Helping Hands: A Toolkit for Helping Children in Care with Loss and Separation

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The pieces

Where are the pieces?
The pieces missing from my heart
The ones scattered on the floor
They're blowing away
I can't see them anymore
And now there are pieces missing
How can I live without the pieces?
I'm like an old puzzle
Where half the pieces are missing
And no one wants it anymore
There goes some more pieces
Just floating away in the wind
Like feathers of a bird
A bird can't fly without its feathers
So how can I live without my pieces?
There is one left
Maybe if I hang on
It will last me
Until I find more pieces
Or I make new ones
But I will always treasure
The last piece
Of my heart

- ***The Heart that Silence Built, Wendy Louise Hayes***

In the Child Welfare System the separation of children from their parents, extended family, their communities and their culture can have a lifelong impact on their quality of life. While some children involved with the Child Welfare System find success and stability in their lives, others are reported to be more likely to have low academic achievement, unemployment or underemployment, homelessness and housing insecurity, encounters with the criminal justice system, early parenthood, poor physical and mental health and loneliness (Kovarikova, 2017). While the reasons for separation are varied, children often blame themselves for family breakdown, particularly without a clear understanding of the story behind it. The disruption of caregivers can leave a child with a sense of belonging nowhere. Many placed children, whether they return to their parents, or live with kin, live in foster care or are placed with an adoptive family, receive little assistance to help them understand and mourn their losses and deal with the impact of numerous transitions and disruptions. While the goal of permanency looks different for each unique child and family, the scars of these experiences are often shared.

Most in the field can agree with and recognize the legislation that outlines the right and the need for the child to be at the center of, and involved in, decision making about their lives. The *Child, Youth, and Family Services Act* (CYFSA) of Ontario affirms and strengthens the rights of all children and youth receiving services under the Act, including their right to have their views heard (Ministry of Children, Community and Social Services website, 2022). A child is entitled to full knowledge of their history, with information provided in a way that is appropriate to their age and stage of development and in fact will have a better outcome if they are provided with the support to understand and process their story.

Child welfare workers are in the position to walk alongside the families they work with and support children and families with their losses. Workers have the capacity to work with attachment theory, cultural attachment, risk assessment, trauma-informed practice, grief work, and a myriad of clinical concepts and models relevant to child protection as a result of their training. With this knowledge, using the tools and opportunities already before them in their day-to-day work, they can provide the support children and families need to make sense of their experiences. While the relationship between child welfare workers and the families they serve can be complex, this relationship is an important vessel for sharing with families the tools and concepts that can support children.

There are many barriers to ensuring that help with separation and grieving is provided to placed children. One might propose that the child welfare system as a whole does not lend itself to the clinical support, procedures and time frames a child might need. As well, workload, the priority of protection issues, the desire to protect children from stressful or disturbing information, and lack of resources all contribute to challenges.

The vision of this guide is to provide child welfare workers with a reminder of the importance of supporting children and families with loss, the basic concepts that underpin the rationale for doing this work, and some ideas and tools to implement it. The focus of the guide will be on practical tools that can easily be used by workers in the regular course of their role to prompt and guide the conversations children need. Each section of the work provides an introduction with case examples and a foundational basis to the chapter, without a repetition of the extensive research that we know exists in these areas. There is an extensive bibliography included and links to other resources.

Note to Readers: The demands of most child welfare caseloads are huge. It is not the purpose of this guide to add another set of expectations to the frontline worker but rather to offer some tools and ideas that the front line worker can easily incorporate into their daily practice.

Secondly, this guide acknowledges that every child and family is different and any "treatment" plan needs to be individually determined. In short, there is not one process or model. Nor is there any one story; part of the complexity of the system is the contrast and variety of outcomes and experiences.

Thirdly, every effort has been made to recognize cultural roots and differing parental practices, while we also acknowledge we may not have noted it at every opportunity. It is vital that this work be done with a culturally affirmative practice lens and cultural safety, recognizing the diversity of the families served in Child Welfare. An important tenet of today's child welfare work is acknowledging the experience of families who have faced interpersonal and systemic racism and discrimination in the child welfare system, in an effort to repatriate and correct mistakes. These experiences are also part of the child's story and need to be understood. Carriere and Richardson (2009) note: "to make...child welfare decisions without regard to historical and current social injustices such as…the imposition of Euro-Western worldviews and practices…is to further these injustices''. Western values which view grieving as largely an individual process are not shared by all cultures. Recognizing that different cultures have different practices around attachment (more aptly referred to, for example, in indigenous cultures as connections), and unique traditions to recognize and heal grief and loss is the only way to support and heal children. Acknowledging that families come in different shapes and sizes and that communities play a role in unique ways is also vital in engagement. For example, there is increased importance in

having a community around you for families in the LGQBT2 population, many of whom have been rejected by traditional family groups. Cultural attachment theory is emerging as a preferred way to think of Indigenous concepts as opposed to applying traditional attachment theory. There is limited research on the subject of complicated grief to address the role of culture, intergenerational trauma and traditional healing practices, but listening to the family and the child can guide our work in this area.

This guide is really about a call to action that we, as a Task Force, have had the personal opportunity to feel and be a part of over several decades of experience. The themes raised are not new to Child Welfare and are embedded in all of the practices we implement daily. This guide is intended to provide tools, examples and ideas that will allow child welfare workers to more easily provide the support that they desire to offer to the families who so desperately need it.

An example: "Danny was an 11-year-old in the permanent care of the Society, living in a supportive foster home. As his worker, I was worried that he seemed detached, not particularly interested in anything, just going through the motions. His mother died from suicide and his father was an alcoholic. He had no available extended family to care for him and support him. I worried that, while he intellectually understood why he was in care he had not grieved the loss of his family. I decided to ask a student whom I was supervising to spend some time with Danny and get to know him . My hope was that because the student was new to him she could ask Danny questions about his past e.g. where he went to school, where he grew up and if he wanted to go back and see his old neighborhood. Danny agreed. He and my student took a day and made a trip to his old school, where, to Danny's delight, a janitor in the school remembered him and gave him a Loonie. The student heard Danny tell the janitor how he lived in a great foster home and was doing well at school, along with many other positives about his life. They saw the apartment building in which he had lived with his parents. On the way home, the student noted that Danny's affect had changed dramatically and he seemed more relaxed, relieved, happier and more engaged. Later, I realized that the experience of revisiting his past helped Danny to open up and invest more emotionally in his foster family, and his future."

Section I: Supporting Children with Grief and Loss

SUPPORTING CHILDREN WITH GRIEF AND LOSS (written by Katherine Duncan & Shannon Deacon)

Allowing children to show their guilt, show their grief, show their anger, takes the sting out of the situation. —Martha Beck

An example: "*Keisha (age 15) was in the Society's care from the age of 12, when her mother died and there was no other caregiver or family to take care of her. She had been doing well in a very supportive foster family, until adolescence, when she had some difficulties that resulted in her running away. She told me, her caseworker, that a family of a friend of hers wanted to adopt her. She became unstable in her placement, was not attending school regularly, and spoke often of the fantasy that her friend's family was going to adopt her. That relationship broke down within six weeks. Keisha came to the office to see me and appeared very anxious, her nerves shaking her leg up and down. Keisha and I had spoken previously about going to visit her mother's grave, but she had refused. That day, I asked her again "when would you like to go and visit your mother's grave?". Her answer was "now". Together, we somehow found the cemetery where her mother was buried. There was no headstone. After Keisha made some jokes about not walking on her mother, Keisha wanted to go to the office to look at numerous headstones that she said she would buy for when she was older. As this experience belonged to Keisha, and not to me as her caseworker, Keisha led the conversation. I noticed on the way back that it appeared as if a great weight had been lifted from Keisha; she was quieter, relaxed and more still. This experience opened the door for her to finally be able to begin to mourn her mother."*

The separation of children from their primary attachment figures can evoke feelings and defenses that we need to understand in order to help children cope with their reactions. Without reiterating attachment and cultural attachment theory, we know that whether secure or not, a child's primary attachment figures shape their ability to trust and engage in future relationships with others and with themselves. Almost always do the children we meet in child welfare context have some level of attachment to someone or something and require support to grieve their losses, including mourning the life that they did not have. Some children, who have lived with extreme neglect and abuse, may be detached from others because of their experiences and need support to cope and understand their feelings of numbness and despair. Unresolved grief can also lead a child to be detached, which can have lifelong consequences for their relationships. The goal of grieving is to come to some kind of acceptance and understanding of what has happened so that the child can open or re-open themselves to positive loving relationships in the future.

There are a number of factors that influence the impact of separation and grief, such as the age and developmental stage of the child, the nature of the relationship to the attachment figure or figures, the length of the separation, any previous separation experiences, the temperament of the child, and the time and quality of assistance with mourning.

Cultural connections and traditions can also play a large role in how and if we grieve loss. The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) in fact states the importance of culture in understanding an individual's duration and expression of grief. From a child welfare perspective, we must also consider the grief connected to the treatment of racialized populations with which we work in historical and current systems burdened with racism.

A framework to assist workers to recall the conditions needed to mourn are quite simple:

- The child needs to remember what is lost and have the opportunity to speak about (or revisit) their past caregivers, siblings, pets, homes and neighborhoods.
- The child needs an environment in which they can freely express and feel their feelings. Caregivers and workers need to create the safe space needed for this to occur.
- The permanency and seriousness of the loss needs to be addressed and supported. Many placed children are in limbo; it is often hard to give them the clear messages that they need. However, it is still helpful to keep them included in any time frames (court, service goals, etc.) and to provide them the information they need to resolve their feelings.

When children are first admitted into care they are often in shock, as the family may be too. A child can appear as if they are "settling in" to a placement, when in fact they are in a deep state of despair. Often a mourning process can be avoided or restricted, for many reasons. While placed children can intellectualize about why they're in care, the actual process of grieving has either been avoided or aborted. Simple tools are available to help workers trigger the mourning process.

When you have a worker and an agency that is committed to grief and mourning you have a long-term improvement in outcomes. Devolld and Rickman (2014) describe a child "…with a sense of who they are and where they fit in the world will be far more successful than a child who has withdrawn from emotional commitment because they experienced too much grief and loss". It is suggested this could lead to more reunifications, increased placement stability, and increased positive outcomes for the child. Simple steps and tools provided to workers and placement caregivers could have a lasting impact.

Section I: TOOLS FOR SUPPORTING GRIEF AND SEPARATION

- What Loss Looks Like for a Child - Considering Customary Care and FGCs
- Effects of Separation and Loss - 3-5-7 Model
- Attachment Considerations and Questions
- Trauma TIPS for Foster Parents
- Culturally Sensitive Support of Attachment with Indigenous Families
- Emotion Coaching / Silence & Anger

- Workbook: Someone Close Has Died
- Considerations for Therapy for Children involved in Child Welfare
- Barrel Children: supporting children separated by immigration

WHAT LOSS LOOKS LIKE TO A CHILD.

For children who are developmentally on par...

Infant to Age 2

Establishment of trust, attachment, and security are essential for infants. When their sense of security is challenged, infants may cry loudly, withdraw, be apathetic, and cry mournfully. Older children may be clingy, cranky, cry, and have sleep disturbances. They may rock, bite, cry excessively, and demonstrate anxious behaviours.

Between Ages 2 and 5

Toddlers and pre- schoolers have not developed logical thinking abilities, and don't understand cause and effect and permanence. When they experience loss, they may feel sadness, hopelessness, denial and guilt. They may behave as clingy, anxious, and stubborn. They may regress with talking, feeding, or toileting. They may have bad dreams, and temper tantrums.

Between Ages 5 and 9

Children may show grief by crying, regression, anxiety, headaches or stomach aches. They may show hostility, have trouble concentrating, have bad dreams and have school problems. They may hide their feelings. And they may have a strong need to control behaviours but have trouble doing so.

Between Ages 9 and 11

Children are able to understand cause, effect, and time. They begin to form logical and concrete thoughts. There may be learning problems or issues at school, preoccupation and worries. They may exhibit anger or hostility, experience anxiety or physical pain. They might be inattentive.

Between Ages 12 and 18

The primary task of a child at this stage is to form their own identity, and issues of independence and differentiation are occurring. They also want to fit in and feel normal. Grief may take the form of withdrawal, resistance, regression, acting out, or mood swings. They may take part in risky behaviour, like substance abuse, eating disorders, cutting, or delinquency. They may have sleeping disturbances. They may act angry or depressed, including expressing suicidal ideation.

While this list is a general guide, it does not account for children who have delays or disabilities and and careful attention must be paid to the unique needs of each child. Grief is a complex process, influenced heavily by the unique experiences of a child's previous trauma and losses. The impact can often be compounded and co-existing.

SOURCES:

Supporting Grieving Children. (n.d.). Ann and Robert H. Lurie Children's Hospital of Chicago. Retrieved from https://www.luriechildrens.org/en-us/care-services/family-services/programs/heartlight/Pages/supporting-grieving-children.aspx

Berrier, S. (2001, November). The effects of grief and loss on children in foster care. Fostering Perspectives, Vol 6(1). Retrieved from: http://www.fosteringperspectives.org/fp_vol6no1/effects_griefloss_children.htm

THE 3-5-7 MODEL – PREPARING FOR PERMANENCE

One way to help children and youth address loss and grief is the 3-5-7 Model (Henry, 2012). This approach is designed to assist children and youth understand the events of their life, grieve losses, and integrate those experiences in order to build relationships and achieve permanence. The 3-5-7 Model is used by some agencies in the Manitoba child welfare system already and the model refers to:

3 tasks to accomplish:

1. Clarification: identification of life events to understand, grieve and reconcile losses
2. Integration: understand connections and build meaningful relationships
3. Actualization: visualize future goals and establish permanent connection

5 questions to support the work of the three tasks:

1. Who am I? (Identity)
2. What happened to me? (Separation & loss)
3. Where am I going? (Trust & attachment)
4. How will I get there? (Relationships)
5. When will I know I belong? (Safety & claiming)

7 skills necessary to assist children and youth:

1. Engaging children, youth and families in the three tasks
2. Listening to them
3. Responding
4. Affirming their experiences
5. Creating safety
6. Exploring the impact of the past on their present situation
7. Recognizing grieving behaviours as expressions of pain

The 3-5-7 Model uses a variety of tools, including lifelines, loss lines, life books, and other activities to assist in engaging the child, and integrating past experiences to understand the present and plan for a secure future. This model is also relevant for youth preparing for transitioning out of care, and for those who have less traditional definitions of "family," as identified by the youth involved in this project.

https://www.darlahenry.org/3-5-7-model-overview/

Things to Consider About Attachment

According to attachment theory, infants and young children communicate attachment behavior to get their caregiver's attention or to be in their proximity. A caregiver's consistent response to these signals is necessary for the infant's physical survival and healthy psychological development. Insecure and secure attachment refer to specific attachment behavior patterns that the infant shows, typically when under stress.

Attachment at Different Ages & Stages

0-2 Months: When the infant is between 0-8 weeks of age, the stage for developing secure attachment is being set. The infant may distinguish between caregivers but in general displays little preference. Baby separation anxiety in relation to the mother has not kicked in yet. *Attachment Behaviours at this age can include…* **Crying, smiling, babbling and sucking to achieve and maintain the attention and proximity of the mother.**

2-6 Months: Towards the latter part of the first half year, the child starts to distinguish more clearly between known and unknown figures. The child starts to get a sense of how their caregiver will react when they are anxious or distressed. The infant's early expectation of responsiveness lays the ground for the specific attachment behavior the infant will develop in half a year's time. *Attachment Behaviours at this age can include…* **Reaching out for, grasping hold of and clinging to the caregiver.**

6-11 Months: the baby has developed a clear understanding as to who his/her primary caregiver is. Attachment *symptoms* are triggered by… **strangers** are not yet perceived as a real threat but they may make the baby uncomfortable and wary…some infants show the beginning of baby separation anxiety while others have it full throttle by now.

11-24 Months: The child's attachment behavior is very clear. The child is very conscious of good strategies for reaching the desired proximity of his or her caregiver. *Attachment Strategies include….* **Clinging to, crawling and walking towards the caregiver** if the child feels his or her security is threatened by either strangers or the caregiver's leaving.

2-4 Years: The child starts to see the caregiver as an independent person with his/her own agenda and goals. The child r**ealizes that other people have feelings** and goals and starts to navigate this. When approaching 3 years, the child doesn't see physical separation as such a threat anymore. With the development of mental consciousness the child starts to enter a phase where negotiation and compromise can be successfully applied. The child may avoid separation distress if there is a plan for the caregiver's departure and arrival.

4-5 Years: The child's need for independence and further exploration is growing in tune with his or her ability to cope with separation. However, the child still faces many new skills to be acquired in a world that may still occasionally seem threatening, so the child may still want to stay close to their caregiver for protection, comfort and a sense of togetherness.

School Age: Attachment issues are less physical and more psychological. The character of the need for attachment has changed into awareness of availability rather than direct physical proximity: The child doesn't need to be near their caregiver as long as they know that the caregiver is available if needed. The child also starts to see the parents as partners with whom they will strive to have a fulfilling relationship and are more willing to make compromises that satisfy all needs and not just their own.

Shannon Deacon/Sherrie Moore 2016

Questions to Ask Yourself About Attachment

- Is the child showing behavioural indicators of distress?
- Is the child having difficulty with regulation? (Incessant crying, temper tantrums, difficulty soothing, etc.)
- Can the parent recognize the child has a mind and feelings? Is the parent sensitive to the child's views and feelings? Is the parent able to empathize with the child?
- How do the parent and child interact? How does the child respond to the parent?
- How does the child react when you arrive? How do they interact with you?
- How does the child show distress? Do they seek out their caregiver?
- How does the parent act on separation from the child? How does the child react?
- How does the parent act on reunion with the child? How does the child react?
- Does the parent comfort the child when they cry? How so?
- Have parents experienced any significant losses or traumas?
- Is there any history of domestic violence? Mental health problems? Substance Use?
- What is the parent's experience of care? Who was their go-to caregiver and how did that caregiver respond when they were sick/scared/hurt?
- What do the caregiver's adult relationships look like? Who do they trust?
- What is your biggest worry regarding the attachment relationship?
- What impresses you most about the child's relationship with their parent?
- Where do the child and parent appear to be having the biggest struggles in their relationship?

Questions to ask the Caregiver About Attachment

- What strategies does the child use to get attention when in distress?
- How do you know when your child is distressed?
- What does your child do to communicate they are sad/scared/hurt? How does your child know that you are there to help?
- When you think about your relationship with your child, what makes you feel most proud? What would your child say is the best part about their relationship with you?
- What would your child say is the best thing about how you respond? What would your child say is the worst part about the way you respond?
- Has there ever been a time when you've felt rejected by your child? Would your child say there are times they feel rejected by you? Tell me more about those times
- Has there ever been a time when you've felt frightened by your child? Would your child say there are times they feel frightened by you? Tell me more
- How do you think your relationship with the child is shaping his/her personality?
- Do you see any similarities regarding how you respond when in distress and how your child responds? Are there any differences? Does anything worry you about those responses?
- Are there any setbacks in the child's development that you worry are your fault?
- How does child relate to other adults? How does child relate to other children?
- Who was your go-to growing up? What did they do when you were sick/scared/hurt?

- What supports do you need to better understand how to help the child learn to see you as secure?

(** Neither list is exhaustive but are to prompt reflection and conversation on attachment!)

Shannon Deacon/Sherrie Moore 2016

Suggestions for Culturally Sensitive Support of Attachment and Parenting with Indigenous Families (Modified from Carriere and Richardson, 2009)

The following suggestions are offered to assist child welfare workers to consider in culturally sensitive ways how children and their caregivers are being supported in their tasks of becoming attached and connected with each other in the parenting process.

