests. Unfortunately, access is often decided on the basis of the rights of the parents, and no thought is given to the effect on the child. This can be particularly damaging to a child when it exposes the child to antagonism between separated parents or when access is ordered against the child's expressed wishes.

Access has a number of variables. Access is not always face-to-face contact. Any contact with a relative, whether it be by mail, or phone, or even by means of a message, whether direct or indirect, has an emotional loading for the child.

A. **ACCESS VARIABLES**

I. **Face-to-Face**

1. *Location*
- home
- foster home
- agency office
- staffed setting
- other

2. *Degree of supervision*
- staff present
- staff available
- plans reviewed
- none

3. *Duration*
- extensive – weekends, holidays, overnights
- brief – a few hours

4. *Frequency*

II. **Telephone Only**

- frequency
- supervision

III. **Messenger Only**

- staff
- other – M.D., lawyer, etc.

IV. **Other**

- letters
- videotapes
- presents

B. **PRINCIPLES OF ACCESS**

1. Access arrangements require clear and thoughtful preparation. Access arrangements are pivotal to casework success, yet often they take place simply as a matter of course, with little thought given to how access is being understood and experienced by the child and family. Plans should take into account such matters as: accessibility, the quality of relationship between the child and family members, and the emotional benefit to the child.

2. Access arrangements should be consistent with the long-term plan. If access plans are not in harmony with the expected casework outcome, then the way is open to confusion and misunderstanding.

3. If no long-term plan is in place, then access is used to gain the information necessary to form the long-term plan. Visits may be used to assess quality of interaction between the child and parents, with particular emphasis on the capacity of the parents to process the factors (their own and the child's) that contributed to the child being in care. The ability to process this with the child in an understanding and non-hostile manner is important for the child's successful return.

4. The reason for access should be understood in the same way by all participants. To the maximum possible extent, it is important that the reason for this particular arrangement be understood the same way by all those involved, i.e. why access is taking place, why this arrangement was decided upon, and how long the arrangement is expected to last. If work is not done to clarify the reason for access, then the way is opened for misunderstanding and the strong

possibility that the various participants will hold different opinions about future casework direction. In such confusion limbo flourishes.

5. Access is not to be used as a punishment or reward to modify the child's behaviour. If there is to be a change in access plans, this should be based on the quality of the access visits and the emotional benefit to the child. Visits should never be given as a reward for compliance nor withdrawn as a punishment for non-compliance.

The following paper entitled "The Role of Access in Permanency Planning" discusses many of these issues more fully and provides direction in making decisions in this important area.

THE ROLE OF ACCESS IN PERMANENCY PLANNING

Margaret Osmond, Nitza Perlman, Nancy Dale, Sally Palmer

THE CHANGING PROFILE OF CHILDREN IN CARE

There is a growing consensus that children in out-of-home care with Child Protective Services (CPS) are more troubled and troubling than ever before in our history (Trocme et al., 1994). Many of them have been exposed to conditions reflective of our changing society: poverty; social exclusion; substance abuse (pre- and post-natal); illegal activities by parents; and homes that are under stress and sometimes chaotic. In out-of-home care, they may have experienced serial placements. These conditions can be traumatic for vulnerable children, affecting their adaptive development.

The present climate and context of CPS contributes to children staying in deteriorating family situations for months or years, for several reasons. First, the standards for acceptable childrearing practices have been in flux over the past decade, moving from an emphasis on keeping families together to an emphasis on protecting children by lowering the threshold for removing them. Second, there is an onus on CPS to attempt multiple services before removing children, so the period before a child is finally removed is often protracted. Third, growing demands and high worker turnover in CPS agencies have meant the withdrawal of services from families who request support, but are not yet functioning below the minimum threshold for child-care. Thus, children tend to be older when they move into out-of-home care and to have experienced prolonged exposure to conditions that lead to behavioural and psychological problems. The effect on child welfare has been a growing population of hard-to-serve children who consume mental health and remedial services at an unprecedented rate. These children tax the resources of the child-placement system and are particularly vulnerable to placement disruption. To counter these potentially damaging conditions, we must use all possible means to support 'permanency' for children in out-of-home care. Continuing contact between children and their families is an important aspect of permanency. This chapter covers principles and practice related to ongoing access for children in placement.

DEFINITION OF ACCESS

Formally, access is court-ordered visitation between non-custodial parents and their children. Access orders may set out conditions for visits: frequency, length, location, participants, and whether or not they will be supervised. For children who are in out-of-home placement under a voluntary agreement between their parents and a CPS agency, there is no court order. The agency sets up the structure for access, with some input by parents, depending on the agency's orientation toward including or excluding them. The most common rationale for access is the goal of reuniting children with their families; however, practice experience in Ontario's CPS agencies suggests that the legal process can complicate decisions about access. In the pressure to

reach an agreement during a court case, access conditions may be drafted that are not in keeping with good clinical practice. This sets the stage for problematic access over the long term, which is further aggravated by a lack of agency resources to manage access. Thus, children's actual experience of visiting may diverge seriously from the treatment plans set up by the agency caring for them.

THE LINK BETWEEN ACCESS AND PERMANENCY

For a child in out-of-home care, permanency is more than a stable placement. 'True' permanency includes a complex configuration involving:

1. a perception of rationality surrounding the events leading to placement;
2. psychological resolution of previous relationships, ideally in the context of some form of continuity in significant relationships;
3. a sense of being cherished by a significant caregiver.

Children experiencing the above conditions are more likely to develop an identity that includes a sense of entitlement, competency, and belonging. Ideally, this will free them to move beyond the pain of the past to look towards a more positive future.

Developing permanency plans for children in out-of-home care can be a challenging task. Often their important early relationships have been troubled and disrupted, damaging their capacity for attachment. If they then experience a period when parental authority is left unclarified, while decisions are being made, their development may be seriously compromised. The case of Tyler and Lorraine illustrates this point.

> *Tyler, four, was placed in foster care following a police investigation of physical abuse by his mother, Lorraine. His behaviour was intensely, continuously anti-social. He bit, spit, ran, urinated and defecated in all the wrong places, refused to eat, smeared food, feces, toys. He was hurtful to animals, people, and himself – in short, he was a four-year-old hurricane. He was quickly rejected by his first two foster placements and referred to treatment foster care.*

As will be seen later, access can be used as part of a clinical plan to meet agreed upon goals. In the case of Tyler, access was used strategically, in the context of treatment foster care (TFC), to teach Lorraine how to control his behaviour and to help them both toward a resolution of their earlier conflicts.

Well-managed access can be an important clinical vehicle for ensuring that family relationships contribute as much as possible to a child's well-being. In this chapter, we shall explore how access can be used as a treatment tool. Well-managed access does not always lead to reunion; sometimes it contributes to permanency by assisting children to come to terms with the past, so they can move on with their lives in out-of-home placement. In regular foster care, there are

often too few resources for managing access in a way that improves parent-child relationships. For example, many children see their parents only under supervision; these visits tend to be limited to one hour per week, because of restrictions on staff time. Well-managed access requires staff who have specific training in this area, as well as the time and willingness to teach parents how to interact constructively with their children.

SUPPORT FOR MAXIMIZING ACCESS

Theory

Theory in child welfare supports the value of maintaining family ties for children in out-of-home placement. The main benefits in theory of ongoing family ties are: (1) minimizing the disruptive effects of separation; (2) helping children to maintain and develop their identity; and (3) increasing the chances of reunion with family.

Minimizing Disruptive Effects of Separation

The attachments formed by children to their basic caregivers are of overwhelming importance to their psychological security. Even children whose attachments are characterized by insecurity and anxiety, as with children abused by their parents, have a stronger basis for development than children whose primary relationships are interrupted after being established (Provence, 1987). With parents who have been extremely unresponsive or abusive, children may not have formed any kind of attachment; such children have been defined as "unintegrated" (Balbernie, 1974). Given the importance of primary attachment figures, separation from parents creates feelings of anxiety and loss; in prolonged separation, these feelings may create psychological disorganization and depression (Bowlby, 1980). Continuing contact during placement prevents children from feeling abandoned. Although contact with parents may be temporarily upsetting, because it reminds children of the pain of separation, visiting assures them of their parents' continuing commitment; moreover it becomes less upsetting after a routine is established. Studies of children visiting with a parent after divorce showed that those with ongoing contact had better development, especially if the two parents cooperated in a positive way (Wallerstein & Blakeslee, 1989).

Helping Children to Develop and Maintain their Identity

The process of identity formation in children depends greatly on a continuing relationship with primary caregivers. Major dimensions of identity formation are a sense of belonging, self-esteem, and growing autonomy (Rosenberg, 1979). For most children these dimensions are intrinsically related to their feelings about and responses from their parents. Being part of a family into which they are born or adopted gives them a sense of belonging; the reflected appraisals they get from their parents provide their main source of self-esteem; and their growing

autonomy depends upon having a secure basis from which to test out independence. Thus, the process of identity formation is immensely complicated by out-of-home placement. Maintenance of family ties provides them with a continuing sense of belonging that is difficult to have in a foster home. The demonstration of continued commitment by their parents increases their self-esteem, which can be irreparably damaged if they feel abandoned by parents. Having two families working cooperatively toward their welfare gives children a secure base from which to seek independence; such children are likely to feel more confident than those whose parents have disappeared from their lives; the latter may well fear they will lose the love of substitute parents if they test out independent behaviour.

Practice Research

The main support provided by research for parental access to children is that visited children are more likely to return to their families, and to return earlier, when contact is maintained (Simms & Bolden, 1991; Mech, 1985). Research has also demonstrated that a child's placement stability can actually be enhanced by well-managed contacts and connections between the child and his or her family of origin (Hess & Proch, 1992; Cantos, Gries, & Slis, 1997; Kufeldt, Armstrong, & Dorosh 1995; Thomlinson, Maluccio, & Abramczyk, 1996). Disruptions occur less often, children make better long-term adjustments, and the possibility for the child to develop a positive, future-looking identity is enhanced. Furthermore, well-managed access can play a key role in resolving family relationship issues, so that the child is available to 'move on' to some form of permanency option. Reunification, if it is appropriate, is more likely to happen when well-managed access is in place (Maluccio, Abramczyk, & Thomlinson, 1996; Kufeldt, 1990). If the possibility of reunification as an option is not clear, well-managed access can contribute to timely decision-making (Hess & Proch, 1988).

A child's identity formation and sense of continuity can be enhanced by access (Palmer, 1995). At the same time, feelings of loss, abandonment, and rejection can be resolved, an important step in allowing the child to feel free to develop new attachment relationships (Palmer, 1995).

Many children in out-of-home placement eventually find their way back to their family of origin, often in contravention of child welfare recommendations. Although the reasons for this vary, one contributor may be the child's idealization of the parent as a result of having contact severed without resolution (Steinhauer, 1991); another may be the child's wish to counteract a sense of living 'in limbo' (Anderson, 1988). Some parents who are not capable of taking care of their children during their dependent years can nevertheless manage regular visiting, thus giving their children a sense that they have a caring biological family.

Clinical Experience

Discussions with children in care about their families have revealed that they are often concerned about the family they left behind – what is happening in the family, and how they feel about their 'lost' member. In particular, children who have taken a caregiver role, possibly with a parent involved in substance abuse, may worry about this parent's well being (Palmer, 1990). Ongoing contact can help to relieve this anxiety and allow placed children to 'get on with' their own lives.

Treatment Foster Carers, because of their training and sense of mission, may be in a better position than other carers to promote family access for children in their homes (Osmond, 1996). Ideally, they view access as part of a healing process to help children maintain their identity and their family relationships. Some of the benefits experienced in a Treatment Foster Care Program have been (Osmond, 1996):

- Maintainance of continuity in the child's life
- Contribution to a more secure identity through providing a sense of personal history, familiarity, and 'belongingness'
- Assistance to the child and family in confronting the reality of the separation, the reasons for it, and the need for change
- Support for parents to begin or continue to take some responsibility for their children
- Assistance to families to cope more adaptively with changing relationships
- Provision of a time and place to practise new behaviours
- Promotion of accurate assessment for both child and parent about the state, limits, and potential of the other
- Provision of an important transition vehicle when a child is returning home

PRACTICE MODELS THAT SUPPORT ACCESS

Two models of practice that support access are 'inclusive foster care' and 'shared parenting'.

Inclusive Foster Care

Inclusive foster care is a model in which caregivers and social workers willingly include children's families in their children's lives. Social workers encourage the continuity of parent-child ties by including parents in the placement from the outset. Ideally, they invite parents to meetings where placement is being planned, have the parent accompany the child on a pre-placement visit, and help parents to discuss with their children the reasons why they must leave home. Social workers also encourage communication between the parents and caregivers, acknowledging the parents' expertise with respect to their child's behaviour and needs. Often social workers decide to exclude parents from the placement process, fearing they are too volatile to handle it without further upsetting the child. In a child's mind, however, the quiet and

unexplained disappearance of a parent may cause more chaos than a noisy, resistant separation. Excluding the parent may operate more as protection for the worker and foster carer than for the child.

In the inclusive model, caregivers recognize the importance of family ties to the child's development, as discussed earlier, and encourage children to value their families. They talk openly about the child's family ties, being as positive as possible about the parents, and cooperating to facilitate family contact. At best, inclusive foster care can be a partnership between parents and caregivers, in which each contributes to the planning and ongoing care of the child. Caregivers frequently develop a teaching and supportive role with the child's parent, particularly with young, single-parent mothers. The benefit to children is that they can acknowledge loyalties to both caregivers and parents and can gain security from seeing the two families cooperate in looking after them.

Shared Parenting

An advanced form of inclusive foster care is 'shared parenting.' This can be defined as teamwork between a child's parents and foster carers with the goal of gradually moving the caregiving responsibilities back to parents. Ideally, this sharing can begin before placement, when a social worker brings a parent or parents to the foster home with the child or children on a pre-placement visit. Initially, the parent's contribution to the team is in-depth knowledge of the child and a longstanding relationship that may enable the parent to influence the child's behaviour. The foster carer's contribution is knowledge of child development and parenting skills. Ideally, each member gradually transfers their knowledge and influence to the other, and the parent eventually acquires sufficient knowledge and skill to resume caring for the child.

Theoretically, shared parenting fits with the needs of parents whose children have required outside intervention to ensure adequate care. These parents are often young, single mothers who lack the support from family and friends that is available to more successful parents. Similarly, they often lack positive parenting models from their own childhood experiences. Moreover, shared parenting allows parents to retain some responsibility for their children, so that the child-parent bond is maintained. The process is much more empowering than the traditional out-of-home care experience, in which all responsibilities are taken away from parents, other than the expectation of visiting their children. Instead, parents are encouraged gradually to assume responsibility for their children as they gain knowledge, skills, and confidence.

From the children's viewpoint, it is valuable to know that people who care for them are cooperating. For children, being physically separated from a parent because of placement in foster care, has many similarities to separation resulting from marriage breakdown: the absent parent is no longer a basic part of everyday life, and the child may feel rejected by this parent, or guilty for living with a caregiver who has distanced her or himself from the absent parent. If there is animosity between the two homes, children are likely to be conflicted over divided loyalties. Research has shown, however, that children benefit from having the non-custodial

parent continue to assume some responsibility for them, as long as the separated parents can cooperate with each other in a positive spirit (Wallerstein & Blakeslee, 1989).

There are impediments and risks to shared parenting as described above. Many foster carers prefer to have minimal or no contact with children's families; agencies frequently acquiesce, without considering the effects on the child-parent relationship. Foster carers frequently have to deal with crises and frustrations related to the care of difficult children, and it may seem too much to expect them to work with the child's parents as well. If foster carers view themselves as taking over from parents, rather than working with them, they may not be ready to address the parents' needs. Parents who have been deprived of family support themselves may latch on to a foster family, seeking to meet their own needs rather than to help parent their children. If a foster family view themselves as working exclusively with children, they may resent these demands. Moreover, parents who neglect and abuse their children have often had their personal boundaries violated in childhood, so have poor judgement about interpersonal boundaries; foster carers who can work with these parents must have good boundaries themselves, so they do not allow the child's parents to exploit them. In extreme cases, parents who are very needy and conflicted in their interpersonal relationships may present a risk to foster carers. If parents have a history of violent or unpredictable behaviour, foster carers should not be encouraged to invite them into their homes.

Despite the impediments and risks, several precedents in Ontario have shown that inclusive foster care and shared parenting can work and may even reduce the level of behaviour problems experienced by foster carers who have the child's parents on their side. These precedents include: the Chedoke Parent Therapist program; Family Partners in the Catholic Children's Aid Society of Toronto; the Treatment Foster Care Program for the CASs of Durham, Kawartha-Haliburton, and Northumberland; and the experience of foster carers who specialize in caring for developmentally challenged children.

Conditions Associated with Inclusive Foster Care/Shared Parenting

Families who might not be ready for full re-entry of the child into the family home may still be good candidates for a more inclusive form of foster care. Parents who may not be ready to change their lifestyle, for example, may feel committed to the child and willing to re-work their relationship with the child in a more positive way. Such parents may not have responded well to traditional agency services. With more limited goals, as in the cases of Katrina and Arthur (discussed below), parents often respond positively to a competency-based, hopeful, service delivery style. Parent characteristics associated with an inclusive approach are:

- Behaviour does not pose a risk to the child or caregivers when contact occurs. (If there is risk, a more clinically managed approach to contact might still be possible.)
- Demonstrated capacity to form a collaborative relationship with foster caregivers and other members of the service team.
- Ability to recognize the child's needs and to make a commitment to work cooperatively to meet them

Programs with Inclusive/Shared Parenting Models

The Chedoke Parent Therapist program, later transformed into a family preservation program, focused on very difficult children who had previously been placed in group care. The caregivers were called Parent Therapists; the generic term Treatment Foster Caregivers (TFCs) will be used, as their role is the same as that of caregivers in Treatment Foster Care. The TFCs were able to care for these children (one per placement) within a structure of enriched training, regular meetings with an agency professional, and a cluster format in which several TFC couples functioned as an extended family to provide ongoing support and relief for each other.

Family Partners is an ongoing program that began around 1990. In 1999, there were 16 families, with plans for expansion. Foster carers are encouraged to develop a supportive teaching relationship with children's parents; for parents who are much younger than the foster carer, this may go beyond teaching to more of a parenting role, depending on the parent's individual needs. The parent spends time in the foster home, modeling and testing out parenting skills in the presence of the foster carer. For example, a foster carer may model how to handle effectively a two-year-old child's oppositional behaviour, while explaining to the mother that this behaviour is part of a developmental stage of seeking independence. When this behaviour recurs, the parent is encouraged to try a similar approach, with guidance from the foster carer.

Foster carers for developmentally challenged children seem naturally to take a more inclusive approach toward the child's parents. Possibly, they are less likely to be judgemental toward parents who have not been able to carry out all their responsibilities, recognizing that these children require a great deal of time and skill. Similarly, parents may feel less defensive about requiring help with exceptional children and more appreciative of the foster carer's role, which sets the stage for successful teamwork.

The TFC Program for the CASs of Durham, Kawartha-Haliburton, and Northumberland has been using the principles of inclusive foster care and shared parenting since 1990. Caregivers in this setting report a significant reduction of placement breakdown which they attribute to: a reduction of disruptive child behaviour associated with loyalty binds and being 'in limbo'; a decrease in the time required to reach permanency planning conclusions; and an increase in adaptive and mutually supportive parent-child relationships. Further, TFCs report increased satisfaction from being mentors to the child's family, as this enhances their sense of professionalism in the caregiver role.

TFCs report that a strong relationship with parents is an important asset for helping a child. It gives the TFCs ongoing access to knowledge about the child's history and plans for the future; the child has less 'emotional baggage' in terms of separation anxiety and divided loyalties; and parents are less likely to undermine the placement. In the Chedoke program, the TFCs felt so strongly that partnership was the key to helping children that the program changed to a Community Family Treatment Program, in which the TFCs became Parent Therapists, working at family preservation in the child's own home, rather than treating children by removing them.

From the child's viewpoint, the experience of having two families cooperating to care for them seems far preferable to being left to resolve the differences between two families who care for them, but who have little mutual communication or cooperation. Moreover, workers with the child protective agencies who are ultimately responsible for children in care have a much simpler task when they are spared the ongoing role of mediating between competing interests.

Experience from the above programs shows that inclusive foster care and shared parenting can work, if the agency makes a commitment to these models, orients foster carers in this direction, and provides ongoing support to those who undertake to work as a team with the child's parents.

USING ACCESS TO MEET CLINICAL GOALS (CLINICALLY-MANAGED ACCESS)

Principles

Access can often be used as an opportunity to meet therapeutic and case-management goals – a vehicle for intervening in family relationships that are troubling to both parent and child. Purposeful access involves: setting child-focused goals that are agreed upon by all parties; planning and orchestrating visits; teaching parents new approaches with their children; and recognizing parents' feelings about visiting. When some of the dysfunctional patterns are under control, visits can be used to talk honestly, openly, and in a healing way about the events of the past and to come to some conclusions about the future.

Setting Child-Focused Goals

It is important to have agreement among caregivers, workers, and families that ongoing contact is part of an overall plan to return children to their families. If visiting is viewed as a burdensome necessity to satisfy parents, then workers and foster carers may not be motivated to make creative use of the contact. Ideally, children's families will be part of their future lives, even if they never live with them again. Visiting should be part of maintaining a child's family ties and helping parents and children to develop better ways of relating to each other.

Planning and Orchestrating Visits

The planned use of visits requires workers and caregivers who are oriented toward making the visit a therapeutic experience for the family. They should be supported by facilities and structures in which visiting can be a learning experience. All parties should be aware of the possible pitfalls of visiting for the particular child and family and should plan how these may be avoided, or used constructively.

Teaching Parents New Approaches

It should not be assumed that parents have the skills to manage visits constructively. Because of deficits in their own upbringing, their leisure and recreation pursuits may tend to involve substances, sex, or danger. They may have to be shown how to play, use toys, speak respectfully to their child, and generally enjoy their company. Visits can be used to teach and promote these competencies, through modeling, direct teaching, and facilitating respectful communication between parent and child. Eventually, parent and child can learn to enjoy each other's company and benefit from their time spent together.

Recognizing Parents' Feelings about Visiting

Often the problems arising in the visit relate to parents' discomfort about having their child in care. Parents who have lost their children, even temporarily, to public care may feel a deep sense of shame (McAdams, 1972). As well, they are experiencing the pain of loss, which they sometimes cover up with anger and resistant behaviour. Parents need a sensitive approach from caregivers and workers to help them handle these feelings around visiting. Thus, a planned approach to visiting includes debriefing parents after the visit to help them deal with their grief, loss, and self-esteem issues associated with being separated from their child.

As the following case shows, clinically managed access can be a powerful tool in working with parents who have frustrated professionals with their oppositional attitudes and behaviour.

Access with Oppositional Parents: Tyler & Lorraine

Tyler, four, described above, had come into foster care through CPS when his mother, Lorraine, was charged with beating him with a wooden spoon, causing extensive bruising to his back. All attempts by CPS workers to gain her cooperation ended in failure, and it appeared that the agency was moving toward seeking permanent custody. The request to the treatment foster care agency was to resolve the issue of Lorraine's capacity to handle Tyler, probably in the direction of freeing him for a permanent substitute home.

Within his first week in the treatment foster home, Tyler had attempted to flush the family pet down the toilet and entered into many battles with Pam, his foster carer. In order to control him, Pam had to enforce time out by standing next to his bedroom door and sending him back time after time when he tried to escape. Probably, no one had ever been this persistent with Tyler before. He was placed on a high reinforcement ratio token-economy that rewarded compliance; he needed to have 'Smarties' dispensed every few minutes just to make it through the most basic of routines. Over time, Tyler began to allow himself to depend on an adult caregiver and complied more and more often with adult directives.

The first few sessions with Lorraine were not unlike the first days with Tyler. She fought, argued, accused, denied, so that normal conversation was almost impossible. The treatment team would

have preferred to give up, but Lorraine insisted on her right to visit Tyler, as ordered by the court. Consequently, the TFC worker became involved in observing the visits. Both Tyler and Lorraine showed another side to themselves during the visits. Lorraine spent most of her visit time in tears, stroking her baby's face. Tyler rolled himself into a little ball on her lap and would not leave. For the first time, we began to ask ourselves what we would need to do to engage Lorraine -- to work past the fear and hostility and actually test out the possibility of reunification.

The process was complex, and the following is only a summary. It required the best skills of the TFC staff to deal with Lorraine's aggressiveness. A continuous message of acceptance, hopefulness, and offers of partnership from the entire TFC team finally made the difference. At the worst times, we worked as a 'tag team,' in which one of us interviewed Lorraine until we began to feel inducted into a struggle, then another team member would take over.

The person Lorraine chose to trust first was Pam, the foster carer. Pam liked Tyler and had established some control over his behaviour. At first Lorraine was appalled when she saw Pam being firm with her little boy; but as she saw him improve she finally asked Pam, "How did you do that?" Rather than telling Lorraine, Pam modeled for her and used other innovative methods. She took videos of Lorraine and Tyler during visits at her house. Tyler would be non-compliant, Lorraine would do nothing or inadvertently reinforce him, and Tyler would escalate. Pam would then move in with a limit. Afterwards, Pam, Lorraine, and the TFC worker would review the tape and would show Lorraine in very concrete terms what was happening. They asked Lorraine to note what Pam had done instead and the relative outcomes. Pam taught Lorraine a simple technique for managing non-compliance and reinforcing compliance. When Lorraine was clear on what was being asked of her, the practice sessions began. During each session, Pat would record each of Tyler's non-compliant behaviours and whether Lorraine had responded. Initially, Lorraine might respond to 3 of 45 incidents of non-compliance. Lorraine may have attempted to argue these findings, but the videotape was there as a reality check.

Lorraine began to share her own childhood experiences that led to her difficulties in putting limits on Tyler. She had had an unhappy childhood and was hurt so much by her parents that she was afraid of being hard on Tyler and hurting him the way she had been hurt. By sharing these feelings with Pat, Lorraine entered a therapeutic relationship. For the next year, Pam mothered Lorraine while Lorraine learned to mother Tyler. Pam set clear goals for her, e.g. when Lorraine could deal with 85% of Tyler's non-compliances successfully, she could have an unsupervised visit; when she could enforce time out three times consecutively, she could have an overnight. Gradually, Lorraine took more responsibility for Tyler and eventually was able to take him home. Today, at age 12, Tyler is still with her and doing reasonably well – he is not in trouble with the law, attends a community school, and plays on local sports teams.

Lorraine was never able to trust CPS workers as she did the TFC team. When Tyler went home, however, a child management worker from a children's mental health agency was able to take over supporting Lorraine where Pam had left off. In particular, the worker gave Lorraine recognition for all the learning she had done in managing her son. An attempt to refer Lorraine herself for psychotherapy was not as successful. The team worked hard to get Lorraine's consent

for this, and to share with the psychologist the narrative and solution-focused techniques that had helped them build on her strengths rather than engage her defensive posture.

The psychologist was unable to engage Lorraine after the first session. He echoed to the team some of their own initial feeling: that Lorraine was the most stubborn and defensive woman he had ever met, and that Tyler should be taken away from her permanently. The team recognized they had initially made a similar assessment of Lorraine. They found, however, that the key to her progress was to be a partner in her desire to parent her son successfully. No other goal offered so much motivation.

As the situation of Tyler and Lorraine illustrates, those responsible for clinically-managed access should help families and caregivers to identify mutual goals and specific strategies for meeting those goals. The structure and process of visits should be aimed at meeting the learning deficits of the family and teaching them skills for positive interaction.

Without such very specific, therapeutically-oriented help, the relationship will likely be unable to progress towards a more mutually satisfactory one. Often such relationships "fizzle out" over time, with neither parent nor child actively looking forward to or wanting the visit, yet unable to end the contact either. The significant relationship remains shadowy, painful; on the infrequent occasions when contact does take place, it stirs up painful feelings for both parent and child.

Access When Parent's Behaviour is Uncontrollable: Katrina & Pat

Some parents are so overwhelmed with their own problems that they seem unable to use access constructively.

Pat, mother of 10-year-old Katrina, had a rapid cycle bi-polar mood disorder that was not being controlled by medication. When manic, Pat was extremely involved with Katrina's life, getting into arguments with teachers, standing on the playground to "protect" Katrina at recess, doing hours of "homework" with her, and signing her up for one frantic activity after another. During the depressive phase, Pat could barely function, unable to cook meals or organize Katrina's life.

Katrina responded to her mother's cycles. During the depressed phase she was quiet and inactive; watched a lot of TV, performed most of her own instrumental tasks, and followed her own wishes and whims. Katrina preferred these periods when she was in control. During the manic phases, Katrina was overwhelmed by Pat's flood of devotion and tended to respond with anger to her lack of control. By age 10, Katrina was beginning to fight back against her mother's intrusion, to the point where physical battles began to erupt.

CPS were drawn in by the school, because Katrina's behaviour there was increasingly out of control, and she had bruises after a fight with her mother. Katrina was placed in care. The CPS workers found working with Pat very draining. When she was 'up', she was constantly harassing the worker, making demands about her daughter's care. When she was 'down,' she wanted to

talk at length to workers about her illness, and her complaints about family members, the agency, and the community. Her workers were always relieved to transfer the case. At no time in her 'cycle' was Pat ever able to admit that her mental illness affected her capacity to parent; thus no decisions were being made for Katrina's future – everyone felt trapped in the mother's cycle.

Access was a means for mother and daughter to continue their dysfunctional pattern. Katrina communicated with Pat by telephone and continued to follow her lead behaviourally, even though they were no longer living together. During visits, Pat's caregiving continued to swing between neglect and intrusion.

When Katrina was placed in a treatment foster care program, the TFC worker tackled the problems of access by attempting to open up the 'secret' of Pat's mental illness and its impact on the relationship. He reviewed specific issues about visits, framing them in terms of mother and child appearing to be on a "roller coaster ride" together. Although Pat rejected this image, Katrina was able to say, "Yes, mother, it's true". With support, Katrina was able to tell her mother that she invested a lot of energy in understanding and matching mother's moods.

The therapist shared that he, too, was finding himself adjusting to Pat's moods. Pat was incredulous that the therapist could even be aware of what state she was in. When he accurately identified her mood, not only for that day, but for all of his recent contacts with her, she conceded that, indeed, he could "tell". With much good humour and laughter, mother, daughter, and therapist began to construct a list of the "signs" of the roller coaster and how they were all able to tell what phase they were in. The session finished with the therapist pointing out how overwhelming it must be to be so victimized by something outside of themselves, over which they had little control. That they had been able to survive as well as they did, and care for each other as much as they did, spoke to their courage and coping ability.

The first session established the tone for the next year of work. Pat's mental illness was open for discussion. They could all relate to the concept of a "roller coaster" which became a rich metaphor for future discussions. Pat felt supported as a person coping with an overwhelming illness, and Katrina heard an adult outside the family talk about the power of the illness. Gradually, they allowed the therapist to 'join' them against a problem that was outside all of them and against which mother and daughter had shown considerable strength.

Over the next several months, the therapist focused on helping help Pat and Katrina have better visits, by analyzing how the "roller coaster" was fuelled by their responses to the cycles and to each other. Together they identified specific problems around the visits and formulated solutions. As Katrina was examining her responses to the cycle, she was experiencing stability and predictability in the foster home, where she was able to "just be a kid". With this corrective living experience, and increased control over the relationship with her mother, her behaviour began to improve.

Pat was genuinely proud of her daughter's behavioural and emotional gains. The therapist reinforced this, praising her for supporting Katrina in "getting off the roller coaster". She

framed this as Pat "parenting the very best she could" by making decisions that were good for Katrina. With help, Pat gained awareness of her moods and decided to keep visits short during bad periods in order to spare Katrina.

The worker supported Pat through critical times, when events made it difficult to "do what is best for my child". She was especially vulnerable to any sense of criticism or blame, which caused her to lock into a combative stance with the CPS worker, lawyers, and even the psychologist who assessed Katrina. The therapist took the position that Pat could not control her illness, but she could control "doing the right thing for my daughter". After a year of the therapist's support and attention, Pat began to accept that she would never have her illness in control enough to care full-time for Katrina. She and Katrina made the decision together – it was not a sad time, but a happy time. Their relationship had improved to the point where they offered support to one another – a cause for celebration.

Pat contacted Katrina's father, from whom she was estranged, and offered to work with him towards assuming custody. Over the next six months, the TFC worker helped her to develop a co-parenting relationship with Katrina's father and his wife. Katrina eventually felt safe and well cared for in her father's home, and she was discharged. She is still there several years later.

Access When a Parent is Developmentally Delayed: Sheila & Arthur

Arthur, at eleven, had been in and out of placement for most of his life; he last lived at home for nine days at age seven. He is the oldest of five children born to a developmentally-delayed, single mother. His early history involved multiple caregivers, chaos, frequent admissions to care, and an ambivalent attachment to his mother, whom he visited at least once a month over the past four years. After visits, Arthur's behaviour was very upsetting to foster carers and led directly to the breakdown of several placements, two of which had been long-term. Workers tried decreasing or increasing the frequency of contact, but nothing changed.

The relationship between Sheila and Arthur had never been addressed clinically, for several reasons. First, Arthur was not expected to go home. Second, Sheila's developmental delay impaired her ability to communicate and process information. Third, Arthur's case had been transferred to the 'Crown Ward' (i.e. children in permanent agency care) unit of CPS, so there was no family worker.

In working with Arthur, the TFC team diagnosed his behaviours around visiting as symptomatic of his conflicts about being in care. Like most children in care, Arthur wanted desperately to belong somewhere. He was angry that Sheila could not take care of him. He knew that she was developmentally delayed, but did not accept the implications; he had a number of magical ideas about how she could be "cured" and take him home. This was supported by his mother's occasional statements that she wished to have Arthur come home. In view of this goal, he became very anxious about any signs that Sheila was unwell or unable to take care of herself.

Arthur brought all his fantasies, fears, and angry feelings to the visits. As a result, he behaved in a way that was 'omnipotent', demanding, coercive, and noncompliant. Sheila did not really understand Arthur's developmental needs. For weeks leading up to his birthday, she promised him a train set. On the big day, she brought a toy suitable for a much younger child. Arthur accepted the present with good manners and attempted to play with it in his mother's presence. However, a few days later the toy was found smashed. Clearly, this mother and son were 'missing the boat' with each other and needed a way to deal with their worries and issues more directly.

The TFC team decided to use the visits to begin to work on the relationship. The worker began meeting separately with Arthur and Sheila to discuss how they might like to change the visits to make them "more fun"; then she helped them to talk about their relationship. They had similar feelings about the relationship, but each had been hesitant to express these for fear of hurting the other: they missed each other and wished that they could live together. While CPS workers had assumed this meant 'immediately', in fact they both believed that this would not be a good idea "until Arthur is around eighteen".

The TFC worker brought together Arthur, Sheila, and the CPS worker to discuss the mother-son relationship, goals for their future together, and how the visits could be used toward these goals. The two workers helped Sheila and Arthur to repeat to each other the wishes they had expressed separately.

As the discussion progressed, Arthur became agitated – he fidgeted, hopped, jumped, twirled, and spun. Sheila and the CPS worker tried to control Arthur, insisting that he "sit down and listen", but he would not stay seated and would not answer any more questions. The TFC worker suggested that Arthur might be listening very closely and doing his very best to participate, but the discussion might be making him anxious. Despite Arthur's continued spinning, they continued the session, addressing Sheila's and Arthur's mutual issues in an open, supportive, non-critical way. To an astonishing degree, they were able to share their mutual fears, concerns, and hopes, and begin to 'clear the air' about the future of their relationship. While Arthur's behaviour began to settle, the TFC worker helped them to plan more "fun" time together and generated ideas for this. The session ended on an upbeat note, with mother and child enjoying a positive feeling of connection.

On the way home, Arthur began to show some acceptance of his mother's condition. He pointed to a 'handicapped' sticker on a car, and began to ask questions about handicaps: how they happen, whether they are present at birth, whether they are passed on to children. He continued to explore this with his foster carer. Would going to school help his mother get "better" or "smarter"? "Could it be that maybe it's not me, but my behaviours, that are bad?" "I want to belong somewhere."

The 'talking about things' sessions were continued and gradually became easier. Arthur and Sheila were able, very quickly, to spend small bits of time together, unsupervised, in the community. It was recommended that Sheila be allowed to visit Arthur in the foster home. Initially, the CPS worker was worried that this plan might disrupt yet another foster care

placement, but eventually she could see the value of including Sheila in Arthur's ongoing care and that in this case inclusive foster care or shared parenting could be a most elegant solution.

CONSIDERATIONS IN SELECTING CLINICALLY-MANAGED ACCESS

Parents' Capacity

- Is the parent motivated to participate in the child's life?
- Is the parent capable, if well supported, of making a positive contribution to the child's care via the access relationship? If parent's behaviour around access is problematic, could it be improved through support and education?
- Are the parent's mental health issues well enough in hand that they do not offer immediate risk to the child in the visit? Workers may want to seek consultation with mental health professionals to assess this. If not, is there a way to help the child understand the mental health problem and to allay fears and myths?
- What is the risk of maltreatment (physical, psychological, emotional) during access visits by the parent towards the child? In particular, parents with a tendency to abuse their children emotionally should be monitored, so they can learn to communicate with their children in a more constructive way.

Potential Benefits to the Child

- Would the child benefit from a regular opportunity to assess the state, well-being, and reality of who the parent is? Through access to regularly updated, accurate information, the child can be prevented from developing 'fantasy thinking' about the parent (e.g. "my Mom is getting better and could care for me").
- Can the child be helped to resolve the loss of the relationship, come to terms with the reality of being in care and, through gaining a realistic understanding of the parent's strengths and weaknesses, come to accept them for who they are?
- Could any existing loyalty bind for the child be managed or resolved through offering a more shared approach to caregiving to the child?

Caregivers' Attitudes

- Can caregivers tolerate the intrusion into their lifespace, or is such a requirement likely to break down a placement?

If the answers to these questions are positive, then this may be a case where well-managed, clinically-focused access may eventually lead to the possibility of greater parental inclusion, with shared parenting as a goal.

FAMILY-FRIENDLY VISITING ENVIRONMENTS

As mentioned earlier, parents are likely to feel some shame and anger about having their children in care. If their ongoing contact is set up in a sterile, controlled environment, in which they are closely monitored, parents may feel unwelcome and unwanted.

Home as the Default Option

Ideally, parents should visit their children in an informal setting that is familiar and welcoming to both children and parents. The most natural setting is the family home, so it should be the default option. This gives children the reassurance of knowing there is still a home where they ultimately belong. Parents are likely to be more comfortable interacting with their children in their own homes. Moreover, home visiting gives children an opportunity to see extended family, neighbours, and friends. It may be in the interests of some children to have parental visits in their foster home, or in a neutral supervised place; but there should be good reasons for this and the reasons should be made explicit to the children and their families.

Visiting in the Foster Home

The foster home may be the preferred location of visits, if parents cannot be trusted to protect their children at home, or if foster carers have an inclusive orientation and are assuming a guiding role with the child. As shown above, TFCs can use the foster home to provide support for the development of positive interactional skills. This allows TFCs to provide guidance and direction to the access relationship, as shown in the cases above.

Supervised Visits in a Formal Setting

Sometimes parents are not trusted to take their children home and not wanted in the foster home, so visits are located in a more formal environment such as an agency. If the child's safety is thought to be at risk, the visits are supervised, usually by someone not involved with the case. Although this may be a necessary precaution, there are a number of drawbacks:

- Agencies may use this option as the default with families who could be encouraged to take responsibility for their children in a less formal setting.
- Parents who are being monitored unnecessarily will probably feel they are not trusted or wanted in their children's lives.
- Parent-child interaction tends to be limited by an impersonal setting.
- Foster carers and workers lose the opportunity to use the visits for clinical goals.
- Visiting plans that require agency time and support may be allowed to lapse, if the results are not clearly positive. (Hess, Mintun, Moelhman, & Pitts , 1992)

DECIDING ON THE BEST KIND OF FAMILY CONNECTION

Deciding what kind of family connection is best suited to a particular family is a challenge for most child welfare professionals. Some guidelines can be clinically useful when considering how to facilitate and develop family connections (Pine, Warsh, & Maluccio, 1993).

Lower Levels of Access

Some parents do pose a risk to their children or the caregivers. Their access to their child should be more limited and carried out under protective conditions. Characteristics of such parents are:

- History of mental health problems, addiction, serious personality disorder, or developmental delay[1]
- History of child abuse or severe neglect, leading to a traumatic response in the child
- Early history of multiple caregivers providing negative care
- Behaviour during contact includes verbal and non-verbal communication that remind child of past traumatic events

CONTRAINDICATIONS TO ACCESS

Potential Damage to Child

Children may be harmed by continuing family contact under certain conditions:

- Parental behaviour on visits is traumatizing to the child, and parents are not willing to change; this can include continuation of abuse that led to the child's placement.
- Foster carers may give negative messages to the child about family contact. Consequently, children may choose not to see their parents because they cannot cope with the divided loyalties. If the foster carers are unable to change, and placement is at risk, it may be too stressful for the child to continue the visits.

Concerns that can be Managed

Sometimes the concerns of caregivers and workers around visiting lead them to limit or end the contact, when there may be more creative ways to deal with these concerns.

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[1] In order to assess risk to children, when parents have psychiatric conditions or they are abusing substances, workers should consult with community service providers who know the parents. Under the above conditions, access may be regularly scheduled, but will likely be infrequent, limited in scope, and well supervised in accordance with the child's age, developmental resources, and the parent's capacity to cooperate in the process.

- Foster carers may be opposed to visiting for reasons more related to their own needs than those of the child, i.e. they may view the family as rivals for the child's affection (Steinhauer, 1991). Ideally, foster carers should be trained from the outset to view themselves as professionals, rather than replacement parents. If they cannot be inclusive of parents, this could be a reason for not placing the child in their home.
- Foster carers and workers may want to avoid the emotional conflict that visiting often stirs up in the children, with accompanying difficult behaviour. Ideally, social workers should educate foster carers in the importance of ongoing contact to help children resolve their feelings about the separation and previous treatment by parents. They should also provide guidance to help foster carers manage children's responses in a helpful way.
- Long-standing relationship problems may continue to be played out during contacts, as shown with Katrina and Pat. With good clinical management, however, access became the framework for achieving a beneficial result – a secure family home for Katrina, with her mother playing a cooperative role.
- Parental visits are relatively empty or chaotic, because the parent is unsure of how to interact constructively with the child. Yet even parents who are developmentally delayed can be taught to communicate and play constructively, as shown with Arthur and Sheila.
- Some children refuse to have visits with their parents, or communicate extreme reluctance, either verbally or behaviourally. Visits should never by "forced"; however, skillful clinical intervention may assist children to deal with the concerns underlying their reluctance about access.

Giving up on Parental Contact

There may come a time when those managing the case have to admit that all attempts at inclusive care and clinically-managed access have failed. The access relationship has been clearly identified as a major impediment to the child's ongoing adaptive development, and there is little expectation that this will change. The best solution may be to give up on contact.

When the decision is made to end contact, social workers or therapists should help children to understand the reasons for the separations they have experienced, accept the reality of their loss, acknowledge their anger and pain, and learn ways of handling these feelings in a non-destructive way. The goal is to find an appropriate place for the 'lost' family in children's emotional lives, so the intrusion of grief on their daily functioning is minimized (Osmond, 1996). To the extent that children complete the above steps of mourning, they will be ready to enter into new attachment relationships with caregivers.

SIBLING ACCESS

Importance

The importance of sibling ties is universally recognized. Ideally, we maintain our sibling ties, like other family bonds, over our lifetimes. Memories that we share with our siblings support our sense of identity. Even when social workers and caregivers are ambivalent about parent-child contact, they tend to support the idea of sibling contact for children in out-of-home placement. Nevertheless, many children are placed apart from their siblings and have little contact with them. An American literature review showed that most children in care have one or more siblings: reports ranged from 56% to 90% (Elstein, 1999). Yet, one study found that 75% of placed children were separated from their siblings for a significant period of time.

Complexity of Decisions about Sibling Access

Access and placement decisions about siblings are complicated for a number of reasons.

- There is little research on siblings in out-of-home care. The research available identifies both benefits and problems around placing siblings together and provides little guidance about access between siblings.
- The views of social workers and caregivers about a child's best interests may not be consistent with the legislation or judicial decisions with which agencies must comply: e.g. most Ontario judges who make decisions about 'Crown Wardship' favour cutting off children's access to their families, apparently to make them more desirable as adoptees.
- An absence of guidelines regarding sibling access causes confusion and frustration for workers, children, and families. Children who would like to see their siblings are being left in limbo for long periods of time while plans are formed by the parties involved.
- It is important to assess the impact of separating siblings when a Child Welfare order is made for one and not the other. Frequently, separation is done without adequate preparation and can be very traumatic for the children.

Theory

Theoretically, we know that sibling contact is important to children's capacity for attachment and identity formation. Siblings are usually the next level of intimate relationship we have after our parents. They provide a relatively safe context in which children learn to negotiate, cooperate, and compete. Experiences with siblings become part of the child's internal working models for other intimate relationships (Dunn, Slomkowski, & Beardsall, 1994). Siblings can be a protective factor for children in deprived and stressful environments (Agger, 1988; Cummings & Smith, 1993; Goetting, 1986).

Benefits of Placing Siblings Together

Children who are uprooted from familiar people and placed in out-of-home care have their continuity disrupted and their experience of self fragmented. Many adults report resentment over their separation from their siblings in childhood. Although separation from parents may be unavoidable, it is generally felt that siblings should be spared a further separation from each other.

It may be expected that sibling bonds become stronger when children have limited physical and emotional contact with their parents and ready access to each other (Bank & Kahn, 1982). Caregivers often find that traumatized siblings develop mutual bonds in the absence of their parents; having an available attachment figure may preserve the child's ability to form stable and satisfying relationships in the future. Thus, siblings may serve one another as buffers, catalysts, safe haven, or barriers (Thorp & Swart, 1992). Separated from parents, children may assume a protective parenting role with siblings, i.e. the 'parentified' child. This protective behaviour becomes an important component of the child's resilience in the face of adversity. That is, once internalized, a 'parentified' role forms the foundation of coping abilities. It becomes an internal model, guides motivation, and shapes the capacity to take part in stable, nurturing relationships. According to attachment theory and research findings, this is a strong predictor of future competencies in cognitive, social, and emotional domains.

It may be expected that the mutual support of siblings placed together will lead to more stable placements. Moreover, children are more likely to see their parents when they are all in one place, and consistent visits with family of origin have been identified as an important predictor of family reunification (Fanshel & Shinn, 1978). It is therefore a sound practice to place siblings together and to maintain strong relationships between siblings unless compelling evidence dictates otherwise.

COMPLICATIONS WITH SIBLING ACCESS

Logistical

From a practical viewpoint, placing a sibling group in a single home is a challenge.

- Siblings may enter care at different times, because of differential treatment by parents. There may be no room in the home for siblings placed subsequently
- Most homes do not have the resources to care for a group of children, especially when the sibling group may have dysfunctional and disruptive behaviour patterns. They will require a lot of agency support to make this work.
- Foster carers with sibling groups may reach the point of giving up with a difficult child, but want to keep the others in their home. This presents a difficult choice.

Clinical

- One sibling has special needs that deplete foster home resources and would prevent others from receiving the attention they need.
- Children who rely on a parentified sibling may be slow to form a trusting relationship with their foster carers. They should be encouraged to move gradually away from dependence on the sibling toward reliance on adults.
- Both siblings may resist efforts to shift the dependency onto an adult: parentified siblings may feel their identity is threatened, while dependent siblings may feel betrayed.
- Some siblings interact in a destructive way, reinforcing maladaptive behaviour that may cause their placements to break down. In treatment foster care it might be possible to intervene creatively, as in the parent-child cases described earlier; otherwise a temporary separation may be necessary in order to preserve the placement.
- An older child may prevent a younger sibling from building ties to a foster family, possibly by giving negative messages. Ideally, this situation, and the reasons for the older sibling's feelings, can be discussed openly with the children involved.
- Some siblings do not appear to have a strong attachment to each other and may even resent one another. In these situations, it may not be important to place them together.

Destructive Interaction between Siblings

Siblings who have been abused may relate to each another in ways that may have been adaptive in the abusive environment, but are maladaptive in a substitute family. Typical examples of this are: siblings who have 'blurred boundaries' and those in an 'aggressor-victim' relationship. Siblings with 'blurred boundaries' have 'fused' with each other in their interpsychic attempts to defend against a frightening environment in the absence of a protective caregiver. This type of relationship is not supportive in the sense of a genuine sibling bond between two independent individuals. Siblings who have blurred boundaries may perpetuate chaotic interactions that tend to exclude adults, including the primary caregiver (Leavitt, Gardner, Gallagher, & Schamess, 1998).

Siblings in an 'aggressor-victim' relationship are probably reenacting a dynamic they learned in the original context of the abuse. The interaction may be destructive to both siblings, and it may be therapeutic to separate them, at least temporarily. Ideally, the sibling relationship can be resumed after there has been some healthy individual development. Clinically-managed access has not been used to any extent to resolve problematic relationships with siblings living in the same home. Judging from the effective treatment approaches described earlier in the case examples, TFC workers might be used to intervene creatively between siblings to reshape their destructive interaction. This would avoid the sad decision to separate children from their siblings as well as their families.

ACCESS IN OLDER CHILD ADOPTIONS

Importance

The preservation of significant attachments for older children moving on to adoption is an important consideration in all placement decisions. As with access generally, the primary consideration must be the child's right to preserve attachments, rather than the rights or needs of parents. A decision to end family contact when an older child becomes a Crown Ward seems to be focused on the needs of the adoptive parents: it is argued that access will interfere with the adoptive parents' sense of entitlement, which may limit the development of attachment and permanency for the new family. Similarly, a proposal to continue access after adoption may be aimed at satisfying a relinquishing parent – rather than losing the child completely, the parent is given "something to hold onto".

Conditions Supporting Access

Conditions pointing in favour of access, from the child's viewpoint are:

- Children have significant attachments to a family member or members that give them a positive sense of self.
- Family members seeking access are supportive of the adoption plan for the child, so that the child is not caught in a loyalty battle. This support must include not only verbal permission for the adoption but also an acceptance on an emotional and practical level of the adoptive parents' role as parent of the child as opposed to temporary caregiver.
- All parties to the access are able to put the child's needs before their own.
- Adoptive parents must be comfortable with the level of contact proposed. They should feel empowered to change the terms of contact, if they believe changes are needed in the child's best interests.
- Adoptive parents and family members with access must be able to relate to and cooperate with one another: there should be respect for each other's different lifestyles and value systems and permission for the child to form allegiances with both groups.

Structuring Access

The purpose of continued contact should be agreed upon by all parties. Ideally, it will be a positive relationship with the child, but no interference in decisions about the child's daily life or long-term goals.

Agreements for access should be set out in a contract that minimizes the threat of family members initiating litigation to change the terms. Contact agreements, no matter how well drafted, cannot predict the future of human relationships. If adoptive parents live in fear of losing their adopted child, physically or in terms of emotional commitment, this may erode their sense

of entitlement to the child and possibly their sense of being strong and competent parents to the child.

Testing of Commitment by the Adopted Child

Threats to the adoptive parents' sense of entitlement may come from the adopted child. Most children have periods when they inwardly question and outwardly challenge their adoptive parents' commitment to them. This pattern of testing tends to be exaggerated for older children, who may have experienced maltreatment and multiple separations. Adoptive parents may need support to weather these testing period(s), and it is important not to build in an access plan that further undermines them.

Seeking Help with Post-Adoption Concerns

Most adoptive parents receive counseling in the early stages of the adoption process, but there is currently no built-in provision for ongoing social work support after the adoption is finalized. This means that the parties must have the ability to negotiate any changes in the nature of ongoing contact, as well as to problem solve when disagreements arise. All of these negotiations require that the parties be able to remain child-focused. Their history of cooperation is likely to be predictive of their future ability to give priority to the child's needs. It is important to make this assessment to ensure that commitments made during adoption negotiations are likely to be followed up.

It is also important to consider the intricate web of family relationships that may surround the person proposing post-adoption contact with a child and how, if at all, these relationships may impinge upon the contact agreement. For instance, a grandparent may be able to provide the child with an important sense of continuity and be in full support of the adoption placement. It is also important that grandparents be able to keep confidential any information about the children and their adoption placements; otherwise, less stable family members may act to disrupt the child's placement, should the information come into their hands.

Contact between adopted siblings can be problematic where one sibling remains within or in contact with the family. If contact is assessed as detrimental to the placement of the younger child, it is suggested that this child's needs be given priority, because of greater vulnerability. Ideally, however, the benefits of sibling access (set out above) should be considered in making decisions.

Successful Cooperation with Adoption and Access: Susie

The following case illustrates many of the principles outlined above.

Susie's early life was marked by abuse and profound neglect by her mother, Angie, who had a serious drug addiction and resorted to a criminal lifestyle to support her habit. Initially, Angie's father, Ted, attempted to support the family, providing financial assistance and encouraging Angie to enter into a drug rehabilitation program. He believed that, with this support, she would be able to "turn her life around" and become a good mother to Susie. He made concerted efforts to ensure Susie's physical needs were met and spent time with her whenever possible. Unfortunately, the situation continued to deteriorate, as Angie's judgement became increasingly impaired by her drug addiction. She would disappear with Susie for periods of time, and Ted worried about them but felt powerless to take action.
When Susie was three-and-a-half years old, the situation was reported to child welfare authorities, and she was placed in foster care. Susie presented as a highly insecure and emotionally vulnerable child and was assessed as significantly delayed in all areas of her development. After her placement in foster care, Ted came forward requesting contact with Susie, and a weekly access plan was set up. Susie looked forward to these visits; Ted attended consistently and devoted considerable time and energy to making the visits child-focused. Initially, visits were located at the CAS office, but they were moved to the foster home when Ted and the foster carer, Dorothy, became more comfortable with one another.

Angie visited sporadically, but her drug addiction persisted. While she stated that she wanted Susie returned to her care, she was unable to admit the impact of her behaviour on Susie, or to make any realistic plans for reunion. Ted struggled over this period with how he could remain in Susie's life. As a man living alone, in his late 50s, he felt unable to provide a plan for Susie's care. He recognized that Angie was unable to resume her daughter's care and that another plan had to be established. At this time, Dorothy expressed an interest in adopting Susie that included a willingness for the contact between Ted and Susie to continue.

Dorothy believed that Ted had Susie's best interests at heart, and she trusted that he would support the adoption. She believed that, despite his love for Angie, he would not divulge Susie's whereabouts to her, as she had been known to behave in unpredictable ways that were unsettling for Susie. Dorothy believed that Ted provided Susie with a positive link to her past: he could answer Susie's questions about her mother and the circumstances of her early life in a way that Dorothy could not. Moreover, Dorothy recognized that she and Ted had similar views on childrearing and had been able to cooperate around access.

Ted fully supported Dorothy's plan: he had experience with her loving care of Susie and was confident that they could negotiate ongoing access and adapt it as needed. As a

result, Susie gained a permanent family, while maintaining an important relationship and link to her past.

Sibling Issues in Access: Joey and Don

Joey, four, and Don, thirteen, came into care when their mother, Crystal, was incarcerated on drug-related offences, and were placed in different homes. Don had been providing most of Joey's parenting: he worried about his younger brother, wanted to be in regular contact with him and to participate in decisions about his care. Joey, on the other hand, became less dependent on Don after his placement, when his needs for security and nurturing were met within his foster home. Crystal was unable to maintain a regular pattern of contact with the boys due to her drug addiction. Joey settled in, despite the erratic contact with his mother. With support, he seemed to resolve the issues from his early life experiences and became emotionally able to invest in the new family. Don, on the other hand, reacted to his sense of abandonment with anger, generally projected onto his caregivers. While intellectually very capable, Don truanted from school and increasingly became involved in offences and substance abuse. Despite this, he maintained regular contact with Joey and clearly felt a strong need to be involved in his life. As Crystal was unable resume care of the boys, a plan of Crown Wardship was presented to the court. Joey, at five, was assessed as adoptable. Don, at 14, was moving from placement to placement and beginning to incur YOA charges. Don's lawyer requested that any adoption plan for Joey include ongoing contact between the boys.