Dignity. The language of dignity may be a more culturally appropriate way of talking about connection between children and caregivers. This came from teachings from former political prisoners and residential school survivors who identified humiliation as one of the worst indignities of violence. Many families who receive child welfare services experience this intervention as an affront to their dignity and a reminder of other humiliating professional interactions. Affronts to human dignity tend to interfere with well-intentioned child welfare interventions, and the energy diverted from parents in dealing with authorities may sabotage their chances of demonstrating what they are doing well. At each stage of life, caregivers such as mothers and fathers need to be accorded dignity so that they can accord the same dignity to their infants and children.

Safe and Secure in many forms. Although many parents do offer their children safe and secure relationships despite not having that same dignity extended to them, energy can be diverted away from parenting in times of negative social situations, creating challenges. When parents talk about the challenges imposed by the outside world, they are sometimes seen as complaining, ranting or not taking responsibility for their part. This is particularly so for people who are socially marginalized and must deal with affronts to their dignity and autonomy daily. In infancy, the dignity of the young one is met by responding, in culturally appropriate ways, to calls for love through the offering of physical contact, food, familiarity of voices and scents, cleanliness, and a safe family and community environment.

Mothering and Fathering. Mothering can be undermined in varying degrees by a lack of security, such as violence, humiliation, and psychological abuse. At this stage in the life cycle, fathers may need to be supported in the role of protector, provider, and nurturer of the mother and the child. This support may take the form of flexible employment, support to be away from work for longer periods of time, and emotional support during a time of transition in the spousal relationship. For indigenous fathers, this may mean that society must address the extremely high rates of unemployment in some Indigenous communities and the obstacles to hunting and food-gathering that exist in Canada. The expansion of the family may mean a change of routine and relationship for all family members.

The Village. Children need the security of extended family, community, and culture to ensure a sense of belonging and to feel a part of the larger group. Families can be assisted by Elders and other family members who share a perspective about raising children and becoming a parent in a long line of tradition in the family. For both the mother and father, learning about the histories of raising children in accordance with familial and cultural ways may support their unique situation, even more than learning through popular books and television.

The Teen Years. While an adolescent asserts their independence and seeks to consolidate their identity, we see the importance of cultural teachers and Elders in reminding them of the good way to live. The teen can experience indignity when asked (often repeatedly) to perform certain tasks—like cleaning their room—that have been assigned by others. Creating space for adolescents to choose, as much as possible, the ways in which they will contribute to the well-being of the family and household, along with parents both accepting their need for independence and holding the teen within safe parameters and value-based expectations for social interaction, may enhance the teen's dignity. Many indigenous adolescents are already parents and learn about culture and appropriate ways of being alongside their children, ideally with the guidance of Elders and teachers.

Cultural Match. The dignity of the whole family may be at stake when it faces discrimination, lack of employment, or various forms of humiliation in the social world and when forced to receive service, particularly from outside the community. Today, dealing with the workplace, educational institutions, or government bureaucracies often involves forms of power abuse that result in humiliation for individuals and that harm their personal dignity.

A Chance to Heal. Many indigenous adults suffer due to the violence and even torture inflicted upon them in state-sponsored institutions and programs. Supporting healing in the community, in ways that proactively restore dignity and prepare adults for roles of leadership and community governance, simultaneously strengthens their capacity to function as role models for community members and as caregivers to children.

The Importance of Elders. Many Elders are the keepers of traditional knowledge and hold the important task of teaching, raising their grandchildren and supporting young parents. Yet Elders, too, need dignity, safety, and security to live out their traditional ways of being. Dignity includes having the freedom to extend caring to others, which is what Elders have often done in their communities.

Research and Understanding. To understand the community devastation of indigenous peoples, it is important to become familiar with the Indian Act and how this legislation continues to undermine First Nation, Métis, and Inuit families in Canada. When families are humiliated and destabilized, in both mundane and large-scale ways, they have less freedom or "room to move" in terms of dedicating their energy to their children while being called upon to address social concerns. For service providers and those engaged in assessing families, it is crucial to use tools that seek to discover what is right with people, rather than what is wrong, and that consider the social context and how disrupted dignity skews the results of assessment.

Carriere, J., & Richardson, C. (2009). From longing to belonging: Attachment theory, connectedness, and indigenous children in Canada. In S. McKay, D. Fuchs, & I. Brown (Eds.), Passion for action in child and family services: Voices from the prairies (pp. 49-67). Regina, SK: Canadian Plains Research Center.

The Validation of Anger

Anger is one of the basic emotions experienced by all. For an emotion to run its course, it needs to be expressed and validated. Suppressed or incomplete anger is particularly toxic. It fuels mental health symptoms like anxiety, depression, OCD and eating disorders - even self-harm behaviors and suicidality. Supporting the expression of your child's anger can be an incredibly powerful tool for healing. In fact, by helping your child to off-load anger, you can expect to see a fairly immediate reduction in symptoms. It will also make it less likely that they will act out their anger physically or with aggression.

If it's so important, why is it so hard to validate my child's anger?

We're human. When someone expresses anger towards us, our automatic reaction is to become defensive. The capacity to remain calm, open and non-defensive in the face of a child's anger is nothing short of a superpower – especially when that anger is directed towards us. Parents have also been taught for generations that anger from children is disrespectful and should not be tolerated. As a result, when our kids are angry, we often feel the need to shut it down. The problem is that children who struggle to express assertive anger are more likely to be bullied or dismiss their needs to avoid conflict. Children who are explosive can also benefit from validation to help calm their "brainstorm" and find more appropriate ways of communicating that all is not well. Typically, when a child begins to yell or use provocative language, it usually means they do not feel heard and reflects a need for validation and connection. In fact, navigating anger together can promote a deepening of the relationship. Children also need to learn how to get angry, and move through anger, in order to navigate some of life's biggest challenges.

My child is always angry. Won't I be reinforcing this pattern?

Imagine that anger is like the air in a balloon. When you validate your child's anger, you slowly let the air out of the balloon. In other words, the child's anger will slowly dissipate and so too will their symptoms. If your child is quick to anger, and angers often, you may discover that their anger serves to cover up deeper feelings of pain - including fear, loneliness, sadness or shame. Validating the anger will allow you to support your child with these vulnerable emotions. Doing so will lead to a further reduction in symptoms, among other positive outcomes.

My child doesn't seem angry at all. Are you sure this will work?

If your child is struggling with a mental health issue, including self-harm or suicidality, assume there is suppressed anger. You should also assume that they are afraid to be angry with you in case it negatively affects your relationship. The best way to "prove" to your child that it's ok to be angry with you is to help draw out their anger. Some parents have found it helpful to recall instances when 1. their child made attempts to express anger towards them or 2. it made sense for their child to be angry, but they did not express it. Go to your child and validate these experiences of anger. If your child denies having felt anger or dismisses your attempts - stay the course, especially if they tend to shy away from expressing this powerful feeling.

Validation Cheat-sheet:

I don't blame you for feeling anger when _____ because ____ and because _____.

Match your child's tone & volume, while ensuring the content is validating and supportive.

Connecting in Relationships: Emotion Coaching Silence

When a person you care about is closed to attempts for connection, it can be painful for all involved, especially if you interpret their behavior as disrespectful or rejecting. Although they may come across as "wanting space", be assured that there are strong (and often vulnerable) underlying emotions that need attention. The approach described below may seem contrary to what common sense would suggest but it's likely to help them to open up, connect and seek/accept support.

Step 1 Validate your loved one's silence. Convey that you can understand why they are closed to your attempts for connection, and from three perspectives:

a. Validate from your loved one's perspective: *"I can imagine why you'd not want to speak to me **because** it can be really uncomfortable to talk to others about vulnerable feelings."*

b. Validate from the perspective of the relationship: *"I can understand why it would be hard for you to talk to me about your feelings **because** we haven't always been in the habit of talking about the tough stuff."*

c. Validate from your own perspective*: *"I can imagine why you would be silent **because** I haven't always been understanding or accepting of your feelings in the past." *This perspective is likely to be the most powerful.*

Step 2 Validate the emotional states (anger, sadness, fear, loneliness, hopelessness) that you believe may underlie the silence / resistance to open up. Remember: making guesses is often better than asking questions.

"I can imagine that underneath the silence, you might be feeling angry because… because . . ., because . . ."

"I can also imagine that underneath the resistance, you might feel sadness because . . . because . . . because . . ." (Repeat with fear, loneliness, hopelessness…)

Step 3 Now, you may wish to communicate to your loved one: _____ (name of loved one), I want you to know that (a) "that there is space for you to build trust…", (b) "that you can take your time…", and that (c) "there is no pressure to engage with me in this moment…". You may also communicate that (d) "I will be there for you no matter what…".

Meeting silence in this way conveys understanding and respect, and this goes a long way toward maintaining connection, even encouraging your loved one to eventually open up. In fact, we've found that it is difficult for many to remain silent or disconnected when met with this type of unconditional support.

Workbook: Someone close to child has died

First assess the child's emotional state and readiness to explore their feelings and thoughts about losing that person. Ensure that a person that the child trusts is there for the child both while working on the book and afterwards.

Design a workbook or buy one. For example: "A Child's Workbook about Loss and Grieving" by Wendy Deaton M.A.

Sample questions:

· Make a list of special things about you.

· List the people that you love.

· Why do you think that your { } died?

· Where were you when that happened?

· What did you think/do/feel when you heard they had died?

· People have all kind of feelings when someone dies (scared, worried, lonely, sad, mad)! What were some of your feelings?

· What do you think happens when people die?

· What might you like to say to the person who has died?

Birgitte Granofsky 2022

Considering Therapy for Children involved in Child Welfare:

WHY? ***If therapy is not carefully considered, it can create instability and uncertainty***

- Therapy (or the input of a therapeutic professional) might benefit a child experiencing:
  - Problem Behaviour: a child may be demonstrating difficult behaviour as a result of uncertainty and change, and/or traumatic experiences. If the child is still in limbo, therapy may not be helpful. However, with the right factors in place, therapy might provide the child with the opportunity to develop new coping skills and self-regulation strategies.
  - Experience of Trauma: If the child has continuity of care in place and has secure caregivers to turn to, they might benefit from therapy to unpack traumatic experiences in their past.
  - Placement insecurity: If the child's placement is at risk, some therapy may be helpful in supporting the child in the home, however it would be vital for this to include the caregivers to work on interactions.
  - Often, the way to support the child is to support the caregiver in helping the child on a daily basis.

WHEN? ***Considerations of the timing of intervention is meaningful in influencing the outcome***

- The child needs to feel secure about their basic needs being met before addressing trauma and abuse can be effective. Ongoing trauma and safety concerns will preoccupy the child's brain and not allow for the learning of new coping skills.
- The child needs to be in a stable placement where they have a supportive caregiver who can encourage and support the therapeutic process.
- The child needs to have sufficient emotional and cognitive capacity to be able to engage in the therapeutic process.
- The therapist will need to work with the child to integrate their current circumstances and past experiences, and work with current caregivers to support the child in any issues that arise as a result of therapy.

HOW? ***What modality might best fit the child's needs and abilities?***

- At times it might be more beneficial for the child's caregivers to engage in a therapeutic process to develop and enhance skills in helping the child to regulate during difficult moments.
- Play Therapy involves a therapist providing opportunities during play (therapist- or child-driven) to therapeutically address themes and experiences.
- Talk Therapy involves a therapist engaging a child in discussions or activities to generate therapeutic strategies for addressing problems.
- Choosing play-based or talk therapy, individual or group depends on the child's age and stage of development, their cognitive and emotional capacity, and their preference.
- In choosing a therapist, consider:
  - Does the therapist have experience working with children who have experienced trauma?
  - Can the therapist help the child to understand and integrate their current and past experiences?
  - Can the therapist provide a sustainable relationship and remain committed to seeing the child for the time needed (i.e.. Are there any changes to their availability in the foreseeable future?)

- Can the therapist work with the child's caregivers to help them support the child at home with resulting behaviours and issues?

Shannon Deacon 2022

Barrel Children: Considering the Impact of Migration and Reunification on Children

Barrel Children is a term coined by researcher Dr. Claudette Crawford-Brown in 1999. The term refers to children who are left behind in countries of origin when their parents migrate to Canada. They are often sent material goods from their absent parent in large barrels that are shipped home, but what might be lacking in these barrels is the emotional care and connection they may long to feel. These children are often waiting to have their parents return or are later "sent for" and moved to the parent's new home. While left behind, children can be cared for by extended family or their community, though they may feel a sense of loss and isolation as other children remain in intact families around them.

When children are reunited with their parents, there are many impacts to consider. These children may not have had a relationship with the estranged parent for several years, and as such might struggle to see them as a safe or nurturing caregiver. Children will often form a narrative themselves of why their parent has left, not understanding that it was likely to build a better quality of life for their family, but instead assuming that they, the child may have done or been something bad to deserve rejection. A caregiver who has made sacrifices and struggled while migrating and settling in a new country might expect a child to come and feel gratitude and assume the child will easily settle back into life together. The clash of these expectations can result in physical discipline, emotional abuse, and parent-child conflict that might land the family in the hands of child welfare. Children expected to settle into a foreign country might also struggle to adapt to vastly different cultural norms and expectations. When the caregiver has themselves faced these challenges without any support, empathy can be lacking, or they assume the child will adapt easily. Experiences of racism and oppression may vary and be more intense for the child in a Western Country, not to mention the grief the child may feel for losing the family, friends and traditions back home.

Child welfare workers working with newly migrated children in these situations might consider:

- Mental health is often a taboo topic for many cultures and should be explored in a respectful and open way. Parents might need psychoeducation to understand how theirs and their child's mental health could have been impacted by their loses and separation.
- Validating the parent's strong and admirable intentions when they came to Canada. Be mindful of the fear attached to speaking about immigration and acknowledge their status does not depend on their engagement in services.
- Helping parents find practical means to help the child adjust, such as simple lessons in Canadian culture or connecting to culturally specific resources in their community.
- Allowing the child to talk about what they've lost, what back home was like, what they felt about their parent being absent, who cared for them back home and what that care meant to them, and what the move has felt like for them.

- Working on the parent-child relationship from a perspective of increasing understanding between parent and child, helping the parent to acknowledge and validate the child's loss, anger or other emotions that have been impacted by the experience.

Shannon Deacon 2023

Section II: Supporting Children To Understand Their Story

SUPPORTING CHILDREN TO UNDERSTAND THEIR STORY (Written by Birgitte Granofsky)

"There is no shame in not knowing. The shame lies in not finding out." – Assyrian Proverb

An example: "Laura grew up in the care of child welfare because her parents were unable to look after her related to her mother being clinically depressed and her father having major problems with substance use. Laura lived in a warm, nurturing and supportive foster family. When she was six, her mother died by suicide. The foster parents, Laura's worker, her grandparents, and her father met with her to tell her about the circumstances of her mother's death. It was a very short meeting and emotional support was offered to her on an ongoing basis. I remained her worker over many years, and from time to time, Laura and I would talk about the reason she was in care, what happened to her mother, the role of her grandparents in her life, etc. When Laura turned 21, myself and other workers who had been involved with her took her out for a celebratory lunch. At this lunch, Laura turned to me and said "Why did nobody ever tell me my mother committed suicide?". I was shocked. We'd gone over the story many times. It was a life lesson for me that children do not always hear what we want them to hear, or integrate the stories they're given until they are ready."

Children have the right to be informed (UN Convention on the Rights of the Child and the Child, Youth and Family Services Act,) and they need to be informed for the sake of their psychological growth.

Children, who have had "good enough parenting" (Winnicott's term), will grow up securely attached. They will mostly have a trusting attitude to the world, to themselves and to their own voice. Whereas children, who have grown up with unpredictable, or even abusive, parental figures, trying to survive physically and emotionally as best they could, might end up with poorly regulated emotions and in a state of chronic anxiety and hypervigilance. Theirs is not a world that can be trusted, and that is the inner working model or script of many children in care.

It must always be a priority to support parents in their role, whether that means help with finances, providing access to relevant treatment and/or supporting skill development. In the meantime, and sometimes more permanently, child welfare must attempt to provide nurturing relationships for the children in their care by help of foster parents, kin or through adoption. These caregivers are greatly challenged as they try to present a model for relationships that is new to the child. The child will, of course, act according to their inner working models. It takes time and consistency for those models to change. And it takes understanding and empathy on the part of the adults. And it takes communication about the past and about the present and help for the child to process that information. The child needs help to put the pieces together that are her life. Who were the people in her life? What were the relationships like? What were good times? What was scary? Safe places? And unsafe? What happened before the child was born? What is the history of the extended family? Of the clan/community? Ideally this work is done together with the child's family of origin, but that depends on safety issues and many other issues, such as the child's permission.

In order to develop a strong sense of identity, rootedness and a strong voice, children need to know:

- Their parentage, their family history and their community of origin. And they need to maintain their connections where possible
- The reasons for being taken to a place of safety as well as the context of the neglect and/or abuse, such as poverty or multigenerational trauma
- Conditions related to the Child Protection System, such as the administrative difficulties or mistakes or insufficient supports.
- In preparation for the first, and successive placements, the child needs to be informed and engaged in a discussion about what is happening, what the future will, or might, bring and also about the uncertainties. And that needs to happen in a way that is age and developmentally appropriate. The child needs to be "kept in the loop" about decisions and events. The child's caretakers need to be informed along with the child, so that they can support the child and help the child process.

What does telling the child the truth look like?

- The way of telling is dependent upon the child's age, maturity, and capacity.
- Timing is important. The child should be informed sooner rather than later.
- What is happening at the moment needs to be communicated right then and there. Communication can be in words, and/or in body language, with use of toys, soothing objects, etc.
- One needs to pay careful attention to the child when starting to talk about traumatic events or about losses that the child has suffered. Does the child indicate interest or not? Is the child entering a state of hyperarousal? One needs to respect the child's refusal or incapacity to hear at that moment, but it is very important to indicate that nothing the child has experienced is too horrible to be talked about.
- Significant others need to be talked about with respect, but, of course, one should listen carefully to the child's feelings towards them.
- Extremely important to ensure that the child has somebody who knows and who is there to provide support as the child processes this material. It would be harmful to elicit strong emotions without appropriate support.
- The telling can be in words, pantomime, by help of toys and drawings.
- Telling the story of the child's life must include all the facts the workers know of – or find out about. Special friends, hobbies, pets, good times, and bad.
- Information needs to be given again as the child grows and matures.

What does "listening to the child's story" look like?

- The child has their own experience of events. The adults need to listen to the child. They need to be informed by the child.
- The child tells their story in behaviour (soiling, tantrums, anxiety and so on), in free play, in structured play and games, in artmaking, and of course, in words.
- It is extremely important that the adult listen to and try their best to interpret this communication and act based upon that understanding. And re-adjust if need be. All depending upon the child's response.

Who should be telling the truth to the child and be listening to the child's story?

- Ideally, children should hear the story of why they are not living with their parents from the parents themselves and be encouraged to ask questions of their parents. When a Family Group Conference is used at the time of children's admission to care, they can have their questions answered first-hand by

the people who know. If there is a good reason to exclude the parents from talking to children about their story, then the child welfare workers and caregivers need to do this important work.

- Child welfare workers have access to information about why the children were taken into care. They also have access to the family history and to other relevant information, albeit on a second or a third hand basis. And they have information about court orders and about plans for the child. And they, hopefully, have an ongoing relationship with the child. Consequently, they are the ones who should provide the needed information to the child, to the parental figures and to the family of origin going forward. And they are the ones who should support the communication between the child and the current parental figure and between the child and the family of origin.
- However temporary the home, the child needs caregiver support when dealing with the given information. And the caregivers need to listen carefully to the child's story as it is expressed in behaviour and in words.
- It is very important that the systems (child welfare, legal, medical) grant the workers and the caregivers the needed authority to do this very important job of informing the child as well as grant them provision of time and any needed professional support.