There was concern on the part of both Don's lawyer and social worker about how Don would sustain another emotional loss, if contact with Joey were severed. Joey, on the other hand, appeared less invested in his relationship with his brother. He no longer looked to Don to meet his needs and, because of the age difference, the boys had little in common in terms of shared activities or interests. There was concern about Don's ability to relinquish his parenting role with Joey, particularly to an adoptive family. There was also concern about Don's anger and his increasing involvement with anti-social activities and what impact this might have on Joey should a decision be made to pursue a fully open adoption. Finally, there was concern about the fact that Don continued to have contact with his mother and sought acceptance from her. It was considered impractical and unfair to ask Don to keep information about Joey's whereabouts from his mother, should she ask him. Given these concerns, a decision was made not to enter into an agreement for face-to-face, post-adoption contact between the boys.

Considerable time was spent with the boys discussing their past together and how each of them required different kinds of planning for their future. Don was introduced to Joey's adoptive parents and they had an opportunity to share their mutual hopes for Joey's future. The adoptive parents agreed to the exchange of letters and pictures between Don, their family, and Joey, so that Don and Joey could be assured of each other's well being over the years. While Don clearly desired more contact with Joey than was negotiated, he was able to accept the plan. Critical to this acceptance was the opportunity he was given

to meet with the adoptive parents. They were able to assure him of their positive motivations for adopting Joey, communicate their acceptance of Don, and acknowledge the critical role he played in providing care to Joey in the early years of his life.

CONCLUSION

Generally, an adoption plan that includes personal contact with families must be child-centred. It is easy to be swayed by the needs of adults and older children involved, particularly when seeking an agreement as an alternative to protracted litigation. At the base of any negotiated agreement, there must be sufficient clinical knowledge to ensure that the plans will meet the needs of the child. Ideally, there should be a sense of cooperation, so plans can be adapted as the child matures. This requires careful planning and is not a decision to be negotiated by lawyers at the courtroom door.

SUMMARY

Generally, the value of family connections for children in out-of-home care is supported by theory, research, and the observations of professionals and caregivers. Nevertheless, contact between children and their families is often discouraged by workers and by the structures set up by agencies to deal with access. Sometimes this is warranted, as with parents who continue to be neglectful or abusive, or with sibling relationships that are detrimental to a younger child. Often, contact could be a positive experience for children, if agencies provided active guidance to the participants. As the experience of TFC programs has shown, clinically-managed access can be used to great advantage in resolving conflictive parent-child relationships; it might also be effective in dealing with destructive sibling relationships, but there seems to be no empirical information on this at present.

Generally, it is acknowledged that the child's welfare should be the top priority in planning for family contact. It is often forgotten, however, that the decision to sever contact means that children will probably go through their lives with a large gap in their history and in their sense of belonging. As this discussion has shown, working to make contact a positive experience can be an invaluable aid to child development.

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IV. **Adoption**

ADOPTION AND THE ISSUE OF ACCESS OR CONTACT

INTRODUCTION

Adoption with access remains a controversial topic germane to the issue of permanency planning. While the debate continues over whether to permit access or contact between an adopted child and members of the child's biological family, it may help to clarify the discussion by setting out the parameters.

ADOPTION CATEGORIES: CLOSED OR OPEN

A closed adoption means that once the adoption is made final there is no further contact between the child and the biological family. In an open adoption there is provision made for some sort of contact between the child and members of the child's biological family. There is a continuum of contact possibilities from the stringent, e.g. the exchange of some information, to the liberal, e.g. ongoing contact between members of the biological family, the child, and the adoptive family.

The principle issues in the matter of which children should be considered for open adoption are set out below. It is understood that there is no way around the requirement to weigh the merits in each individual case.

a) There are children whose biological parents cannot adequately parent them and would be willing to relinquish them for adoption, if they did not have to sever contact with them completely. It is also recognized that some adopted children, particularly those with emotional attachment to birth family members, could benefit from contact with such family members. Without contact, many adoptees reach adulthood still struggling to establish their identity.

b) In some cases, there is concern that the contact agreement could interfere with potential adoptive parents' willingness to adopt and/or interfere with the attachment process between the child and the adoptive parents. The desire to see open adoption as a means of moving children out of limbo is offset by the possibility that open adoption may lead to controversy between the participants that would involve the child in emotional conflict.

c) At present there is no legislation in place in Canada to support open adoption, so that any contact between the adopted child and biological family makes it more possible for the biological family members to initiate court proceedings. The spectre of potential litigation can be a threat to continuity of care and can challenge the sense of security and permanence of the adoption. In the absence of legislation, the only way to enforce a prior agreement for access/contact is through litigation.

d) For open adoption to be successful, both the biological and the adoptive parents must be able to put the interests of the child ahead of their own. There may be a difference in attitude between

parents who voluntarily relinquish their child for adoption and those who have had their children apprehended. Families in which there is poor emotional functioning and inability to make competent decisions may disrupt an open adoption agreement.

e) There is the risk that in situations where contact would be detrimental to the adoption, open adoption may be proposed as a means of gaining consent for the adoption from the biological family.

f) The process of deciding on and implementing a plan for open adoption requires input from trained and experienced professionals. It will be labour-intensive and time-consuming.

SAFEGUARD PRINCIPLES

Given the possibility that there may be legislation on open adoption, the task force has set out some principles that such legislation should contain.

1. Access/contact must be in the best interests of the child. This is the predominant principle in all cases.

2. Access/contact can only occur if both the biological parents and the adoptive parents support the adoption and the contact plans and do not directly or inadvertently undermine them.

3. The principle reason for access/contact should never be to gain the consent of the biological family to the adoption.

4. There must be a mechanism for the court to expedite the varying of access/contact, if the plan proves not to be in the child's best interest.

5. In the case of an adopted child, where there has been no contact with the biological parents since adoption, a strong case would have to be made that renewed contact was in the child's best interests before the matter could be heard in court.

FURTHER DISCUSSION

To help clarify the discussion and give some direction, the task force has included three papers. The first is a clinical paper by Dr. Paul D. Steinhauer entitled "Adoption with Access". The paper sets out some principles for deciding which children should be considered for open adoption. The second paper is from the legal perspective and looks at ways to mediate open adoption. This paper is by Marvin Bernstein, the chief counsel of the Catholic Children's Aid Society of Metropolitan Toronto, and is entitled "Using Mediation as an Effective Technique to

Achieve Success in Open Adoption". The third paper, by Nancy Dale, deals with adoption with access under the heading "Access and the Changing Face of Adoption".

ADOPTION WITH ACCESS

Paul D. Steinhauer

[Note: This chapter was prepared for publication by the editor.]

The courts are aware that there are a number of children who could be taken out of limbo and adopted if it were not for the wish of their biological parents to maintain some kind of contact. There continues to be pressure to relax the adoption procedure to allow for some sort of contact in situations judged to be appropriate.

Adoption with access is not a simple solution, but it does seem the least detrimental alternative for protecting the development and the permanency of placements for a relatively limited group of children who satisfy the following conditions:

1. They are older (at least age four, possibly some three-year-olds as well).

2. They require a continuous out-of-home placement until they reach maturity.

3. They remain sufficiently attached to one or more key figures from the past – biological parents, grandparents, siblings, previous foster caregivers, etc. - *who really mean something to the child* (i.e. not as a matter of the adult's right). The child would be in danger of not mourning them successfully (i.e. failing to separate from them emotionally and, thus, remaining in limbo), if a physical separation (i.e. no access) were imposed as part of an adoption order. However, those past figures are incapable of parenting these children at least at a minimally acceptable level that would meet their basic developmental needs. This is especially so if the parents were likely to persist in challenging the out-of-home placement every six months or so, thereby threatening the permanence of the placement in the mind of the child and/or the substitute parents.

4. Some of these children are proposed for adoption by potential adoptive parents who are ambivalent about or opposed to including any or all figures from the past in the life of the child. This is because they want sole claim on the child's affections and/or because they cannot recognize the importance and/or cannot genuinely support access to figures from the child's past. (Such parents might agree verbally to allow access on a voluntary basis at the time when adoption was considered, but their ambivalence or opposition to it might become overt and/or grow when the adoption has been completed). *If adoption with access were a possibility*, this solution might be proposed by the agency. Some foster caregivers, in such a situation, might not agree to adoption if access were involved. If so, this would become clear, and the agency would face the issue of which might be the least detrimental alternative: planned permanent foster care or adoption. Other foster caregivers might agree to adoption with access as a condition. In this case, the child would be protected from having the bond to members of the biological family (or valued others) unilaterally severed. Hopefully, in time

and with assistance, both sets of parents could be helped to overcome their antipathy to each other for the sake of the child, just as some biological parents do when access is originally forced on them following a highly conflicted marital separation.

e.g.: A nine-year-old child, who is cherished and has done well in an excellent foster home, has biological parents and siblings about whom he cares deeply, although it is clear that his biological parents would be unable to meet even his minimal developmental needs were he to be returned to their care. He looks forward to seeing his biological family in his biweekly visits and is not upset either before or after the visits. There is tension, however, between the biological parents and the foster caregivers whom the biological parents at times upset by threatening to go back to court to regain custody. It is felt that the best alternative for this boy would be to remain in the care of the foster caregivers - but with access to the biological parents - until maturity. The agency would like to ensure the permanence of the placement by moving towards adoption, at the same time recognizing the value to the boy of continuing access to the biological family. In the absence of adoption with access as an option, the agency must choose between:

a) Planned permanent foster care that is vulnerable to repeated court challenges. (It also holds the possibility for the boy and/or the foster caregivers to hold back emotionally because of the threat of such challenges.)

b) Adoption without conditions (with the foster caregivers agreeing verbally to allow access but remaining free to change their minds and cut off access at will once the adoption has been completed).

The difficulty of determining the appropriateness of adoption is complicated by the fact that many children want and fantasize about adoption. They may have been told that adoption is a guarantee of permanence, even though, in reality, they are incapable of tolerating - and are very much threatened by - the intimacy associated with true involvement in a family relationship. It should be recognized that both children and potential adoptive parents may have intense fantasies: of rescuing or of being rescued; of all existing problems dissolving through the longed-for loving relationship that will automatically follow the adoption. These fantasies can make it more difficult for both potential adoptive parents and older adoptive children to consider the risks and benefits of adoption realistically. It is important that children be informed clearly why a decision has been made to deny their parents' custodial rights. Obviously, this will have to be done sensitively and in a way - and at a time - that the child is capable of understanding the reasons for the termination of parental custody.

In the above, the author assumes that:

1. Children in limbo are better off retaining the potential for access (based on their needs) than they are being kept away from an important (to them) figure whom they will continue to remember, and possibly long for.

2. There would be greater protection for the permanence and security of the out-of-home placement, and safeguard from repeated challenges, if the placement had adoptive rather than

planned permanent foster care status. If this is true, the question arises whether adoption with access would have benefits for the child beyond those offered by a "foster care with tenure" arrangement. This kind of arrangement would be a form of planned permanent foster care whose continuity either could not be challenged at all, or, at the very least, could only be challenged by establishing in advance that such a challenge - and the disruption of continuity it would contain - were in the best interests of the child.

3. In some cases where foster caregivers or adoptive parents genuinely appreciate the continuing importance of the past parental figures to the child, they would not oppose access and would support it voluntarily. Such cases would, in effect, be like the "shared parenting" model discussed in *The Least Detrimental Alternative* (analogous to a child having two families after a harmonious marriage breakdown), in which the adults important to the child cooperate in the raising of that child (Steinhauer, 1991, pp. 164-172). Many such cases might do as well in planned permanent foster care (PPFC) as in adoption. In this case, the only - if any - advantages of moving to adoption might be: (a) financial: i.e. decreased costs to society, (b) to secure the placement against the threat of overly zealous Child Protection Services (CPS) workers who equate permanency planning exclusively with either reunification or adoption. Here the threat would come more from the agency than from the foster caregivers or biological parents. (In the author's opinion, many CPS workers are naive in having unrealistic views that adoption is *always* less detrimental than foster care, since foster care is *always* second class and/or unstable and that, to *some* children, having the status as adoptees might be very important.

4. Even in cases where the foster caregivers or other figures from the past to whom the child remained attached remained unreliable and/or hostile to the placement, if the child longed to have access, *at least at times and under conditions favourable to the child*, access is still indicated for the following reasons:

    (a) At least the parents' desire to retain contact gives the message that the children are in care because the parents are unable to care *for* them, *not* because they do not care about them and have rejected and/or abandoned them. The latter, of course, has major implications for the child's self-esteem. It would be very important for children to be aware that they were - and *are* - wanted even though their biological parents are unable to meet their needs.

    (b) Over time, despite what the biological parents say, such children will see for themselves the reasons why their needs can be met far better in care. This is also a far better way of helping a child see through such parents' statements as "We didn't want to give you up: the Children's Aid Society grabbed you away for no reason".

    (c) To be helpful for a child in care, visiting should be accompanied regularly by an active working through of thoughts and feelings aroused by the visits. Careful observation and a sensitive validation and working through of changes in feelings and behaviour before, during, and after visits may play an all-important role in helping the child accept and come to grips with the reality of his life. Not all children will respond to visits the same way. Children will differ in the nature, intensity, and

duration of feelings evoked by their visits. This may involve their current feelings about the parent(s) they are visiting; unresolved feelings related to the separation; tension and conflict between the adults involved; the arbitrariness of and their inability to control the visiting schedule; or even the length of the drive involved in the access. Children will also differ in how quickly and how successfully they cope with these issues and in their ability to resolve the issues and feelings related to separation from their major attachment figures by coming into care. Many - but not all - children will need help and support by adults sensitive to the child's feelings and ways of expressing them in order to deal with these feelings optimally. Usually, it will be the custodial caregivers - and for the child in care, the foster caregivers - who will be most available and best able to support the child in coping with these feelings. It will also be important to ensure that the nature and frequency of the contacts continue to serve the best interests of the child, since those interests are likely to vary over time.

None of the above should be taken as an endorsement either of unrestricted access, or of access in response to the "rights" or needs of the parents. The critical issue is an objective determination of whether or not an ongoing exposure to the biological family will be consistent with the child's best interests.

5. Access by the adopted child to siblings who continue to live with, have access to, or have strong fantasies about natural parents will lead the adopted child to speculate about, create fantasies about, and/or idealize, and/or want contact with the natural parents. For this reason, the author believes that it is naive to think that one can allow access to sibs who live with or are in contact with biological parents without kindling in the adopted child fantasies about and/or longing for contact with those parents.

Many adoptive parents are enormously committed, with some being prepared to persevere for years in caring for extremely difficult children despite enormous obstacles such as continued distancing, mistrust, rejection, and/or behaviour that can be very disruptive and frustrating to all members of the adoptive family. Placing such difficult children on adoption will require very competent adoption staff and the CPS's commitment to ensure that - *regardless of budgetary constraints* - adequate supports are in place *for as long as is needed*, which may range from six months to years. However, there can be problems:

- The supports provided are at times considerably less than they should be, thereby increasing the risk of a breakdown that will prove damaging to both the child and the family involved. Reasons for this include the general overcrowding of all child welfare and mental health services resulting from repeated downsizing and the fact that the Ministry draws upon different budgets for children (a) prior to and (b) after the completion of adoption.

- Potential adoptive parents' fantasies, hopes, and good intentions may exceed what they are capable of delivering. Many children also approach adoption with fantasies and hopes that are unrealistic. Some CPS workers have distorted expectations of both foster caregivers

and adoptive parents and may overestimate a child's capacity to adjust to an adoptive family. Both older adoptees and their adoptive parents are likely to have to cope with the often slow and painful death of such illusions. The success of many older child or multiple child (sibling group) adoptions depends upon the extent to which the parties can accept what is truly possible. This may fall far short of what they hoped and believed to be possible when they decided upon adoption in the first place. They must deal with the shortfall without needing to protect themselves from their losses by externalizing and projecting blame or by emotional withdrawal.

Some Opinions About Adoption and Responses

1. Some foster children believe that adoption is a guarantee of permanence which it is not.

   *They can be encouraged to believe this by naive or biased CPS workers.

2. Some children and workers believe that a change in legal status from foster care to adoption will automatically be accompanied by a change in relationship/feeling status.

   *This may or may not be true.

   *To some children, adoption implies total accepting and total acceptance. They may long for this and see adoption as a way of achieving it, but may be incapable of tolerating it.

3. Some children say that they want to be adopted (meaning by their foster caregivers), while the agency takes that statement as an invitation to search for (other) adoptive parents.

4. The literature shows that children know when they are genuinely *cared for,* whether their caregivers are foster caregivers or adoptive parents. When they feel cared for, they are free to proceed developmentally.

5. Any adoption, especially of an older child or of a sibling group, is really little more than a statement of intent. Unless they have lived together for some time, neither the adoptee nor the adoptive family really knows what it will be like for them to be joined in adoption. Much of the thinking on both sides - even if everyone has been given the straight facts, which at times does not occur - may be romanticized and unrealistic to an almost delusional degree. Only after they have lived with each other long enough for the illusions to be punctured - which may take years - can they have any real idea of what it would be like to live together permanently as a family. Only after they have experienced what life together is like can they make an informed decision about permanence.

   A sincere and caring couple had fallen in love with and were determined to adopt a very beautiful but equally disturbed four-year-old who had experienced chronic neglect and abuse before coming into care at age two-and-a-half. This child had since been extremely

difficult to manage in several excellent foster homes. The adoption worker, while in no way opposing their application, tried to tell them about the difficulties this boy was likely to present if they were to adopt him. She also had them meet the boy's foster caregivers and observe for themselves the problems he was presenting in the foster home. The adoptive couple did everything that was asked of them, but insisted on completing the adoption as soon as possible, confident that they could manage.

Less than two years later, a very depressed and embarrassed couple contacted the CPS again, tearfully stating that the relationship with the child had broken down so completely that they could no longer cope with him. When asked what had led to things breaking down so badly, they described behaviour similar to what they had been told about - and observed - in the foster home. When this was pointed out to them, they acknowledged it, adding, "We know. You told us what it would be like. But we didn't believe you. All the way through, we kept on thinking. 'That's what he's like now. *But once he experiences what it's like when he's part of a family and realizes how much he's loved, he's bound to change. He'll be a different kid in six months.' But he isn't a different kid. Despite our love, he's every bit as difficult now as he was then and probably even worse. Our whole family is in a state of crisis. You told us, but at that time, unfortunately, we couldn't hear a word you were saying."*

6. For some children in care, wanting to go by the foster family's name is important, to protect them from questions from teachers and peers. This could be allowed by mutual agreement between children in permanent plan foster care and the foster caregivers who have committed to parent them till maturity.

7. A refusal by foster caregivers to adopt does not always mean a second-class commitment. Forcing some foster caregivers either to adopt or give up a child to whom the family has bonded is analogous to forcing well-functioning common-law partners to get married. Foster caregivers, who are aware of residual difficulties in a much-loved foster child and who are not willing to give up having the support of the agency should the child need special services in adolescence, are being realistic rather than rejecting.

8. In other cases, a refusal of long-term foster caregivers to adopt may indeed indicate a second-class commitment. The issue should be the quality of the caring, not whether or not they agree to adopt. Prompt but sensitive clarification of this issue is crucial.

In summary, when a child known to have significant unresolved difficulties is placed on adoption probation with a family with whom he has never lived for any length of time, that child will, of necessity, go through a period in limbo. The intention of the adoptive parents to provide a permanent family for the child must, at that point, be seen for what it is, i.e. a statement of intent. Only after having lived with each other long enough to know what living together is like will either the child or the other members of the adoptive family know what adoption will be like and if they truly have the desire, the will, and the resources to go through with it. Until that point has been reached, they will all be in limbo. Simply acknowledging the reality of the limbo and

how hard it is to tolerate may prove supportive both for the child and for the family involved. This is often difficult for the child, the family, and the workers, but honesty is always preferable to encouraging wishful thinking and fantasy.

If an older child with a well-established personality, identity, and set of problems of his own is freshly placed with a new family on adoption probation, the adoptive status may put additional - and unnecessary - pressures on both child and adoptive family (parents and sibs). This may well undermine the chance of the adoption graft taking. The adoptive parents, who have offered to be the child's family forever, may have excessive feelings of guilt and failure if, over time, it becomes clear that, despite everyone's best intentions, the fit is not a good one. This is likely to increase their tendency to deny and/or hide the fact that the relationship is in trouble, thereby keeping them from getting help in the early stages when their rejection of the child is not yet complete. In such situations, the child is exposed to increasing, but often masked, rejection and scapegoating for a prolonged period before the relationship eventually breaks down.

Some agencies are more open and therapeutically oriented than others, and some may not be as open as they think they are. Agencies that are more open routinely tell adoptive parents right from the start that the adoption of an older child or sibling group is bound to create difficulties for child and family, at least from time to time; and that they are likely to need help at some points in their continuing evolution as a family. This could take the form of self-help or adoption resource groups, or of other forms of counseling or therapy. There is a need for a variety of resources and a responsibility for the supervising agency to ensure that adequate services are available. Different families will have different needs, and what is acceptable to various families may vary. Anticipating that help is likely to be needed at some point may lessen the guilt and the sense of personal failure when difficulties do arise.

Potential adoptive parents should be told that, while everyone involved might hope and plan for permanence, there is no way to be certain how a given older child or sibling group would fit into their family. They would have to have lived together for a substantial trial period to become aware of how living together would affect all of those involved (including the natural children of the adoptive family). Not until then could they make an informed decision about the pros and cons of adoption. One might suggest, then, that they foster the child, and have access to the supports available to other foster caregivers. False hopes would be minimized and decisions would involve less of the pressure implied by immediate placement on adoption probation. Having experienced living together as a family, the potential adoptive parents would be helped to accept counseling and support during the crucial period of adjustment. This might result in the self-selection of a different pool of potential adoptive parents, perhaps a good thing, as it would eliminate those whose need for a child of their own would interfere with their need to perceive and respond to the specialized needs of the child that might well differ from their own.

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USING MEDIATION AS AN EFFECTIVE TECHNIQUE TO ACHIEVE SUCCESS IN OPEN ADOPTIONS[1]

Marvin M. Bernstein, B.A., LL.B., LL.M.

A) INTRODUCTION

Over the past three decades there has been a trend towards ever-increasing "openness in adoption", particularly as practised by private practitioners. Openness in adoption is an ongoing process and the needs of the parties will evolve over time. There is a distinct role for mediation in assisting the members of the adoption triangle in finding an individualized and matched "comfort level" within the continuum of adoption openness.

Etter has provided empirical evidence of the advantages of "mediated open adoption" in the case of private sector infant adoptions[2] and "cooperative adoption mediation" as a permanency planning tool in the case of public agency adoptions for neglected and abused children in care.[3] This is an option that ought to be utilized in appropriate cases particularly in view of the systemic limitations of court adjudication.

B) THE EVOLUTION OF OPEN ADOPTION

The definition of "open adoption" that will be used in this paper is the one originally formulated by Silber and Speedlin: "Open adoption is any form of communication between birth parents and adoptive parents, either directly or through an intermediary."[4]

The traditional or closed adoption was based on the sense of there being a "clean break" from the past. It is now understood that there is no "clean break" that can eradicate the sense of loss of the child and birth parents.

The trend toward more openness has been furthered by fuller communication of the adoption

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[1]This section represents a summary of the following source: M.M. Bernstein, *Using Mediation as an Effective Technique to Achieve Success in Open Adoptions* (1998) 16 Canadian Family Law Quarterly 1 at 1-72.

[2]J.Etter, *Levels of Cooperation and Satisfaction in 56 Open Adoptions* (1993) 72 Child Welfare 257. See also J.Etter and M. Giovannini, *Adoption Mediation: Applying Preventive Conflict Management to Open Adoption Planning* (1988) 21 Mediation Quarterly 51.

[3]J. Etter, *Cooperative Adoption Mediation Process: Using CAMP to Create Cooperative Plans and Adoptions* (Eugene, Oregon: Adoption Teamwork of Oregon Press, 1994).

[4]K. Silber & P. Speedlin, *Dear Birthmother: Thank You For Our Baby* (San Antonio: Corona Publishing Co., 1983) at 5.

events, by changing attitudes towards search and reunion, and by the increased desire on the part of birth mothers to exercise more control over the adoption process.[5]

C) THEORETICAL CONSIDERATIONS FOR AND AGAINST OPEN ADOPTION

The following is a summary of the theoretical considerations that address both the benefits and risks of open adoption for birth parents, adoptive parents, and adoptees.

1. Benefits of Open Adoption for Birth Parents[6]

a) Open adoption enables birth parents to resolve their feelings of loss and grief, since they know that the child is well-cared for by his or her adoptive parents.

b) Birth parents, who choose the adoptive parents and negotiate access rights, tend to feel in control of their lives as having made a plan for the child, rather than feeling like they have abandoned the child.

c) Birth parents can participate in attempting to renegotiate the degree of openness they desire as their needs change over the years.

d) Birth parents have peace of mind when they have participated actively in the adoption plan, with the knowledge that they have the opportunity for answers and information over the years.

e) Birth parents tend to exhibit better mental health over time than those who have participated in traditional adoptions.

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[5]Health and Welfare Canada, *National Adoption Study of Canada* by K. Daly & M.P. Sobol , eds. (Ottawa: National Welfare Grants, 1993).

[6]See R. Pannor & A. Baran, *Open Adoptions as Standard Practice* (1984) 63 Child Welfare 245; C. Chapman, P.Dorner, K. Silber, & T.S. Winterberg, *Meeting the Needs of the Adoption Triangle through Open Adoption: The Birthmother* (1986) 3 Child & Adolescent Social Work Journal 203; K.W. Watson, *Birth Parents: Living with the Adoption Decision* (1986) 44 Public Welfare 5; P.A. Curtis, *The Dialectics of Open Versus Closed Adoptions of Infants* (1986) 65 Child Welfare 437; K.W. Watson, *The Case for Open Adoption* (1988) 46 Public Welfare 24; R.G. McRoy, H.D. Grotevant, & K.L.White, *Openness In Adoption: New Practices, New Issues* (New York: Praeger Publishers, 1988); L. Caplan, *An Open Adoption* (Toronto: Harper & Collins,1990); K. Silber & P. Martinez Dorner, *Children of Open Adoption* (San Antonio: Corona Publishing Co., 1990); M. Berry, *The Effects of Open Adoption on Biological and Adoptive Parents and the Children: The Arguments and the Evidence* (1991) 70 Child Welfare 637; D.L. Chappel, *Adoption: Reassessment and New Alternatives* (LL.M. Thesis, Faculty of Law, University of Toronto, 1991);M.M. Bernstein, D Caldwell, G.B. Clark, & R. Zisman, *Adoption with Access or 'Open Adoption'* (1992) 8 Canadian Family Law Quarterly 283; and A. Baran & R. Pannor, *An Open Adoption Policy Is Best* in A.Harnack, ed., *Adoption: Opposing Viewpoints* (San Diego: Greenhaven Press Inc., 1995).

f) Birth parents assume more responsibility for the decision to relinquish and are empowered as full participants in the adoption process.

g) Birth parents experience more directly the process of separation from the child and are better able to fulfill the following tasks of mourning: (a) accepting the reality of the loss; (b) experiencing the pain of the grief; (c) adjusting to life without the child; and (d) withdrawing of emotional energy from the child and reinvestment in another relationship.

h) Open adoption may assist birth parents in placing the child for adoption, if they feel they can maintain some contact with the child and/or access to post-adoption information in the future.

2. **Benefits of Open Adoption for Adoptive Parents**[7]

a) Open adoption allows adoptive parents to replace fantasies about their child's background with accurate details and to deal more honestly with themselves and their child about the adoption.

b) Adoptive parents involved in open arrangements tend to feel less threatened by the child's biological parents than those involved in closed adoptions.

c) Openness often dispels the adoptive parents' fears of the birth parents by reassuring them that the birth parents would never attempt to disrupt the child's life.

d) In the case of infants who are voluntarily placed for adoption at birth, adoptive parents in open arrangements often report positive feelings about having been chosen by the birth parents.

e) The process of being selected by the birth parents gives the adopters a heightened sense of entitlement to the child, and this often facilitates the development of an attachment between the child and the adoptive parents.

f) The process of knowing the birth parents enables adoptive parents to provide the child with background information, based on first-hand knowledge and direct contacts.

g) Open adoption helps the adoptive parents face the fact that their child was not born into the family, which produces a healthier adjustment to adoption.

h) Open adoption allows for self-determination by providing a continuum of choices from which prospective adoptive couples can choose.

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[7]Ibid., at listed authors. See also C. Chapman, P. Dorner, K. Silber, & T.S. Winterberg, *Meeting the Needs of the Adoption Triangle Through Open Adoption: The Adoptive Parent* (1987) 4 Child & Adolescent Social Work Journal 3.

3. **Benefits of Open Adoption for Adoptees** [8]

a) Open adoptions that acknowledge a child's history and preadoptive genealogy support a more complete identity development for the adoptee. Since the child is in touch with his or her biological roots, he or she can move beyond the secrecy and sense of rejection that often accompany closed adoptions.

b) It allows the adoptive parents to provide any information which the adoptee requests about his or her birth family to fill in missing identity gaps, thus preventing the child from becoming troubled or obsessed with unanswered questions.

c) The continuing link with the birth parents dispels the notion that the adoptee was abandoned and forgotten and eliminates the adoptee's need for search and reunion with biological family members.

d) In open adoption, important background information - including genetic and medical histories - is readily available.

e) Open adoption practice facilitates better mental health for children by encouraging communication within the family on the subject of adoption.

f) Openness allows the adoptee to ask questions freely about the birth family without feeling disloyal to the adoptive parents.

g) Open adoption avoids the child's fantasies of a "real parent" that bear no resemblance to reality.

h) Open adoption produces a greater sense of cooperation and appreciation between birth and adoptive parents, which creates a healthier home environment for the adoptee.

i) In open adoptions involving infants relinquished at birth, the adoptees, as they grow older, often feel a stronger sense of belonging or attachment to their adoptive families, since they know that their biological parents chose their adopters to parent them.

j) As the adoptee gets older, he or she may have a greater role participating in discussions concerning the need to adjust the existing parameters of adoption openness.

k) Coupled with legislative reform, open adoption would allow placement for adoption of older Crown Wards, who are currently stranded in foster care because of outstanding orders which judges are reluctant to remove, and there may be more judges willing to allow adoption to

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[8]See listed authors above, note 6. See also C.Chapmen, P. Dorner, K. Silber, & T.S. Winterberg, *Meeting the Needs of the Adoption Triangle Through Open Adoption: The Adoptee* (1987) 4 Child & Adolescent Social Work Journal 78.

proceed, if they know the child can still maintain meaningful ties with their birth parents and/or other relatives.

4. **Risks of Open Adoption for Birth Parents** [9]

a) The increased knowledge and contact available through open adoption may encourage birth parents to avoid experiencing the loss, to postpone or prolong the separation and grieving process.

b) Ongoing contact may serve as a stimulus for the fantasy that relinquishing a child is not really a loss at all.

c) Open adoption for birth parents may well take on the characteristics of foster care, an ongoing arrangement around which they may build their lives emotionally to the detriment of their own personal progress.

d) Open adoption that includes continued contact may pose a serious threat to the psychological health of the birth parents, since the grieving process may be impeded and necessary counseling may not be secured.

e) Ongoing contact may serve as a continuous reminder to the birth parents of their loss.

f) In the case of voluntary infant adoptions, the potential benefits of open adoption may persuade some adolescent birth parents to relinquish a child when they would not have otherwise done so.

g) In the case of voluntary relinquishment, birth parents would have enough difficulty in deciding whether to give the child up for adoption and may be unable to weigh properly the advantages and disadvantages of an open arrangement. The concern about making an informed decision as to open adoption would be heightened in the case of a very young birth parent.

h) The attachment between birth parents and the adopted child, as a result of ongoing contact, may create ambivalence and confusion for the birth parents, instead of alleviating their guilty feelings.

i) Where the birth parents never agreed to open adoption in the first place, there would be an invasion of their privacy if ongoing contact with the adopted child were to occur.

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[9]See Curtis; McRoy, Grotevant, & White; Caplan; Berry; Chappel; and Bernstein, Caldwell, Clark, & Zisman, all cited above, note 6. See also A.D. Kraft, J. Palombo, D.L. Mitchell, P.K. Woods, & A.W. Schmidt, *Some Theoretical Considerations on Confidential Adoptions, Part I: The Birth Mother* (1985) 2 Child & Adolescent Social Work Journal 13; A.D. Byrd, *The Case for Confidential Adoption* (1988) 46 Public Welfare 20; and A. D. Byrd, *A Sealed Adoption Policy Is Best* in A. Harnack ed., *Adoption: Opposing Viewpoints* (San Diego: Greenhaven Press, Inc., 1995).

j) In a face-to-face meeting, the birth parents may feel ambivalent or may want to reject the adoptive parents, but would feel uncomfortable in doing so.

k) Unsupervised meetings between the adoptive parents and a birth parent could result in adoptive parents offering gratuities to the birth parent. This could then lead to undue pressure for the birth parent to accede to the wishes of the adoptive parents.

l) There are no cultural patterns for birth parents to follow in open adoptions. Some may think of themselves as aunts/uncles, sisters/brothers, or godmothers/godfathers, but they are placed in the difficult position of creating a relationship model because of the absence of existing role models.

5. Risks of Open Adoption for Adoptive Parents [10]

a) Open adoption may inhibit the adoptive parents' ability to experience healthy bonding with the newly adopted child. Many childless adoptive parents begin adoption with a general sense of uncertainty about both their ability to parent and the permanence of the adoption. Wondering if ongoing contact will cause the birth parents to change their minds about permanent relinquishment could impede this bonding process.

b) The ability of the adoptive parents to develop a healthy bond may also be affected by their feelings about the birth parents. Ongoing contact may cause the adoptive parents to experience guilt about receiving benefits from the birth parents' misfortune or pain, and this may translate into an inability to treat the child as their own.

c) Continued contact with the birth parents may further impede the bonding process between the adoptive parents and the adopted child, since it serves as a constant reminder that they are not the biological parents. This not only re-emphasizes the biological infertility of the adoptive parents, but leads to feelings of psychological infertility as well.

d) Adoptive parents in continued open adoptions may carry the additional burden of the dependency of a birth parent. Since the birth parents are often equated to extended family members, there may be anxiety about the possibility of the birth parents using this connection to serve their own individual needs.

e) Many birth parents are young adolescents, who may look to the adoptive parents as surrogate parents, placing an added strain on the new adoptive parents.

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[10] Ibid., at listed authors. See also A.D. Kraft, J. Palombo, D.L. Mitchell, P.K. Woods, & A.W. Schmidt, *Some Theoretical Considerations on Confidential Adoptions, Part II: The Adoptive Parent* (1985) 2 Child & Adolescent Social Work Journal 69.

f) Open adoption may cause conflict and competition between the adoptive parents and the birth parents, as may develop sometimes in families of divorce. For instance, the adoptive parents and birth parents may have different lifestyles and values, and the adopters may be concerned about the birth parents attempting to undermine their influence over the child.

g) Adoptive parents may feel as though they must "perform" for the birth parents during their face-to-face visits in order to give a favourable impression.

h) A negative impression of a birth parent could lead to a transference to the adopted child.

i) Prospective adoptive parents are often given little real choice concerning openness in adoption. They are at the mercy of agency demands if they are to achieve parenthood. Their needs and rights to privacy may be sacrificed in order to satisfy the needs of birth parents.

j) Open adoption may result in a decline in the number of potential adoptive parents who are willing to provide homes for children in need of substitute families.

k) Extending the number of relationships that the adopted child and the adoptive family must deal with could increase the potential for adoption breakdowns.

l) Open adoption could expose adoptive parents to ongoing litigation from birth parents and other members of the birth family with respect to either increasing access, or potential custody disputes, or attempts to control the adoptive families' lives, for example, by preventing them from moving out of the jurisdiction.

6. Risks of Open Adoption for Adoptees [11]

a) Open adoption interferes with the process of bonding between the adoptive parents and the adoptee, thereby impairing the adopted child's healthy development and adjustment within the adoptive family.

b) Young adoptees are not equipped to deal with the differing value systems of two sets of parents, and the child may become confused even to the point of rejecting both value systems, thereby increasing the risk of psychopathology in the adopted child.

c) Openness may interfere with the adoptee's ability to resolve normal adolescent conflict with the adoptive parents in a healthy manner. For instance, older children of open adoption may seek to live with their birth parents when they are upset with their adoptive parents, rather than addressing these conflicts within the security of the adoptive home.

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[11] See listed authors above, note 6. See also A.D. Kraft, J, Palombo, D.L. Mitchell, P.K. Woods, & A.W. Schmidt, *Some Theoretical Considerations on Confidential Adoptions, Part III: The Adopted Child* (1985) 2 Child & Adolescent Social Work Journal 139.

d) The introduction of multiple parents into the life of an adopted child, through the process of openness, may cause the child to feel like a foster child rather than a full member of the adoptive family and may increase the potential for adoption breakdown.

e) An adopted child could misinterpret information given to him or her leading to feelings of rejection and denial.

f) An adopted child could resist an unsympathetic report of his or her birth parents by the adoptive parents, or, alternatively, suspect that a sympathetic report is untrue.

g) The adopted child's psychological need for permanency precludes, in time, the need for biological identity.

h) Any argument in favour of the adopted child's need for contact with the birth family is more applicable to later years than to the developmental needs of infancy and childhood. Therefore, simple access to adoption records would eliminate the need for open adoption.

i) Open adoption could expose the adopted child to ongoing litigation at the instance of the birth family with respect to custody, access, or mobility issues.

j) If adoption with contact were available as a statutory option, there could be potential misuse by the judiciary, counsel, and parties as a plea bargain device or as a panacea, regardless of the needs of the child or how disruptive the birth family members may be.

D) EMPIRICAL RESEARCH INTO THE EFFECTS OF OPENNESS

Empirical research is only beginning to document the effects of open adoption upon the members of the adoption triad. Some studies show that there are advantages in openness for all concerned.[12] At present, there is no comparison of adoptee outcome between traditional adoption and various forms of open adoption.

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[12]See J. Fratter, *Family Placement and Access: Achieving Permanency for Children in Contact with Birth Parents* (Ilford: Barnados, 1989); and H.E. Gross, *Open Adoption: A Research-Based Literature Review and New Data* (1993) 72 Child Welfare 269.

E) THE BENEFITS OF MEDIATION

1. The Meaning of Mediation

A helpful definition of mediation is the following: "The intervention in a negotiation or a conflict of an acceptable third party who has limited or no authoritative decision-making power, but who assists the involved parties in voluntarily reaching a mutually acceptable settlement of issues in dispute".[13]

Another way of describing mediation is as follows: "The process of mediation aims to facilitate the development of consensual solutions by the disputing parties. The mediation process is overseen by a non-partisan third party, the mediator, whose authority rests on the consent of the parties that [he or] she facilitate their negotiations. The mediator has no independent decision-making power, or legitimacy, beyond what the parties voluntarily afford [him or] her."[14]

2. The History of Mediation

The concept of mediation has a long and venerable tradition and can be traced back in legal history almost eight hundred years to the time of the Magna Carta, which was itself the product of a mediated truce. In the context of this long history of mediation, it is important to recognize that we are now only beginning the third decade of mediation of family disputes and are just settling into the second decade of adoption mediation. Clearly, the use of mediation in adoption cases is still in its infancy.

3. The Benefits of Mediation

The following is a composite list of the advantages acknowledged in the literature:[15]

1. Mediation is generally less expensive in terms of dollars, when contrasted to the expense of protracted litigation.

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[13]C.W. Moore, *The Mediation Process: Practical Strategies for Resolving Conflict* 2nd ed. (San Francisco: Jossey Bass Publishers, 1996) at 15.

[14]J.Macfarlane, *The Mediation Alternative* in J. Macfarlane ed., *Rethinking Disputes: The Mediation Alternative* (Toronto: Emond Montgomery Publications Ltd., 1997) at 2.

[15] M.M. Bernstein, *Child Protection Mediation: Its Time Has Arrived* (1998) 16 Canadian Family Law Quarterly 73, where various factors were taken and adapted from the following three sources: See C. Moore, *Merits of Mediation*, contained in materials *Mediation in Child Protection: A New Alternative* (Toronto Law Society of Upper Canada 1989) at B6-B9; J. Wildgoose, *Alternative Dispute Resolution of Child Protection Cases* (1987) 6 Canadian Journal of Family Law 61 at 82-83; and G. Weismann & C. Leick, *Mediation and Other Creative Alternatives To Litigating Family Law Issues* (1985) 61 North Dakota Law Review 263 at 279-280.

2. While court calendars are generally backlogged for long periods, mediation cases can be heard shortly after the dispute arises.

3. Mediation is flexible and can be offered at times convenient to the parties.

4. Mediation is often held in neutral, non-court settings that are more comfortable for the disputants.
5. Mediation sessions are generally held in private, so that disputants need not air their grievances in a public setting.

6. With few exceptions, the mediator will respect the confidentiality of the discussions and will not disclose the specific subject matter.
7. Mediation opens communication between the disputants.

8. Mediation helps the parties identify the issues, reduce misunderstandings, vent emotions, clarify positions, find points of agreement, explore new areas of compromise, and ultimately negotiate an agreement.

9. Mediation is procedurally simple and more likely to lead to truth finding.

10. Mediation is capable of dealing with the causes of problems, not just the problems.

11. Mediation permits the airing of all grievances, not only those that are legally operative.

12. The mediation process takes problems out of the adversarial win-lose setting of the court and moves them into a setting that is non-adversarial and neutral.

13. The peaceful resolution of disputes helps to prevent problems from escalating.

14. Mediation diminishes the emphasis on fault finding and blameworthiness, thereby limiting any hostility and alienation between the parties.

15. Parties who negotiate their own agreements, with the assistance of a mediator, often feel more personal empowerment than those who use surrogate advocates such as lawyers to represent them.

16. Mediated agreements can be more comprehensive than court orders and can address both legal and extra-legal issues.

17. Parties who engage in mediation have a greater degree of control over the outcome of their dispute, with more predictable gains and losses than in the court process.

18. The parties can customize their agreements through mediation in order to meet their individualized needs, instead of having settlements imposed upon them by a third party.

19. Mediation is effective, with the vast majority of cases resulting in agreements.

20. Parties are generally more satisfied with outcomes that have been mutually agreed upon, than with those that have been imposed by a third-party decision-maker.

21. Solutions reached through mediation generate a higher rate of compliance and last longer because these solutions represent the views of both parties and are perceived as fair and acceptable over time.

22. A mediated agreement that addresses all parties' interests can often preserve a working relationship in ways that would not be possible with a win-lose decision-making procedure. Mediation can also make the termination of a relationship more amicable.

23. Parties who mediate their differences are able to address the fine details of implementation. Since mediated agreements can include specially tailored procedures for how the decisions will be carried out, there is a greater likelihood that the parties will comply with the terms of the agreement.

24. Interests-based, mediated negotiations can lead to outcomes that are more satisfactory to all parties than a compromise decision or a win-lose result achieved through either power-based negotiations or rights-based adjudication.

25. Mediated settlements tend to be more elegant and durable over time, and if a later dispute results, the parties are more likely to utilize a cooperative form of problem-solving to resolve their new differences.

F) THE APPLICATION OF TRADITIONAL MEDIATION BENEFITS TO ADOPTION CASES

1. Introduction

It was in the early 1980s that the concept of adoption mediation was first conceived as having potential value. In January 1982, during his annual report on the state of the judiciary, former U.S. Supreme Court Chief Justice Burger specifically mentioned divorce, child custody, and adoption as prime candidates for some form of alternative dispute resolution, including mediation[16]. Jeanne Etter has also reported that she began practising some form of adoption mediation in approximately 1983, and she has been writing and conducting research in this area since that time.[17] So too, in 1984, Bernard Mayer authored an excellent article on the topic of

[16] W.E. Burger, *Isn't There a Better Way* (1982) 68 American Bar Association Journal 274.

[17] J. Etter & J. Chally, *Adoption Mediation Training Manual* (Eugene, Oregon: Adoption Mediation Seminars. 1988)

conflict resolution in child protection and adoption, where he makes the following concluding remarks: "Conflict resolution procedures have proved useful to divorcing families. Their application to child protection and adoption is a new and largely unexplored field. Yet preliminary efforts suggest that they can offer some significant benefits in these areas as well."[18]

2. **Empirical Research**

a) Private Sector Infant Adoption Mediation

In 1989, Jeanne Etter conducted a pilot study [19] in order to examine the ability of biological and adoptive parents to cooperate in post-adoption contact. She applied mediation techniques to help birth and adoptive parents design their own adoptions. These open adoptions included a written agreement, which described any visits as well as other contact and related issues.

In her study, Etter surveyed 129 birth and adoptive parents in 56 mediated open adoptions. Thirty-six birth parents and 93 adoptive parents participated. Their adoptions were an average of 4.5 years old. The research question was: "Are birth and adoptive parents able to cooperate in a way that lowers conflict and increases positive feelings about the adoption?"

The main limitations of this study were both the lack of a control group from subjects in closed adoptions, or from open adoptions without mediation, and the lack of interviews with the adoptees because they were too young.

Participants in this study reported high levels of compliance with the mediated agreements and high levels of cooperation. The survey found that 100% of the biological parents were keeping their mediated agreements with respect to visits, while the adopted parents were only slightly less reliable with 98.2% compliance. Most participants, 75.1%, reported no conflict in their relationship. Of those who reported some conflict, 71.1% reported that the conflict was solved or mostly solved. Most respondents, 77.1%, reported satisfaction with their contact with each other. A large proportion, 78.2%, was also satisfied with the mediation process. Most importantly, 93.8% of all respondents were also satisfied with their adoptions being open.

Etter states in her study that "these high levels of satisfaction and compliance suggest that the mediation process provides some critical elements that meet clients' basic needs."[20] She then identifies the three critical elements as being: i) choice of the type and level of openness before the parties are matched; ii) thorough preparation of the proposed adopters through counseling and support groups, and iii) the use of a written agreement, which is planned prior to the adoption placement.

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[18]B. Mayer, *Conflict Resolution in Child Protection and Adoption* (1984) 9 Mediation Quarterly 69 at 81.

[19]See Etter above, note 2. See also J. Etter, *Open Adoption: A Survey of 56 Families* (Eugene Oregon: Teamwork for Children Press. undated).

[20]See Etter above, note 2 at 264.

b) Cooperative Adoption Mediation as a Permanency Planning Tool for Neglected/Abused Children in Care

In 1992, Etter and Roberts became involved in a two-year pilot project in Oregon, called the "Cooperative Adoption Mediation Project", or "CAMP," [21] which included Oregon's child protection agency, the State Office for Services to Children and Families. This agency had identified specialized adoption or child welfare mediation as a means of achieving permanency planning for abused or neglected children who were in the agency's care.

During the two years of the pilot project, Oregon aimed to demonstrate that specialized adoption or child welfare mediation could: empower parents to make cooperative permanent plans for their children; reduce the necessity for termination of parental rights litigation and the expenditure of state dollars; and reduce the time children spent in foster care awaiting permanent homes.

Innovative tools were developed and proved essential to involving abusive and neglectful parents in planning cooperatively for their children.

At the end of the two-year period, the findings were as follows:

i) Of the 36 CAMP cases entering mediation, 86% (31 cases) were resolved cooperatively and avoided contested trials. Of the 31 cases resolved by mediation, permanent cooperative plans for the children included cooperative adoptions in 90% of them (28 cases); return home plans in 7% (2 cases); and long-term foster care in 3% (1 case);

ii) There were substantial cost savings in the cooperative adoption mediation process. Whereas the cost of the average contested termination of parental rights case in Oregon was $22,000.00, the cost of the average mediation was $3500.00;

iii) The cooperative adoption mediation process freed and placed children for adoption quickly. Whereas it was not uncommon for children to wait two to five years in foster care for the court process to free them for adoption, the average time between referral to mediation and being freed for adoption was 3.7 months. The average time from referral to adoption placement was 5 months; and

iv) Participants in the cooperative adoption mediation project expressed high satisfaction levels. When asked if mediation was helpful, 95% of the birth, foster, and adoptive parents said "yes", while 100% of the child welfare staff gave the same "yes" response.

[21] J. Etter & D. Roberts, *Child Welfare Mediation as a Permanent Tool* (Eugene, Oregon , undated) [unpublished]. See also Etter above note 3.

c) Child Protection Mediation Sometimes Leading to Adoption

In an earlier article on child protection mediation, this author lists seven child protection mediation research studies [22] and summarizes the common empirical benefits which emerge from them:

i) There have been high settlement rates, in the range of 80%, whenever child protection mediation has been employed;

ii) There have been high compliance rates with the terms of mediated agreements;

iii) There have been positive levels of user satisfaction among parents, child protection workers, administrators, lawyers, and judges;

iv) There have been substantial savings in financial and emotional costs;

v) There has been a substantial increase in the speed or timeliness of case resolution;

vi) There has been an improvement in the ongoing relationship between social workers and family members; and

vii) Mediated agreements have tended to be more durable than court-imposed dispositions.

G) SELECTED CONSIDERATIONS IN MEDIATED OPEN ADOPTION

1. The Meaning of "Mediated Open Adoption"

Jeanne Etter has formulated a useful definition of "mediated open adoption": "Mediated open adoption is a process whereby clients design their own adoptions and arrange for a channel of communication and/or contact that remains open as the child grows up."[23]

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[22]See Bernstein above, note 15, where the author names and discusses these pioneering studies, which for the most part have taken the form of time-limited pilot or demonstration projects: (i) The Boulder/Denver Colorado Child Protection Mediation Project, ii) The Center for Policy Research Evaluation Project: Hartford, Connecticut, Los Angeles, California and Orange County, California; iii) The Demonstration Project of The Children's Aid Society of Metropolitan Toronto; iv) The Project of the Centre for Child and Family Mediation in Toronto, Ontario; v) The Victoria, British Columbia Child Protection Mediation Project; vi) The Barsky Toronto Child Protection Mediation Project; and vii) The Nova Scotia Child Protection Mediation Program.

[23]J. Etter, *Use of Mediated Agreements in Adoptions* (1998) 22 Mediation Quarterly 83 at 84.

2. Entry Points for Mediated Open Adoption

Mediated open adoption can occur at a number of entry points in a facilitated open adoption process. It can occur prior to an adoption placement;[24] after an adoption placement,[25] but prior to finalization; and subsequent to the granting of an adoption order.

Pre-placement mediation, which is the most common form of mediated open adoption is usually "preconflict or preventative, mediation [which] helps [the parties], first to discover whether the adoption plan is right for them and change it at an early stage if it is not right; second, to design a written agreement with minimal obligations and maximum opportunities for informal arrangements; and, third, to develop a cooperative relationship before placement."[26]

In planning an adoption, disputes may occur between birth mothers and fathers, and between birth mothers and their parents and members of the extended family.[27] In such circumstances, dispute-oriented, pre-placement mediation can be helpful in resolving their differences.

Post-placement and post-adoption mediation, on the other hand, may arise in the context of a limited dispute,[28] such as whether a visit should occur on a special occasion or be of a certain duration.

Post-adoption mediation may also be activated where there is a potential or existing legal action rooted in a dispute involving a birth parent attempting to reclaim a child,[29] or an adoptive parent refusing to honour a previous commitment or contractual stipulation for continuing birth family contact.

Adoption mediation can also be used as a tool for resolving differences at the much later stage of adoption reunion. "As difficulties arise between various parties - adult children, birth parents, and adoptive parents - both before and after reunions, mediation is increasingly becoming regarded as a device for working through feelings and impasses that are likely to arise."[30]

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[24]J. Etter, *Permanency Planning and Adoption* (Eugene Oregon, undated) [unpublished].

[25]Ibid.

[26]See Etter & Giovannini above, note 2 at 53.

[27]See Etter above, note 24.

[28]Ibid.

[29]Ibid.

[30]Ibid., at 3.

3. Cases Not Appropriate for Mediated Open Adoption

While mediated open adoption is a highly useful instrument in many situations, there are specific cases that would not be appropriate for mediated open adoption:[31]

i) Where there is an immediate risk to the physical safety of the child;

ii) Where there is a power imbalance between parties that cannot be equalized (i.e. where there is spousal violence between the birth mother and birth father, who is also a "legal parent");

iii) Where a party is not considered competent to participate in the mediation process. Certain circumstances would present significant barriers to this, such as: severe psychological impairment, severe psychiatric impairment, severe behavioural problems, substance abuse, or cognitive impairment;

iv) Where a party declines to voluntarily participate in the mediation process; and

v) Where there is, at the pre-placement stage, a significant difference in the positions of the birth parent(s) and the adoptive parents as to ongoing contact and communication.

4. Equalizing Power Imbalances

The mediation process presumes that the parties are able to negotiate with each other on a relatively equal basis. If there is a significant imbalance in power between the parties, this may jeopardize the mediation process.

Moore has stated that "[p]ower is not a characteristic of an organization or person but is an attribute of a relationship. A party's power is directly related to the power of an opponent".[32] "Power" has been defined as "the ability to coerce someone to do something he would not otherwise do,"[33] through "the control of or access to emotional, economic and/or physical resources desired by the other person".[34] "Exercising power" typically means "imposing costs on the other side or threatening to do so".[35]

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[31]This list is drawn from the following sources: See Bernstein above, note 15; Etter above, note 24 at 22; and Etter & Chally above, note 17 at 49.

[32]See Moore above, note 13 at 333.

[33]W. Ury, J. Brett, & S. Goldberg, *Getting Disputes Resolved: Designing Systems to Cut the Costs of Conflict* (San Francisco: Jossey-Bass, 1988) at 7.

[34]J. Haynes, *Power Balancing* in J. Folberg & A. Mitro, eds., *Divorce Mediation: Theory and Practice* (New York: Guilford Press, 1988) at 278, as cited in D. Neumann, *How Mediation Can Effectively Address the Male-Female Power Imbalance in Divorce* (1992) Mediation Quarterly 227 at 229.

[35]See Ury, Brett, & Goldberg above, note 33 at 7.

Wall argues that the mediator's primary task is to manage the power relationship of the parties. In unequal power relationships, the mediator has a responsibility to attempt to equalize any power imbalance[36]. Landau and her colleagues have suggested some techniques that might be used by a mediator for managing various types of power imbalance:[37]

a) Ensuring that the parties make full disclosure to each other of all relevant information;

b) Referring the parties for appropriate outside professional assistance, including the provision of independent legal advice before any mediated agreement is finally signed.

c) Ensuring that only one individual speaks at a time;

d) Preventing the parties from interrupting each other;

e) Preventing one party from attacking the other personally;

f) Restating the position of the weaker party, particularly where there may be some language difficulty;

g) Helping the weaker party to make more direct statements about his or her wishes;

h) Requesting an individual session with one party or recommending an individual caucus during a joint session in order to assist a weaker party;

i) Giving positive reinforcement and support during the session whenever the weaker party demonstrates more assertive behaviour; or

j) Giving positive reinforcement to the more dominant party whenever he or she demonstrates cooperative behaviour.

Etter also suggests that two specific provisions in a mediated adoption agreement may protect the proposed adopters against an unrealistic amount of birth parent contact/visitation and future litigation.

The first provision relates to visitation and sets out a minimal expectation of the birth parent's entitlement to visit the child and adoptive family in a neutral setting no less than once or twice per year. The visits are then stated to be "at the option and request of the birth parents and at the convenience of the adoptive family".[38]

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[36]J.Wall, *Mediation: An Analysis Review and Proposed Research* (1981) 25 Journal of Conflict Resolution 157 at 164.

[37]B. Landau, M. Bartoletti, & R. Mesbur, *Family Mediation Handbook,* 2nd ed. (Toronto: Butterworth's, 1997) at 104-105.

[38]See Etter above, note 23 at 87.

The second provision is an invalidation clause which stipulates that "[i]f the birth parents assume an adversarial relationship with the adoptive parents [except in regard to enforcement of the agreement], the adoptive parents no longer have to comply with the visitation and communication clauses. The purpose of the invalidation clause is to make it clear to the birth parents that if they take legal steps to regain the child, the relationship with the adoptive parents changes".[39]

5. Focus on Child's Best Interests

It is important for the open adoption mediator to retain a focus on producing an open adoption agreement that will not only meet the needs of the birth and adoptive parents, but also promote the best interests of the adoptive child. Sharon Gollert has endorsed such a child-centered approach: "Decision making and planning within adoptions should be made by viewing the results of the decisions from the adopted child's perspective. For the sake of the adoptee, an honest measure of good will between the parents involved as well as their mutual ability to put the needs of the adopted child first, is crucial."[40]

H) THE USE OF MEDIATED WRITTEN ADOPTION AGREEMENTS

1. Benefits

Etter has outlined a number of benefits served by the use of a mediated written adoption agreement:[41]

a) It provides the foundation for successful adoption planning in which the adoptive family stays in contact with the biological relatives as the child grows up. It clarifies mutual expectations and spells out the mechanics of the relationship.

b) It dramatically improves peace of mind for both birth and adoptive parents. Adoptive parents say that they no longer fear that birth parents will attempt to reclaim their child in the future, and birth parents report no longer fearing that they will be shut out of their child's life after they have relinquished their legal rights.