Section II: TOOLS FOR SUPPORTING A CHILD'S STORY

- SOS (Signs of Safety) Words and Pictures
- Questions to Bring the Voice of the Child
- My Three Houses
- The Remembering Book
- Your World in Colour
- The Talking Feeling Doing Game
- Questions to Guide the Making of a Story

WORDS AND PICTURES (Signs of Safety www.SignsofSafety.net)

The SOS model uses a tool called Words and Picture to help explain to children their stories, using age-appropriate words and drawings to explain concerns and safety plans that are child-focused. Workers can collaborate with the family and foster parents to create a story the child can understand and contribute to.

My Three Houses™ Tool

The Three Houses method was first created by Nicki Weld and Maggie Greening from Child Youth and Family, New Zealand, and is a practical method of undertaking child protection assessments

with children and young people (Weld, 2008). The My Three Houses tool takes the original method and simplifies it to make it more usable for practitioners. It matches the three key assessment questions of Signs of Safety assessment and planning – 'What are we worried about?', 'What's working well?' and 'What needs to happen?' – and locates them visually within three 'houses' to better engage children in the conversation.

My Three Houses is now available for devices using the Android and iOS operating systems. The app offers a drawing pad for working with children, provides 'how to' guidance for the professionals, and contains an animated video that introduces the tool to children along with another video designed for parents. More information is available at www.mythreehouses.com.

Steps for using My Three Houses include the following:

1. Wherever possible, inform the parents or carers of the need to interview the children, explain the three houses process to them, and obtain permission to interview the children.

2. Decide whether to work with the child with or without parents or carers present.

3. Explain the three houses to the child, often using one sheet of paper per house.

4. Use words and drawings as appropriate and anything else useful to engage the child in the process.

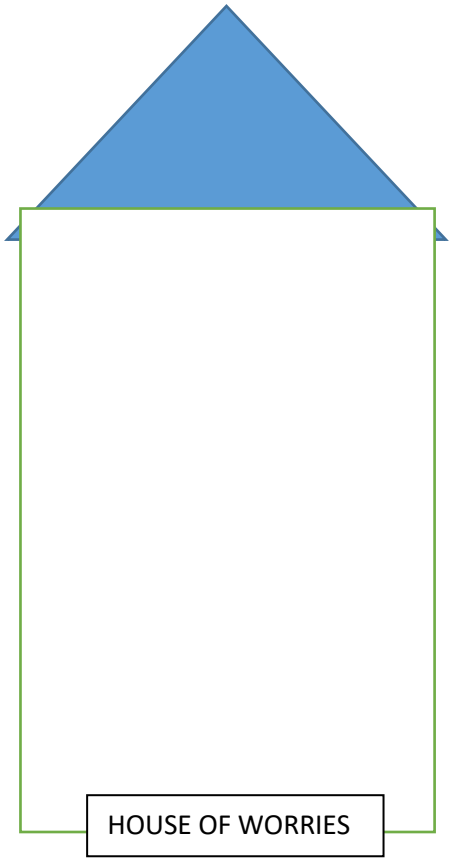
5. Often start with the 'House of Good Things', particularly if the child is anxious or uncertain.

6. Once finished, obtain permission of the child to show others – parents, extended family and professionals. Address any safety issues for the child in doing this.7. Present the three houses assessment just as the child said, wrote or drew it. For parents/caregivers, it is often helpful to begin with the 'House of Good Things'.

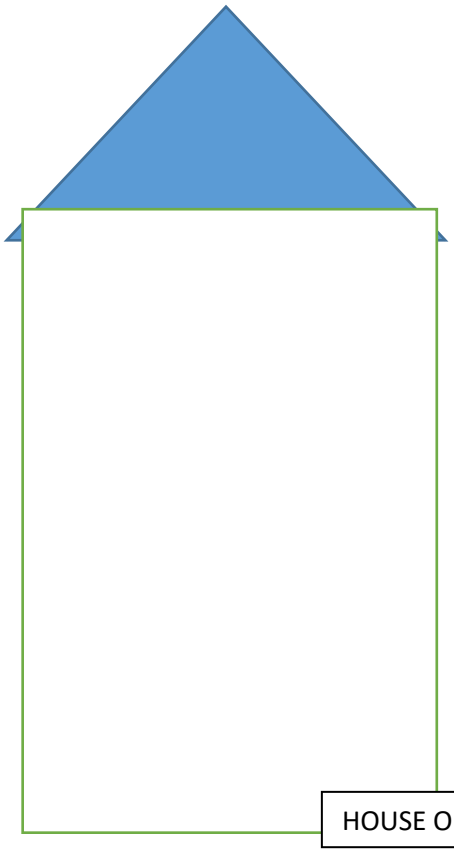
(Turnell & Murphy 2018)

The use of the 3 houses has been found by frontline workers to be very useful in helping parents understand the impact of their domestic violence on their children. For example, while many parents say their fighting and arguing does not affect the children because they "are asleep", the children will say in the "house of worries " that they are so frightened and scared when their parents argue and fight after they have been put to bed that they cannot sleep, are often awakened by the fighting and have night terrors. When the children's responses are shared with their parents, with the child's permission, the parents are often quite surprised and it may open their eyes to the pain they are causing their children.

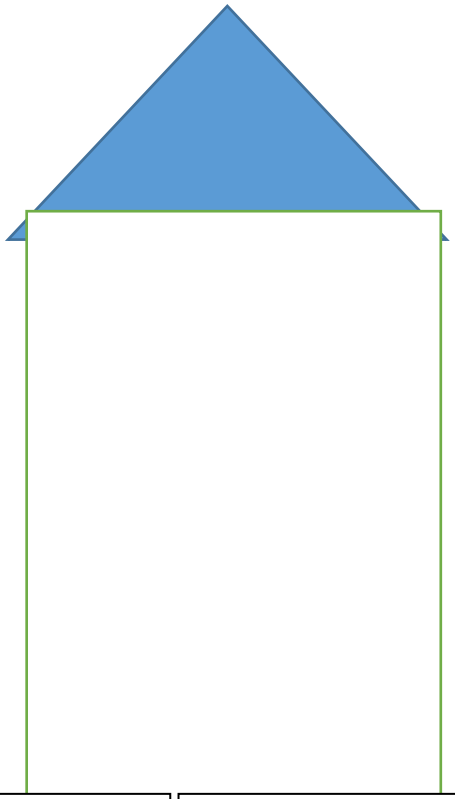
MY THREE HOUSES



HOUSE OF WORRIES



HOUSE OF GOOD THINGS



HOUSE OF HOPES & DREAMS

<u>Your World in Colours, Shapes and Lines</u>

“Close your eyes and go into your space. See your world – what is it like for you? How would you show your world on paper just using curves and lines and shapes? Think about the colours in your world. How much space would each thing take on your paper? Where will you put yourself in the picture?”

Draw your world below…

Birgitte Granofsky 2022

HIGHLIGHTS · Predictably engages resistant and inhibited children
· Excellent complement to The Storytelling Card Game
· Serves as point of departure for psychotherapeutic interchanges

In a procedure based on standard board game play, the child and adult place their playing pieces at START, each in turn throws the dice, and moves a pawn along a path of squares.
Depending upon the color of the square on which the piece lands, the player selects a TALKING CARD, FEELING CARD, or DOING CARD.

The questions and directions in each set of cards range from the least anxiety provoking ("How old are you?") to the moderately anxiety provoking ("Everyone in the class was laughing at a child. What had happened?").

If the child responds they receives a token reward chip. The winner is the player who has accumulated the most chips after the players have reached FINISH.

The child's responses are generally revealing of those psychological issues that are most important at that time. The information so gained serves as a point of departure for meaningful psychotherapeutic interchanges with the child and guides the therapist in providing responses to his (her) own cards that would be most pertinent to the patient.

The engaging game format utilizing token reinforcement enhances the child's interest and elicits spontaneous revelations. The information gained provides diagnostically meaningful insights into the child's psychodynamics and is of therapeutic value because each response can serve as a catalyst for therapeutic interchanges. The game is of value in group psychotherapy (with up to 4-5 players), in the treatment of children with learning disabilities (because many of the cards are particularly applicable to these children's problems), and with children who can reveal themselves more freely but who may also need a respite from more anxiety-provoking therapeutic endeavors.

The Talking, Feeling, & Doing Game, by Richard A. Gardner, has been utilized as an effective play therapy tool since 1973. Young children do not have the emotional nor verbal capacity to express their feelings in a traditional therapy setting. Play therapy games, such as the Talking, Feeling & Doing Game, facilitate the exchange of important psychological information from child to therapist. (October 12, 2012 Gary Yorke)

The Remembering Book

By: Margaret Osmond, MSW & John Keating, MSW

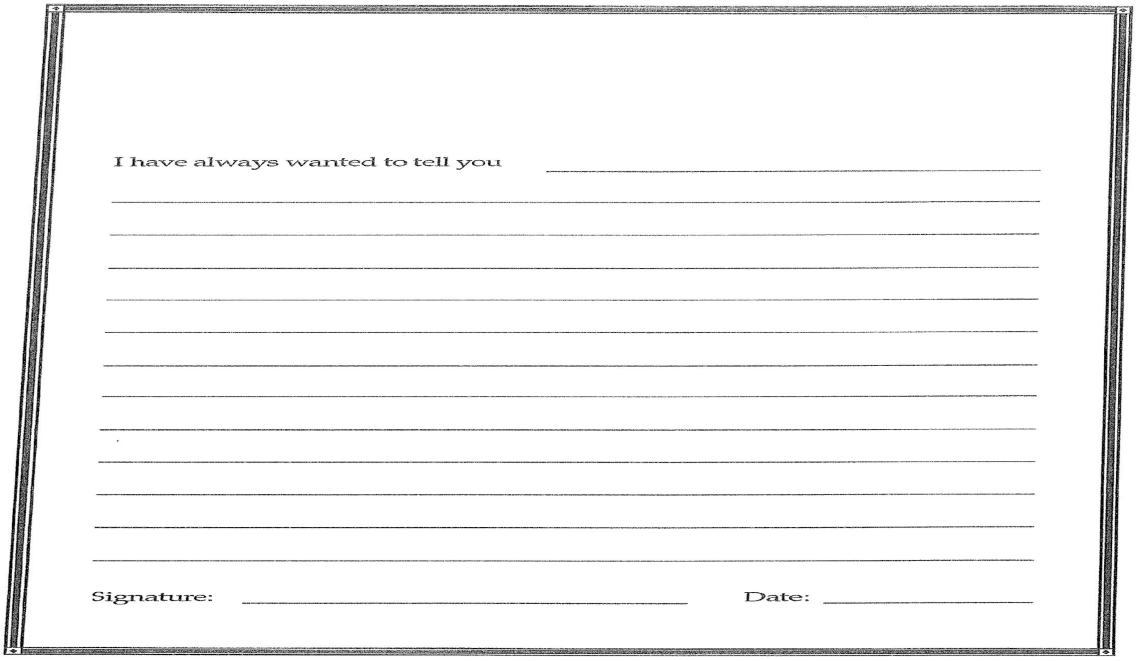
Available here:

An excerpt:

"The ***Remembering Book*** is a clinical protocol for use with children… The book is based on the work of Dr. Paul Steinhauer and Dr. Jim Wilkes, pioneers in the area of understanding the importance of attachment and the devastation of attachment failures…. The completion of (tasks for attachment troubled children) may preserve the ability to bond emotionally and may help the child to more easily integrate into the surrounding society. Reminiscence therapy… Memories of overcoming adversity, and that confirm the meaningfulness of life can be healing…

The book has been constructed to help children reminisce in a structured, safe way…The child's memories are expected to trigger intense feelings of loss and grief, bringing them to the surface so that the child can finally deal with them. It is expected the book can take several months to complete… Workers and other adult feedback is included to ensure that, as much as possible, the child knows the truth about what happened and why.

Some examples from the book are below and can be used verbatim or as inspiration.


I have always wanted to tell you
Signature:
Date:

Questions for bringing the Voice of the Child into Assessment:

Eliciting questions posed to children can help them to bring forward their thoughts and feelings, to be considered in the planning and assessment being done about them. The following is a list of questions (not exhaustive) to prompt discussions about the children's perspective.

- Tell me about who is in your family. Who do you live with? Who is in your extended family?
- What are some words that describe you/what sort of person are you? (If parent is present, can ask them to add some words to describe the child)
- Can you give me 3 words that describe your mom? Your dad? What's it like to be with them?
- Can you give me 3 words that describe your relationship with your mom? With your dad?
- How are you similar to your mom/dad? How are you different?
- Can you tell me about a time that you were upset and wanted help?
- Can you tell me about a time that your mom/dad helped to when you needed him/her? Was there a time that your mom/dad wasn't able to help you?
- Is there ever a time when you feel that your parents don't love you? When? Do they know that?
- Is there ever a time that you've felt unsafe or scared by/around your mom/dad? Tell me about that.
- On a scale of 0-10 how safe do you feel when you're with your mom/dad? (Assign feelings to 0 and 10 that match the child's stage of development)
- What happens when your mom/dad gets angry or gets upset with you? What do you call it? Can you describe what they look like?
- What does it look like when you get angry or upset? What does your mom/dad do when that happens?
- Why do you think you can't live with mom/dad right now? Do you ever feel responsible for that? Do you think your mom/dad knows that? (Allowing for an opportunity for you/the parent to give the child an age-appropriate explanation for why they're in care and what needs to happen for mom/dad to keep me safe)
- What are the things that your mom/dad does really well? What are the things that you wish they did differently?
- Is there anything that your current caregiver does that helps you, that you wish your mom/dad could do as well?
- Is there anything your worried about? Do you think your mom/dad knows your worried? How worried are you about this? (Scaling)
- Is there anything you'd like your mom/dad to know that you've had a hard time telling them?
- If you had three wishes, what would they be?

Questions to Guide The Making of a Story:

I am in Foster Care because_____

The problem started when_____

I can go home when_____

My Mother/Father needs to_____ before I can go home.

The reason my Mother/Father can't take care of me is_____

My Mother/Father needs to learn to _____before I can go home.

What I need to learn about being in Foster Care is_____

The decision to go home is made by_____

What I want to know about why I'm in Foster Care is _____

The person to answer my question is_____

I understand I live in a Foster home because_____

I do not understand why I live in a Foster home because_____

It is best for me to get information from _____

When I see my Mother/Father in the CAS office the questions I want to ask are

_____

_____

The questions I want to ask my worker
are_____

_____

The best ways for me to remember the reasons I am in care are_____

If I forget I can_____

These questions help me because _____

My other question is_____

From: Tell Me My Story: The Treatment Benefits of Knowing the Truth. Mary Rella. <u>There are No Wizards</u>: <u>The Child Welfare Conundrum.</u> Children in Limbo Task Force 2010.

Using Family Group Conferencing to prepare children for placement, for moves in care, and continuing contact with their original families - by Sally Palmer

Introduction to Family Group Conferencing (FGC)

FGC originated in New Zealand to address the over-representation of Indigenous children in foster care and jail. It is now included in Ontario's Child, Youth and Family Services Act. It is designed, in part, to address the power imbalance between family groups and child welfare agencies.

The family group refers to the child and their 'extended family group' as defined by the family group themselves. It includes people important in the child's life such as extended original family members, supportive people (neighbour, teacher), and prospective or current caregivers, if these are not part of the extended original family.

Leadership in the FGC is shifted from child welfare professionals to the family group which includes extended family, supportive people, caregivers, and the child. Structure is provided by a coordinator who is trained in leading FGCs.

The coordinator is expected by all participants to be impartial and holds no child welfare authority over the plan that the FGC develops. The coordinator prepares all participants prior to the conference, chairs the first session of the meeting, and organizes a leader from the family group for the second session. This is the private time in which the family group develops a plan for the child's care and brings their plan back to the total group. During private time, the family group works toward a decision about: keeping the child at home; initial placement; a move within care; access to family members; return home; and possible supports to the original family or caregivers. They also seek offers of support from members of the family group to ensure that the plan will be successful. When the family group has formed a plan for the child, they meet again with the coordinator and others from the initial session to tell them about the decisions they have reached in the private family time to address the reasons the child welfare agency is involved. At this point, child welfare professionals may question the plan and suggest modifications.

The third/final session is when the final decision is made by all participants, either to accept the family group's plan or modify it to meet the agency's concerns. Following this, the coordinator records and distributes the plan developed during the conference to all participants.

The role of child welfare professionals is to provide information to the family group about why the agency is involved and to invite the family group to develop a plan to address the safety concerns. During the final session, the child welfare professionals confirm that they accept the plan developed in the meeting as addressing the initial concerns and agree to implement the plan.

Stages of supporting child's involvement in FGC

The coordinator prepares the child for FGC by explaining the reason and process for the conference: asking the child what they want their family to know and how they would like to share this during the conference. If the child would like assistance in putting their thoughts together, the coordinator and the child decide who is the best person to help them.

The coordinator prepares a support person from the child's own network to focus on the child during the conference if the child agrees to have a support person present. The support person helps the child to express their thoughts and feelings, ensures a respectful reception for the child's input; and can move a young child to another room when needed. The coordinator provides a flexible location for the conference, as well as childcare when needed, so the child can move in or out as needed.

The coordinator role is complete after putting the Plan into final form and distributing it to all participants who were present at the conference. The child welfare worker is responsible for implementing the plan which includes regularly reviewing it with the family group to ensure it is current, relevant, and achievable. The group can reconvene for a follow-up FGC when the plan needs revisions.

<u>Potential benefits of FGC to children and families….</u>

…In Understanding Their Story

During the process of planning for a child it's important to bring together those involved in the child's life to help piece together the child's story.

The experience of having all these people involved in the conference demonstrates to the child that all participants are concerned about them and want to support them.

It is valuable for the child to be present when decisions are being made by those who care about them, and to have the opportunity to participate actively in these decisions, and ask questions.

While a child may not be able to return to their family of origin, the process can help fill in understanding of who was part of their story, and at an FGC the family can be encouraged to provide pieces of the story that may have been missing.

Soul Journey

The Black Education Awareness Committee (BEAC) was established by the Children's Aid Society of Toronto (CAST) to provide leadership within the agency and to promote learning about and celebration of Black History Month. The purpose of the BEAC is twofold: 1) To promote understanding amongst youth and staff regarding Black History; 2) To aid in empowering children and youth with Caribbean or African descent who are involved with the CAS, by increasing their self-esteem and knowledge about their history and roots through educational opportunities.

A key method used with the CAST Black children and youth in care to help them advance their knowledge of and connection to their cultural history has been the Soul Journey expeditions. The Soul Journey trips were developed through BEAC's mentoring initiatives which aim to provide educational, cultural and spiritual awareness learning opportunities for children and youth of Caribbean-Canadian or African-Canadian descent who are receiving support from CAS of Toronto. These specially planned trips with youth and CAST chaperones are to historical areas of importance related to the Black culture. Examples of past excursions include trips to Nova Scotia and Washington, DC. Previous evaluations of the Soul Journey experiences have found these trips to positively impact on the young people by improving their knowledge of roadblocks and oppression related to Black history, by aiding in raising the youths' self esteem, and by providing them with positive memories of their involvement with CAST.

The film maker for Soul Journey who filmed 2 trips (one to Windsor/Detroit and one to Halifax, Nova Scotia -where a replica of the slave ship Amistad was visited) describes the purpose of the expedition attended by youth, chaperones and Black leaders, as an opportunity to give Black youth an experience of slavery, their roots, and the contribution Black people have made to this country. When asked what stood out for him about the Nova Scotia experience, he stated that he was surprised about how therapeutic this trip was for the youth. He said it seemed to fill in the gaps of the youths' knowledge about where they came from and gave them more appreciation of the sacrifices made by their ancestors and put their present struggles in a powerful context to perceive themselves as members of a racist society. Many youth had no knowledge of the depth of their Black history as it was not taught to them.

What Youth Say About the Journey:

The youth told the filmmaker that the program gave them a sense of belonging and purpose linked by intergenerational struggles of racism.