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[39]Ibid.

[40]S. Gollert, *Openness Within Adoption: A Perspective of the Benefits* (Toronto: April 1996) [unpublished] at 1.

[41]See J. Etter, *Cooperative Adoption Mediation Process: Using* CAMP *to Create Cooperative Plans and Adoptions* (Eugene, Oregon: Adoption Teamwork of Oregon Press, 1994). See also Etter above, note 2; Etter & Chally above, note 17; and Etter above, note 23.

c) It is designed to deal with the potential for future conflict by stating clearly the terms of contact between birth and adoptive parents after the child is placed.

d) The empirical evidence points to such agreements providing the parties with a high degree of satisfaction with openness, when they were assisted in negotiating and choosing comfortable levels of openness.

e) The empirical evidence has shown close to 100% compliance rates with mediated written adoption agreements

2. Contractual Provisions

The model form of contract developed by Etter usually involves dealing with the following issues:[42]

a) Visitation
This provision states that the birth parents have the right to visit the child and adoptive family in a neutral setting at least once or twice a year at the option and request of the birth parents and at the convenience of the adoptive family.

b) Communication
This provision stipulates that the parties agree to communicate either through an intermediary or directly while the child is a minor. They agree to keep the intermediary or each other informed of their current addresses.

There is also a clause providing for the adoptive parents to send letters and pictures to the birth parents at least once a year and allowing the child to send and receive letters from the birth parents.

The adoptive parents usually agree to inform the birth parents of serious illness, accidents, or the child's death. There also may be an agreement that the parties will inform one another of significant events in their own lives, such as additional adoptions, marriage, or divorce.

c) Contingency Arrangements
The adoptive parents agree to appoint a guardian for the child with the requirement that the guardian abide by the terms of the agreement. There can be a contingency provision that stipulates that the birth parent *may* be considered as a potential guardian.

d) Financial Responsibility
Both parties spell out who pays various costs, including reimbursement by the birth parents if they decide not to proceed with the adoption after the child's birth. Generally, the adoptive

[42]See Etter above, note 23 at 81; and Etter above, note 41.

parents will cover the costs incurred by any intermediary services up to a specified yearly amount.

e) Modifications
There is a provision that the parties understand that they can make informal changes in the stipulated plans when they all agree, but that the agreement cannot be formally changed, except in writing, signed by all parties.

f) Invalidation
If the birth parents assume an adversarial relationship with the adoptive parents, except in regard to enforcement of the adoption agreement, the adoptive parents will no longer have to honour the agreement. The purpose of the invalidation clause is to make it clear that if the birth parents take legal steps to regain the child, the relationship with the adoptive parents changes.

g) Parties
The parties are the birth parents and adoptive parents. Where the child was neglected/abused and previously in a child protection agency's care, the agreement should stipulate that the child protection agency is not a party to the agreement and has no responsibility for its enforcement.

h) Enforcement and Mediation
This provision indicates that the adoption agreement is to be incorporated into the adoption order. If any action is required to enforce a specific provision of the agreement, the parties agree to attempt mediation before establishing an adversarial relationship.

3. **Enforceability**[43]

There is presently uncertainty in Ontario as to whether an adoption agreement would be held to be legally enforceable. Absolute certainty will only derive from the litigation of this issue or from legislative reform. The best we can say, at present, is that an adoption agreement *may* be legally enforceable.

As a starting point, it is important to remember that the Ontario Child and Family Services Act[44] is silent on the issue of the validity and enforceability of adoption agreements, sometimes also referred to as post-adoption contact agreements.

Although the Child and Family Services Act prohibits a court from granting access to a birth family member at the time of the granting of an adoption order or any time thereafter under part

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[43] See also M.M. Bernstein, "The Use and Enforceability of Mediated Written Adoption Agreements" (1998) 42 Ontario Association of Children's Aid Societies Journal 19.

[44] R.S.O. 1990, c. C.11.

VII of that legislation,[45] the prohibition does not affect any pre-existing access order made under Part III of the Child and Family Services Act[46] and does not preclude a post-adoption access or custody application being brought under the Children's Law Reform Act.[47]

From the standpoint of the case law,[48] subsequent to the granting of an adoption order, the courts may, in exceptional circumstances, be prepared to entertain an application by a birth family member. Some "exceptional circumstances" criteria that have been held to justify a post-adoption access application are as follows:

a) The establishing of a new post-adoption relationship between a biological family member and the adoptee.[49]

b) The provision of assurances to birth family members by prospective adopters as to post-adoption access, particularly where there is also reliance on such assurances, by one or more courts, as a basis for granting specific relief.[50]

c) The initiation of an application under Part III of the Child and Family Services Act by a child, who is subject to that Part's jurisdiction, for access to his/her birth sibling, who has been adopted by different parents.[51]

d) The pre-existence of an access order between a biological family member and an adoptee that has survived adoption;[52] and

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[45]Ibid., S. 160 (i).

[46]See P. (M.A.R.) (*Litigation Guardion of) v. Catholic Children's Aid Society of Metropolitan Toronto (1995),* 15 R.F.L. (4th) 330, (sub nom. *Catholic Children's Aid Society of Metropolitan Toronto v.* P.(M.A.R.))84 O.A.C. 308 (sub nom. V. (A.) v. P. (M.A.) (*Litigation Guardian of)) 126* D.L.R. (4th) 673 (Ont. C.A.), affirming (1995), 11 R.F.L. (4th) 95, 122 D.L.R. (4th) 719 (Ont. Gen. Div.), affirming (1994),9 R.F.L. (4th) 385 (Ont. Prov. Div.), leave to appeal to S.C.C. refused (1996), 18 R.F.L. (4th) 217 (note), 130 D.R.L. (4th) vii (note), 199 N.R. 239 (note), 92 O.A.C. 160 (note) (S.C.C.).

[47]*The Children's Law Reform Act,* R.S.O. 1990, c. C. 12.

[48]For a review of the relevant case law, see M.M. Bernstein & L.M. Kirwin, *Child Protection Law in Canada* (Toronto: Carswell, 1990).

[49]See *W. (C.G.)v J.(M.)* (1981), 24 R.F.L. (2d) 342, 34 O.R. (2d) 44 (Ont. C.A.).

[50]See *H. (J.) v G.(B.),* May 31, 1993, Doc. ND/1510-10, Ont. Div. Ct., dismissing judicial review application from March 9, 1993, Doc. Toronto D 1171/86, Ont. Prov. Div., summarized at [1993] W.S.F.L. 762 (Ont. Div. Ct.).

[51]See P. (M.A.R.) (*Litigation Guardian of) v Catholic Children's Aid Society of Metropolitan Toronto* (1995), 11 R.F.L. (4th) 95, (sub nom. *V. (A) v. P. (M.A.) (Litigation Guardian of))* 122 D.L.R. (4th) 719 (Ont. Gen. Div.). See above, note 46, for full citations at all four Court levels.

[52]See above, note 46.

e) Other justifiable emerging categories of "special circumstances."[53]

I) CONCLUSION

Since the adjudication process has been criticized "as a system that is too expensive, too slow and cumbersome, and too adversarial for relationship disputes",[54] it is important that the legal profession discharges its duties under the Rules of Professional Conduct to "use alternative dispute resolution (ADR) for every dispute and, if appropriate, ... inform the client of ADR options and, if so instructed, take steps to pursue those options".[55] The hope is to educate both the public and the legal profession in terms of viewing court adjudication as one "tool" in a "toolbox" of possible dispute resolution techniques, with the adjudication process being reserved as the "tool of last resort" for those disputes that cannot be resolved in other ways.

It has been suggested that resort to litigation is particularly ineffective in family law matters "since the law is a blunt instrument with which to deal with personal problems."[56] Mediation, in contrast, "appears to offer a much more appropriate level of support, and is relatively cost-effective judged against four criteria for evaluating methods of conflict resolution: their ability to settle the dispute; the cost of the process; the justice of both process and outcome; and the promotion of social goals."[57]

In view of the empirical studies that demonstrate the myriad benefits of open adoption, through the use of both mediated open adoption (i.e., in the private sector) and cooperative adoption mediation (i.e., in the child protection sector), mediation can be seen as "the logical [process] for allowing [the parties] to design their own adoptions"[58] and to find their own comfort levels of openness within the constraints of the law. Gritter has said that "[e]very open adoption is the creation of those who are involved in it. The vitality and promise of open adoption is its ability to adapt to circumstances that emerge over time".[59] In other words, there is no "openness in

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[53]See above, note 51. See also D.A.R. Thompson, *Rules and Rulelessness in Family Law: Recent Developments, Judicial and Legislative* (2001) 18 Canadian Family Law Quarterly 25 at 66-69.

[54]See Landau, Bartoletti, & Mesbur above, note 37 at v.

[55]*The Rules of Professional Conduct of the Law Society of Upper Canada,* Rule 2.02 (3) (Toronto: The Law Society of Upper Canada, adopted by Convocation June 22, 2000; effective November 1, 2000).

[56]J Walker, "Family Mediation" in J. Macfarlane, ed., *Rethinking Disputes: The Mediation Alternative* (Toronto: Emond Montgomery Publications Ltd., 1979) at 57.

[57]Ibid.

[58]See Etter, *Open Adoption: A Survey of 56 Families* above, note 19 at 8.

[59]J. L. Gritter, *The Spirit of Open Adoption* (Washington: CWLA Press, 1997) at 305.

adoption" blueprint for the adoption mediator, and each open adoption will have to be tailored to meet the existing and evolving needs of each of the participants. While this represents a challenge for the adoption mediator, it is a challenge that should be welcomed and embraced, rather than resisted and discarded.

ACCESS AND THE CHANGING FACE OF ADOPTION

Nancy Dale

THE CHANGING FACE OF ADOPTION

Before specifically addressing the issue of access in the context of adoption planning, it is important to consider the changing face of adoption itself. The following section will include a brief description of the children currently being placed for adoption in Canada today. This will be followed by a description of the range of "openness" that characterizes these placements, including considerations to guide practitioners formulating post-adoption contact plans.

The number of children born in Canada and subsequently placed in adoptive homes has declined steadily over the past decade. There has been a 47.3% drop in the use of domestic adoption as a means of family formation across the decade (Sobol & Daly, 1993). This drop is due to the declining number of healthy newborn infants relinquished for adoption by single young woman who increasingly are choosing to parent (Sobol & Daly), the impact of the family preservation movement within child welfare resulting in a different profile of child being freed through that system for adoption, and, finally, an increased trend towards international adoption as a means to build a family.

Currently, children being placed through child welfare agencies often face special challenges. They have generally been "freed" for adoption through the courts, typically after a protracted period of litigation during which time planning for the child's future remains in limbo. While the reasons why protection agencies bring children before the court requesting a termination of parental rights to enable adoption planning on behalf of the child are varied, generally, children in these circumstances have experienced abuse and/or neglect or were judged to be at significant risk for such maltreatment if they remained in their parent's care. These children have often experienced numerous separations from caregivers, both within and outside the "care system", resulting in multiple attachments of differing qualities. A common feature in these children's histories is prenatal exposure to substances resulting in developmental and cognitive deficits. These deficits are sometimes compounded by genetic factors inherited from the child's birth family, placing these children at risk of developing mental health problems as they mature. In summary, children being placed for adoption by public agencies are generally older at the time of adoption placement and at increased risk of suffering from emotional and developmental difficulties associated with their prenatal and early life experiences, as well as their genetic make-up.

Adoption planning for these children is complex. Adoptive parents must have the personal flexibility and emotional maturity to weather and deal appropriately with the many challenges they will likely face as their child matures. These parents must have an extensive support system and be comfortable in dealing with helping agencies, as it is likely that they will have to reach out for help to ensure their child's needs are met.

The National Adoption Study conducted in Canada in 1993 by Sobol and Daly notes that, in 1990, only 42% of all adoptions facilitated by public agencies involved infants, while infant placements represented three-quarters of the placements undertaken within the private sphere. Private adoption agencies are not mandated to provide child protection services. Thus, when infants and children are brought to them for adoption planning, the parent or guardian is doing so voluntarily. While public agencies are able to provide voluntary adoption placement services, there has been a marked decrease in the number of voluntary placements undertaken by public agencies in the last decade. While there is no specific data to explain this shift, it is assumed that the diminishing number of healthy, newborn infants available to be placed for adoption has increased the power of relinquishing mothers to determine the nature and form of voluntary adoption placements, and these woman are increasingly choosing the private sphere to assist them in arranging placements to meet their needs.

The Daly and Sobol study indicates that service providers noted that the most prevalent reason for a woman pursuing adoption planning on behalf of her child was, they felt, that she felt she was too young (51% of the respondents), followed by financial problems (26% of the respondents) and the fact that parenting at that juncture would interfere with the woman's career aspirations (21%). Clearly the parent's ability to become voluntarily involved in a process of planning for her child's future through a voluntary adoption placement process is highly correlated with a decreased number of risk factors in the child's prenatal and postnatal care. Thus, children placed within the private sphere are not only younger, but have fewer special needs than those children placed by public agencies.

In times past, the adopted child was typically a newborn infant voluntarily relinquished by a single woman who did not have the means or support to raise her child. Frequently the adopted child was raised "as if born" to his adoptive parents. While the child may have been made aware of his or her adoptive status, this did not occur in all instances. Many families did not share this information, believing it to be potentially damaging to the child's sense of his or herself. Even for children who were made aware of their adoptive status, this acknowledgement was generally not accompanied by social history information with respect to the child's birth family. Early adoption practice did not recognize the value of such information to adopted children vis-à-vis their identity formation, and thus there was little incentive to collect it or disseminate it to the adoptive parents, along with education regarding how it could be shared with children throughout their development. Identity formation was seen to commence with the adoption placement itself, and it was assumed that the child would absorb the history of his or her adoptive parent's family as if it were their own. This belief was supported by adoption policies such as the amendment of birth certificates to indicate that the adopted child was born to the adoptive parents and strict rules prohibiting the exchange of any identifying information between the parties.

In recent years, there has been an increasing recognition that adoptees almost universally have the need to know about their biological roots and that the appropriate sharing of this information can facilitate not only the adoptees' healthy personality development, but also their attachment to their adoptive family. It has been suggested by Kirk that adoptive families who can acknowledge their "difference" from biologically formed families, particularly with respect to the experience

of loss that is shared by both the adoptee (loss of a pre-existing or potential relationship with their biological parents/family) and the adoptive parent (loss of the biological child who through genetics would have been "just like them", loss of an intimate knowledge and understanding of the child's earliest moments in life, and loss of opportunity to protect the child from earlier trauma he or she may have suffered) is key to the success of adoptive placements (Kirk, 1981).

This knowledge has led to a significant shift in adoption practice over recent years. Education of prospective adoptive parents now emphasizes the need to accept and acknowledge the adopted child's biological roots and encourages them to share, in an ongoing and age-appropriate way, information about the child's biological family and the reasons for the adoption. Inherent in this new educational thrust is a recognition that the ongoing sharing of developmentally appropriate information with the adoptee about his or her biological roots and the circumstances of his or her adoption is a key opportunity for members of the adoptive family to foster a sense of attachment, based on a deep understanding and respect for each member's individual history.

OPEN ADOPTION

Current best practice in adoption placement planning includes many of the components consistent with Demick's definition of "restricted open adoptions" (Demick& Wapner, 1988). Both public and private adoption placement agencies ensure adoptive parents are provided with written, non-identifying, social history information pertaining to the child, his or her biological family and the circumstances of the adoption, including pictures of family members and significant others if available, to assist them in interpreting the child's past to him or her. It also includes, where feasible, involvement of the birth family in the selection of the adoptive family for their child from a series of pre-approved, non-identifying, adoptive parent profiles and/or consideration of their input, if possible, on what qualities they would wish for in an adoptive family for their child.

Foster parents who are providing care for children must also be actively involved in the selection process, particularly if they have provided care for a period of time and, as a result, have both a highly developed sense of the children and their needs, as well as an emotional investment in their future well-being. In this situation, the foster parent can act as both the practical and emotional bridge for children from their birth family and foster family to their adoptive family. Foster families can assist adoptive parents to understand children and their needs, while at the same time supporting children in the early stages of forming a new attachment to the adoptive family. Clearly, the older the child and the longer the period of the child's placement with the foster parent, the more pivotal this involvement will be.

The quality of the information that can be provided to adopted children and their adoptive families about their birth families and the circumstances of their adoption is dependent upon eliciting the cooperation of the birth family. Without this cooperation, the information shared is generally restricted to limited facts and impressions gleaned by the social worker who met with the birth family during the relinquishment process. Within the public sphere, this often presents

genuine hurdles if the matter of the child's future is being litigated and the relationship with the family has become strained and problem-focused. In other situations, children may have been abandoned in foster care, and little or no information is known about their extended biological family. The social worker must attempt to piece together information about the child's biological family from a variety of sources and augment it with information about the child's early development and relationships within his or her foster home placement(s). The latter is often a rich source of positive information about the child, whose life before care may be a virtual unknown beyond the negative events that precipitated the admission to care and the decision to proceed to court for a permanent wardship order.

If children are older and have memories of events and people who have been meaningful to them, they should be actively involved in the process of preparing a "life book" that is truly their own story as they see it. Any additional information obtained by the social worker can be interwoven with the child's information, if appropriate, or provided in a separate document to be differentially interpreted to children as they mature. In many circumstances, the non-identifying social history must include carefully interpreted information about the painful facts that led to the child's adoption. Social workers must provide a context for social issues such as drug addiction and mental health problems that will allow children and their adoptive families to understand the negative impact such problems had upon the birth family's ability to make good decisions for themselves and their children, often in spite of their good intentions.

This information, where possible, can be augmented by letters prepared by birth family members, foster caregivers who have cared for the child, and other significant people involved in the child's life prior to the adoption decision being reached. These letters explain, in the birth family's own words, why the child was placed for adoption and their hopes and dreams for the child's future. Clearly, the ability of birth family members to participate in such an exercise is often linked to whether the child's placement was voluntary. The anger and hurt often associated with court proceedings resulting in the involuntary termination of parental rights can significantly mitigate against the social worker's ability to engage birth family in the adoption process for their child. When decisions are made through mediation, negative feelings tend to be minimized. However, this is an area where assumptions should not be made. With persistence and sensitivity, social workers are sometimes able to engage birth family in the process, through an acknowledgement of and sensitivity to the profound sense of loss they are suffering, as well as through empowering birth family members with the task of determining how they want their child to know them (e.g. through letters or other materials prepared by them).

Clearly, this process requires highly developed clinical skills on the part of the social worker. The social worker must assist the birth parents to work through their sense of anger and helplessness to a point where they are able to prepare information that will truly assist their child in understanding, generally at some later date, who they are and the circumstances that led up to the decision to place the child for adoption. While the information must be truthful, it must also be sensitive to the child's need for permission to attach emotionally to their adoptive family.

In some situations, agreements may be struck that allow for the ongoing exchange of pictures and non-identifying information about the child through a third party, typically the placement

agency. While this ongoing sharing of non-identifying information through a third party, for differing periods of time, is quite common within the private adoption sphere and in voluntary placements within the public sphere, it is less so with the adoption placement of children who are wards of the state. Often the purpose of these arrangements is to reassure the birth family of the child's well-being in their adoptive family, so they can begin to bring closure around the loss they have suffered and "go on" with their lives. This is ultimately seen to be in the interests of the adoptive parents and the child who, by virtue of their "connectedness", have an emotional investment in the birth family's well-being. While many of the arrangements for the exchange of information do not span extensive time periods, if an exchange is anticipated, workers should carefully consider how the children will view such arrangements as they mature and ensure that there is a mechanism to vary the agreement, should a child feel uncomfortable with the nature of the exchange.

Any plan for exchange of information should be avoided if there is a possibility that the information shared could inadvertently identify children and their whereabouts, and there is a pattern of violent and/or unpredictable behaviour on the part of a birth family member who would have access to the information. If the birth family member who proposes contact of this nature has a history of self-destructive and/or transient life styles, careful consideration should be given to his or her capacity to maintain the necessary level of organization that such agreements require (e.g. maintaining contact with the third party so information can be forwarded to them, storing the information in a safe place). Adoptive parents who prepare such information need to believe that it will fulfill a positive purpose for both the birth family and the child. This motivation is difficult to maintain should the birth family have an erratic or limited response to the information prepared; this may result in disappointment about the birth family on the part of the adoptive parents that may be communicated, however unwittingly, to the child. Finally, the adoptive parent must feel comfortable in fulfilling the request for information, based on a true understanding of it and belief that the child will benefit.

The practice of non-identifying meetings between birth family and prospective adopters, described by Demick as "semi-open adoption", is also relatively common in both public and private adoption practice, particularly if the adoption decision is voluntary on the part of the birth parent. These meetings require active planning on the part of the social worker. The social worker must ensure that each of the parties has had the opportunity, prior to the meeting, to process their understandable fear of being misunderstood or rejected by the other. The parties must also be given active assistance to plan the essence of what they wish to share during the meeting itself. Without this level of preparation, the meetings will likely lapse into a minefield of emotion, potentially leaving each of the parties with negative feelings that could go on to colour negatively the adoption itself. For reasons mentioned earlier, it is frequently difficult to engage birth parents in such a process if they have not voluntarily entered into the adoption decision. Adoptive parents may express fear of meeting birth parents if there is a history of violent or unpredictable behaviour. In making the decision to proceed with such meetings, the social worker must consider whether the participants will be able, with support, to exchange information that will be helpful to children as they grow, and will provide an opportunity for both the birth parent and adoptive parent to develop a very real sense, and hopefully acceptance, of each other as people who have a common interest in the child's well-being.

Demick describes "fully open adoption" as an adoptive placement which includes not only a meeting between the birth parent and the adoptive parent(s), but also the sharing of identifying information. While more common within the private adoption sphere, where placements are voluntary in nature, the practice is generally restricted to kinship placements or placements involving former foster parents to the child, who were also known to the birth family, within the public sphere. Such placement decisions require a high degree of trust amongst the parties. This trust is generally related to a strong consensus that the placement is not only in the child's best interests, but one the birth parent has truly chosen. The adoptive parents must feel comfortable with this "choice" and have confidence in the birth parent's overall decision-making. A decision to proceed with a fully open adoption must include an in-depth understanding of the motivation of each of the parties. One must carefully consider whether birth parents have the capacity to understand the permanence of the decision they are making and the ability to respect this permanence over time, although their life circumstances may change. The social worker must also ensure that the adoptive parents' acceptance of such a plan has not been driven by a desire to please the birth parent in an effort to secure the placement.

Finally, Demick describes "continuing open adoption" as those adoptive placements that include within them a plan for continued contact between the adoptee and birth family. The frequency and nature of contact is determined by the adoptive parents and birth family and often arrangements are drafted to reflect the agreement reached. While increasingly common within the private sphere, such agreements are quite rare within the public sphere due to the background and the fact that the existing law neither anticipates such contact, nor provides a predictable legal framework to resolve issues of non-compliance with the terms of the agreement. Research as described in the foregoing section by Marvin Bernstein has indicated a general satisfaction on the part of birth parents and adoptive parents with the agreements reached within that sector, however a trend of diminishing contact after adoption placement is also noted. What is clear is that there is insufficient longitudinal research to assist in assessing the impact of the range of "openness" selected on children's long-term development.

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V. Placement Out of the Family Home

INTRODUCTION

When a child is taken into the care of Child Protective Services (CPS), there are a number of placement variables to be considered. Ideally, the placement decision is made before the child is admitted into care, but in practice the child is often admitted on an emergency basis to a temporary foster placement or staff-operated receiving home until a suitable placement plan is made.

The placement decision is made on the suitability of the setting for the particular child. The severity of the child's behaviour may have some bearing on the decision, but often a significantly disturbed and difficult child can be helped in foster care. Important considerations will be the quality and training of the foster caregivers and the amount of therapeutic and staff support available. It used to be the case that there were two broad categories of placement, and these were foster care and staff-operated settings. However, the situation has changed so that specially trained staff can be made available to support foster placement and staff-operated settings can work closely with the biological family. It is helpful to consider placements as falling somewhere within two sets of polarities: one polarity has to do with the administrative tone (homelike vs. institutional) and the other has to do with the amount of staff involvement (no staff vs. staff only).

Homelike

No Staff Staff Only

Institutional

An example of a placement on the homelike/no staff end of the polarities would be a long-term foster placement where the foster caregivers make the parenting decisions in the child's life and the family functions with only supervisory involvement from the CPS. The more rules and regulations that limit the fostering family's functioning, the more institutional-like the placement becomes. If a child is particularly difficult, the foster home may require staff support in the home or frequent visits by support staff. A placement on the institutional/staff only end of the polarities would be a staff-operated institutional setting, such as a hospital or a residential treatment setting, in which there are tight regulations and restrictions on visiting and contact with family members. When there is a wide range of possibilities to choose from, it becomes possible to be more flexible and plan specifically for each child.

FOSTER CARE

James R. Wilkes, Sally Palmer

The most common placement for children taken into the care of Child Protective Services (CPS) is a foster home. The theoretical base for such practice is to have a child parented in a family home, thereby providing the most emotionally nurturing situation possible.

As discussed in the section dealing with staff-operated settings, children are not placed in a particular type of setting on the basis of severity of behaviour or diagnostic category. The decision is made on how suitable a child is for that particular setting. Often, a significantly disturbed and difficult child can be helped in a foster home. Important considerations will be the quality and training of the foster caregivers and the amount of therapeutic and staff support available (see below). Foster care remains the least expensive and most available resource for the placement of children in care. CPS must take care not to overburden foster homes by placing unsuitable children or by not providing the extra support required for special needs children.

A) VARIABLES IN FOSTER CARE

Aside from the obvious variables of the individual child and the particular foster home, foster care arrangements vary in a number of other important ways.

1) Wardship Status

Voluntary Agreement - A child may be taken into the care and protection of CPS with the agreement of the parents. The parents remain the child's legal guardians.

Society Wardship - The court orders that the child be made a ward of CPS for a temporary period.

Crown Wardship - The court orders that the child be made a permanent ward of CPS.

2) Relationship Between CPS and the Foster Home

i) Supervision - Supervision of a foster home is a skilled process that involves a thorough knowledge of the needs of children, as well as sensitivity to each home's own interests and values. While there are regulations about the minimum supervision required, the frequency and amount of time required for supervision will be a matter of judgement. An important aspect of supervision is who makes what decisions in the child's life (see "Clarity of Roles", p.136).

ii) Funding - The amount of money CPS pays the foster home will vary according to various funding formulae. As a rule, there is a certain base rate, with the possibility of an increased *per diem* attached to the more difficult children.

iii) Support staff - In some foster care arrangements, when a child is particularly difficult to manage, there is the provision of support staff beyond that generally provided by CPS. Such staff may be provided by CPS or by staff of a mental health facility.

iv) Training and education - It is important to provide support to foster homes by providing adequate and ongoing training and education. Training and education is of particular importance in the foster care of children with special needs.

v) Administrative responsibility - Most CPS agencies have their own foster homes. There are also private agencies that provide foster care where CPS can place a child in their care.

3) **Length of Stay**

Foster care may last a few days or a number of years. Long-term foster care in some cases is really like adoption for the particular foster child, except that it is easier to involve the child's biological family. There is a category called "Foster Guardianship" that, as the name implies, means that the foster caregivers become the actual guardians and the child welfare agency provides support and remuneration on an as-needed basis.

B) PRINCIPLES OF CARE

1) Maintain the homelike atmosphere.

Foster care is based on the principle that a child is best cared for in a home. While it is important to ensure that children are safe and well cared for, it is important that CPS not intrude into the home through personnel, regulation, or infringement on decision-making to the point that the home loses its sense of autonomy and becomes a mini-institution. Foster placement remains the least expensive and most available (albeit increasingly less so) resource for the placement of children in care. It is an improper use of a resource to overburden a home by placing a child who more appropriately belongs in a staff-operated setting.

2) Provide early and adequate assessment.

Adequate planning for a child requires knowledge of the child's emotional and behavioural needs and strengths. If it is not possible to assess the child adequately prior to the child coming into care, then such an assessment should be made as soon as possible after the child is in care. When assessment becomes part of the casework only when a child is in difficulty, there will be casework drift and the promotion of limbo.

3) Remember the importance of the parents to a child's emotional and psychological development.

The care and sensitivity that goes into the casework dealing with the relationship between the child and the child's parents will, in large part, determine whether the relationship is enhanced or harmed by the child being in foster care. Some of the important casework principles are as follows:

a) *Work to overcome the parents' resistance to cooperating.* Working with a resistant and sometimes hostile client is difficult and emotionally taxing, and it is easy to buy into parents' resistance and let them drift away and leave the child to drift into limbo. On the other hand, when competent casework is met by continuous lack of cooperation, then it is likely that access between the child and parent should be terminated or drastically reduced and the reasons for such a decision clearly explained to the child.

b) *To the greatest extent possible, include the parents in planning decisions.* When parents take part in decisions, even regarding seemingly inconsequential issues, they feel a sense of empowerment and are more likely to stay involved.

c) *To the greatest extent feasible, encourage the parent/foster caregiver relationship.* This begins when the child is first placed. Ideally, the parents accompany the child to the foster home on a pre-placement visit. At such a visit, there is opportunity for the parents to share information about their child and ask and answer questions with the foster caregivers. In such a situation, the child feels supported by the parents and will suffer less of a sense of abandonment. The more the parents are able to be included in the entire foster care process, the less likely it is that they will withdraw and leave the child in limbo.

d) *Make access plans as soon as possible.* Sensible access plans are essential to a positive outcome.

e) *Access for infants should be as frequent as possible.* Frequent access is important to allow the infant to attach properly to the parent. Where feasible, assuming that the infant will be returned to the parent, access should be daily.

f) *Update the child at regular intervals about the parents and the possibility and timing of the child returning home.* Often, because of a lack of clarity in the casework planning, or ongoing instability in the parents, there is no clear understanding of what is going to happen, and the child is left in the dark. The thinking seems to be "If the child doesn't enquire about it, why expose the child to the ongoing uncertainty". The point is that it is always important to keep the child informed, even if there has been no apparent change. This is true in all situations, but it is particularly important in situations in which it is not clear when the child is going to return home, and the child waits in the foster home for improvement in the parent(s) to take place. A common problem in this regard is substance abuse by the parent(s). The child waits in care until the parent is no longer using drugs. Too often the child waits expectantly without receiving any information, sometimes even being unaware of the parent's use of drugs. While the child waits without adequate information, he or she cannot anticipate the future and is not able to process the past or reach out for alternative nurturing relationships. Workers often hesitate to bring information about lack of progress on the parent's part, because they feel they are unnecessarily burdening the child. Yet withholding information, no matter how kindly intended, prevents a child from being able to process what is going on in his or her life, and the child drifts into limbo. If, in the end, the child is not returned home, as often happens, the child greets the information with anger and mistrust and is much less likely to adapt to the next plan than he or she would have been if kept informed (see also 4 below).

g) *Deal sensitively with the separation.* No matter what quality of parenting a child may have received, separation from the parents is always emotionally stressful. It is important that the reason for separation be clearly stated and that the child be helped to understand it. Ideally, the parents should take part in the explaining. Collusion with parents who wish to hide issues (e.g. drug abuse, criminal behaviour) from the child only serves to lead the child into vagueness and limbo. When the truth eventually comes out, it is no more palatable, and the child has learned to mistrust the caregivers. Sensitive handling of the separation also involves helping the child to accept and deal appropriately with the feelings around separation throughout the time in care.

h) *Help parents and child to understand any areas of difficulty in their relationship and support measures to improve these areas.* Access visits can be helpful in this regard (see "The Role of Access in Permanency Planning", pp. 59-88).

4) Use the distinct roles of CPS worker and foster caregiver to advantage.

The CPS worker can be seen as the messenger and facilitator, while the fostering person is the caregiver. When they work as a team, they can help the child process what is going on in the child's life. This can be particularly useful in situations where the biological parents, for whatever reason, are being non-compliant with

the plan of care. In such situations, planning becomes difficult and it is often delayed. In such cases the foster parent can ask questions on the child's behalf, such as: "Do you think the parents can change?", "How long are you going to wait before going for Crown Wardship?", " What do the parents have to do before John can be returned home?". It is unlikely that the CPS worker will be able to answer such questions clearly or with certainty, but it is important that they are asked, because in so doing, the child's legitimate questions are validated, and he is less likely to drift into limbo.

5) Maintain clarity of roles.

a) *Maintain clarity of responsibility for decision-making.* Foster care is a complex situation in which there are a number of day-to-day decisions that have to be made. The roles of the caseworker, foster caregiver, and biological parents have to be clearly understood or the child will be caught in confusion and conflict. The roles should delineate how decisions and arrangements will be made about such things as teacher-parent interviews, visits to physicians or mental health professionals, purchasing clothes or toys, visits with friends or family members. It is important to explain to a child when a change in decision-making responsibility takes place.

b) *Allow for changes in roles over time.* If a child remains in a placement over sufficient time for the foster caregiver to get to know the needs of the child well, then it makes sense for the caregiver to take on more of the decision-making and become more active in arrangements for visits and appointments. The relationship that a child has with the foster family is much different for a child who has been in a family for a year or more than it is for a child who has just arrived, and the casework procedures ought to reflect this difference.

STAFF-OPERATED SETTINGS

Margaret Osmond, Sally Palmer, James R.Wilkes

In a publication that is aimed at promoting and developing a permanent plan for every child, the inclusion of a chapter on staff-operated settings would seem to be a step in the wrong direction. Ideally, when children have to be taken from their homes, it would be best to place them in another home for as long as needed. The reality is that placement decisions have to take into account all the important variables involved. With this in mind, there is a place for staff-operated settings.

At the outset, it is important to point out that there is a wide range in the quality of staff-operated settings available. There are wide differences in staff/resident ratio as well as in the quality and training of staff. It is also important to point out that there is no litmus test to tell which children require a staff-operated setting. There is no way around adequate assessment and good clinical judgement. The important point is that an assessment be performed as quickly as possible and a suitable placement found, thereby avoiding children lingering in unsuitable placements until a crisis develops and they have to be moved again.

The reluctance to place children in staff-operated settings when there is no other suitable placement available can lead to children going through several failed settings before they are placed appropriately. At present, the majority of children in staff-operated settings have had at least one failed foster placement and most have had more than one. Many children who need the structure of a staff-operated setting are not placed there until they have had several failed foster home placements. Two research projects involving children in Ontario Children's Aid Societies showed that many experienced an unconscionable number of moves in care. A study of 73 children showed that 48% had three or more placements, and 18% had six or more placements, during a median time of four years in care (Kufeldt, Armstrong, & Dorosh, 1989). Another study of 169 children showed that 20% had four or more placements over five years in care (Palmer, 1990).

Each time they are rejected by a foster family, children are likely to distance themselves further from caregivers, recognizing that attachment becomes a source of pain when they are moved again. Workers should make every effort to identify children who are likely to experience multiple moves when they are in their first placement. It should then be agency policy to place such children in a staff-operated setting until they are ready for a more intimate setting. Agencies have been slow to give up on foster home placement for these children because staff-operated settings are usually much more expensive. The human cost of repeated failed placements, however, is too high a price to pay for a monetary saving. A study that focused on youth experiences in staff-operated group homes found that many of them were relieved finally to live in a setting where they were reasonably assured of permanency (Anglin, 2000).

When making the placement decision for a staff-operated setting, consideration should also be given to placing the child in a parent-operated group home or in a treatment foster home.

Nevertheless, it is much less stressful and traumatic for children to be placed in a staff-operated setting that can contain and support them than to be placed in another placement that breaks down. In a staff-operated setting, the child can be properly assessed, and this assessment can be used to help develop realistic expectations for the child's behaviour and make it more likely for the child to succeed if moved to a foster home. The decision to move a child from a staff-operated setting to a parent-operated setting will depend on the child's suitability for the new setting and not on a predetermined length of stay. Before making such a decision, it is good practice to consider the child's social skills and capacity to control aggressive and sexual behaviour. There are some children who will require a staff-operated setting on a long-term basis.

Before a child is placed in a staff-operated setting, the following points should be considered:

1. All suitable and available support services for the child's own home have been considered and deemed inadequate to deal with the problem.

2. The child is not suitable for a parent-operated home.

3. All feasible ways of placing and supporting the child in a parent-operated home have been considered and rejected.

4. The setting is appropriate for the child.

FACTORS TO CONSIDER

1) The Child

At the outset, it is important to recognize that not every child exhibiting excessively difficult or dangerous behaviour is thereby excluded from placement in a home setting. Indeed, there are children with severe and dangerous behaviour who are being well cared for in foster placements. In making the decision to place a child in a staff-operated setting, important factors other than diagnosis and behaviour deserve consideration. Among such factors to consider are the context in which the behaviour developed, the meaning of the behaviour, and the malleability of the child (younger age, responsiveness to input, lack of exposure to failed treatment attempts).

With the above qualifications in mind, it is understood that staff-operated settings are often required in the following situations:

a) Difficult or dangerous behaviour

The behaviour of some children is too difficult for a family home to handle. The child who is prone to setting fires, to sexually predatory behaviour, or to aggressive assault usually cannot be managed safely in a home. It could be argued that with enough added

security (sufficient strategic locks and alarms) a home could be rendered safe for everyone living there. The question becomes: "When do such measures effectively turn a home into a mini-institution?".

b) Children with severe attachment difficulties

The emotional demands of living in a family setting are too much for some children with attachment problems. These children may do better in a staff-operated setting where the emotional demands are diluted and where their difficult behaviour does not set them up for rejection (see "The Recognition, Prevention, and Management of Attachment Disorders within the Child Welfare System", pp. 144-171). It is possible that over a prolonged period of time such children will be able to move to a parent-operated setting.

c) Diagnostic category

The decision to place a child in a staff-operated setting is not made on the basis of diagnosis. Children from all diagnostic categories can live in and be maintained in a home as pointed out above. An important factor in maintaining a child in a home setting will be the availability of required treatment.

d) Dangerous or violent biological parents

In some exceptional situations the children's parents behave in a way that makes it impossible for a foster family to care for their child. It is virtually impossible to keep the name and location of a foster home secret from a biological parent. There is a range in the tolerance level of homes for disruptions from outside. No foster home should be subjected to disruption beyond its tolerance. More importantly, no foster home should be vulnerable to dangerous, violent, or threatening behaviour from the parent of a foster child.

2) **Setting**

a) Location

As a general rule, the closer the setting is to the child's home and family the better. The principal reason for this is access to the child's family. One of the most important therapeutic goals of residential placement is to deal with the child's relationship to major attachment figures. If the child is to be returned home successfully, it will be necessary to deal with any family interaction issues that contributed to the child coming into treatment. It is difficult to do this without having sufficient contact with the people involved.

b) Staffing

i) Staff-resident ratio: In most settings, the number of staff on duty at any time will depend on the number of children in the home. Modifications are usual during night hours. The severity of the child's behaviour and the demand for close supervision will also influence the number of staff required.

ii) Professional training: For financial reasons, some settings use untrained staff to do work that ought to be done by trained staff. Therapeutic opportunities may present at all times and not just during programmed activities. Trained staff ought to be available at all times. Staff should also be provided with the opportunity to upgrade their training continually.

iii) Supervision: Ongoing supervision is a protection against slipping into non-therapeutic practices.

iv) Professional consultation: A setting should be open to having outside professional consultation as the program and treatment needs require.

c) Treatment Philosophy

i) Safety considerations: All institutional safety regulations are in place, and sufficient measures are in place to prevent injury or abuse of residents or staff.

ii) Coherent theory: The policies of a setting should have a theoretical base, and the program and treatment goals should be in keeping with the theory.

iii) Management of access: When a family member visits a child there is an opportunity to deal with attachment and relationship issues. Visits should be planned and viewed as opportunities to work through important issues and should not just happen as a matter of course.

iv) The length of time a child stays in a setting should be decided on the basis of the best interests of the child and not on an arbitrary policy of the setting. There must be flexibility in the length of stay because there are a number of variables that will affect the duration a child needs to be in a setting and often these change after the child has been admitted.

v) When children's behaviour has been stabilized in a treatment setting, agencies may be tempted to move them to a less expensive placement. If the child is not ready for another move, because of past disruptions, the move could undo much of the healing.

vi) Relationship with the referral source: The setting works to maintain ongoing communication with the referral source and works to clarify the distinctive roles of all the staff involved.

vii) Sensitive use of the distinctive roles of the CPS worker and the staff of the setting can make the child's situation clearer to the child. In similar fashion to the foster caregiver and the CPS worker (see "Foster Care", pp. 139, "Maintain Clarity of Roles"), the setting staff can ask the CPS worker questions on behalf of the child. The staff can later help the child process the answers.

viii) Outcome evaluations: The setting uses outcome evaluations that are based on a thorough initial assessment and compliance with a clear treatment plan that includes a means for addressing the identified issues.

3) **Expected Length of Stay**

a) Short Term

For a short-term plan to be effective, expectations have to be understood in the same way by all involved, and the casework plan must have a clear rationale. It is not good enough to place a child with the understanding that "this will only be a short placement". Unless there is a clear plan about the nature of the treatment the child will receive and how this is expected to help, as well as a clear plan about what the parents have to do and how they are going to accomplish it, the length of time will be anybody's guess. Without such clarity, the child will be burdened with uncertainty.

If it is unlikely that the child is to be returned to his or her own home, it is useful to tie the short admission to a foster caregiver who has already been selected.

b) Long Term

Children with severe behaviour problems that cannot be managed adequately in the community and who have not benefited from previous treatment interventions often require a longer stay in care. Commonly these children also have a poor attachment history and are likely to show cognitive deficits and poor academic performance.

At the outset of long-term care, it is often unclear whether the child will return home or not. This is often masked by the understanding that the child will return home once the child's behaviour improves. While improvement in a child's behaviour is often an important goal of treatment, it should never be dealt with in isolation. The child/parent relationship should never be allowed to drift into the background. When the focus shifts away from the parents, the child is left in limbo. The child/parent relationship should always be an important part of the treatment. If the child is in care awaiting changes in the parents, then the child should be updated regularly on how the parents are doing. All

too often, the situation is allowed to drift. If the child is not updated regularly, then a final decision that the child will not be returning home can come as a shock and make the child even more resentful and mistrustful. If the child is to return home, work will have to be done between parent and child to help effect reunification.

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THE RECOGNITION, PREVENTION, AND MANAGEMENT OF ATTACHMENT DISORDERS WITHIN THE CHILD WELFARE SYSTEM

Paul D. Steinhauer, Margaret Osmond, Sally Palmer, Harriet MacMillan, Nitza Perlman

INTRODUCTION

There are almost no children in the care of the child welfare system who are harder to contain in one placement and manage successfully than those who have a Reactive Attachment Disorder. These children have often been exposed to years of repeated neglect, abuse, and discontinuity within their own families, frequently aggravated by the cumulative effect of the multiple placement breakdowns they experience in the foster care system while moving from foster home to foster home to group home to institution and back again. Because so often their needs for nurture and continuity have gone unmet, they have never developed what Bowlby termed "basic trust", that is, the confidence that their caregivers can be relied upon when needed to relieve their distress (1969). Due to their lack of basic trust, they see no adult as being any more reliable than those who have neglected, abused, and rejected them in the past. Because adults are interchangeable to them, they fail to discriminate among them, and, therefore, they lack the capacity to form "selective attachments". Children who have formed selective attachments – that is, those who trust and prefer their primary caregivers above all others as a source of relief and comfort when they are anxious or distressed – will go to great lengths to protect their relationships with their caregivers. But children who lack a selective attachment have already learned not to let anyone matter to them. As a result, they are not inclined to seek contact with or to protect their relationship with their caregivers. This makes it extremely difficult for caregivers to bond to them, since the formation of an attachment is a reciprocal process that requires both partners to reach out and respond to each other. It is this failure to reach out and respond that places infants and children who are attachment-resistant at such high risk for burning out one placement after another.

IMPLICATIONS OF RECENT KNOWLEDGE ABOUT BRAIN DEVELOPMENT

Recent knowledge on brain development has confirmed the work of earlier studies of attachment in children whose mothers were known to maltreat them (Perry, 1997; Lamb, Gaensbauer, Malkin, & Schultz, 1985). A number of studies have shown that somewhere between 12 and 18 months of age, a "window of opportunity" for forming attachment relationships appears to close (Schneider-Rosen, Brunwald, Carlson, & Cichetti, 1985). Children who have not by that stage already formed even one selective attachment are likely to remain trapped in what Bowlby, in the 1950s, termed "permanent detachment" (1960). We prefer the term "attachment-resistant", since it has been known since 1979 that some children known to lack selective attachments can, if exposed to good-enough substitute parenting for a long enough period of time, form successful reattachments (Tizzard & Hodges, 1978). We are concerned that using the term "permanently detached" implies that nothing can be done to help these children. In fact, many of them are capable of responding to a program designed to meet their specific needs. Such programs

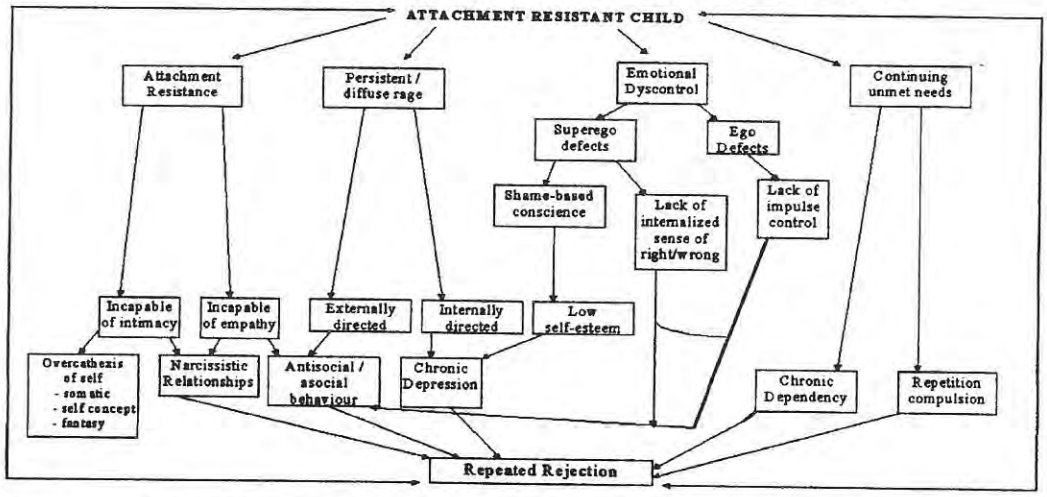
recognize that these children have developed attachment strategies that, while understandable in the context of the original attachment relationships, now have the effect of making all relationships difficult and unsatisfying. These children have learned to keep adults at a distance through avoiding them emotionally, as if allowing themselves to care would ultimately lead to punishment, rejection, or abandonment. Alternatively, some such children show such extremely exaggerated demands for attention and nurture that they exhaust adult caregivers and ultimately drive them away.

THE TWO PROFILES OF ATTACHMENT-RESISTANT CHILDREN

Caregivers of attachment-resistant children need to recognize that both the above profiles are characteristic of the major emotional and behavioural responses – narcissistic, manipulative, self-serving patterns of relating to others; asocial and antisocial behaviour; chronic depression; pervasive dependency – typically seen in the attachment-resistant child (Rosenfeld, Altman, Alfaro, & Pilowsky, 1994; see Figure 1). These behaviours serve to keep others at a distance, either through active withdrawal, rejection and/or punishment, or through inappropriate and exaggerated attempts to connect that make failure inevitable. Programs that manage attachment-resistant children successfully are able to provide an appropriate and, to the child, acceptable degree of emotional availability, while avoiding excessive expectations or emotional intrusion. Either intrusiveness or excessive expectations can provoke the child to take refuge in the maladaptive relationship strategies developed in the past. Such a milieu creates the climate and allows the time necessary for the child to develop sufficient trust to take a chance on becoming close to an adult once again. Without such understanding, attachment-resistant children continue to invite rejection and punishment again and again within current relationships, thereby repeating the rejection they experienced in their past relationships.

FIGURE 1

EMOTIONAL AND BEHAVIOURAL RESPONSES OF ATTACHMENT RESISTANT CHILDREN



Source: Modified version of diagram first appearing in: Steinhauer, PD (1988) *The preventive utilization of foster care* The Canadian Journal of Psychiatry, 33: 462

CHANGES IN OUR UNDERSTANDING OF ATTACHMENT DISORDER

Since the late 1970s, it has been recognized that about half those attachment-resistant children who do experience a sufficiently long-term placement with surrogate parents who are empathic, committed, and sensitive to their particular needs will, in time, overcome their mistrust enough to begin to form a meaningful attachment (Tizard & Hodges, 1978). That does not mean that they will be free of problems. Many of them will continue to have residual problems in focusing their attention, in working independently in school, and in maintaining successful relationships with their peers. Rutter originally noted that such deficits commonly remained even after children who had failed to form a selective attachment in their earliest years had succeeded in attaching to adoptive parents (1979). More recent work suggests that at least some of the residual social and cognitive deficits may stem from defects in the hard-wiring of the brain resulting from the susceptibility of the developing brain to the neglect, violence, and abuse to which the children, as infants, were exposed in their families of origin in their early years (Shore, 1997; Score, 1994). We know that brain development during the critical early years is very much influenced by children's environmental experiences. Optimal brain development requires enough of the right kind of stimulation – lots of being touched, held, talked to, sung to, read to, and many opportunities to interact with others – but not too much of the wrong kinds of stimulation. Those who live with constant conflict and periodic violence are likely to become hypervigilant; their brains are exquisitely tuned to danger. At the slightest threat, their hearts race, their adrenals pour out stress hormones, and their brains are on the lookout for future danger and unable to turn off the stress response (O'Brien, 1997; Perry, 1994). Such babies develop brains programmed to overreact to anger or anxiety, and deficient in the capacity to soothe themselves, focus their attention, and modulate anxiety and aggression (Perry, 1997; Shore; Cicchetti & Toth, 1995).

HOW TO RECOGNIZE A REACTIVE ATTACHMENT DISORDER

Factors suggesting the presence of a Reactive Attachment Disorder are summarized in Table 1. The more such factors are true of a given child, the more likely that child is to be attachment-resistant and the more severe that attachment disorder is likely to be. In addition, many such children also experience other emotional and behavioural disorders that coexist with and complicate their ongoing attachment problems.

Table 1: Factors Clinically Suggesting a Reactive Attachment Disorder

1. History	History of severe/long-term neglect and/or abuse. History of multiple moves and caregivers.
2. Predominant attachment strategy	Does not seek comfort from adults when distressed. Wears adults out by demands for constant attention.
3. Fails to react to separation from primary caregiver	Shows little or no protest, anxiety, rage, distress, apathy, or longing for reunion in response to separation.
4. No evidence of selective attachment	Indiscriminately affectionate as toddlers; fail to show normal stranger anxiety. Older children will not change behaviour to protect key relationships.
5. Impairment in relationships with others	At first, may appear charming, open; but with repeated contact, one realizes child is relating by rote (without warmth) and the relationship does not develop over time. Children typically say what they think others want to hear, not what they really think, want, feel or believe. Highly manipulative and self-serving in all relationships. Incapable of empathy for others.
6. Learning problems	Frequent problems focusing attention (Attention Deficit Hyperactivity Disorder (ADHD) common). Cannot work in school without constant supervision.
7. Unable to maintain peer relationships	Unable to sustain friendships: their lack of empathy and warmth, and their demanding, controlling, manipulative, unpredictably aggressive behaviour alienate their peers.
8. Typical response to limits/ demands/confrontation	Any limit/demand/confrontation responded to as attack or rejection; they routinely feel picked on or unfairly treated, or else they tune out; may persist in denial even if caught in the act.
9. Typical response to adults' attempts to get close	Anxiety. May go into shell to achieve distance, or may become demanding and antisocial, inviting punishment. Either behaviour invites caregiver disappointment, frustration, and, ultimately, rejection.

PROBLEMS IN DIFFERENTIAL DIAGNOSIS OF ATTACHMENT DISORDER

Mental health professionals are considerably less likely to recognize – or to treat appropriately – Reactive Attachment Disorders in such children than they are to diagnose and treat the ADHD, Oppositional Defiant Disorder, Conduct Disorder, Anxiety Disorders, Dysthymic and Affective Disorders, Post-Traumatic Stress Disorders whose symptoms often dominate the clinical picture and accompany, coexist with, and complicate the Attachment Disorder (Rosenfeld et al., 1994, p. 891). The children often do meet the criteria for several of these more obvious disorders. But

along with them, and often provoking reactions that perpetuate the more obvious disorders, lies an attachment disorder. Holland, Moretti, Verlaan, and Peterson have pointed out that attempts to treat only the more obvious externalizing disorders are likely to fail unless the underlying attachment disorder is also recognized and addressed (1993). We would suggest that this is also true for the internalizing disorders that these children often show. Attachment-disordered children lack the empathy that has been shown by Tremblay, Pihl, Vitaro, and Dobkin to be one of the strongest protective factors against violence and delinquency (1994). As a result, they are frequently aggressive, and they resist others' attempts to establish a therapeutic alliance and to use the relationship, once established, to persuade them to modify their behaviour. Indeed, premature or intrusive attempts by well-meaning adults to try to establish a close relationship in order to influence the child's behaviour are likely to prove counter-productive. They are more likely to evoke distancing behaviours in the child and to upset the fragile balance between inadequately controlled aggression/impulsivity/anxiety and the child's already inadequate controls over these powerful feelings.

PREVENTION OF ATTACHMENT DISORDERS

Anything that can support the secure attachment of infants to their caregivers will decrease the numbers of infants and children who are attachment-resistant. In particular, anything done to help high-risk mothers to be able to respond sensitively to the physical and emotional needs of their infants will decrease the risk of their infants being so repeatedly frustrated that they give up on their mothers as a source of security [1]. Mothers whose own needs were consistently poorly met by their own parents are often, because of their unresolved attachment issues, at greater risk for not being able to provide the involved, sensitive caregiving that infants need to form secure attachments (Main & Hesse, 1989). A satisfying long-term relationship with a parental surrogate or mentor, a stable and supportive relationship with a marital partner, and a good long-term experience with a social worker or psychotherapist, can all reduce the likelihood of the mother repeating the cycle of maltreatment in the next generation (Egeland & Erickson, 1990).

The greater the stress experienced by the primary caregiver during the critical period for attachment - whether because of social factors (e.g. poverty; housing conditions; family conflict) or because of psychological factors (e.g. postpartum depression or other intrapsychic liabilities) – and the fewer the supports available to counteract these, the greater the risk that infants' capacity for attachment may be undermined. "One major study has shown that a home-visiting program for psychosocially disadvantaged first-time mothers can reduce the rate of child abuse and neglect by almost half (Olds, Henderson, Chamberlain, & Tatelbaum, 1986; Olds, Eckenrode, Henderson, Kitzman, Powers, Cole et al., 1997). Several more short-term interventions for mothers having trouble interpreting and responding appropriately to their babies' cues are also

[1] In Canada, it is almost always mothers who serve as the primary caregivers for infants and toddlers. The absence of a partner, or ongoing interaction with a partner who is distant and/or abusive is likely to undermine further the high-risk mother's ability to parent sensitively and effectively. Having an involved and caring father can help protect the normal development of infants whose mother's capacity for sensitive attunement is seriously compromised.

reporting promising results (Andres, Stroud, Moore, & Pepler, 1996; Muir & Thorlaksdottir, 1994; Egeland, Erickson, & Wattenberg, 1998). It is important to identify such situations and begin interventions early, since it has been demonstrated that, given continued exposure to maltreatment between 12 and 18 months of age, up to half the infants who were securely attached at 12 months have slipped into insecure and avoidant patterns of attachment by 18 months (Schneider-Rosen et al., 1985). For this reason, it is important to support biological parents in meeting their babies' needs whenever possible. At the same time, it should be recognized that some parents are so damaged by their cumulative life experiences that they are incapable of providing the sustained, sensitive attention and nurturing that infants require for optimal development. This is important to take into account, since wrap-around treatment and family preservation programs are currently being vigorously promoted, at times without sufficient recognition of their limitations (Savoury & Kufeldt, 1997). We must bear in mind that a failure to recognize when intensive attempts to support parenting are not succeeding risks leaving young children far too long in a neglectful or abusive family that continues to undermine their capacity for attachment, for self-regulation, and for cognitive and language development (Cameron & Budgood, 1990; Pecora, Fraser, & Haapala, 1990; Cohn, 1980; Wells & Tracy, 1996). For this reason, a rigorous, critical and ongoing evaluation should be a required component of all wrap-around and family preservation programs[2].