One female youth spent time in the part of the ship where the slaves were kept and saw how her ancestors, some girls her age, were forced to live. She cried and cried and was full of new insights as to how her ancestors' experience had such a powerful impact on her life.

Present on the trip were Caucasian youth, Indigenous or First Nations youth, and youth from other racialized communities. They were overwhelmed and all could truly empathize with the Black youth's history.

Section III: The Importance of Clinical Access

THE IMPORTANCE OF CLINICAL ACCESS (Written by Katherine Duncan & Shannon Deacon)

As a child, I was very careful not to erase my mother's writing on the chalkboard because I would miss her. — Joyce Rachelle

An example: "Cheryl's two sons, aged 1 year and 2.5 years showed significant growth failure and developmental delay because of neglect; this led to them being placed in foster care. Cheryl had been working with the Society for some time before the boys were placed, always ensuring she had food in the house and a safe routine, yet the boys remained at risk. A Therapeutic Access Plan was put in place where Cheryl was expected to parent the boys for four hours at a time in the access centre, where she could develop skills and engagement with her boys with support of the worker *and her ability to be engaged with her boys could be assessed. One of the expectations included that Cheryl come in early to engage with her workers in planning and exploring her own emotional challenges. At first, Cheryl showed up promptly 15 minutes before the visit and slumped into her chair with arms crossed, reluctant to talk. As she gained comfort and connection with the workers, she began showing up earlier and earlier, eager to engage with her workers, discuss her challenges and prepare for parenting. When Cheryl began to respond to the nurturing offered during her access, the boys also began to thrive, and were quickly able to return home to a mother who had the emotional ability to provide them with attuned parenting."*

Access is, at its purpose, not just about family contact. Access can and should provide:

- Maintenance of continuity in a child's life and cultural practices
- Contribution to a secure identity through knowing one's family and cultural heritage
- Assistance to the child and family in confronting the reality of separation, the reasons for it, and the need for change
- Support for parents to take responsibility for their children
- Provision of a time and place to practice new behaviours
- Promotion of an accurate assessment of both the child and parent, from the perspective of attachment and risk
- Provides an important transition vehicle for children returning home

Access should be based on an assessment of the family's needs around attachment and risk. An access plan should be reflective of the case work plan and be tailored to each family's unique situation. For example, where there is no plan for the children to return to their caregivers, access in the family home can be very upsetting. Conversely, when the family is working toward reunification, an access setting does not always provide the opportunity for parents to practice a wide range of parenting behaviours.

The concept of clinically- managed access is one that many agencies have seen benefit from adopting. This involves shifting from supervising visits to supporting families to promote behavioural changes. It has allowed families to feel more supported by their child welfare team, provides an opportunity for assessment and teaching, and assists workers in obtaining a more thorough and accurate assessment of the families with whom they are working.

Clinically managed access is an essential tool to help children manage separation and grief. Well managed access provides a vehicle for assessment and intervention that can expedite the decision-

making process, reducing the length of time that the child is left in uncertainty. It is also an opportunity for children to confront the feelings and questions they have about separation and loss in their birth families, and an opportunity to develop early and successful permanency plans.

When we provide supported, well-planned clinical access, it gives an opportunity to assess, teach, mentor, and heal, helping families to move toward change and more adaptive parenting. We know that, in order to promote the development of secure attachment, and repair the experience of insecure attachments it is necessary to change the behaviours of the primary caregiver. When the caregiver is given the environment and support to use visiting time as parenting time, an opportunity is formed for child welfare workers to better assess and understand the caregiver-child relationship, and for the parent to address the ruptures that exist. Where change is not possible and the caregiver's capacity is limited, there is opportunity for the child to experience the parent's capacity in a safe place and ensure they're given support and time to process losses.

Successfully managed clinical access contributes to placement stability. Children often worry about their family members when they are in care, particularly when they did some of the caregiving. Feeling responsible for the family breakup is a common response for placed children, making it hard for them to settle if these issues are not addressed. Access helps the child not feel abandoned. Seeing their parents committed to working on the family problems is very reassuring. When foster caregivers connect positively to the child's biological family then the child's loyalties are less conflicted, and they will feel more secure. Many long-term placements break down because the child/youth has so many repressed feelings and unanswered questions that they begin to act out, and constantly need to move.

Initiating an access arrangement and plan is a vital first step in a family's healing journey. Often we bring a child to a place of safety, and a few days later we reunite them with their family for a visit, but no one discusses what happened. These are opportune moments to assist families and children in finding meaning in their loss, acknowledging and addressing traumas and accepting their new reality, be it short or long term. With the right tools and strategies, workers can use those first few visits to support a child and family in the first steps of supporting grief.

Access should be reviewed often to ensure it is meeting the needs of the family. Reviews should be at, but not limited to:

- The time of court proceedings
- The time of legislated planning meetings (every 90 days)
- The introduction or exit of a new family member or partner
- A disclosure by the child or family member
- A change in placement
- A dramatic change in the child's behaviour
- A decision to recommended extended legal care to the court
- A decision to proceed to a trial or an opposed hearing
- A significant change in the parent's lifestyle or circumstance
- Any key points along the child's maturational and developmental process.

Involving the child in these reviews, as well as in their planning meetings, Family Group Conferences, and Family Centered Conferences needs to be carefully considered, factoring in the child's age, stage of development, level of comprehension, state of grief and emotional capacity.

We have often held "goodbye visits" for children placed in extended care. The value of goodbye visits is now being evaluated as they can be extremely intense experiences for both children and parents. Many conflicting feelings of anger, sadness, hopelessness, and uncertainty are felt in both. This practice needs to be closely examined for its benefits and risks. Having an official time to separate from past relationships and losses can be of use to both the child and the caregiver if they are prepared and supported for the intense emotions. At the same time, these experiences can be very painful for both parents and children to witness each other's pain and experience conflicting feelings. Adoption Openness has really changed this process and the need to say "goodbye" is less frequent (see next section).

When we are planning for access we also need to take into consideration the child's existing relationships and needs. For example, siblings should be supported in seeing one another outside of the parental relationships when possible and where necessary. Access for parents who are not planning to be or have not in the past been in a caregiving role requires a plan that is designed for their particular role. Our access environments must always factor in the need to support children/youth or caregivers with disabilities, and make accessible various traditions, tools and representations with which BIPOC families can identify. Involving community resources can be an excellent way to support families in culturally appropriate access plans. As well, using access to collect contributions for a child's memory bank or lifebook can be accomplished when we incorporate pictures and mementos from these experiences.

Section III: TOOLS FOR SUPPORTING CLINICAL ACCESS

- Therapeutic Access/SOS Assessment Worksheet
- Assessment Tool considerations
- Tips for Visits After Admission
- Parent Interview Questions
- Tips for Engaging Fathers

Therapeutic Access/SOS Assessment Worksheet

Parenting Domain	What's Working Well?	What are we Worried about?
Parent Model *What is the parent's idea about their jobs as a parent?* H*ow has the parent's culture taught them how to parent? What did culture look like in their family?*		
Behaviours Affecting Parenting *ie. Dismissive, withdrawn, attentive, scary, frightened, unavailable, attuned*		
Attachment Relationship *How confident is the child that the parent can keep them safe? Responses to distress*		
Parental Responsibility for Change *Views of the need for change and their role in creating change*		
Complicating Factors:		
What Needs to Happen Next? Questions?		

Shannon Deacon 2018

Considerations for Assessment Tools in Child Welfare

Effective case service to families involved in child welfare involves an assessment of risks and strengths. Sometimes, additional assessment needs to take place outside of traditional casework. When a child is brought to a place of safety and a parent is asking for reunification but has not addressed the protection concerns, the service team should be developing a solid plan for what goals need to be met and how they will know that change has been made. Access is often the place for assessment to occur but is sometimes not the entire answer. Below is a (not exhaustive) comparison of three possible assessment tools: Therapeutic Access, Parenting Capacity Assessments, and Psychological Assessments, to help workers consider which path is best for the family they are servicing.

	Therapeutic Access	**Parenting Capacity**	**Psychological**
WHEN ASSESSMENT TOOL IS NEEDED:	Need an assessment of parenting skills and/or parenting behaviours Need teaching/intervention Need to organize/formalize the assessment you have	Need assessment of parent's capacity to parent Interventions or teaching during family visits have NOT been successful or cause stress to the child Parents are unable to engage in working with the Society Previous children have been involved or removed and outcomes do not appear improved	Need assessment of parent's mental health Need assessment of parent's ability to learn and cognitive functioning Need assessment of parent's ability to form relationships
ASSESSMENT QUESTIONS TO BE ANSWERED:	Does the parent see the need for change and their role and responsibility in it? What is the parent's attachment style? What are the risks and strengths in the parent-child relationship? What are the parenting behaviours impacting safety?	Does the parent have the capacity to understand their roles as a parent and enact them? Does the parent have the capacity to understand and apply safety? Does the parent have the capacity to learn?	Does the parent have any mental health or personality challenges that are impeding parenting? Does the parent have the ability to learn or any challenges preventing?
FACTORS TO CONSIDER:	Worker time and skill Agency Support	COST Waiting lists? Who chooses the assessor? How long does it take to complete?	COST Waiting lists? Who chooses the assessor? What measures will be used?

Shannon Deacon 2022

Parenting/Access Assessment Formulation Interview Questions

At the start of assessment it is important to gain understanding of a parent's parenting model and how they have come to view the world through their own attachment models. The following questions (though not exhaustive) will help engage the parent in a conversation about their experiences, and help guide assessment and access planning.

1. Who do you remember being closest to as a child? Why?
2. When you were upset as a child, what did you do?
3. What would your father/mother do when you were:

- Sick/Hurt
- Scared
- In trouble?

4. Could you describe a separation from your parents?
5. Did you ever feel rejected as a child by your parents?
6. Do you think your parents realized they were rejecting you?
7. Were your parents ever threatening towards you – for discipline or jokingly?
8. How do you think your overall early experiences have affected your adult personality?
9. Why do you think your parents behaved as they did during your childhood?
10. What are some things you are/are not repeating in your relationship?
11. What is your relationship with your parents like for you currently?
12. What did your growing up experiences teach you about mothering/fathering?
13. How do you know when your child is sick, hurt, scared, disappointed?

- What do you do at those times?
- Are there times when you don't know what to do?

14. How did you learn to attend to your baby's needs to be close to you/distant from you?
15. Could you give me five phrases to describe how your child might see you or describe your mothering/fathering?
16. How do you think your relationship with your child is shaping his/her personality?
17. Are there setbacks in your child's development that you worry are your fault?

2010 Adapted from Mary Rella/Attachment Interview

***Con*siderations for Access Visits Post-Admission**

A child's admission to care represents a significant and sometimes traumatic event in a child's relationship with their caregivers. The event itself can be precipitated and followed by chaotic tasks and feelings…for the child, the parents, the family and the worker!

The first access visit arranged after admission is the family's first point of contact after the storm. As such, it is an important time to repair, establish and assess the family's strengths and challenges. This first visit can set the tone for the success of the family's ongoing visits and can likely have a positive or negative impact on how the child does in care. At the same time, there is recognition that the first visit comes at a chaotic time for the worker, AND often parents are still angry, sad or frustrated with their worker over the apprehension that just occurred.

Some factors to consider when planning the first visit:

- What was the nature of the admission? How might the child have experienced the events on the day of their admission, or leading up to? Was it scary? Confusing? Chaotic?
- How did the parent react to the separation? Were they able to stay calm and help the child? If not, are there things they can do now to repair that? (i.e. bring items the child left behind, apologize for the chaos, talk about the events, etc.)
- Research suggests that visits should occur within 48 hours of placement – this is not always possible, but is in the child's best interest.
- The primary purpose of these visits is to maintain the child's emotional attachments. Children often perceive limitations on contacts as punishment for something the child did.
- Where should the visit occur to make it safe AND comfortable for the family? Who should be present? Can the foster parent or worker bring the child in, instead of a stranger/driver?
- What were the child's experiences of their caregiver BEFORE they came into care? This visit is your first opportunity to assess and provide information to the foster parents.

Tips and Strategies for the First Visit:

- If possible, allow the child and parent a *phone call* as soon as possible after the placement, to encourage the maintenance of contact and to allow the child reassurance that the parent is safe. This call should be fully supported to ensure the parent is able to give the clear messages the child needs to hear.

- Parents should be encouraged to bring clothes, comfort items, school work, medicine, or family pictures to the first visit, and time can be set aside to talk about medical history, routines, traditions, cultural practices and other needs the child has, if they were not discussed at the time of admission.

- Meet with the parent for some time BEFORE the child arrives. This allows the parent to get their initial reactions and concerns out of the way prior to the child's arrival. It also allows you a chance to talk about what the child may have experienced during the admission, to prepare the parent for the child's questions and to talk with the parent about what the child might need to hear from them. Ask the parent "what do you want to say to the child about what happened? What do you think they might need to hear from you? How do you think the child might feel hearing that?"

- Providing the parent with information about the child's activities, foster home, etc. will help the parent feel reassured that the child is safe and doing ok. Things like what the foster parents' first names are, whether there are other children in the house, what the child has in their room, what the foster caregiver did to make the child comfortable when they arrived, etc.

- Talking to the caregivers about the purpose and importance of access helps them to understand that it is an opportunity for the family to have contact, for the parent to practice parenting skills and behaviours, and for the workers to support them. Let the parent know that an Access Plan will be created with them that will fit with their case service plan. For example, at the Intake level, the access plan would be to provide an opportunity for assessment, and an ongoing worker might adapt this plan to include tasks to be completed in access that work toward the Society's, parent's and child's goals for access.

- Parents can be encouraged to think about how they can reassure the child that the separation was not the child's fault. For example, you might tell the parent "you know, Joey is probably pretty confused by all this and might feel like it's his fault he came into care. What do you think you could tell him to reassure him that it's not?" Provide the parent with statements such as "I am so sorry this has happened to us, but I want to be sure you know that NONE of this is your fault", or "I wasn't able to take safe/proper/good care of you and that's why you came into care.. it is NOT your fault".

- Talk to the parent about how they might feel when they see the child for the first time, and what they are going to do with those feelings. For example, acknowledge that they might feel sad or cry when they see the child, and talk about how the child might experience this. Make a plan with the parent in the case they are NOT able to make it through the visit without becoming too emotional. Acknowledge their feelings BEFORE the visit, talking with them about what they are experiencing, and helping them organize themselves. Let them know that it's ok if they need to take a break, or that you'll let them know if you feel the child needs to be removed from the room.

- Provide parents with some orientation to the Access Centre, such as showing them where they'll find toys, dishes, etc. so that they can feel comfortable and confident when their child arrives.

- Facilitate some conversation during the visit about the admission by:
- Acknowledging they haven't seen each other since that day, make it ok to talk about it.
- Ask the child why they think they're in care, give a chance to talk about their experiences.
- Ask the child (or, better yet, have the parents ask) if they have any questions about what happened or why they had to come into care. If the parents aren't able to verbalize reasons in a way that is safe for the child (talk beforehand to assess this), do so yourself, reassuring the child that the worker will be helping the parent to work on the problems that led to their admission.

- Help the family to talk about what they would like their time together to look like going forward. What are the child's goals for access? What are the parents' goals for access? Let them know that they will likely have an access worker to help them develop a plan. You can provide them the Access Plan Worksheet for parents and encourage them to share it with their ongoing worker once assigned.

- Help the family with their departure by encouraging the parents to talk to the children about what they'll do when they return to the foster home, how many "sleeps" until they see each other again, and what the child wants to do at their next visit, to assist the child with the transition.

Shannon Deacon/CAST 2013

Engaging Fathers in Supporting Children

Often, Fathers and paternal families can become somewhat invisible in Child Welfare work. Whether by their own choice, the efforts of a mother trying to be protective, the results of ruptured relationships or abusive behaviours, or by nature of the work itself, we can often lose focus on the father, who could in fact be a pivotal support to a child. Regardless of a father's parenting time status, there are some things to consider about how we can involve fathers in the work:

- Consider the relationship between child and father pre-intervention. If we don't know what that looks like, it can be helpful to arrange an access visit and observe interactions between parent and child, in consultation with the child's wishes and perspective.
- Fathers who have been deemed to be abusive in a partner relationship might be assumed to have been directly abusive to the child but might in fact have had positive parenting behaviours.
- If a father has been deemed to have had abusive behaviours that are of low to moderate risks to the child, engaging them in a fathering program can help them to develop insight into the impact on the child.
- Understanding and building on a father's strengths will help them feel engaged & empowered.
- Helping a child to understand their father's story will help them to understand their own. Even if a father is not involved, gathering as much information as we can about him can help fill in missing pieces for a child.

TIPS TO SHARE WITH FATHERS:

- We never stop being a role model to our children, even when absent. Research shows that when dads are not in the picture, kids wonder about them and may think they themselves were not enough to keep their father around.
- Giving your child the message that they are loved and respected will go far, even if circumstances have prevented you from seeing them regularly.
- Actions speak louder than words. If you say one thing, but do another, you child will remember what you do.
- Most mistakes are not forever. If you acknowledge your mistakes and change your behaviour, you can regain your child's trust and respect.
- Building on a positive relationship with the child's mother, or at the least reflecting respectful communication to and about her, will go far in building a positive relationship with your child.
- While fathers have often been expected to be the financial providers, having money does not make you a good father. Consistently providing what you can and being engaged teaches your child responsibility.

An example: "When Janet's three children were brought to a place of safety, she repeatedly insisted to her worker that their father, Brad, was not involved, had no relationship with his children, and was in fact a very dangerous person. After a few months of working with the family, the worker made efforts to reach out to Brad, and learned that he was, in fact, eager to be involved. The worker was eventually able to arrange an access visit with the children. When the children arrived, instead of showing the apprehension that the worker expected, they ran excitedly to see their father and were greeted by him with warm hugs and affection. The visit demonstrated that, in fact, Brad had some strong caregiving skills and the children saw him as a safe and nurturing caregiver."

Section IV: Supporting Adoption and Permanency

Supporting Planning for Children moving to Permanency Placements – Customary Care, Legal Guardianship and Adoption (Written by Pat Convery)

"Adoption carries the added dimension of connection not only to your own tribe but beyond, widening the scope of what constitutes love, ties, and family. It is the larger embrace."
- *Isabella Rossellini*

Every child placed in care deserves permanency. Whether that is to return to their families of origin, be placed with kin, under Customary Care, with Legal Guardianship, or adoption. While the goal of the work is always to repair and rebuild a child's connection and safety in their family or origin, we know that is not always possible, despite the growth we have made as a field to engage families in the work. Permanency outside the family are for those families where reunification was not possible and ALL other options have been explored and exhausted.

The word "adoption" lands differently for different people, however the concept of adoption as a permanency plan is one that has been around in child welfare in many forms. Historically the process of adoption has gone through many transitions. While we can't change the past, over time we are learning the harmful consequences for children of not preparing them for permanency, not respecting their cultural origins, not maintaining connections with their families, and not supporting children in understanding their stories as a whole. It is also important to acknowledge the values and practices that hold true then and now: We have always known that, when children know their stories, when we prepare families for openness and assess for readiness, the outcomes are improved. As we discuss the principles of permanency and the options for it, we hope to do so with this lens.

The importance of a child having an ongoing relationship with birth family once a permanency plan is made is an accepted belief within Ontario. The concept of maintaining connection has only more recently gained the label of "openness", as the legality of adoption made space for ongoing relationships with birth families. The hope of openness is that adopted children will develop stronger identities if they are supported in having healthy ongoing relationships with their families of origin.

When a child is in society care, Children's Aid Societies (CAS) make every effort to maintain a child's contact with birth family members including extended family members and siblings who are not living in the same foster home. As a result, when a child is placed in Extended Society Care and an adoption or guardianship plan is being considered, a child may have any number of positive relationships that are important to maintain post permanency.