PREVENTION OF ATTACHMENT DISORDERS BY CHILDREN'S AID SOCIETIES

Because of space limitations, only three of the most important ways that Children's Aid Societies can prevent the development of attachment disorders will be discussed at this point. For a more detailed discussion of the topic, the reader is referred to *Children in Limbo*, which describes in detail how professionals in the (a) child welfare, (b) children's mental health, and (c) family court systems, can minimize the number of children who first slide unnecessarily into limbo and then, if allowed to remain in limbo too long, slide further into attachment disorder (Children in Limbo Task Force, 1996).

In times of economic constraints, financial support to CPS agencies is reduced. The result is cutbacks in community programs and increases in caseloads for CPS workers. The resulting dilution of response capacity, when combined with the accompanying constantly increasing need for service, leads many Societies to raise the threshold of abuse or neglect that they require in order to intervene. The same pressures at times also contribute to children being returned by Societies, even to parents who are known to be at best ambivalent, if not neglectful and rejecting. In addition, the tendency in most jurisdictions to give the autonomy of the family priority over the safety, development, and well-being of children is one that predisposes to the development of attachment disorders. Frequently infants, when first apprehended and placed in an adequate foster home, show only minimal upset, rapidly settling down and giving up their symptomatic behaviours. All too often, however, their emotional and behavioural symptoms recur soon after they are returned a few months later to a natural family whose ability to parent them remains

[2] See chapter entitled: "When Should Children Be Removed From Their Families and Taken Into Care?"

unimproved. Within months, the same child is often readmitted to care, usually to a different foster home, since the place in the previous foster family is now usually filled, this time showing behaviour that is more disturbed. On this admission, the child takes considerably longer to settle and to begin forming a relationship to the second set of foster caregivers. Nevertheless, in time the child generally settles, only to be returned again to a family whose attitudes and parenting remain unchanged. With each subsequent admission, the child seems more distressed and exhibits more disturbed behaviour. It is often clear that the child has lost the gains made in the previous foster placement, takes longer to settle into the new foster home, and is more guarded and resistant when it comes to relating to each new set of foster caregivers. Eventually, and often well before the age of five years, many such children show the manifestations of a resistant attachment, to the point where they can no longer be contained or have their needs met even by an experienced foster family. By this time, such children typically show many of the behavioural patterns summarized in Figure 1, are incapable of responding to the foster caregivers' attempts to nurture them, and behave in ways likely to precipitate repeated rejections. Thus, CPS workers can prevent the unnecessary development of attachment disorders by promptly, carefully, and systematically assessing parenting capacity. Such an assessment involves determining the strengths and weaknesses of the current parenting. It also includes the setting of explicit goals to monitor whether the parents' ability has changed sufficiently while their child is in care to meet at least the minimal developmental needs of their child (Steinhauer et al., 1995). The literature clearly demonstrates that returning foster children to parents who do not meet this standard regularly results in the loss of any gains that they have made while in care, while increasing the likelihood of their bouncing back into care – and into limbo – in the near future (Rzepnicki, 1987; Wald, Carlsmith, & Leiderman, 1988; Wolf, Braukmann, & Ramp, 1987).

THE ROLE OF INCLUSIVE FOSTER CARE IN PREVENTING ATTACHMENT DISORDERS

Agencies that take infants or toddlers into care can also minimize the risk of their developing attachment disorders by ensuring that, as long as there is a realistic possibility of their being returned to their birth family by the courts, their primary caregiver visits them and participates in their care at least two or three times a week. The purpose of this is to encourage the child to form attachments to both the birth parents and the foster caregivers. The rationale for this is that, if the birth parent does not regularly participate in the child's care, young children will, within weeks, form an exclusive attachment to the foster caregiver. Should the court then decide to return the child to the birth parents, the child will be forced through yet another and, this time, unnecessary separation. Such children will lose the foster caregivers, who have become their psychological parents (and, thus, the basis of their security), when they are returned to their birth parents. The latter, by this stage, though biologically related, have been allowed through agency indifference to be forgotten by the infant and have become, psychologically speaking, strangers to the child (Steinhauer, 1991).

DOES PSYCHOTHERAPY HELP ATTACHMENT-RESISTANT CHILDREN?

Because of the magnitude of distress experienced by attachment-resistant children, and the disturbing effect of their acting-out behaviours on others, child welfare workers refer many such children to the mental health system for psychotherapy or residential treatment. Such referrals, however, can do more harm than good, since they can shift the agency's focus away from the need for CPS to move aggressively to remove the child from limbo by implying that the child's distress and disturbing behaviours are being adequately addressed by resolving the child's internal problems through therapy (Children in Limbo Task Force, 1996). What children in limbo need most is not therapy, but to be freed for the permanent placement best suited to their needs.

Many attempts at psychotherapy (including play therapy) with such children, especially therapy by relatively inexperienced professionals who focus heavily on the child's relationship to the therapist, or who attempt to explore the child's feelings of abandonment early in the therapy, are contraindicated for children with attachment disorders. Rarely will once or even twice weekly psychotherapy prove helpful to such children. Because they are attachment-resistant, they tend to distance themselves from the therapist, making the formation of trust and a therapeutic alliance unlikely. Also, unless their therapist can adapt the therapeutic process to a format compatible with the special needs of the attachment-resistant child, psychotherapy is likely to intensify the child's acting-out rather than to succeed in working through the child's conflicts (Steinhauer, 1993; Rosenfeld et al., 1994). This is because such children usually lack the impulse control and the capacity for relationship that are prerequisites for successful psychotherapy (Steinhauer, 1991, pp. 260-64). As a result, such therapy may increase the pressure towards a placement breakdown or may necessitate removing the child from therapy, either of which the child is likely to experience as yet one more failure and/or abandonment.

The helpful therapist will understand that he or she can best assist such children by supporting the developing relationship with the caregiver, not by developing an alternative to that relationship in the therapy room. A more focused and reality-based form of psychotherapy that first helps children identify and then validates what they are feeling, along with helping them learn to express their feelings verbally, may help them avoid having to repeat the past by evoking rejection and abuse from others. Such treatment would, for example, focus on helping them recognize what they were feeling and learn to express it in words, instead of acting the feelings out. At the same time, it would take care to de-emphasize the relationship with the therapist and to avoid distracting the agency from what should be its primary goal – getting the child out of limbo (Steinhauer, 1996). In such cases, it is crucial that there be good communication between the child's therapist and the caregivers, since one of the most useful aspects of the therapy may be its ability to support the child's relationship with the caregiver. It can do this either by providing a forum for the child to explore the meaning of that relationship in a neutral setting, by providing information about how the relationship is progressing, and/or by helping the caregivers understand and empathize with the behaviour and feelings of the child, thereby helping resolve impediments to progress. Nevertheless, one-to-one therapy will remain a relatively minor part of what such children need. It is the long-term corrective emotional experience of well-trained and

adequately supported caregivers that has the best chance of helping attachment-resistant children develop the capacity to trust and relate.

OPTIMAL MANAGEMENT OF ATTACHMENT-RESISTANT CHILDREN WITHIN THE CHILD WELFARE SYSTEM

It goes without saying that the best management of attachment disorders, wherever possible, is to prevent their development by minimizing the amount of time that children are left unnecessarily in limbo. When this is not possible, however, it is important to recognize the attachment-resistant child as early as possible, in order to avoid the cycle of multiple placement breakdowns that compound the child's mistrust and sense of alienation. Each successive breakdown is experienced by the child as yet another failure and rejection as, eventually, even experienced foster caregivers prove unable to tolerate the pervasive distancing and behavioural symptoms of the attachment-resistant child. Thus, the sooner the underlying problem is identified, the sooner the CPS can adapt its care to meet the special needs of the attachment-disordered child (Cicchetti & Toth, 1995).

To the best of our knowledge, there are no randomized, controlled studies dealing with the treatment of attachment-resistant children. Based on our reading of the literature and our clinical experience, the authors would suggest that once an attachment disorder is diagnosed, the first goal of management is to stop that child from being passed from placement to placement. This means stabilizing the child as soon as possible in whatever placement is realistically considered most capable of retaining the child long enough to allow her to overcome her mistrust sufficiently to test the waters of trusting within a relationship. This can occur either within a highly specialized treatment-oriented foster home or in an equally specialized staffed setting. Very few foster families or staffed settings can tolerate and remain emotionally involved with attachment-resistant children long enough to sustain their placements. Usually, somewhere around the two-year mark, those who have the capacity to do so begin forming a tentative attachment to them. Without understanding the special needs and problems involved in dealing with attachment- resistant children on a day-to-day basis, and without the ongoing support of informed and well-trained mental health professionals, most placements of attachment-resistant children break down, usually within a few months. The expectation of being part of a family regularly evokes distancing behaviours in the attachment-resistant child.

PREREQUISITES FOR THE SUCCESSFUL MANAGEMENT OF ATTACHMENT-RESISTANT CHILDREN

There are a number of factors that characterize all settings capable of successfully meeting the needs of attachment-resistant children. These include:

- The caregivers have access to regular relief from the strain of constantly caring for the attachment-resistant child. Without regular relief, staff or foster caregivers are likely to lose the objectivity and sense of perspective essential for effective management. In staffed settings, this relief is built in through regular shift changes. In treatment foster care, it is best supplied by establishing an "extended family" group of treatment foster homes, where members of the family of foster homes who are all dealing with attachment-resistant children regularly provide emotional support and relief for each other, often on an informal basis, and the children get the sense that they are a part of a system of care, not just of a single foster family.

- The caregivers, whether foster caregivers or staff, are in control of the emotional distance between the child and themselves. It is common, at first, for many of those caring for attachment-resistant children to attempt to rescue them by trying to draw them into a relationship through excessive caring. But attachment-resistant children see such attempts as intrusive and threatening. They typically respond to them by withdrawing, running, or by evoking punitive and rejecting responses from their caregivers, which then confirm their own internal working model (i.e. expectations) that sees all adults as manipulative, punitive, and rejecting. If the caregivers do become punitive or rejecting, or if they begin to wall themselves off emotionally in order to protect themselves from being hurt, the child will perceive them as being disinterested, rejecting, and unreliable. Initial attempts at engaging these children usually fail, and it is the caregivers who are able to examine their contribution to the failure who are most likely to learn to be successful in the long run. For these reasons, the proper control of distance is crucial to the success of such placements. The importance of informed, regular, and sufficient supervision will be critical to keep the caregivers from burning out.

- Unless the caregivers have sufficient sources of satisfaction in their personal lives, they are unlikely to be successful with attachment-resistant children. The placement is likely to be in trouble if the caregivers need to rely upon success with the child in order to maintain their own sense of well-being and self-esteem. Unless they can tolerate losing many battles, they are unlikely to win the war for the child's trust. Caregivers who need the child to come through for their own personal reasons are likely to put too much pressure on both the child and themselves, thereby undermining the therapeutic process.

- To be successful, caregivers have to understand what it means that the child is attachment-resistant, and why attachment-resistant children behave as they do. Only if they realize why such children need to distance – and reject – them repeatedly will they have a chance of interpreting this behaviour as part and parcel of the child's disorder, rather than taking it as a personal rejection or as a sign that they have failed. They need to understand this both intellectually and emotionally, in order to be able to avoid being defensive when friends, family, and teachers make them feel responsible for the child's misbehaviour, or treat them as if it is their inadequacy that is making the child behave as he does. Only if they recognize that they are not personally responsible will they be free to advocate successfully for the child and to help others avoid personalizing the child's behaviour.

- At the same time, caregivers of attachment-resistant children must be aware of their own personal responses to the child and how these may be affecting the child's behaviour. A child who comes to a family or a group setting so impaired is usually extremely disturbing to others. Attachment-resistant children have an almost uncanny ability to press the buttons that set off the unresolved issues of their caregivers. Just as it is important that the caregivers refrain from taking responsibility for the behaviour of the attachment-disordered child, it is equally important that they not hold the child responsible for the inevitable times when they will temporarily lose perspective. Everyone dealing with attachment-resistant children loses perspective at times. It is the ability to recognize and discuss this when it is happening that is the key to successful treatment.

- For this reason, caregivers must be open enough that they can put on the table issues that they did not handle well, feelings of frustration, discouragement, rejection, inadequacy, and competitiveness, or tendencies to rescue the children in their care. At the same time, they must have available to them supervisors and consultants who have both the specialized knowledge of how attachment-resistant children behave and feel and the ability to help the caregivers retain their objectivity. It is much easier to be objective from a distance; we can always see better the traps someone else has fallen into than the ones that we have fallen into ourselves.

- In order for this to occur, the supervision must be sufficiently mutually empowering that it is safe for caregivers to acknowledge a mistake. Much of the supervision will probably occur in groups, with caregivers assisting each other as well as being helped by supervisors and consultants. Understanding the child and his needs must always take precedence over anyone's – including supervisors' or consultants' – need to be right. Supervisors and consultants need to be able to discuss examples of times when they were confused or wrong, instead of implying that it is only the caregivers who are ever less than brilliant.

Other personal qualities that are enormous assets in work with attachment-resistant children include a sense of humour, patience, and the ability to live with uncertainty while generating and testing out hypotheses that may improve understanding. The capacity for true empathy that allows the caregiver to behave like the Sun rather than the North Wind is also crucial.[3] Without these conditions, it is unlikely that any setting – be it therapeutic foster home or a specialized staffed residence – will be able to provide both the quality and the continuity of care that attachment-resistant children need to begin trusting again. The demands and frustrations of

[3]In Aesop's fable of *The North Wind and the Sun,* the North Wind and the Sun were arguing about which of them was the more powerful. Looking down and seeing a lonely traveller with a cloak, they decided that the one who was able to make the traveller take off his cloak first was the more powerful. First it was the turn of the North Wind. He blew up a gale, but the harder he blew, the more tightly the traveller wrapped the cloak around his shoulders. Then it was the Sun's turn, and he began to shine. The more he shone, the warmer it became and, when the traveller felt ready, he removed the cloak from his shoulders of his own accord. This fable is a useful metaphor for all therapists, but particularly important for those of attachment-resistant children. We cannot "make" others attach; we can only establish the conditions that encourage them to feel safe enough to give trust and relationships with others another chance.

caring for such children are considerable and, unless there is a significant investment in staff training and support, caregivers are likely to burn out and give up on the children and demand their removal. Without such an investment, the continuity that was the primary goal of the placement is likely to be undermined, and the child is being set up by the system to fail yet again.

CAN ONE MAKE AN ATTACHMENT-RESISTANT CHILD ATTACH?

The goal of such a setting is to provide the "good-enough caregiving" that, over time, will prove secure enough to induce the child to begin forming an attachment to at least one of the caregivers. One cannot manipulate or coerce a child who is attachment-resistant to form an attachment. All one can do is provide the conditions in which the more resilient or least damaged attachment-resistant children will, after years of distancing, feel enough trust in the milieu to allow themselves to risk becoming involved with an adult again. Often such children show signs of trusting another child in the home considerably before they begin trusting one of the caregivers. If they do begin to show signs of allowing one of the adults to become special to them – i.e. if an early attachment is indeed formed – this will be clear by the child's having selected someone from the treatment milieu. This will be either a worker or foster caregiver particularly responsive to the child's needs or someone with obvious power in the milieu who suddenly is treated by the child as if he or she is "special". How to know when this is occurring will be described below but, when it happens, the child's symptomatic behaviours are likely to improve. This improvement, however, is not initially internalized and remains highly dependent upon the availability, continuity, and ongoing management within the tentatively formed new attachment relationship.

THE TWO STAGES OF TREATMENT FOR ATTACHMENT-RESISTANT CHILDREN

Ideally, in such a milieu, there are two distinct phases in the treatment. The child moves from the first, the stage of containment, to the second, the stage of treatment, only when it is clear that she has already selected some adult in the milieu as special and has begun to form an attachment to that person.

During the stage of containment, the milieu makes no real attempt to probe the child's feelings or resolve underlying conflicts. Rather, the goals of this stage are:

a) To contain the child in a predictable and safe setting in which he will neither hurt nor be hurt by others;

b) To become increasingly aware of the child's particular ways of expressing his needs that will enable the caregivers to serve as the "good enough" caregivers that the child has never yet experienced;

c) To use behavioural interventions in a non-punitive way to help the child learn the rudiments of social behaviour and to recognize the way others usually respond to his behaviour;

d) To establish that, in this setting, everyone is safe, since everyone's needs are valued and protected by the milieu.

Given continuous exposure to such a milieu, many such children, usually though not invariably in their second or third year, will begin to form a special (i.e. early attachment) relationship with one or more of the caregivers of their own choosing. The older the child, the longer the exposure to severe neglect and abuse, and the more deeply entrenched the child's mistrust of and hostility towards adults, the longer it is likely to take. It is when they are beginning to form an attachment that their behaviour will improve exclusively for that chosen person. They will also begin to spend more time with that person, to check on the whereabouts of that person when he or she is away, to modify their behaviour and even accept limits or demands in a way that they would not for other adults or caregivers. They will continue to pursue their relationship with their chosen care-giver even when he or she frustrates them, and may show signs of missing and/or being angry at him or her during any periods of absence (i.e. on vacation; off shift for a few days). These behaviours, taken together, indicate that the chosen staff member has been invested with special importance by the child, who is beginning to form a tentative attachment with him or her.

Once it is clear that such a child has selected some adult to be her attachment "partner", the second stage, the stage of treatment, begins. Now, for the first time, it may be possible to begin to explore with the child how hard it was to allow herself to trust. At this point, for the first time, it may be possible to explore the origins – and the effects – of the feelings of deprivation, mistrust, and rage that have, for so long, distorted her feelings and relationships, without the attempts to do so having explosive results. From this stage on, others in the milieu can follow the lead of the child's chosen therapist/partner, hoping that in time the child's trust will generalize to include other adults also seen as caring and trustworthy.

WHAT HAPPENS IF AN ATTACHMENT-RESISTANT CHILD FORMS AN ATTACHMENT ONLY TO BE MOVED AGAIN?

If the treatment setting interprets the child's behavioural improvement as evidence that the child no longer requires "treatment" and discharges her, the child is likely to become even more angry and mistrustful than she was before. Having been seduced by the milieu into overcoming her fears of closeness enough to take the chance of caring about and trusting another adult, she interprets her discharge, regardless of the way it is explained to her, as evidence that once again she has been betrayed. Some children with attachment disorders who spend lengthy periods in residential treatment centres or therapeutic foster homes do settle down symptomatically after about 18-24 months. But those children soon lose their behavioural gains and often become worse if the setting, failing to appreciate that it was the developing attachment, not the "treatment", that was making the difference, discharges them.

It should be obvious from the above that if the child is discharged from the therapeutic milieu at this point, for reasons either of cost or of institutional convenience, much if not all of the trust that has been established will be undone. Children who have been wooed back into a strategy of trusting others after years of pervasive mistrust are extremely likely to regress if forced to move on for institutional reasons. For this reason, programs that are responsive to the needs of attachment-resistant children must be prepared to allow them to remain within the relationship and setting that they have learned to trust until they reach maturity. Given the security of knowing they can stay, some will be discharged from the setting when they have demonstrated that they are ready to move on, for example to a birth family whose gains have paralleled their own, or to independent living for which they have been adequately prepared and given the option of a continuing visiting relationship with those whom they have learned to trust.

It is at times administratively tempting to reclassify such children who have done well for a sustained period of time as no longer in need of a therapeutic component to their placement, for example, by changing them from a "treatment case" to a "regular foster child" while protecting the child's place in the milieu with its extended family of relationships. We would advise against reclassifying such children since, no matter how carefully one manages the transition, the change in status sets up expectations – and pressures – within caregivers, child, and agency – that place the still vulnerable relationship in jeopardy. Even after they have formed an attachment, attachment-resistant children remain quite needy, especially under the pressure of new developmental tasks. At such transition points, relationships need to be reconfigured and children are therefore at heightened risk. Access to support, supervision, information, and a supportive check on the caregivers' objectivity will again become as necessary as they were during the earlier phases of the child's treatment before the attachment was formed. The difference at this stage is that such regressions are shorter and more easily resolved. For this reason, we would suggest that such children and their caregivers will always require a support team around them, although they will not always utilize it to the same extent.

For those attachment-resistant children who never reach the point of forming an attachment bond – for those for whom moving from one setting to another remains similar to what the average person experiences in moving from one hotel room to another across the hall – it is obviously less important to preserve the continuity of the child's placement. Never having put down roots in the therapeutic milieu, such children have far less to lose if they move on, but, for them also, the greater the continuity experienced, the better their level of function is likely to be.

The task of preparing attachment-resistant children for independence is not standard and requires considerably more planning, time, patience, separation, support, and rehearsal than is needed for less disturbed children. Such children may need to be walked through many of the situations and tasks that they will have to assume when independent and may struggle against the attempt to prepare them for independence as if it were a rejection. One needs to establish carefully a balance between backing off – when the movement towards independence is too anxiety-provoking – and returning to the task, when the next opportunity presents itself.

TWO MODEL PROGRAMS THAT HAVE BEEN SUCCESSFUL IN MANAGING ATTACHMENT-RESISTANT CHILDREN

Here are two examples of programs that have been successful in treating attachment-resistant children, in order to give a picture of two different models in operation:

A) The Tri-County Treatment Foster Care Program[4]

This program was originally established in 1989 by three neighbouring Ontario Children's Aid Societies as a two-year residential treatment option designed to meet the needs of children who would normally be referred to staffed group homes. The clinical model involved variations of learning-based techniques. The results of the pilot study (Osmond, 1992) were promising and consistent with other similar studies of treatment foster care, in that these children were retained within the foster care system at considerably reduced cost while achieving a high degree of satisfaction within each of the Societies involved (Rubenstein, Armentrout, Levin, & Herald, 1978; Steinhauer et al., 1989; Peters, Bernfeld, Petrunka, & Coulter, 1994; Meadowcroft, Thomlinson, & Chamberlain, 1994). During the pilot study, children were discharged from the project either to their birth families or to other forms of foster care.

Results on a standardized measure of child functioning were equivocal. While children with externalizing (e.g. conduct) disorders made significant progress, those with internalizing disorders (e.g. those primarily anxious and depressed) actually became worse over time. A later analysis revealed that children with internalizing symptoms were largely female victims of sexual abuse. This led the leaders of the project to seek a less program-focused and more child-centred approach to treatment, eventually leading to the publication of the program's response to sexually abused children (Osmond, Durham, Leggett, & Keating, 1998).

Two more years of study established that children who had made significant behavioural gains within the program subsequently experienced breakdowns in their post-discharge foster home placements. Attempts to avoid this by improving management of the discharge transition and by increasing support to their subsequent caregivers were unsuccessful. Finally, project leaders consulted specialists on childhood attachment and began the long journey that led to understanding attachment-resistant children and the management strategies that work with them. It became clear that such children are best served not by discharge into "less intrusive" settings, but through maintaining them to maturity in specialized, highly supported forms of foster care (Steinhauer, 1991, pp. 258-282).

From this philosophical shift, a relatively sophisticated foster-family-based residential treatment response eventually evolved, incorporating the key concepts detailed in this chapter. Clinical experience – that is, reports of the program's foster caregivers, staff, and

[4]The Children's Aid Societies of Durham, Northumberland, and Kawartha-Haliburton were the three societies that sponsored the Tri-County Treatment Foster Care Project.

consultants, a decrease in placement breakdowns, and significant behavioural, emotional and relationship changes in the children over time – have suggested that the resulting model is effective in working with attachment-resistant children.

Foster families are recruited from among successful foster-care providers in the traditional foster care system on the basis of their personal characteristics (sense of humour, tolerance, determination, ability to make use of learning, stress management skills, among others). Once recruited, they are trained in the theories and techniques of child treatment, which helps them understand and respond to the child's presenting behaviour.

These care providers receive weekly clinical supervision from a worker who provides an opportunity for debriefing, specific management suggestions, and supervision of the implementation of clinical strategies and programs adapted to the needs of each child. The supervisory element is key, in that expertly guided practice building upon formal learning ensures that the caregivers remain motivated, responsive, and in control of their day-to-day milieu. Workers have small caseloads (1:8) to accommodate the intensity of support required and to meet other case management objectives.

Other supports include: (a) 24-hour access to a clinical hot-line; (b) relief at least once a month, and more frequently if needed; (c) attendance at a monthly support group; (d) long-term supportive relationships with treatment foster care peers; (e) reasonably responsive access to clinical services (e.g. assessment; psychotherapy); (f) the capacity to provide practical supports to school personnel and/or access to special school placements or contract workers in the school when needed. In some ways, the TFC environment could be seen as the "ideal" way in which to deliver all foster care services.

Supporting each placement is a multidisciplinary clinical team with representatives from psychiatry, psychology, behaviour therapy, social work, as well as child and youth workers. Members of some of these disciplines are available on contract as consultants, while the social worker and child care staff are full-time positions. The team orientation is towards an open model of practice, with frequent reviews by specialists in the areas under question. A team approach to assessing and planning for children is taken, and the culture stresses striving to perfect one's clinical work. The impact of such a culture has been to keep staff and caregivers highly motivated in the face of the inevitable difficulties that caring for attachment-resistant children involves. More importantly, it has led to the development of a working style that keeps the needs of the children as a constant priority, while encouraging and supporting the caregivers/staff team to look for creative and adaptive solutions to child behaviours that might otherwise invite rejection. Staff identify the synergy between the various roles, the individual expertise of the program staff, and the contributions of the program's consultants as essential to successfully serving attachment-resistant children within a family-based model.

Another key element is the clinical coordination role provided by the support team (in collaboration with the children's child welfare workers) which focuses on getting children out of limbo. This involves: (a) providing assessments to define the child's needs and the

parents' capacity to reach the point of meeting those needs; (b) actively working with the child's family to resolve conflicts and develop a plan for meeting both the child's and the family's goals; (c) enlisting parental cooperation through forms of inclusive foster care or "shared parenting" (Steinhauer, 1991, pp. 158-72; Kufeldt, 1994; Palmer, 1995); (d) assisting parents and child to achieve the optimal level of connection by clinically managing family work and access visits (Mallucio, Warsh, & Pine, 1993; McCart, Hess, & Ohman Proch, 1988). The more these services are provided, the more effectively issues keeping the child in limbo can be dealt with, without relying exclusively on the court to make key decisions. When court decisions are needed, the collective expertise of the clinical team makes possible more thorough and effective presentation to the court of caregiver information, family assessment material, and expert interpretation of the meaning of observations and the needs of the child. This also reduces the length of time in limbo.

The main objective of the TFC program is to provide, as early as possible, the optimal conditions that are required by attachment-resistant children before they can take a risk on trusting adult caregivers. A second goal is to maintain these conditions long enough to allow the children to begin to form attachments. Optimally, signs of attachment begin to appear within eighteen months of placement. In the most severe cases, especially where both evidence of abuse and cognitive limitations exist, it can take several years for the child to trust enough to begin to form a tentative attachment. Sustaining the energy and commitment of the caregivers over such a long and often frustrating period, often without appreciable evidence of progress for long periods, has been a key factor in the development of the model.

Since 1989, lessons learned through the TFC experience include:

(1) The techniques and priorities identified earlier in this chapter are as important in a family-based model as in a staffed setting. However, to implement those techniques successfully requires a long-term commitment to supporting the developing caregiver/ child relationship as a paramount objective. Doing "whatever it takes as long as it takes" is both a hallmark of successful treatment foster care (McCart et al., 1988) and of family-based treatment with attachment-resistant children.

(2) Attachment-resistant children appear to respond best to a neutral, instructive stance that makes few emotional demands while demonstrating an active interest in the child's experiences, beliefs, and perceptions. A form of "running commentary" helps put the child's experiences into words and reflects on how those experiences may be impacting on the child. Foster caregivers can be taught to offer such reflections, which both help the child identify his feelings and serve as a model for verbalizing rather than acting them out. Such a commentary also helps the child understand his current reality in a way that offers both child and caregiver a sense of hope for the future.

(3) The third critical factor is time – up to three years, or even more, of careful, responsive daily care. Generally speaking, the earlier the attachment problem is

identified, the better the prognosis for a successful later adjustment. Younger children have had fewer years of reinforcement of self-defeating internal working models, fewer placement breakdowns, and more time in a safe, attuned, and predictable setting. Many older attachment-resistant children and teens can be maintained in a TFC model if their behaviour responds to a behaviour management approach. For attachment-resistant children, a reasonable goal of care is to develop an affiliation with a caregiver that will sustain the child through later stages of development and prepare her for successful independence.