The effort to provide a child with a comfortable and stable day-to-day life in an alternate family care setting is a primary focus while the CAS works with immediate birth family members to address the issues of concern that led to the need for the child to leave the family of origin. In an effort to 'fit in' and 'be a child', sometimes a child loses a sense of their larger family identification and cultural heritage. A child may have lost some connections with extended family, religion and culture when the decision is made that they are unable to return to the birth family members they were removed from and alternative permanency plans are explored.

The child then is expected to integrate into a new family, including rituals, extended relationships, and sometimes new cultural identity. Decisions are often made, directly or inadvertently, that causes a child to lose connections. The ideal, and the challenge, is to maintain the positive connections children have, and need to have, with birth family members and culture.
Fears and worries sometimes override the willingness to consider opportunities to maintain connections with family members once CAS is no longer involved:

- safety planning around protection concerns;
- a parent's history of lack of follow through and inconsistent attendance at access visits;
- fears that birth family members might not be able to respect boundaries or there may be acrimonious relationships;
- the fear of adoptive parents that the child will not become part of their family if they maintain bonds to their birth family;
- the fear of birth parents that adoption will diminish their relationship with the child;
- for Kin adoptions and foster parent adoptions, there are specific issues that may arise in light of pre-existing relationships.

Legislative direction:
The importance of openness planning has been clearly embedded in legislation and Ontario Child Welfare practice policies. A review of **the Children, Youth and Family Services ACT (CYFSA 2018)** clearly notes that services for children and young persons should:

- Respect their need for continuity of care and for stable relationships within a family and cultural environment;
- Take into account their unique needs. This includes their physical, emotional, spiritual, mental and developmental needs;
- Reflect who they are: their race, ancestry, place of origin, colour, ethnic origin, citizenship, family diversity, disability, creed, sex and sexual orientation, gender identity and gender expression.
- Take into account the child or young person's culture and language;
- Provide early assessment, planning and decision-making to achieve plans for them that align with their best interests;
- Support the participation of the child or young person, their parents and their extended family and community, where appropriate.
- The child's views and preferences, giving due weight according to the child's age and maturity.

- For First Nations, Inuit and Métis children, the importance of preserving their cultural identity and connection to community is highlighted. For First Nations, Inuit and Metis children, this includes enabling openness applications from their bands or communities.
- New requirements exist for societies to maintain relationships if a planned permanency disrupts or breaks down.

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Considering the Voice of Youth

Research involving young adults who were adopted in closed arrangements as children reports that adoptees often voiced displeasure about not being informed of the essential parts of their history. Several youth have expressed overwhelming worry and fear about the health and safety of birth family members with whom they are not able to contact or receive information about. When a youth has knowledge of a sibling with whom they are not able to have contact they almost always note that they think about the child all the time and wonder how they are doing in their life. Youth often express anger about their inability to answer questions about their birth family members, family history or cultural background when asked about these things by peers or in school projects. Conversely, studies conducted with youth who had been able to maintain connections with birth family members, highlight the positive impact of all of these areas. Youth indicated that they needed to have some help from adoptive parents in navigating connections and youth adopted at an older age (over 7) expressed the importance of listening to the youth voice in initial planning and in later years as well.

Remember that, at the time of permanency planning, several years may have passed since child came into care with resulting in the child having relationships with new caseworkers, and several moves leading to both new relationships and loss of relationships that may still have importance/benefit for the child's future identity and development.

Putting forward an Openness Plan is not a one-size fits all. Workers, Lawyers, Foster/Kin parents and Judges must carefully consider: Why this plan? What is the information to support the plan working? What are the supports that will be needed to build and maintain this relationship?

Even if there is no Openness at the outset of a permanency plan, at the adoption finalization stage, the court has to be convinced that the applicants understand the special role of adoptive parents. Increasingly this includes the Adoptive parent's willingness to be open with the child and accept the child's need to connect with birth family: Are they prepared for the challenges ahead? Disruption sometimes happens when the permanency parents are not prepared for the child's desire to connect with birth family members. Preparing families is most important but we must also consider what supports they have or will need. It is not sufficient to dismiss the need for Openness because ongoing supports are not readily available.

Capacity of permanency parent to facilitate contact

Prospective adoptive parents receive training about Openness while they become Adopt-ready but may need to expand their learning within the context of the needs of a child(ren) placed with them. Kinship families may need formal training to help them in understanding the importance of, and benefits for maintaining connection with birth family members they are not related to or who may not have been involved with the child in a positive way.

Permanency families benefit when Mediation or Alternative Dispute Resolution is offered to meet directly with birth family members and work out an Openness plan that may become an agreement or, in some cases, a court order. Mediation service expenses are covered and Ontario provides Child

Protection Mediators with specific training on supporting Openness planning for adoptive, Kinship and Customary Care families.

Once a placement has occurred, the support of the CAS worker in 'practicing' Openness during the adoption probation period is needed. During the adoption probation period of 6-12 months, the worker and the birth parent counsellor (if available) are able to work more closely with the adoptive and birth family members to coach and support success in the initial openness connections. With additional support in navigating these early connections, adoptive families have developed confidence and competence in managing future connections with the foundation established during the probation period.

Capacity of birth family member to understand their role post permanency

Birth parent counselling is critical as they move to a new role in their children's lives, often after losing a long and hard fight to regain custody of their children. Specific Birth Parent counselling needs are: acknowledgement of grief; coaching, info about permanency/openness and help with processing loss.
They will need support to meet the adoptive family in person and begin building the new relationships that will be in place. This is important even when a child is with a Kin Family.
Birth parents should always be invited to share information about the child's early life and the extended family stories. Often these stories are not previously heard given the conflict and chaos that often surrounds the relationship between birth family members and the CAS.
Birth family members need to understand that they can reach out for support in future if issues arise navigating the Openness relationship set up initially.

Capacity of child to understand the different roles of 'parents' and accept the adoption or guardianship relationship

Children need to understand their story and have access to life books and other resources to assist them as they process information in the present and in the future**.** They need to have some understanding of the family-finding and decision-making processes in selecting a permanent plan for them. Children will need to have a voice in transition planning and know that therapy will be available in the future as they deal with complex issues of identity, belonging and loss.

While CAS is limited in resources to provide long-term support to adoptive families, Ontario programs, funded by the Ministry, that are available include Adopt4Life and Adoption Council of Ontario, Pathway to Permanency programs. These programs provide specific coaching and counselling assistance to adoptive families. Funding subsidy is provided in some cases including counselling for children to help with transition to new relationships and routines with birth family members or supervision assistance with family visits when they are required to ensure safety for a child.

An example: "Three young children (18 months, 3 and 5 years of age) were brought into CAS care from a young single parent mother with an abusive boyfriend. The children were exposed to domestic violence and left alone on several occasions. The children were placed in a foster home together. They were returned to their mother after she made efforts to change the protection issues that necessitated the children's admission. They were soon readmitted to foster care as the same safety issues re-emerged. The mother alternated from being involved in visiting with the children to disappearing for periods of time. After 2 years of contested hearings before the Court, the CAS was made permanent guardian of the 3 children. While in care over the nearly 3 years of being away from their mother, the 3 children were

moved once to a new foster home as the first foster family was not able to handle the aggressive behaviour of the older child. Considerable work and support was put into place to help the children connect to the second foster family, including individual and family therapy and a Child & Youth Worker. When permanent plans were discussed with the children about their not returning home and a "forever family" being sought for them, the older child was adamant that he wanted to go home to his mother. The 2 younger children were very connected and doing well in their foster family and didn't want to move. Think for a moment all the issues involved in helping the children, the biological mother, the foster parents and the prospective adoptive parents move on to a successful permanent family with openness for their mother."

Section IV: TOOLS FOR SUPPORTING PERMANENCY AND OPENNESS

- Checklist for Preparing for Openness
- Preparing a Child for Permanency
- Lifebooks
- Use of FGCs for Openness and Permanency Planning

- List of books about adoption for kids/caregivers

Checklist for Assessing and Preparing for Openness in Child Welfare Planning

The following is a **Checklist to guide Mediators, Children's Lawyers, Family Lawyers** interviewing of parties involved in Openness – CAS workers, birth family members, prospective permanency parents (adoptive/kin). CAS workers may use this checklist as a guideline in preparing materials for case conferences and court hearings and in assessing prospective families in their ability to support the appropriate level of ongoing connections for the child.

This list is meant to address and help parties understand the clinical considerations including:

- whether openness is in the best interests of a specific child recognizing that best interests change as the child moves through developmental stages.
- the type of openness that may be appropriate for a child;
- education required for the child, birth family and adoptive family
- what supports may be required to ensure reasonable opportunity for successful planning for the child, birth and adoptive family.

Preliminary Considerations - ask the following questions about current contact a child/youth has

- Who does the child currently have contact with?
- Who else could or should be involved in an ongoing relationship with the child?
- What type of contact is currently happening – frequency, type, duration, supports required to facilitate connection?
- Are there issues concerning safety or the child's well-being?

Key information to know about the CHILD:

- Child's attachments/relationships- who/how many
- Child's developmental level
- Child's understanding of permanency and adoption
- Reason for initial and continued separation from birth family
- Child's emotional well-being and stability
- Other stresses the child is experiencing
- Child's views about ongoing contact with birth family

Key information to know about/from the BIRTH FAMILY:

- Reasons for permanency plan (abuse, neglect, mental health, parental disability)
- Safety issues that need to be acknowledged.
- Characteristics of relationship with child
- Birth family views about adoptive placement
- Previous experience with contact
- Ability to respect boundaries

- Stage of grieving and supports to help with resolution
- Ability to accept review, mediation and ongoing supports.

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Key Information to know about/from the ADOPTIVE/KINSHIP family:
(If family has not been selected, identify realistic/concrete factors that will be considered in selection)

- Views about ongoing contact and understanding of importance for a child
- Experience with accepting new people into extended family constellation
- Geographic proximity to birth family members
- Other demands on family time related to this child or other children in the home
- Attitudes toward birth family -empathy
- Adoptive parent's capacity to set healthy boundaries
- Ability to engage in open communication
- Cultural differences between birth family and adoptive family
- Ability of a system to provide family with support for review, assistance, and mediation.
- Parents' ability to accept support and be open to change.

Identify the factors that are likely to support success in openness planning?

- Do birth and permanency families seem to have a mutual concern for the child's well-being?
- Is there reason to believe that a friendship or personally satisfying relationship could develop between adults?
- Do adults have a reasonable ability to manage direct communication and respect boundaries?
- Can education and/or support be provided to adults (Birth/kin/foster & Adoption family) to develop a relationship that will prevent the further loss of birth family connection for the child?

Identify the factors that are most likely to be barriers to success in openness planning (and cannot be mitigated with supports). Such as:

- poor ability to manage boundaries that are set out
- lack of acceptance of "others"
- lack of external family support or understanding
- lack of community support or understanding
- geographical distance
- major differences in lifestyle, values

(This tool is available in a fillable pdf document – contact: patconvery@sympatico.ca)

Consider solutions that can be considered in planning that respect the needs and views of the child:

CAS workers, courts and mediators can help parents (adoptive/kin and birth family) to create the foundational structure for an ongoing contact plan for a child through agreements and court orders. They will benefit from having relevant information gathered, shared, and considered in the early stages of permanency planning and reviewed as appropriate through the transition of the child out of foster care to legal permanency with a family.

Ultimately, the success of any plan will be determined by the relationship and positive regard that develops between adoptive and birth family members over time, with the child as witness to this developing relationship and their sense of encouragement and normalcy from all family members, whether through biology or legality.

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BULLETIN FOR PROFESSIONALS

October 2013

Preparing Children and Youth for Adoption or Other Family Permanency

What's Inside:

Children leaving out-of-home care for adoption or other family permanency require preparation and support to help them understand the past events in their lives and to process feelings connected to their experiences of abuse and neglect, separation, loss, rejection, and abandonment. Child welfare, foster care, and adoption agencies often assume that permanent families will provide the healing environment for these children and youth, and these agencies spend considerable resources to recruit, train, and support foster and adoptive parents to provide legal permanency and well-being for these children. While a high percentage of these adoptions are successful—in that they are not legally

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dissolved—both children and families often struggle or suffer from stress that might have been mitigated by better preparation practices for all parties.

This bulletin discusses services for children and youth to address their readiness and preparation for permanent relationships. While adoption is not the first or preferred permanency goal for children and youth in foster care, this bulletin focuses on preparing those children whose goal is adoption; however, much of the information on preparation is also applicable to children and youth with other permanency goals. We look at what has previously been considered adequate preparation as well as current practices and those in development to more effectively ensure that children and youth are better prepared for permanent family relationships, including both legal and relational permanency (permanent relationships with caring adults).

REINSTATEMENT OF PARENTAL RIGHTS

Several States currently permit the reinstatement of parental rights after termination. These new laws were developed in response to the number of youth leaving foster care with no permanent family. To find out more, visit the webpage developed by the National Resource Center for Permanency and Family Connections: http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/reinstatement-of-parental-rights.html

Evolution of Preparation for Permanency

From the time that children and youth are removed from family care, they face numerous emotional stressors as they adjust to their ever-changing status: for example, foster child, dependent child, former adopted person, delinquent, and various diagnostic labels, among others. They are challenged by new surroundings and must come to some level of understanding of what happened to them, as well as affirm their own identity and allow themselves to create new relationships and redefine existing ones without protective adult relationships to support and guide them.

Achieving permanency is not just an **outcome** for these children and youth; it is a **process**. Whatever their legal status may be, at all ages, they are most interested in the relational permanency that they can find, create, maintain, or develop in the safety of a parent child relationship. Ensuring that children and youth are ready for relational and/or legal permanency, in what has proven to them to be a world that offers little stability, is a critical step.

Traditional Preparation Practices

No specific practice modality has been established across the child welfare delivery system to prepare children and youth for adoption. Rather, approaches to this work have been agency and individually based, with some similar components and services. Traditionally, services to prepare children and youth have focused on getting children ready for the adoptive family, helping them to understand the legal process, and obtaining

their consent for such a move—although the specifics of what this entailed could

vary widely (Hanna, 2007). This remains the practice in many agencies. Assessment of children's readiness for a new permanent family generally focuses on their behavior in foster care, with input from social workers and mental health professionals. Decisions are based on the assumption that children will accept new homes and families once they understand that it is unsafe for them to live at home. Actual preparation activities may consist of several conversations with the child or youth to talk about the family who wants them and then to plan for the placement. The emphasis is on where the child is going, with limited mention of biological parents and possibly siblings.

Numerous States and private adoption and foster care programs use established curricula to provide content and materials to train and approve potential parents, generally in compliance with Federal and State policies.[1] In fact, much of the preparation work is done with the prospective family, who, after reviewing the background of the child, meeting him or her, and having preplacement visits, determines that they want the child and can manage the behaviors of the child. In cases where a child is already living with a foster family and becomes legally free for adoption by that family, the change in legal status often occurs with little preparation for either the family or the child regarding other aspects of permanency.

The Adoption and Safe Families Act of 1997 (ASFA) brought about a number of changes in adoption:

- Elimination of long-term foster care as a permanency goal
- A shorter timeframe to termination of parental rights
- Change in emphasis in public agencies to a focus on time-specific goals to permanency, specifically, risk and safety assurances
- Shift in caseworker roles to case management functions
- More specialized work with children and youth, based on assessments and mental health treatment services

While the goal since ASFA has remained permanency for children and youth, service delivery has shifted toward a behavioral health perspective for treating the behaviors of children and youth. These behaviors are often viewed from a perspective of pathologies related to the trauma of abuse and neglect or the trauma that may have resulted from long-term foster care, group care, and impermanence in relationships. Thus, caseworkers and other important adults in the lives of children and youth may rely on therapists or behavioral specialists to prepare children for permanency. The focus often is on correcting behavior—to the exclusion of helping the child heal past hurts, resolve issues with past relationships, and prepare for relational permanency with the birth family, relatives, or adoptive parents.

Only a few models of preparation of children and youth have been developed. Hanna (2005) outlined the evolution of these models in the following table (used with permission from M. D. Hanna's 2005 Ph.D. dissertation, Preparing School Age Children for Special

1

Needs Adoption: Perspectives of Successful
Adoptive Parents and Caseworkers,
University of Texas at Austin):

Summary of Models of Child Preparation for Adoption	
Author	**Model's Key Components**
Chestang & Heymann (1976)	Consider child's relationship to biological parents Help child to understand they are not in foster care because they were "bad" Do not vilify biological parents Relieve child of guilt for placement Assure child of his or her right to caring and nurturing parents Help child understand foster care is temporary and adoption is permanent Worker should have consistent contact with the child – at least once a week Worker should explore type of family the child wants and seriously consider the child's wishes Child's participation may vary with age
Jones (1979)	Four stage process – Help child to understand legal termination of parental rights Help child understand difference between foster care and adoption Completion of the life story book Preplacement visits with adoptive family
Kagan (1980)	Strategic therapy approach to be used after adoptive placement prior to finalization. Assumes child is resistant to placement and has problem behaviors. Child has five tasks to resolve to successfully adjust to placement: Adjustment to current placement; learning the rules, expectations, roles, and norms Grieving the loss of parents and other significant individuals Expressing feelings of anger, fear, and sadness, preferably to new parents Developing a positive identity and self-image separate from previous parental figures Reattaching and forming primary bonds with the new adoptive parents
McInturf (1986)	Five-stage process using the lifebook as the primary tool of preparation. The facts The whys The feelings The goodbyes The plan for the future

Summary of Models of Child Preparation for Adoption

Author	Model's Key Components
Fahlberg (1991)	Identifies 14 tasks to be accomplished in transitioning child from foster care to adoption: Introduce adoption to the child Arrange first meetings Provide "homework" for child and family Share information Get commitment to proceed Plan subsequent preplacement visits Discuss name changes Initiate the grief process Discuss the "worst of the worst" Obtain permission for the child to go and do well Facilitate goodbyes with foster family and other people important to the child Provide ideas for welcoming ritual Facilitate postplacement contacts Arrange postplacement follow-up
Henry (2005)	The 3-5-7 Model – Three-step model with focus on involving the child in the process. Step 1 – Help child integrate past and present Clarification of past and life events Integration of all family roles and memberships Actualization of being a member of the new family Step 2 – Help child answer five questions What happened to me? Who am I? Where am I going? How will I get there? When will I know I belong? Step 3 – Critical elements of involving the child in the adoption process Engage the child in the process Listen to the child's words When you speak, tell the truth Validate the child and the child's life story Create a safe space for the child as they do this work It is never too late to go back in time Pain is part of the process

Where the Field Is Going

There is a growing recognition of the need to develop better practice models that guide children and youth toward permanency in

relationships and connections. In response, many public and private foster care and adoption agencies, residential treatment facilities, and therapeutic treatment agencies have begun to offer adoption and permanency services for children focused on issues related to the trauma caused by abuse and neglect. These services often provide excellent support for children but may be fragmented when it comes to addressing all of the relationships within the child's social network. Better preparation addresses all of the relationships—past and present—in children's lives, supports their grieving, and helps them identify new permanency sources. The type of support that children need for this work is not exclusive to therapists but can and should also be provided by other important adults in their lives. Agencies must develop and cultivate the skill and understanding needed by birth, foster, and prospective adoptive families to do this important work.

Promising Practices for Preparing Children and Youth for Permanency

Working with children and youth to guide them toward permanency in relationships should include both steps to address past traumas of loss and abuse and opportunities to give meaning to existing and future relationships.

Addressing Past Experiences in Preparation for Permanency

Those working with children and youth who have been in out-of-home care and are preparing for permanency need a basic understanding of the child's point of view, including these common experiences:

Loss and grief. Children and youth who are placed in the child welfare system often have a long history of losses and unresolved grief. They may have losses directly related to the circumstances that brought them into care (abuse, neglect), and they may experience additional losses when they are removed from their family and caregivers. Each move can bring more losses of friends, siblings, supportive adults, classmates, pets, familiar surroundings, and more.

Confusion and anger. Many children are left to wonder what really happened that brought them into care, why their families may not be able to continue caring for them, and who will be there to take care of them and protect them. A child may experience anger, sadness, and even depression. Many children struggle with their changed role within the family system or sibling status when they are removed from their birth family. Unresolved grief, effects of feeling unwanted and unloved, and confusion about who they are and where they will live have been shown to lead to behavioral issues, psychological confusion, emotional stress, and difficulty in forming new relationships.

Divided loyalties. Many children, particularly adolescents, have conflicting feelings about being a permanent member of a new family. These children may have difficulty with their sense of identity, may lose connections to immediate and extended family, and may have very little information about their own personal history.

Caseworkers who understand the child's experiences from the child's point of view will be better able to help the child or youth address past issues and explore the possibilities of new relationships.

Foundational Principles of Preparation

A number of foundational principles can help agencies shape an overall approach to support and guide children and youth as they identify and establish permanent relationships:

- All children and youth deserve relational permanency.
- Just as adoptive parents and guardians need preparation for the new relationships they are entering, so do children and youth.
- Readiness practices are needed regardless of the permanency goal or outcome.
- Permanency is a *process* for a child, not just an outcome. It starts with birth family relationships and continues with reunification, adoption, or other permanent familial relationships. Establishing or maintaining connections to the birth family or important people from a child's past may help to mitigate loyalty issues, whatever the permanency outcome.
- Permanency work with children requires time, consistency, and honesty from social workers.
- Work with children and youth should not be considered only in the context of therapy. Although behavioral health services may be appropriate for any individual child, engaging the child in activities, tasks,

  and conversations to prepare him or her for permanency can be the work of caseworkers, caregivers, social workers, family members, court personnel, and others. In some cases, birth parents or other birth relatives may be able to help the permanency process by giving their children "permission" to move on to a new family.
- Work with children and youth is a process that begins before placement and can extend past final adoption. (Unfortunately, many efforts do not start until the child has been freed for adoption when termination of parental rights has occurred, and many agencies provide only limited supports and services after adoption finalization.)

Engaging children and youth in readiness activities must be developmentally appropriate. The cognitive and emotional abilities of the child or youth must determine the types of activities (e.g., lifebooks) and resources used in permanency preparation work.

Permanency planning (the legal process) is distinct from permanency preparation work (the relational process). Children and youth can be empowered by their participation in the planning process, including their involvement in recruitment and family finding activities. Although these activities may engage them in some of the emotional tasks of preparing for permanency, a more comprehensive preparation program may help them explore their feelings about life events and support their readiness for permanency.

The work of the child or youth is to grieve old relationships in order to move toward new ones. The work of the caseworker and other adults is to prepare and support the child through the entire process.

Agency policies and caseworker practices that take a holistic view of permanency preparation work, considering it from the perspective of the child and encompassing the resolution of past issues and readiness for new relationships, will be better able to help children and youth bring their own meaning to permanency.

Permanency Preparation Practices

Most models of child preparation follow three basic stages (Hanna, 2007), and these general steps provide a good organizational structure and sequence for agencies and caseworkers responsible for preparing children and youth.

. Help the child to understand the facts of his or her removal.

2. Help the child explore feelings of loss, anger, and confusion.

3. Empower the child to be part of the plans for the future.

Henry's (2005) 3-5-7 Model© takes the three step process even further by specifying three tasks, five questions, and seven skill elements. The model offers a guided approach for workers and other adults helping children and youth explore and understand permanency in relationships. It focuses on the tasks of (1) clarification of life events, (2) integration of the experiences and meanings of relationships in different families, and (3) actualization of memberships in their identified network of families. The child or youth works on these tasks by exploring five conceptual questions, each of which addresses a specific issue. A 2011 article (Henry & Manning) suggests activities to support the child's work with the three tasks and issues related to the five questions.

1. What happened to me? (Issue: loss) (activity: create a loss line[2])

2. Who am I? (Issue: identity) (activity: make a life map or life path[3])

3. Where am I going? (Issue: attachment) (Activity: review pictures and memories)

4. How will I get there? (Issue: relationships) (Activity: create a collage)

. When will I know I belong? (Issue: claiming/safety) (activity: take a family photo together)

Creating a lifebook is essential to this work. Lifebooks help children remember and maintain connections from their past as well as integrate their past experiences into their current lives. Permanency/adoption practice models agree that children and youth need to process loss and grieve the losses related to their removal from birth families to help them develop healthy attachments to new adoptive families and permanent connections. At least one State (North Carolina) requires foster parents to be trained in making lifebooks before they can be licensed (Lifebooks, 2013). A number of resources exist to help workers, biological family members, foster and adoptive parents, and other important adults work with children and youth on creating and maintaining this record of their lives (see, for example, https://www.childwelfare.gov/adoption/postplacement/lifebooks.cfm).

The final component of Henry's 3-5-7 Model©, the seven skill elements, may vary slightly according to the age of the child. The elements identify the necessary philosophies and skills of those working with children and youth. Henry and Manning (2011) note that the seven elements are just a few of the many skills that adults need as they support youth through their grieving and preparing for new relationships:

. Use engagement activities that encourage expression of feelings and thoughts about life experiences.

. Create a safe space for expressing feelings.

. Recognize that behaviors are based in pain and trauma.

. Respond briefly to the child or youth's comments in order to provide space to grieve.

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[2] A loss line is a timeline of losses that can be created by the child or youth. See, for example, AdoptUSKids' *Lasting Impressions: A Guide for Photolisting Children,* available at http://adoptuskids.org/_assets/files/NRCRRFAP/resources/ lasting-impressions.pdf

[3] This activity involves stepping stones (e.g., sticky notes) that represent a life path events for the child (see Fahlberg, 1991, p. 363).

5. Listen.
6. Affirm their stories.
7. Be present as they do the work of grieving.

While the guided approach outlined by the 3-5-7 Model© can be woven into other child welfare practices, the application of the concepts requires training, leadership, and effective communication skills. It also requires a time commitment by the caseworker so that the child or youth has continuity throughout the process. The worker and youth should meet at least once every 2 weeks, with interim phone calls (Henry & Manning, 2011).

In a recent guide to help agencies find families for older children, AdoptUSKids provides a number of strategies that workers can use with older youth who may present barriers to adoption (AdoptUSKids, 2012; see http://adoptuskids.org/_assets/files/NRCRRFAP/resources/going-beyond-recruitment-for14-to-16-year-olds.pdf). Youth's common concerns as listed in the guide include:

- Not understanding what adoption means
- Not believing that anyone would want to adopt them
- A worry that adoption would prevent them from ever having any contact with their birth family, including siblings
- Feelings of disloyalty to their birth family
- Worry about changing their name
- Worry about moving far away

The guide outlines a number of strategies to counter these concerns, most of which revolve around providing factual information in a candid and sensitive manner.

Youth engagement and empowerment is an important part of permanency preparation work, especially for older youth who may have experienced greater disappointments and have more reluctance to seek out a new family. In one study, the Wendy's Wonderful Kids (WWK) program interviewed 74 youth about strategies that workers had used to help the youth overcome their lack of hope and their distrust about achieving permanency (Ellis, 2011). Youth identified the following worker strategies as successful:

Emphasize the advantages of adoption

Seek relatives and other connections to adopt

Be open and honest about the adoption process and possible outcomes

Empower youth throughout the adoption process

Address questions and concerns

Build a relationship with the youth

Promising Programs

Many child welfare agencies recognize that children and youth in care need opportunities that will prepare them for permanency. The following list spotlights jurisdictions that have incorporated a significant preparation component for children—not just families—into their permanency efforts.

Description of Programs

. **The National Institute for Permanent Family Connectedness (NIPFC)** (http://www.familyfinding.org/), at Seneca Family of Agencies, Oakland, CA, provides comprehensive, collaborative partnerships with child welfare agencies throughout the nation to build capacity to find and engage families that can become permanency resources for youth living away from their birth families. Instruction

is available to families to encourage their attention to loss and grief work with youth. Specialized training is provided on the Family Finding model, developed by Kevin Campbell. The technique of Mobility Mapping is used to identify connectedness of relationships, and information on families is collected through a discovery phase. These components are then coordinated for youth in a Blended Perspectives meeting with family members interested in building relationships with youth. Lifetime support networks are developed to secure permanency for youth. NIPFC provides training, coaching, and technical assistance to many State and regional programs, in addition to Federal grant programs. A Facilitator's Guide is available to deliver a curriculum for the implementation and integration of the process of Family Finding.

2. **Wendy's Wonderful Kids (WWK)** (http://www.davethomasfoundation. org/what-we-do/wendys-wonderfulkids), at the Dave Thomas Foundation, has established an effective program for the recruitment of adoptive families wherein recruiters practice child-focused recruitment. Their strategy is to focus exhaustively on an individual child's history, experiences, and needs in order to find an appropriate adoptive family. Child preparation teams consist of child welfare caseworkers, adoption workers, and therapists. Elements for the preparation of children are identified and, generally, provided through individual workers who engage in monthly contact with children. Determinations of preparedness for adoption and whether the child has needs that should be addressed before moving toward the adoption process are the objective of these activities. An evaluation study of outcomes over 5 years at 21 grantee agencies showed that children served by WWK were 1.7 times more likely than children not receiving WWK services to be adopted (Child Trends, 2011). The program currently has more than 100 recruiters in all 50 States and Canada.

- **Extreme Recruitment** is a program of the Foster & Adoptive Care Coalition of St. Louis, MO (http://www.foster-adopt.org/ carleen-goddard-mazur-training-institute/ extreme-recruitment/). Funded by the Children's Bureau, Extreme Recruitment is a 4-year trial that models the practice of diligent recruitment to reconnect youth (10 to 18 years) to kin through child-specific recruitment, intensive family-finding, and support services. The preparation component involves examining the youth's life for factors that impact readiness for permanency and addressing mental behavioral and physical health needs, peer and adult relationships, and educational needs. Preparing resource parents for permanency is also included.

- With a focus on the concurrent preparation of both children and their prospective adoptive families, **Family Focus Adoption Services** of Queens, NY, promotes a carefully paced transition phase in adoption placement (http:// familyfocusadoption.org/adoptionguides. html). The agency believes that much of the preparation work is best done by the children themselves, at their own pace and to their own level of satisfaction. Adult protection is provided throughout the process and is intended to help build children's self-confidence. A trained and well-supervised adult guides each child from placement through the child's decision about adoption. Using a graduated visiting schedule and taking the child through a series of adoption levels that are marked by six cards collected by the child over 5 months, children can become more and more certain that being adopted by the particular family they are with is the right decision for them.

- **Robert G. Lewis**, of Wooster, MA, trains and supports agencies and States in preparing youth for permanency in a program called Family Bound (http://www.rglewis.com/RGLewis%20 Site/index.html). His curriculum, *Family Bound Program: A Toolkit for Preparing Teens for Permanent Family Connections*, provides the

philosophy and activities to engage youth in this work. Youth attend group or individual sessions to discuss nine topics (e.g., the Real Truth About Families, Loss Is a Part of Living, etc.). It is a therapeutic, educational process that teaches concrete skills and provides teens with the opportunity to open up avenues for personal growth through healing relationships. The lessons are reinforced by opportunities to practice on family weekend visits. Currently, he has created a video project for use with teens to tell their stories about their lives, hopes, and dreams to explore meanings of potential permanent relationships.

6. A number of jurisdictions use the **3-5-7 Model©** to support permanency work for children and youth, including California, Delaware, New Hampshire, Pennsylvania, and Wisconsin (Henry & Manning, 2011). As described above, the 3-5-7 Model© provides a guided approach to help children, youth, and families do their work of grieving losses and rebuilding relationships, working toward the goals of well-being, safety, and permanency. The model is a strengths-based approach that empowers children and youth to engage in grieving and integrating significant relationships. In several programs, the model is woven into family-finding activities and Family Group Decision Making conferences. Practice applications are made both at intake and throughout ongoing case management services, including protective and placement services that can also support kinship, foster, and adoptive family placements. The 3-5-7 Model© provides tools (e.g., lifebooks, loss history chart) to support work around issues of separation and loss, identity formation, attachment, and building relationships, and it also supports deeper therapeutic work around abuse, abandonment, and neglect experiences.

Tools and Resources

There are a number of tools that workers may find useful in their permanency work with children and youth.

The Annie E. Casey Foundation developed a *Permanency Case Planning Tool* to help caseworkers and supervisors working on permanency cases understand the case factors that are potential barriers and/or facilitators to permanency teaming and outcomes. http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={28123D47-0363-46B4A592-974FCCB07FA7}

The Children's Bureau's National Resource Center on Adoption (NRCA) provides consultation and technical assistance to States to enhance their capacity to provide services to ensure that all children and youth have permanent families. The NRCA developed an *Adoption Competency Curriculum* that includes seven modules, one of which is *Child/Youth Assessment and Preparation*. The NRCA offers training to States on the curriculum; also, the handouts for the child/youth assessment and preparation include a number of tools, worksheets, and recommendations and are available online. http://www.nrcadoption.org/wp-content/uploads/TG-ChildAssessment-Preparation-4-111.pdf

The Center for Adoption Support and Education offers a number of resources for children, teens, and adults, including book lists and other resources. The website offers information about the seven core issues in adoption that apply to all members of adoption circle: loss, rejection, guilt/shame, grief, identity, intimacy & relationships, and control/gains. http://www.adoptionsupport. org/res/index.php

Wisconsin's Coalition for Children, Youth & Families has produced *Touchpoints: Preparing Children for Transitions* to help caseworkers prepare children. The guide breaks down key discussion times, points to discuss, and who should be involved and provides helpful materials to use for each step (books, videos, guides, and activities).

http://wiadopt.org/ToolsforWorkers/TouchpointsTool.aspx

- The Center for Advanced Studies in Child Welfare at the University of Minnesota, in partnership with Anu Family Services, developed the Youth Connections Scale to help child welfare agencies better work with youth to strengthen and build relationships. The scale measures the strength of relationships between youth and adults: http://www.cehd.umn.edu/ssw/cascw/attributes/PDF/YCS/YCSImplementation. pdf

The Children's Bureau has funded several grant clusters that focus, in whole or in part, on improving permanency outcomes:

- Diligent Recruitment of Families for Children in Foster Care: http://www.adoptuskids.org/ about-us/diligent-recruitment-grantees
- Permanency Innovations Initiative: https://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=123&sectionid=19&articleid=3087
- Family Connection Grants: http://www.nrcpfc.org/grantees.html
- Youth Permanency Cluster: http://www.nrcadoption.org/resources/ypc/home/

Conclusion

Helping children, youth, and families served within the child welfare system to prepare for permanent relationships offers greater opportunities for their improved well-being. Children and families often have both the strength and resilience to overcome hurtful life experiences and move toward resolution of past losses. Models of intervention that establish these practices are beginning to demonstrate a practical and viable method to support successful outcomes with families.

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Using Family Group Conferencing to prepare children for placement, for moves in care, and continuing contact with their original families - by Sally Palmer

Introduction to Family Group Conferencing (FGC)

FGC originated in New Zealand to address the over-representation of Indigenous children in foster care and jail. It is now included in Ontario's Child, Youth and Family Services Act. It is designed, in part, to address the power imbalance between family groups and child welfare agencies.

The family group refers to the child and their 'extended family group' as defined by the family group themselves. It includes people important in the child's life such as extended original family members, supportive people (neighbour, teacher), and prospective or current caregivers, if these are not part of the extended original family.

Leadership in the FGC is shifted from child welfare professionals to the family group which includes extended family, supportive people, caregivers, and the child. Structure is provided by a coordinator who is trained in leading FGCs.

The coordinator is expected by all participants to be impartial and holds no child welfare authority over the plan that the FGC develops. The coordinator prepares all participants prior to the conference, chairs the first session of the meeting, and organizes a leader from the family group for the second session. This is the private time in which the family group develops a plan for the child's care and brings their plan back to the total group. During private time, the family group works toward a decision about: keeping the child at home; initial placement; a move within care; access to family members; return home; and possible supports to the original family or caregivers. They also seek offers of support from members of the family group to ensure that the plan will be successful. When the family group has formed a plan for the child, they meet again with the coordinator and others from the initial session to tell them about the decisions they have reached in the private family time to address the reasons the child welfare agency is involved. At this point, child welfare professionals may question the plan and suggest modifications.

The third/final session is when the final decision is made by all participants, either to accept the family group's plan or modify it to meet the agency's concerns. Following this, the coordinator records and distributes the plan developed during the conference to all participants.

The role of child welfare professionals is to provide information to the family group about why the agency is involved and to invite the family group to develop a plan to address the safety concerns. During the final session, the child welfare professionals confirm that they accept the plan developed in the meeting as addressing the initial concerns and agree to implement the plan.

Stages of supporting child's involvement in FGC

The coordinator prepares the child for FGC by explaining the reason and process for the conference: asking the child what they want their family to know and how they would like to share this during the conference. If the child would like assistance in putting their thoughts together, the coordinator and the child decide who is the best person to help them.

The coordinator prepares a support person from the child's own network to focus on the child during the conference if the child agrees to have a support person present. The support person helps the child to express their thoughts and feelings, ensures a respectful reception for the child's input; and can move a young child to another room when needed. The coordinator provides a flexible location for the conference, as well as childcare when needed, so the child can move in or out as needed.

The coordinator role is complete after putting the Plan into final form and distributing it to all participants who were present at the conference. The child welfare worker is responsible for implementing the plan which includes regularly reviewing it with the family group to ensure it is current, relevant, and achievable. The group can reconvene for a follow-up FGC when the plan needs revisions.

Potential benefits of FGC to children and families….

…In Finding Permanency and Exploring Openness

An FGC at decision making time can bring together those who are involved in a child's life so all can contribute to finding a permanent plan for the child.

The experience of having all these people involved in the conference demonstrates to the child that all participants are concerned about them and want to support them.

It is valuable for the child to be present when decisions are being made by those who care about them, and to have the opportunity to participate actively in these decisions.

It is important that the family group has some input into plans for the care of the child. They are more likely to cooperate with plans they have helped to make. Also, they have heard the concerns of the professionals in an open environment where the family has been given some leadership.

The FGC usually elicits offers of help to the child from extended family that would not have come forth without the time spent in the conference. Where parties cannot provide a secure permanent placement for a child, they might continue to provide stability and support to the child in other capacities.

An FGC could be held once permanency is found to discuss what openness might look like and how boundaries can be protected.

LIFEBOOKS

Lifebooks are a meaningful and easy to create tool that helps children to carry with them the story of their life. The foster parents, workers and family can collaborate to bring together the details of a child's life, with pictures, memorabilia and information about their people, places and events. Below are some excerpts from "My Lifebook" by Judy Archer, September 2016. The entirety of the book can be found and used from: INSERT LINK

BIRTH FAMILIES

Everybody has a birthmother and a birthfather. These are the people who give us many precious gifts, including the gift of life!

From our birth parents and other members of our birth family (i.e., grandparents, etc.), we get many of the wonderful things that make us so special and so unique! These things or characteristics include the way we look (i.e., eye colour, _____), our ancestry/culture (i.e., _____), some of our talents (i.e., music, _____) and personality traits (i.e., happy, _____, _____), and sometimes, even some of our health conditions (i.e., allergies, _____, _____).

Even though birth parents give us life and love us, not all birthmothers and birthfathers are able to raise their children. Sometimes they are just too young! Sometimes they have too many grown-up problems. And sometimes, they just don't have the knowledge and skills it takes to look after children and keep them safe. Skills are learned. It takes time, practice and help from someone else, usually a grown-up, to learn a new skill.

Two of the skills I am learning are:

√_____

√_____

Some of the skills that parents must have to look after children & keep them safe are:

√_____

√_____

√_____

√_____

Even though they can't always care for their children, no birth parent wants to fail. Some birth parents actually know that to grow up healthy and strong, happy and safe, their children must be raised by another family. Realizing this probably makes these birth parents feel _____ and _____.