(4) The facilitation of an attachment relationship is not the only goal of placement, but it is the first one. The development of an attachment offers the child an important relationship opportunity that can sustain him while he begins to work through the results of past maltreatment and abandonment. It also provides an antidote to his expectations of only rejection, manipulation, neglect, and abuse from adults that, in a less sensitive milieu, often become a self-fulfilling prophecy.

(5) Placement breakdown is always possible when dealing with family-based care, and sometimes acts as a compelling reason to choose group care over family-based care. Life circumstances change and family relationships alter. The TFC program has even had to deal with the death of a caregiver. However, protection against the loss of key relationships can to some extent be mitigated by setting up a "community of caring". Children can derive comfort and security from the working together of their caregivers, other caregivers in the network (both informally and through the provision of relief), and the clinical support team. Where possible, the inclusion of the birth family in the child's world is another way to offer protection against potential disruptions (Cantos, Gries, & Slis, 1997).

(6) A professional culture of open practice focuses on the refinement of one's own practice contribution rather than finding fault with the work of others. Regardless of the model of care, successful treatment of attachment-resistant children requires an effective and open working together by both child welfare and children's mental health professionals. Rarely, if ever, can either service system help these children succeed without the help of the other.

B) A Staffed Group Home Model

Between 1964 and 1979, the first author served as a consultant to a specialized group home established by the Executive Director of an Ontario Children's Aid Society to accommodate four teenage boys. Each of these boys had previously spent between two and four years in a long-term residential treatment centre and, within seven months of their discharge from the treatment centre, had proceeded to provoke rejection by no fewer than three foster homes. Recognizing that he had no foster homes that could contain those boys, each of whom clearly had an Attachment Disorder, yet determined to provide for them a home that they could call their own and a sense of stability and predictability, the

Executive Director purchased a home in a subdivision and installed the boys in it, staffing it initially with an idealistic young minister and his wife. They agreed to do their best to care for the children and to implement the prescribed therapeutic milieu, and were given extensive teaching, supervision, and support by the Society. By the end of six months, it was already clear that, despite their best intentions, the couple was beginning to withdraw emotionally from the boys in order to protect themselves. Also, by that time, the group home supervisor and the psychiatric consultant recognized that they were holding back from demanding of the foster caregivers the level of self-examination and commitment to change that they considered critical in order to keep the therapeutic milieu attuned to the boys' needs. For that reason, instead of waiting for the foster caregivers to burn out and the arrangement to break down, a decision was made to shift to a staffed model of care. The thought was that, if at some point in the future we were to lose another key person, the boys would never again be faced with the loss of all their caregivers at the same time.

With that in mind, we hired from the local newspaper a housemother – a 60-year-old retired practical nurse with no mental health training – and two certified Child Care Workers to be on call from 3:00 to 10:00 p.m. every day and all day during the weekend. We supplemented these by university students carefully selected for their sensitivity, idealism, and eagerness to learn. Our goal was to create a staffed milieu that would be as responsive as we could make it to the individual needs of each of the four boys – later it increased to six and seven boys and girls – placed in the group home.

To do this, we intuitively invested heavily in staff training and support. The group home had its own supervisor and I, as the agency's psychiatric consultant, spent one hour weekly with the staff and one hour biweekly meeting with the children and the staff together. I also made myself available to back up the staff by telephone in emergencies. I believe that it was as a result of this emphasis on staff training and support that we were able to ensure continuity by keeping the house-mother, who was strongly committed to the program but minimally psychologically minded, for 14 years, and the Child Care Workers for 11 and 9 years respectively. At the same time, the staff were providing a milieu that was as sensitive to the needs of attachment-disordered children as any the psychiatric consultant has encountered in thirty-six years of work in the child welfare field, regardless of model.

Years later, when inspecting what were labeled some of the top facilities in England and Israel for impossible (i.e. delinquent) children and youth, several other facilities that provided a similar milieu for the same type of children were discovered. The Director of one of these articulated for the first time in a coherent way the theoretical rationale underlying what the staffed group home had developed intuitively (Balbernie, 1966; Balbernie, 1974). There are undoubtedly other settings that provide a similar milieu for attachment-disordered children, but what needs to be conveyed through this example is that:

(a) For attachment-resistant children, a properly staffed setting should not necessarily be seen as a last resort. In some situations it may be the treatment of choice. The time to place a child with an attachment disorder in a specialized milieu is as soon as the child's

attachment resistance is recognized, as the attachment-resistant child is likely to provoke rejection after rejection in the average foster home unless it is supported by the quality and level of support and education described above. Placing such a child in a suitably staffed and supervised setting may spare that child many unnecessary rejections and stabilize him or her by making possible the continuity that is a prerequisite for effective intervention (Hanegbi, 1971).

(b) Such settings, provided the continuity and sensitive attunement of the staff are given the highest priority, may be better suited to the needs of some of the more disturbed and disruptive attachment-resistant children than family settings.

(c) Not all the children in such a staffed setting need be of the same age or sex. Indeed, the children often experiment by forming their first tentative attachments to younger or older house-mates and by carefully observing how the staff are relating to others before they themselves are ready to risk an emotional involvement with any of the staff. Also, the influence of the peer group in such a setting may be an important source of social re-education (Feuerstein, 1971).

(d) For such a setting to provide the "good enough" caregiving, with the necessary sensitivity and continuity of staff that are critical to the effectiveness of the milieu, giving a high priority to the support and professional development of the staff becomes both a practical and an ethical imperative.

(e) Any adults who acquire meaning to the child involved – parents, former foster caregivers, teachers, athletic coaches, etc. – are incorporated into the child's plan of treatment in whatever way best suits the needs of the child.

(f) Children are not discharged from the staffed group home after an arbitrary time period or for systemic convenience. Such programs must be committed to maintaining attachments that form within the program, unless it is in a particular child's best interests to move elsewhere. While some children from the program being described were gradually reintegrated within their birth families, most remained in the program for years, until they had been prepared for independent living. After discharge, many of them maintained a visiting or telephone relationship with the group home staff, gradually attenuating it over time as the need to maintain the affiliation became less compelling.

LIMITATIONS OF THIS CHAPTER

This chapter has three major limitations. First, the models we are proposing as the basis for the management of attachment-resistant children within the child welfare system have never, to our knowledge, been empirically tested using quantitative measures. As a result, our recommendation of these models of intervention is based largely on clinical experience and anecdotal reports. To this objection, we have no adequate answer, other than to suggest the need

to design and carry out randomized controlled studies to evaluate the effectiveness of these and other approaches to caring for attachment-resistant children. The literature on the similarly staffed Youth Aliyah children's villages used in Israel to deal with a variety of children and youth, 80% of them from a disturbed family and social background, and that of the Youth Communities of the SOS Children's Village Association, have also demonstrated the usefulness of a staffed group model, but neither, to our knowledge, has proved its effectiveness using a randomized controlled design (Feurstein & Krasilowsky, 1971; Arieli, 1972; Kashti & Arieli, 1986; Wollensack, 1988). The successful treatment of severely disturbed foster children, many of whom would presumably be attachment-resistant, in treatment foster care has also been described (Fine, 1993; Rosenfeld et al., 1997; Rubenstein et al., 1978). The Chedoke-McMaster Parent-Therapist Program did confirm that treatment foster care was, at significantly less cost, as effective as residential treatment in providing family-based care for emotionally disturbed children unable to remain at home and unlikely to be managed within the regular foster care system (Rubenstein et al.) However, while the Chedoke-McMaster program was empirically sound, it is not clear how many of its children were attachment disordered. Also, since it was designed essentially as a time-limited alternative to residential treatment for severely disturbed children, it is not completely comparable to the TFC model described in this chapter.

Second, there are the widely held opinions – we consider them biases – that a family placement is always better suited to the needs of preadolescents than a staffed one and that a staffed setting must, by definition, be institutional and impersonal. We believe that it is the sensitivity and continuity of the caregivers in the milieu and its ability to meet the characteristics described earlier in this paper that is most important, not whether it is family-based or staffed. While some jurisdictions may best be able to achieve this through a treatment foster care model, others may do so more effectively through a specialized staffed group home. However, to place attachment-resistant children in a staffed group home without providing the education and support to the staff that are critical for the quality of the milieu and the continuity of its staff is practically and ethically unacceptable.

The third possible objection to the models described in this chapter is a financial one. The cost of setting up and maintaining staffed settings or treatment foster care programs that meet the criteria described in this chapter evokes strong resistance in administrators and funders in this age of diminishing resources, although seasoned front-line workers, from their own past experience, intuitively recognize what these children need. This objection typifies the attitude that we believe is all too common when it comes to spending on children in care: the saving of money has a higher priority than does the saving of children (Giovannoni, 1995; Rosenfeld, Wasserman, & Pilowsky, 1998; Province of British Columbia Task Force on Safeguards for Children and Youth in Foster or Group Home Care, 1997). But if one considers the cost, human and financial, of failing to meet the highly predictable needs of these children, would the cost of the proposed approaches be so much greater than:

- the waste of precious foster homes and treatment beds;
- the high cost of remedial services for attachment-disordered youth and adults;
- the cost of placing attachment-resistant children in residential treatment centres that often do them more harm than good;

- the costs related to the disproportionately high number of attachment-disordered youth and adults repeatedly admitted to correction facilities for youth and to prisons and penitentiaries (National Crime Prevention Council, 1997);
- the lifelong cost of chronic dependency and diminished productivity;
- the moral cost to society of its collusion in the abandonment of these children?

We cannot be sure of the efficiency of such programs, since here again rigorous studies of the cost-effectiveness of alternative interventions with attachment-resistant children have never been done. Moretti and Holland (1993) have demonstrated that interventions that address ecologically the attachment issues of conduct-disordered adolescents represent some improvement over traditional interventions for conduct-disordered youth that ignore the attachment disorder and attempt to deal only with the symptoms of the conduct disorder (Goetting, 1994). In view of these promising results, it is worth studying empirically whether early recognition and utilization of the models described above can provide a more effective, more efficient, and more humane response to the needs of those children with attachment disorders within the child welfare system.

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VI. Youth Transition to Independence

YOUTH TRANSITION TO INDEPENDENCE

Cheryl Milne

INTRODUCTION

Young people face much adversity and many challenges when attempting to make the transition from foster care to independent living. At a time when young people are relying on parents for financial support for a longer period of time, society's most vulnerable children are expected to become society's most independent youth often by the time they reach 18 years. The purposes of this paper will be 1) to identify factors affecting youths' transition to independent living; 2) to explore the importance of ensuring a uniform and standard program of transition; and 3) to provide some best practice principles which, if adopted, may reduce the barriers youth face. The transition to adulthood is best facilitated by providing the young person with support and resources to make the transition gradually. A key element of this process is clarity in expectations for youths in these circumstances. True independence generally entails complete financial self-sufficiency, an expectation few families have for youth in our society. Are we expecting this of youth in care at too early an age?

LAWS GOVERNING AGENCY RESPONSIBILITY

Many jurisdictions define a child as a person under 18 years of age;[1] however, protective services may be unavailable at age 16 unless the "child" is already the subject of a protection order or a protection application has commenced. When children in care reach age 18, the continued assistance of the child welfare agency is usually at the agency's discretion based on a framework such as Ontario's Extended Care and Maintenance program (ECM). Although the Ontario ECM guidelines apply to all child welfare agencies in the province, implementation remains inconsistent. In any event, the ECM program terminates at age 21, which may still be problematic for some youth who have not been able to become self-supporting.

Concerns about the discretionary nature of the ECM program have led children's advocacy groups and child welfare proponents to argue that ECM should be considered a right not a privilege for wards. Both the Ontario Association of Children's Aid Societies (OACAS) and policy analysts have called for a more standardized program to be developed that would be implemented in a uniform fashion across jurisdictions (OACAS, 1993).

[1] In Ontario, the *Child and Family Services Act* (CFSA) in section 3 (1) defines a child as a person under 18 years of age, while a "child in need of protection" is a child under 16 years of age, unless already subject to a court order for protection.

EARLY INDEPENDENCE

Another significant issue for adolescents in care is the move from foster or other residential care to living independently prior to their eighteenth birthday, but with continued financial support from the agency. The lack of foster care placements, the difficulties some youth have with group home settings, and/or the effects of multiple placement changes, make the independent living arrangement very attractive for many adolescents. In a study of a group of youth who were in child welfare care after their sixteenth birthday, Fay Martin found that 74% chose to leave care prior to their eighteenth birthday (Martin, 1996).

As with ECM, there is significant variation across agencies, and even among individual workers, as to the criteria used for determining readiness for independence. The choice for the young person is sometimes between continued agency support for a transition plan unacceptable to the young person or complete termination of the wardship ("the agency's way or the highway"). Often, the young person's social worker alone assesses the suitability of a child's plan to make such a transition and qualify for agency support. Youth who have a poor or fair relationship with their worker may find it a difficult task to convince their worker that they are ready for such a change from foster or, more commonly, group home care to independent living. Often the young person must convince the worker that he or she is "responsible enough" to qualify for continued support.

FACTORS AFFECTING YOUTH TRANSITION TO INDEPENDENCE

a) Developmental Issues

Developmental and psychosocial issues of adolescents and young adults dictate the necessity of a supportive and stable transition program. Adolescence is a particularly vulnerable stage in human development. It is at this time that goal-directedness and future aspirations should be a top priority. It is an ideal time to encourage higher education and/or job skills training. It is paramount at this stage for youths to be assured that positive opportunities are available to them. But without financial and emotional support, such opportunities may be illusory.

The typical adolescent transition from being a member of a family to being on their own challenges young people to develop a more individualized sense of self and to redefine family relationships (Rycus and Hughes, 1998). This transition can be difficult for youths who have spent years in foster care, whose care has been permanently transferred to the agency, who have lost touch with their birth family, and who have resided with several foster families during their time in care. Youths with attachment disorders face even greater challenges. The transition can be a traumatically disruptive experience for youth who have a critical need for a sense of security and trust (OACAS, 1993). The availability of social supports thus becomes integral to a successful transition to independence.
Upon exit from care, youths require a solid and stable social support network to help build a foundation for a successful transition to independence. After-care research studies have

indicated that those who have such supportive relationships upon leaving care are more likely to function well than those who do not (Mallon, 1998). Supports should be threefold: agency services, community, and friends and family with whom youth are still in contact. Ongoing relationships can serve both to nurture and educate the young person. They can provide role models and provide assistance with the development of life skills.

Discharge from care without a continuing program may adversely affect the youth's treatment goals and plans. Provisions need to be made to include the possibility of continuation with programs that address outstanding clinical issues. For example, youths leaving care are often dealing with the long-term effects of childhood maltreatment such as post-traumatic stress symptoms; many have special needs related to addictions or mental and emotional health concerns such as depression. These children continue to be at high risk of suffering from long-term psycho-emotional problems whether they remain in or leave care (Trocmé, 1991). Independent living programs need to address such issues and ensure that appropriate care is provided.

Upon leaving care, a child's primary advocate, his or her social worker, may no longer play such an instrumental role. However, discharge from foster care should not be equated with discharge from agency care and supervision. Problems arise because of the high turnover rates for social workers in child protection. A child who has been in care from a young age may have had several different workers assigned to their case complicating, and possibly hindering, the ongoing assessment process. A continuing social worker can assess the special needs of the youth and assist by advocating for services, or in the facilitation of referrals to the appropriate interventions and programs.

Ministry guidelines currently require only an annual review of a plan of care for youth on ECM. In contrast, prior to exiting care, a child care file is reviewed every three months. The ECM review could be required on a more frequent basis. The frequency of the ongoing review of the plan of care should be gradually reduced over time and not ended abruptly, e.g. every six months over the first two years.

b) **Education**

Education is another critical area that requires attention in preparation for independence. In one American study measuring after-care outcomes, it is not surprising to note that the adolescents studied who had a sound educational base and employment history were considered to be better equipped for independent living (Mallon, 1998). Several North American studies have indicated that the level of educational achievement of former foster children is low and that youth in care are at least one year behind in their education (Whiting Blome, 1997). Difficulties in school performance are related to disrupted education patterns, family problems, and frequent re-locations. Every effort should be made by child welfare agencies to assist the youth in securing accommodation in their current school district while in care and continuing past discharge.

Access to post-secondary programs must also be ensured. Youth in care need to be encouraged to pursue advanced education and/or training and, therefore, workers and educators need to be aware of where they may inadvertently reinforce low expectations youth may have for themselves (Whiting Blome, 1997). Career and academic counseling should be ensured for these youth in the school setting. Currently, in Ontario, individual education plans (IEPs) for exceptional students are required to address the transition to employment or post-secondary education goals as early as grade 9. Transition plans should be part of permanency planning for all adolescents in care at the same stage.

It is imperative that youth are given the opportunity for expanded government student loan programs, scholarships, and other resources that would better prepare them for post-secondary study. Alternative education programs can also be a beneficial approach to preparing youth for independence. Cooperative programs, literacy classes, and correspondence courses are important resources for youth facing other barriers.

Youth leaving care may have a host of developmental and emotional issues requiring attention. A youth who desires to participate in such a program should not be discouraged simply because he or she cannot participate on a full-time basis. The programs that work best for these young people accommodate these exceptional needs.

c) **Youth Unemployment**

Youth unemployment rates seriously affect youth transition to independence. In Canada in 1996, the unemployment rate for youth stood at 18% (Human Resources Development Canada, 1996). Young workers have been adversely affected by economic downturns and changes in labour market conditions. Because of inexperience and a lack of seniority, young workers are often the first to be let go (Human Resources Development Canada, 1996). Moreover, the unemployment rates for youths leaving agency care have been found to be significantly higher (Martin, 1996).

There is a strong need for employment opportunities that provide adequate wages and meaningful experiences that promote career goals, develop and enhance workplace skills, and help to secure more long-term positions. Enhancing employability should be a central goal of an after-care program. In addition to basic education skills, social workers should ensure that youth are given the opportunity to acquire general pre-employment skills (job search strategies, interview skills) as well as specific marketable skills (knowledge or skill in a specific area) (North, Mallabar, & Desrochers, 1988). Such skills however can be transferred from other settings including the arts, organized sport, and extra-curricular activities. Agencies and educational professionals should ensure that during and after care youth are participating in such programs and that their participation is not precluded by financial constraints.

d) **Poverty**

Current Canadian research indicates that twice as many poor teens aged 16 and 17 drop out before they complete high school as teens from more financially stable backgrounds (Ross, Scott, & Kelly, 1996). This research from the Canadian Council on Social Development indicated that poor teens were more likely to live in unsafe or unsuitable housing, have higher rates of teen pregnancy, and also found a strong relationship between low income and poor physical health. The correlation between former foster care placement and future homelessness has been reported in several fields of study (Gaetz, O'Grady, & Vaillancourt, 1999). All too often, youth leave middle-class foster homes for lifestyles below the poverty line, where seventy percent of their income is spent on maintaining a residence. This situation is particularly exacerbated in concentrated urban centres where the cost of living on a whole is higher in comparison to less populated regions.

ECM funding does not appear to take into account regional disparities of this sort. In addition, there appears to be no general provision for incidental "start up" costs associated with moving to a new location. Unless an individual agency will approve a youth's request for additional funding to cover such unanticipated costs, a youth may be found in a precarious position by having to cover unanticipated expenses. The long-term benefits of providing adequate financial support at times of transition are obvious. The consequences of failing to do so will continue to exert pressure on other aspects of the social welfare system.

Poverty is a recognizable disadvantage that youth face upon transition. After-care programs must ensure that a youth's resources meet the requirements of an adequate standard of living. Children's rights advocates propose that such a standard of living would be conducive to non-poverty, to proper housing, to health, to knowledge, to rest, to leisure, and so on (Andrews & Kauffman, 1999). This ideal further supports the contention that education, employment, and access to social services are integral elements of a comprehensive system that addresses the entire needs of this special population. Youth who are concerned with coming up with monthly rent may shift priorities away from education or special skills training, to employment sectors that are 'dead-end' and that can barely support a subsistence level of living.

ESTABLISHING A STANDARD TRANSITION PROGRAM

It is important to note that all of the above mentioned factors affect youth's transition to independence in an interrelated fashion. A standardized program for youth transition to independence would begin to address a number of social and emotional factors. Programs need to ensure emotional and financial support, but at the same time encourage education and preparation for the work force. The unique problems faced by youth in care as they grow older have long been identified, as have some of the solutions (Mech, 1988).

In 1998, there were over 12,000 children in the care of a child welfare agency in Ontario alone (OACAS, 1998). Fifty percent (50%) of these children are permanent wards or are on Extended Care and Maintenance and will likely remain on ECM until the age of 21. Consequently, the need for comprehensive and standardized transition programs has never been more evident. A holistic approach that addresses all aspects of the social welfare system is needed to address the needs of this special population adequately. The following recommendations describe program components that can lead to a more effective, supportive and successful transition to independence.

a) **Community Approach**

The National Youth in Care Network has advocated for a "support team" approach to be adopted during youth transition. A team comprised of helping professionals may be better able to assist in developing a service plan and facilitating referrals to the appropriate community resources. Education, child welfare, and mental health representatives who have contact with the youth may act as guides in assessment and serve as professional on-going support at the discretion of the child. This aspect may be most helpful prior to the transition to independent living.

b) **Partnerships with Community Organizations and Programs**

Connected to the idea of a community approach is the formal partnering of local agencies and organizations to service this population and their needs. A coordination of the Preparation for Independence programs run by the agencies and the various community youth support programs may provide a more comprehensive approach to preparing for independence. Career counseling, job search skills, and other independence-related activities can be served best by centres providing specialized services. The New York City Administration for Children's Services has embarked on such a partnership. The organization has contracted with Green Chimneys Children's Services, a voluntary, nonprofit, child welfare agency, to provide independent living skills programming for adolescents preparing for discharge (Mallon, 1998).

Inter-ministry and government collaboration can also be beneficial. When youths leave care, they find it difficult to locate safe and affordable housing, especially in urban areas like London and Toronto where government housing and co-ops are in high demand. Because of the length of waiting lists (from five to ten years in Toronto), public housing is simply not an option for young people (City of Toronto, 1999). This group should be seen as a special population deserving of a "priority" status on waiting lists. In addition to finding new resources in the community, it is essential that youths be able to continue with services they are receiving after leaving care where possible.

c) **Life-Skills Programming and Preparation**

Prior to leaving care, adequate life-skills need to be acquired. Skills such as budgeting, household maintenance, and meal preparation are recognized as critical, however, many youth have found that they were unprepared for these demands of an independent lifestyle. Preparation can be provided on an informal basis through the foster or group home, or on a more formal basis through community agencies as discussed above.

d) **Increased Child Welfare Agency Involvement**

More intensive and hands-on involvement from child welfare agencies is desirable from a policy perspective, however it may not be feasible from a financial standpoint. As discussed earlier, reviews of ECM agreements should occur on a twice-yearly basis upon initial transition and should gradually decrease in frequency. The assignment of transition workers is also recommended. Such workers can implement initial ECM agreements, conduct ongoing reviews, and act as an agency liaison for incidental services like referrals and requests for additional funding.

e) **Youth Participation**

The participation of the adolescent who is leaving care is critical at all time points. Playing an ongoing and instrumental role in the development of their transition can foster feelings of empowerment and self-responsibility at a much-needed time. Current Ministry guidelines call for a youth to provide input in the creation of their goals and service plan. Participation can occur on a much larger scale however. Several studies have pointed toward the creation of mentoring programs for adolescents and young adults. In Toronto, the Pape Adolescent Resource Centre ("PARC") has experienced considerable success with peer mentoring programs in which older youth gain more independence skills as they offer programming and supports to younger youth. This program has been described as a layered service in which as many as four "layers" might operate – PARC staff supervise university-age youth who are working with high-school youth who run programs for even younger youth in care. Such programs can provide solid peer support between young adults who have made successful transitions and those youth who are planning for independence. The Youth-in-Care Network has been able to provide youth with the opportunity to communicate with other youth and to become involved in research projects. Participation should also be encouraged on advisory boards and community programming boards.

f) **Provision of Clinical Services**

For many youths who are living independently, clinical services become remote and difficult to access after leaving care. Services available to children are often inappropriate for young adults and adult services are inadequate. Private counseling can be expensive and adult

programs tend not to be geared to the issues young adults face in post-care. To help address this shortage, a volunteer counseling match-up program is being coordinated through the Toronto CAS. Former child welfare social workers are matched up with youth in transition to provide individual counseling (Silva-Wayne, 1999).

g) **Revisions to the Extended Care and Maintenance Program**

Through their responses in research studies, youth have highlighted the importance of clearly communicating the ECM program available through their home agency. Ministry guidelines in this area are vague. The 1994 guidelines state: "the Ministry expects that children's aid societies will offer this option to all former Crown wards" (Ontario Ministry of Community and Social Services, 1994). The guidelines do state, however, that ECM allowance should be the "primary source" of financial support for former Crown Wards. Additional expenses are not covered under the guidelines and are left to the discretion of individual agencies. The provision of a guaranteed "start up" allowance would alleviate the financial strains associated with independent living (utility deposits, rent deposits, furnishings, etc). Negotiations for extra requests will likely be hampered by the new child welfare funding framework. Surpluses are smaller and scarce as a result of financial restructuring. As a result, youth living independently will likely receive fewer additional benefits under the new framework. A second financial recommendation would be to include "start up" funds as part of the calculated ECM expenditures in individual agency budgets.

Another recommendation clearly communicated by youth and professionals as essential is one that encourages the age of termination of ECM to be raised beyond the age of 21. There are cross-Canada variations in the approach to income maintenance for this population. Most provinces extend support to the age of majority, whereas New Brunswick and British Columbia allow support to continue to the age of 24. All the provinces operate the program on a discretionary basis, except for Nova Scotia where such a decision to extend care involves a court process. Given the societal trend to pursue further education and training programs, at a minimum, support should extend until the young adult completes his or her education or secures employment.

CONCLUSION

Youth leaving care for independent living are a special population with highly identified needs. As such, they present both financial and service challenges to the province. Child welfare services (often the only support a child knows) should not be removed in a swift manner. Rather, a gradual removal of formal supports can occur if informal ones are built in their place. An integrated approach to independence that focuses on education, job training, the development of life-skills, and the ongoing provision of treatment programs where needed is beneficial from a clinical and policy perspective. The development of independence can foster needed feelings of self-assurance and empowerment while encouraging youth to make active contributions to their

community and become productive adults. The consequences of inadequate support can be devastating, as failure to achieve a sense of autonomy, initiative, and industry can adversely affect a young adult's ability to develop a stable and positive identity.

The reality is that in our modern society young adults have spent more time in their family of origins for both extended monetary and emotional support. The state has assumed responsibility for these "children", and they are entitled to benefits similar to their peers'. Upon a youth's eighteenth birthday, all of their needs and vulnerabilities do not simply disappear. An integrated and standardized approach to youth transition may help to alleviate some of the barriers and difficulties that this population faces.

RECOMMENDATIONS

1. Extended Care and Maintenance should be considered a right not a privilege for wards. It should be a mandated program of child welfare agencies, not merely discretionary.

2. In addition to finding new resources in the community, it is essential that, where possible, youths be able to continue with services they are receiving after leaving care. Continued programs that address outstanding clinical issues should be available for youth after discharge from care. Discharge from foster care should not be equated with discharge from agency care and supervision.

3. Review of the extended care and maintenance program provided to the youth should be required on a more frequent basis (twice yearly). The frequency of the ongoing review of the plan of care should be gradually reduced over time and not be ended so abruptly, e.g. every six months over the first two years.

4. The assignment of transition workers is also recommended. Such workers can implement initial ECM agreements, conduct on-going reviews and act as an agency liaison for incidental services like referrals and requests for additional funding.

5. Every effort should be made by child welfare agencies to assist the youth in securing accommodation in their current school district while in care and continuing past discharge.

6. In Ontario, individual education plans (IEPs) for exceptional students are required to address the transition to employment or post-secondary education goals as early as grade nine. Similar timing of such plans should be part of permanency planning for all adolescents in care.

7. Enhancing employability should be a central goal of an after-care program.

8. After-care programs must ensure that a youth's resources meet the requirements of an adequate standard of living. The provision of a guaranteed "start up" allowance would alleviate the financial strains associated with independent living (utility deposits, rent deposits, furnishings, etc.).

9. There should be greater coordination of after-care programs and formal partnering of local agencies and organizations to service this population and their needs.

10. This group should be seen as a special population deserving a "priority" status on waiting lists for such services as housing.

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