Even though they may not be able to raise their children, birth parents never, ever stop thinking about their children.

MY BIRTH FAMILY

I have a birthmother and a birthfather.
My birthmother's name is _____.
She was born on _____, 19____ in _____.
Her Nation/culture is _____. She is from the community of _____.
_____ is approximately ____ tall and weighs about _____ pounds/kgs.
She has _____ hair and _____ eyes.
Here is a picture/drawing of my birth mother.

My birthmother completed a grade ___ education.
My birthmother worked as a _____ and a _____.

Some of the things my birth mother also enjoyed/enjoys doing include:
◁ _____
◁ _____
◁ _____
My birthmother was the _____ child in her birth family. She had _____ sisters and _____ brothers.
Some of the other things I know about my birth mother and her family are:
☼_____
☼_____
When I think about my birth mother, I feel _____ and _____. I also wonder:
? _____
? _____
? _____
_____ I was born, my birthmother had _____ children. They are my s_____ and b_____. Their names are:
♥ _____ born _____
♥ _____ born _____
Some of the things I remember/know about my life with _____ are:
√_____
√_____

My birthmother wasn't able to look after any child when _____.
She wasn't able to care for children because _____

SPECIAL MEMORIES OF MY LIFE WITH _____

♪_____

♫_____

♪_____

MEMORIES OF MY PLACEMENT WITH _____

→_____

→_____

→_____

Whenever I think about some of the things that have happened to me I feel ___ _____.

I feel this way because_____

These feelings are perfectly normal for anyone who has faced **really big changes** in their life! Anyone who has gone through as many changes as I have is really **brave**! Whenever I get upset from thinking about some of the **big changes** that have happened to me, I remember that there are people who will help me. There are also special things I can do, to make myself feel better. Some of these people are:

☺_____

☻_____

☺_____

Some of the things I can do are:

√_____

√_____

√_____

Here is a picture of me taking care of myself and my feelings.

VISITS

Even though I live in a foster home, I still get to have visits with members of my b_____ f_____. We still visit one another because _____.

This makes me feel _____.

Some of the things I do with the members of my birth family, when we visit are:

Here are some pictures of my visits with members of my birth family.

My Lifebook, by Judy Archer, MSW, RSW (revised, September 2016)

SPECIAL THINGS ABOUT ME!

★I AM _____ **YEARS OLD**
★I AM OF _____ **ANCSESTRY/NATION**.
★MY **BIRTHSTONE** IS _____
★_____ IS MY **ZODIAC SIGN**
★I LIVE IN A _____ **FAMILY**
★I HAVE ___ **BROTHERS** AND ___ **SISTERS BY** _____
★SOME OF THE PEOPLE WHO **LOVE** ME ARE: _____
★FROM MY **BIRTHMOTHER**, I INHERITED OR LEARNED
_____
★FROM MY **BIRTHFATHER,** I INHERITED OR LEARNED
_____
★SINCE JOINING MY _____ FAMILY, I HAVE **LEARNED** TO
_____
★IN MY _____ HOME, I HAVE A **PET** _____,NAMED _____.
★_____ IS MY **BEST FRIEND**
★I AM IN **GRADE** _____ AT SCHOOL
★MY **TEACHER'S NAME** IS _____
★TWO **SKILLS** I AM LEARNING AT SCHOOL ARE _____ and _____.
★WHEN I GROW UP, I **WANT TO BE** A _____
★MY FAVOURITE **COLOUR** IS _____.
★MY FAVOURITE **MEAL** IS _____.
★MY FAVOURITE **DESSERT** IS _____.
★MY FAVOURITE **THING TO DO** IS _____
★MY FAVOURITE **TELEVISION SHOW** IS _____
★MY FAVOURITE **TOY/GAME** IS _____.
★MY FAVOURITE **BOOK** IS _____
★MY FAVOURITE MOVIE IS _____
★I AM **REALLY GOOD** AT _____
★OTHER **SPECIAL THINGS** ABOUT ME ARE _____ &
_____
★I AM VERY **BRAVE** & _____
★I DESERVE TO BE _____ & TO RECEIVE _____ **CARE** AT ALL TIMES
★TWO OF THE THINGS I **WORRY** ABOUT ARE _____ and
_____
★IF I COULD HAVE **3 WISHES** I WOULD WISH FOR _____,

★HERE IS *A* **PICTURE** OF **ME!**

My Lifebook, by Judy Archer, MSW, RSW (revised, September 2016)

Adoption Booklist

For Parents:

1. *The Open-Hearted Way to Open Adoption* by Lori Holden
2. *The Eye of Adoption* by Jody Cantrell Dyer
3. *The Connected Child* by Karyn B. Purvis, David R. Cross and Wendy Lyons Sunshine
4. *Attaching in Adoption* by Deborah D. Gray
5. *But the Greatest of These Is Love* by Debbie Barrow Michael
6. *Blackbirds* by Greg Santos
7. *It's Not About You: Understanding Adoptee Search, Reunion, and Open Adoption* by Brooke Randolph
8. *Ohpikiihaakan-ohpihmeh (Raised Somewhere Else): A '60s Scoop Adoptee's Story of Coming Home* by Colleen Cardinal

For Kids:

6. *Tell Me Again About the Night I Was Born* by Jamie Lee Curtis
7. *The Day We Met You* by Phoebe Koehler
8. *ABC, Adoption & Me* by Gayle H. Swift
9. *I Wished for You: An Adoption Story* by Marianne Richmond
10. *A Mother for Choco* by Keiko Kasza
11. *I've Loved You Since Forever* by Hoda Kotb
12. *Born from the Heart* by Berta Serrano
13. *What is a Family? A Question and Answer Book* by Tamia Sheldon
14. *For Black Girls Like Me* by Mariama Lockington
15. *When You Were Born in China: A Memory Book for Children Adopted from China* by Sara Dorow
16. *Three More Words* by Ashley Rhodes-Courter

Section V: Supporting Children Transitioning from Care

SUPPORTING THE NEEDS OF YOUTH AGING OUT OF CARE – written by Roxanne Williams

Going through life unknowing
Family to Family
Families who scare and beat
Families who care and are sweet
Defaces thinks this is for the best
I would love to give them a test
Take them from who they love
Put them in homes who beat
Move them from school to school
Test their will to survive
Just like they test ours
We who overcome their blind eyes
And live to age of 18
Live to age and get dumped
Dumped into a world who judges
And deface thinks this is for the best
This is life in foster care
Life with no real family
No real home, But who cares
We are not their problem
Just a child, a number, a case
To dump on anyone
Foster care, more a hell than a life - Michael Matthews

The "Aging Out Stage" for young adults is the most crucial stage that can either set the tone for their success or be the reason that they "fall through the cracks". Often people compare youth aging out of care with adults leaving the parental home. They are not one in the same. When a youth enters Ready, Set, Go (the program to provide financial support to youth leaving care in Ontario) and moves into their own living space they can be as young as 16 years old. That is truly when the aging out and "separation" process begins. Youth go from living in a group-home with anywhere from 5-10 other kids in similar circumstances and a rotation of 3-5 staff multiple times a day to a quiet apartment, alone almost instantly. That transition is traumatic. As someone with lived experience in foster care, I remember my first few nights of independence. I slept in the bathtub at my apartment because I was afraid of the noises and the bathroom door was the only door I could lock. When a young adult from a regular two-parent household moves out on their own they almost are never 16. Also, they have the option to do a gradual move in and can go back anytime they get lonely. They aren't separated so abruptly. Youth on Society support don't have that option. More times than not group homes don't accept visits from previous youth; partially because of confidentiality and in part because it's standard policy and they're on a set schedule. This leaves our youth with little natural support to help them manage a crucial and emotionally impactful time.

I give my success credit to the fact that I was able to maintain relationships with staff and youth from most of my living placements. We can't raise successful young adults and then push them out into the real world and cut all ties and expect them to flourish; you must continuously water a plant for it to survive.

When youth are in care it's imperative that we give them as many skills and provide them with as many coping strategies as possible, because once they age out, the system we have in place right now doesn't favour a successful outcome.

There are two categories of youth who are on Society support: youth with contact with their birth families and youth without contact. Having the family portion can either give the youth more positive support, or they can be a negative influence. Every case is unique and should be treated as such. What works for one youth may not be beneficial for another.

Personally, I did not have family contact which means that I would rely completely on the supports that Durham CAS put in place for me. Even more reason why arbitrarily cutting off support can be detrimental to the success of youth. I'm not only referring to financial support. A 16-year-old teenager is not capable of leaving the "parental home" and becoming successful without any outside help. We also must keep in mind that our youth have far more moving parts that would negatively affect their ability to cope. Many youth have had to deal with trauma, psychological and developmental delays with not yet fully developed brain capacity**.**

Workers have the potential to provide youth with the supports and resources that would assist them in making this difficult transition. There are so many factors to consider and put in place that it can be overwhelming for child welfare staff, and nowhere in the mandates of the job are there requirements to provide this kind of parenting role. Let's consider some of the factors.

Imagine raising a youth in the system who has suffered severe trauma, giving them the best counselling services for t*en or more years,* and then cutting them off abruptly. Add to this, making that young adult choose between one counselling session a week or groceries. Does that sound like youth are being set up for success? Being a young adult out in the world alone is hard enough without dealing with a fraction of what *placed youth* deal with on a day-to-day basis. Nationally there are *approximately* 1,100 suicides on college campuses annually. Having therapy available at an affordable rate is imperative. How can we provide our youth with the best care and then at 21 pull the plug? As a former Crown Ward, for more than 15 years I was provided with the best counselling services. Art therapy, Play therapy, conventional therapy. You name it I was involved in it all. I'm forever grateful because I do believe in the power of having a safe place to unload or bounce ideas off. But I will say that it was not until in my mid 20's and now in my 30's that I'm working through my experiences. Things I didn't know would affect me later in life. The expression "one bad apple can spoil the bunch" in this situation means that we don't want to expose youth who are healing back to toxic parents/family members. If they are all healing and working through their issues, then the hope is that they won't do more harm.

Think about it like this: the youth is the body of a car; the engine is the youth's will to want to make change for the better and the tires are the mental health services and counselling that keep the youth moving forward.

When Youth embark on the journey that is Extended Care and Maintenance an ongoing challenge is finances. Both workers and youth need to work together and come up with a plan for success. Long and short-term goals are needed. When dealing with children in extended care, it is important to remember that we are hearing most information for the first time, if at all. Something as simple as not knowing that it's ok to only make the minimum payment on a credit card. I had a similar situation happen to me and my CAS worker paid off the card as a one-time saving grace. I didn't know that I had the option to make the minimum payment because no one told me. In a regular household those topics would be discussed, but for youths living on their own, those things are often missed.

Youth who are enrolled in full time (part-time if registered with a permanent disability) post-secondary school are eligible to remain on Society support until the age of 25, which means they have access to the Health, Dental and Vision benefits. The youth who choose to not go into post-secondary school or trades are removed from the medical plans and Society support monthly living cost at the age of 21. Youth who don't have benefits will most likely not spend their money on prescription medications that they feel aren't needed. While in college I was on Birth Control, had an EpiPen and 2 different inhalers and I can confidently say that if I had to pay for those things, I wouldn't have gotten them. As lifesaving as they are, things are already tight enough, so extras often and aren't seen as important. It's a fine line between Society support and homelessness especially with the rise in the cost of living. I do want to highlight that youth who come from "normal" 2 parent households still need these skills as well. Everyone would benefit from things like financial literacy and counselling services. All youth are navigating through a difficult time in their lives and any additional supports across the board would be beneficial.

Having said that, I know that my experiences within the child welfare system are not common. Over the years I've lived with hundreds of youths in homes across the province and I can say with certainty that a lot of them didn't turn out as well as I did. I am who I am because I had a phenomenal Children's Aid Worker who worked tirelessly to ensure that I had the best tools at my disposal. Which is why this manual is so crucial. It's impossible for every worker to know everything. This manual will serve as a reference, a template and a box of tools so that other youth within the system can excel like I did. Having a "go to" guide to help youth and youth care workers/parents navigate through the many obstacles that they will face. At the end of the day youth in care are not much different than youth who grow up in "normal" two parent households. We can give them all the tools in the world but if they don't want to change for the better than they won't. It's important that we understand that not every youth will have a successful outcome, but that doesn't mean we shouldn't try. Not every story is the same, there are factors that change how a youth's life plays out. We must treat each case individually. Some things that worked for me may not work for another youth who came from a similar background with similar traumas. In my adult years I get asked the same question a lot; "Why did you make it?". I typically answer the same way. I made it because the adults around me didn't give up on me even when I had given up on myself.

TOOLS FOR SUPPORTING YOUTH AGING OUT OF CARE:

- A checklist for supporting youth aging out of care
- Resources for independence
- The Aging Out Without a Safety Net report
- Using FGC for post-care planning

Checklist for Supporting Youth Transitioning Out of Care

The following is a non-exhaustive list of things to consider when supporting a youth aging out of care. These categories are meant to prompt us to consider information or resources we can link our youth to which we may not have considered.

Housing:

- Help finding affordable/safe housing
- Furnishings/a bed/a couch/dishes/small appliances
- Setting up a Hydro/ Water tank account if needed. Linking it to their bank account for easy bill payments
- Information about tenant rights, emergency numbers, etc.

Immigration:

- Immigration assistance for youth/young adults and their families
- Getting a hold of documents while the youth is a minor as the process is significantly easier
- Permanent Resident Applications
- Canadian Citizenship Applications
- Passport Application help

Transportation:

- G1, G2 and G driver's license help (Other licenses if needed for Trades)
- Drivers Education Training
- Ontario Photo Card if a Driver's License isn't an option
- Help purchasing the right vehicle (Do's and Don'ts)
- Help getting proper car insurance/Registration/ Plates
- PRESTO Card help for Public Transit (City buses /Go buses/ Trains)

Criminal Justice:

- Probation help (Regular follow ups)
- Sealing Youth records (They have to complete their probation before their 18th birthday for the file to become sealed)
- DNA on file
- Diversion Programs
- Conditions Youth / Young Adults must abide to
- Youth/Young Adults with Family members who have criminal records/Conditions
- Non-Contact orders/ removing non-contact orders if youth choose to pull them

Education:

- Graduating High school supports and options for education/adult learning

- GED Test and Prep
- Distance learning
- Registering as a student with a permanent disability in both High school and Post-Secondary
- Tutors
- Grade 10 Literacy test prep
- Career aptitude testing
- Guidance counsellor support
- Applying to Colleges/Trade school and Universities
- Free tuition portion through OSAP at all Colleges and Universities in the Province
- Applying for bursaries and scholarships

Employment:

- Resume / Cover letter help
- Job Search Assistance
- Extra training
- Student Placements / Internships available to Children's Aid Youth/young adults through OACAS
- Interview help/ Prep
- References
- Training (First Aid, Smart Serve, WHMIS, Food handling, Security License, UMAB)

Young Parents:

- Regular checkups pre and post pregnancy
- Medications
- All things breast feeding vs bottle feeding
- Parenting classes/ Books
- Setting up baby's room/living space
- Baby and Toddler classes (Mommy and Me)
- Registering baby 's birth and identification
- Postpartum Depression help
- Paternal support
- Child Support (FRO)

Religion and Culture:

- Ensuring the youth maintain a connection to their culture/religion
- While in care we should seek out programs/groups they can attend in order to maintain the relationship
- Reach out to the parents if possible to ask what the youth is accustomed to and what workers can do to mimic this
- Having more of a presence of staff from all backgrounds so youth have role models that look like they do
- Ensuring group homes and foster homes try to incorporate cultural foods when youth from background are living in the placement. Teach them how to cook their nationalities dishes

IMPORTANT RESOURCES FOR INDEPENDENT LIVING

EMERGENCY NUMBERS:

Police/Fire/Ambulance: 9-1-1
Toronto Police non-Emergency Line: 416-808-2200
Gerstein Crisis Centre (24/7): 416-929-5200
Toronto Distress Centre (24/7): 416-408-4357 or text 741741 (2am-2pm daily)
Kids Help Phone: (24/7) 1-800-668-6868 (up to age 20)
Canada Suicide Prevention Service 1-833-456-4566

HOUSING:

Housing & Shelter – City of Toronto

Home (torontohousing.ca)

WoodGreen – housing help and other support services in East Toronto

The Access Point – housing help for mental health and addictions

Homepage - Canadian Centre for Housing Rights (housingrightscanada.com)

Housing Support Referrals & House Hunting Tools - The 519

Street-involved Youth | Yonge Street Mission (ysm.ca)

Home - Covenant House Toronto – youth shelter for 16-24 years of age

Tenant Hotline (Mon-Fri, 8:30am-6pm): 416-921-9494
Landlord & Tenant Board (Mon-Fri, 8:30am-5pm): 416-645-8080

FOOD SECURITY

Food Secure Canada

Afri-Can FoodBasket – Healthy Food – Healthy Communities (africanfoodbasket.ca)

Black Creek Community Farm (blackcreekfarm.ca)

Find a Food Bank - Food Banks Canada

FINANCES

Social assistance | ontario.ca

Tax credits and benefits for people | ontario.ca

Income tax - Canada.ca

Youth Opportunities Fund | Ontario Trillium Foundation (otf.ca)

Financial Literacy | YouthRap

CNH Easy Access Voicemail – low-cost voicemail services

How do I open a bank account? | New Youth

EDUCATION

Go to college or university in Ontario | ontario.ca

OSAP: Ontario Student Assistance Program | ontario.ca

Student aid - Canada.ca

Home | Sky's the Limit Youth Organization (stlonline.org) – resources and funding for technology

Employment Profile (gov.on.ca) – program feedback on all post-secondary courses

Educational Support - cafdn – CAS foundation offers scholarships, college tours, etc.

Heritage Skills Development centre HSDC – Home (hsdconline.org)

EMPLOYMENT

CEE Centre For Young Black Professionals – Careers | Education | Empowerment (ceetoronto.org)

ECLYPSE Youth Employment Program - Rapport Youth & Family Services

Get help finding a youth or student job | Ontario.ca

Employment Ontario | ontario.ca

Apprenticeship in Ontario | ontario.ca

Youth Works Program - cafdn

CRIMINAL JUSTICE

Legal Aid Ontario

Lawyers – Legal Aid Ontario

Home - CLEO (Community Legal Education Ontario / Éducation juridique communautaire Ontario)

Home - Steps to Justice

YNOT Services | Restorative Justice Program

Home - Black Legal Action Centre | Legal Services for Black Ontarians

Collective of Child Welfare Survivors (collectiveofcws.ca)

Youth - FASDJustice CA

Youth Justice - Central Toronto Youth Services (ctys.org)

What happens if I get arrested? | New Youth

PARENTING

Healthy Babies Healthy Children – City of Toronto

Planned Parenthood Toronto – boldly empowering toronto's youth (ppt.on.ca)

Support for Mothers and Caregivers – The Jean Tweed Centre

Massey Centre – young parents resources and residence

Jessie's Centre | Helping Young Pregnant & Parenting Women (jessiescentre.org)

Rosalie Hall | Home – young parents residence, resources and school

Register a birth (new baby) | ontario.ca

Ontario Child Benefit | ontario.ca

IMMIGRATION

Immigration and citizenship - Canada.ca

Home | New Youth – online community and resources for immigrant youth

Child Welfare Centre for Excellence - Free Immigration Advocates for youth having left care

TRANSPORTATION

Get a G driver's licence: new drivers | ontario.ca

Register and insure a vehicle in Ontario | ontario.ca

Ontario 511 (511on.ca) – road safety and reports

CULTURE & COMMUNITY

Fostering Community – an online community for youth in and formerly in care

Black Youth Helpline

Home (cheersyouthmentorship.com) – youth mentorship program for black youth leaving care

HOME | Project Outsiders – youth-led social organization for former foster care youth

Naseeha – helpline for Muslim Youth

2Spirits - Your Spiritual Home – 2Spirited First Nations resources

Wraparound | Lumenus | Programs & Services – services up to 25 years of age

Youth in Care Networks - The National Youth in Care Network: Youth in Care Canada

Never Too Late Program - helps youth find connections to "family"

HEALTH

Find a doctor or nurse practitioner | ontario.ca

Free Dental Care – City of Toronto

Renew a health card | ontario.ca

TAIBU Community Health Centre (taibuchc.ca)

Women's Health in Women's Hands (whiwh.com)

Casey House – Living with or at risk of HIV

Parkdale Queen West Community Health Centre (pqwchc.org)

Unison Health & Community Services (unisonhcs.org)

Telehealth: 1-866-797-0007

COUNSELLING & MENTAL HEALTH

Community Mental Health Programs - Toronto Central - torontocentralhealthline.ca

Walk-In Counselling - Family Service Toronto

Health & Fitness Toronto - Mind Your Life And Associates (mindyourlives.com)

Belfon Psychological Services - Enhancing the wellbeing of children in their Homes, Schools, and Communities. (belfonpsychology.com)

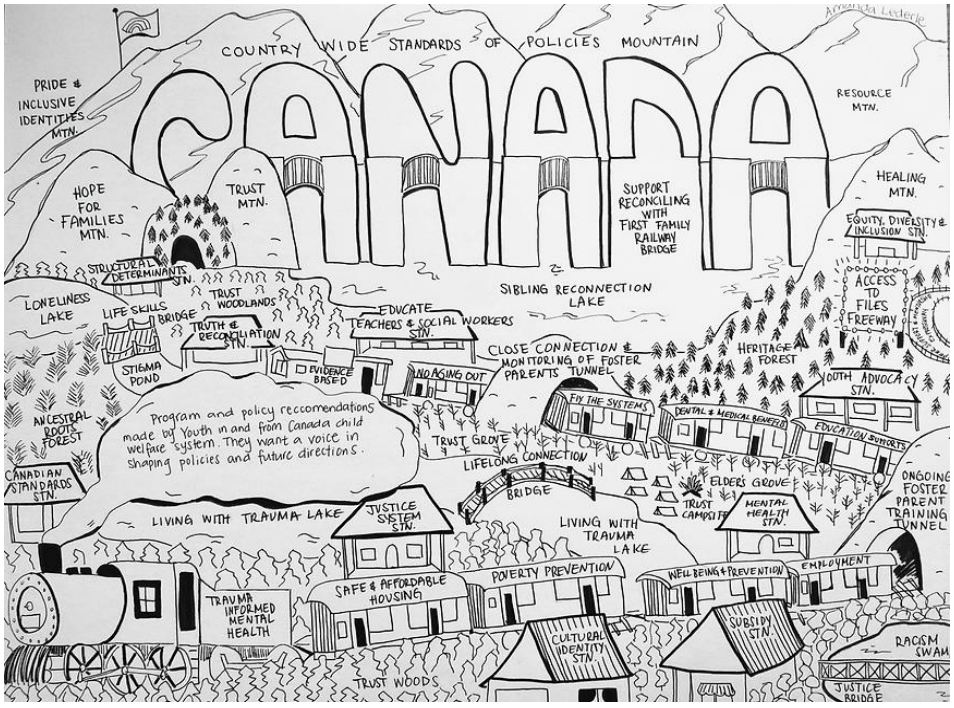
Home - Healing Consultants

Stella's Place Young Adult Mental Health Toronto (stellasplace.ca)

Across Boundaries – We are leaders in providing equitable, holistic mental health and addiction services for racialized* communities.

Home - Umbrella Mental Health Network (umhn.ca) – LGQBT2 counselling and support

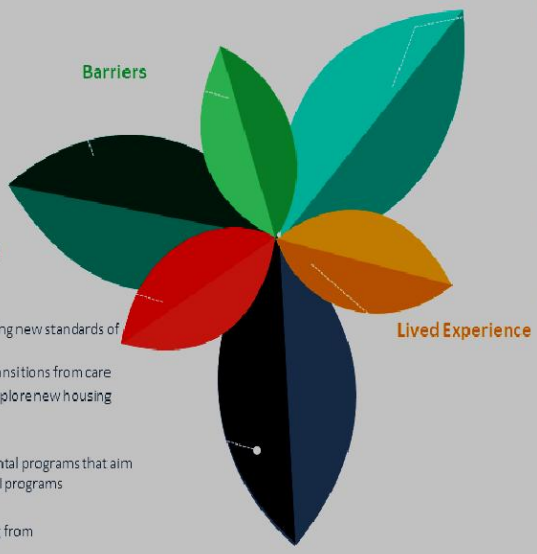
About Me (composetherapy.ca) – therapist focused on black youth



Aging Out Without a Safety Net was a four-year project (2018-2022) funded by Women and Gender Equality Canada. The project explores how transitioning to independence, also known as "aging out" of the child welfare system affects the economic security of young women+. The project identifies barriers to economic security and includes policy and program recommendations to remove these barriers. The project is compromised of the voices of 107 young women+ between the ages of 16-32. The report can be found here (AGING OUT WITHOUT A SAFETY NET | permanency.ca) and the key findings are summarized below.

Individual level

- Improve programs that focus on life skills and preparation for independent living
- Create opportunities to learn from living experience and contribute to change
- Develop programs that support (re) connection with cultural roots
- Facilitate access to personal files
- Raise awareness about available supports



Broader systems

- Enhance training and support for social workers, including new standards of practice
- Provide wrap around supports and services for youth transitions from care
- Revamp social and subsidized housing programs, and explore new housing models such as communal living programs
- Revisit the curriculum and educational policies
- Implement universal basic income and other governmental programs that aim to alleviate poverty and replace other need-based social programs
- Actively challenge systemic racism and discrimination
- Expand health benefits programs for youth transitioning from
- Develop national standards for aging out of care

Relational and interpersonal levels

- Create networks and pathways for mentorship
- Access to counselling and therapy for all (therapy for first families, youth in care, youth who have aged out of care) Educational/schooling (Additional supports, flexible schooling, consistent education and curriculum)
- Promote consistent and sustained connections with workers
- Develop structured supports for reconnecting with first family
- Introduce new standards for screening and monitoring foster parents
- Develop parenting skills program and resources to guide youth in and from care who become parents
- Cultivate trauma-informed approaches and sensitivity training in hospital and other healthcare settings

Using Family Group Conferencing to prepare children for placement, for moves in care, and continuing contact with their original families - by Sally Palmer

Introduction to Family Group Conferencing (FGC)

FGC originated in New Zealand to address the over-representation of Indigenous children in foster care and jail. It is now included in Ontario's Child, Youth and Family Services Act. It is designed, in part, to address the power imbalance between family groups and child welfare agencies.

The family group refers to the child and their 'extended family group' as defined by the family group themselves. It includes people important in the child's life such as extended original family members, supportive people (neighbour, teacher), and prospective or current caregivers, if these are not part of the extended original family.

Leadership in the FGC is shifted from child welfare professionals to the family group which includes extended family, supportive people, caregivers, and the child. Structure is provided by a coordinator who is trained in leading FGCs.

The coordinator is expected by all participants to be impartial and holds no child welfare authority over the plan that the FGC develops. The coordinator prepares all participants prior to the conference, chairs the first session of the meeting, and organizes a leader from the family group for the second session. This is the private time in which the family group develops a plan for the child's care and brings their plan back to the total group. During private time, the family group works toward a decision about: keeping the child at home; initial placement; a move within care; access to family members; return home; and possible supports to the original family or caregivers. They also seek offers of support from members of the family group to ensure that the plan will be successful. When the family group has formed a plan for the child, they meet again with the coordinator and others from the initial session to tell them about the decisions they have reached in the private family time to address the reasons the child welfare agency is involved. At this point, child welfare professionals may question the plan and suggest modifications.

The third/final session is when the final decision is made by all participants, either to accept the family group's plan or modify it to meet the agency's concerns. Following this, the coordinator records and distributes the plan developed during the conference to all participants.

The role of child welfare professionals is to provide information to the family group about why the agency is involved and to invite the family group to develop a plan to address the safety concerns. During the final session, the child welfare professionals confirm that they accept the plan developed in the meeting as addressing the initial concerns and agree to implement the plan.

Stages of supporting child's involvement in FGC

The coordinator prepares the child for FGC by explaining the reason and process for the conference: asking the child what they want their family to know and how they would like to share this during the conference. If the child would like assistance in putting their thoughts together, the coordinator and the child decide who is the best person to help them.

The coordinator prepares a support person from the child's own network to focus on the child during the conference if the child agrees to have a support person present. The support person helps the child to express their thoughts and feelings, ensures a respectful reception for the child's input; and can move a young child to another room when needed. The coordinator provides a flexible location for the conference, as well as childcare when needed, so the child can move in or out as needed.

The coordinator role is complete after putting the Plan into final form and distributing it to all participants who were present at the conference. The child welfare worker is responsible for implementing the plan which includes regularly reviewing it with the family group to ensure it is current, relevant, and achievable. The group can reconvene for a follow-up FGC when the plan needs revisions.

Potential benefits of FGC to children and families….

…In Supporting Youth Leaving Care

An FGC might be useful to a youth leaving care to review who are the people in their lives who might support them, and to develop a specific plan for the youth to have the supports they need.

The process of developing a formal plan might help the youth to determine what they're prepared for and what they have not yet considered.

Consideration could be paid to the roles supports might play in day to day needs, but also who will be the emergency contact? Who will the youth spend holidays with? Who will the youth look to for financial advice or support? Etc.

Seeing all of the people attend this process could demonstrate to the youth that they have meaningful relationships and people they can rely on, which would be emotionally impactful in so many way.

Section VI: The Impact of Doing the Work on Workers and Caregivers

<u>THE IMPACT ON THE WORKER AND CAREGIVER OF DOING THE WORK</u> - written by Mary Price-Cameron and Duane Durham

"*The expectation that we can be immersed in suffering and loss daily and not be touched by it is as unrealistic as expecting to be able to walk through water without getting wet"*
– Dr. Naomi Rachel Remen

The emotional impact on Child Welfare workers, caregivers, family members and youth comes in various forms and ways. One way we see this is in vicarious trauma which is the emotional, psychological, and mental impact of being with a person and hearing their story of trauma and suffering. It is the process of being changed by another person's traumatic telling of their experiences. We also see the impact of compassion fatigue which is a slow developing indifference or numbing your emotional pain, suffering and adversity. It is an emotional erosion that takes place when workers/caregivers aren't able to refuel and recharge. Finally, Burnout is a disconnection and disengagement from your helping role as a result of chronic and unaddressed stress, fatigue and vicarious trauma. (TFC training Neurobiology of Helping).

We all experience some form of impact as a result of our helping profession, and it would be helpful to view workers/caregivers as first responders in many ways. It does not make us weak, or not good at our jobs, it means we are human and are experiencing normal reactions to another person's suffering, adversity, and pain (TFC training Neurobiology of Helping).

Workers and Caregivers have many system challenges as well that inhibit them doing this work. These can include but are not limited to lack of funding, high caseloads for Society Workers, insufficient training opportunities for workers/caregivers, high staff turnover and poor retention of caregivers, which all contribute greatly to the impact of the work (TFC training- Importance of Self Care). It would be very beneficial if we made relationships between children and workers/caregivers a priority when determining service delivery models and caseloads (youth leaving Care Hearings 2013). The single most important factor in the success or failure of trauma work is the attention paid to the experience of the helper! (Saakvitne and Pearlman)

It is also important to note that as children/youth move through different placements they experience grief and loss. Grief is the physical and emotional responses to the death, separation or loss of a beloved person or thing. Grief is the price we pay for being in a loving/caring relationship. In the telling of their story workers and caregivers can be greatly affected and may also grieve for many reasons. Personal issues, hopes and dreams for the child, change of placement, ability or inability to help children, grieving of the relationship, grief of biological parents of the child, and grieving the abuse and neglect experienced by the child.

Most workers/caregivers have some unresolved grief and loss (it is normal). This can be seen through triggers, emotionally not in tune with yourself and others, masking and denying of emotions and an impact on relationships (becoming guarded, distant, poor quality of intimacy). Common myths about grief are: "time heals all wounds", "you can replace the loss", "grieve alone", "be strong for others", "bury your feelings and keep busy"; however without support and processing of these emotions workers and caregivers are often left having increased emotional impact of the work.

"*To spare oneself from grief at all costs can be achieved only at the price of total detachment, which excludes the ability to experience happiness." Erich Fromm*

Self care is a process and an attitude. It's not an event! Essential tools to stay positive are hope, trust, tenacity, professionalism, management of strong feelings and caring.

We need to engage in Collective Care for all involved in the supportive work. This is the process for which your team takes care of each other and shares the weight of the emotional work. This might include debriefing (formally or informally), peer support, reciprocity, and humour.

Lastly, we need to help and support resiliency with workers and caregivers. Resilience is the ability to overcome adversities, traumatic events or conditions, hardships, or suffering. With increased resilience we can often resist the effects of hardship, bounce back from, return to, or even excel at functioning in the work and day to day tasks. To help promote resilience in workers/caregivers it is suggested to be deliberate and attentive to planning prior to intervention. (The Resiliency Project). Resiliency factors promote insight, independence, relationship, initiative, creativity, humor, and morality.

An Example: "A worker on my team was attending the funeral of a youth who had been caught in the crossfire of a gang war. While attending the service, many gunshots were heard outside of the church, and the congregation dropped to the floor for cover. No one was hurt, but when the worker returned to the office, I noticed she was very distressed, and she told me she had feared for her life. A referral was made to the agency's peer support team. She met with a peer support member for a critical incident stress debriefing and was given some psychoeducational material to prevent PTS and STS. A few days later, the worker told me how helpful the intervention had been for her mental health."

Section V: TOOLS FOR SUPPORTING THE IMPACT OF CLINICAL WORK

- Understanding and Planning for Secondary Trauma
- Professional Quality of Life Scale Questionnaire
- Peer Support Teams
- Critical Incident Stress Debriefing from a Traumatic Event
- Progressive Muscle Relaxation Techniques

The CENTER for VICTIMS of TORTURE

Secondary Traumatic Stress

Definition

Secondary traumatic stress (STS) refers to the distress and emotional disruption resulting from continued and cumulative contact, or after single exposure, with individuals who have directly experienced trauma. Work that involves witnessing a great deal of suffering, either by observing or listening to narratives of trauma, can result in lasting emotional distress to health workers. For example, healthcare professionals hearing about one firsthand trauma experiences of their patients may experience STS with the same intensity as others who hear stories repeated over time [1,2,3]. The symptoms of STS usually have rapid onset[1] and may lead to healthcare workers using more sick leave and creating lower morale. This ultimately leads to less effective healthcare workers.

Work that involves witnessing a great deal of suffering, either by observing or listening to narratives of trauma, can result in lasting emotional distress to health workers.

Signs & Symptoms

STS is a syndrome of symptoms that are identical to post-traumatic stress disorder.

Physical	Emotional & Cognitive	Behavioral
• Difficulty sleeping (nightmares) • Hypervigilance	• Feeling afraid • Anxiety • Irritability / anger • Feeling numb and/or detached • Images and thoughts of the traumatic event(s) popping into your mind without your being able to control these • Avoiding thinking about the traumatic event(s) • Disrupted beliefs	• Heightened startle response • Avoiding places, people, things that remind you of the traumatic event(s) • Increased use of substances: nicotine, alcohol and/or illegal drugs

Case Example

Sara is a physician working in the emergency department of a large hospital. She has been engaged in emergency medicine for 10 years. In the course of her work as a physician, Sara has worked with patients presenting with life threatening injuries including victims of traumatic car crash injuries and brain injuries, survivors of physical and sexual assault, as well as other health emergencies such as heart attacks. Sara's hospital has been short staffed and she has therefore had to frequently work double shifts over the past two months.

Sara is feeling increasingly fatigued as she has been having difficulty falling and staying asleep. Her sleep is interrupted by bad dreams of patients' injuries. She wakes up from these dreams with a startle, a fast heartbeat and an extreme feeling of anxiety and fear. Sara is unable to fall back asleep and usually averages about 5 hours of sleep per night. Sara is more irritable with her children and husband and is less able to manage her feelings of anger which has resulted in her having more heated arguments with her husband. Sara has found that she is more jumpy when she hears loud noises and is finding it hard to relax. She increasingly feels dread about going to work and has started taking sick leave more frequently.

Vulnerability Factors

Research indicates that there are several risks that can increase the possibility of developing STS. This includes increased and frequent exposure to others' trauma stories[3], feelings of professional isolation and larger patient loads.[2]

Another risk factor is related to the type of coping strategy the healthcare worker uses. Healthcare workers who use problem-focused coping tend to have lower rates of STS because problem-focused coping works to reduce or eliminate the source of stress.

In contrast, healthcare workers who use emotion-focused coping often have higher rates of STS.[3] Emotion-focused coping is where the healthcare worker tries to regulate feelings such as anger, sadness, anxiety that have resulted from the stress. Emotion-focused coping has been correlated with higher levels of STS.

Prevention & Recovery

Organizational Practices

Robust organizational practices including the acknowledgement of STS are key to reducing both the stigma and silence around the impact of listening to traumatic stories.

Other methods to prevent and decrease exposure to secondary trauma can include:

Education and Training	• Education on trauma-informed care including STS to prevent STS and retain healthcare workers • Trainings to develop an understanding of STS, identify symptoms, and learn prevention and reduction tools

Organizational Culture & Dialogue	• In addition, feeling supported and prepared to manage patient cases, particularly those with trauma histories, can reduce the negative impacts on healthcare workers and decrease the potential for STS. • Senior leadership recognition of STS as a challenge experienced by healthcare workers • Creating an organizational statement regarding trauma support and ways to access resources • Organizational encouragement and support of a healthy work-life balance and wellness, including encouraging regular leave
Supervision & Support	• Regular peer support groups • Supervisor trainings around issues of STS and staff support • Regular individual supervisor support and STS evaluations • Providing staff with time flexibility for self-care • Debriefing protocols
Workload Management	• Decreased exposure by dispersing high trauma cases among healthcare workers

Robust organizational practices including the acknowledgement of STS are key to reducing both the stigma and silence around the impact of listening to traumatic stories.

Individual Practices:

Self-care practices as well as social support are essential elements in preventing the development of STS. It is therefore recommended to identify and engage in replenishing self-care strategies that promote physical, emotional, and spiritual wellbeing with intentionality. Once you begin to routinely practice healthy self-care habits, they become part of your overall prevention plan. Not only do self-care practices strengthen your ability to cope while in the moment, but they can also help your body remember how to bounce back to a healthier state.

By focusing on building your strengths and carrying out self-care activities, you contribute to your behavioral, cognitive, physical, spiritual, and emotional resilience. The following strategies are helpful with building resilience:

Behavioral	• Focus on the four core components of resilience: adequate sleep, good nutrition, regular physical activity, and active relaxation (e.g., yoga, meditation, relaxation exercises). • Get enough sleep or at least rest. This is of great importance, as it affects all other aspects of your work—your physical strength, your decision making, your temperament. • Take regular breaks or leave away from work to allow your mind to rest. • Create individual ceremonies or rituals. For example, write down something that bothers you and then burn it as a symbolic goodbye. Focus your thoughts on letting go of stress or anger or on honoring the memory, depending on the situation. These rituals can also help you set a boundary between work and home, for example changing clothes as soon as you get home, having a shower, or putting on a specific song just before work and when you leave. • Be open to learning new skills to enhance personal and professional wellbeing. Brainstorm these with colleagues to learn what others are doing to take care of themselves. • Seek professional support if you recognize that you are feeling overwhelmed or your symptoms are interfering with your ability to work or do your daily activities.
Cognitive	• Create positive perceptions of the supportiveness of your work environment and compassion satisfaction, the perception that your work is effective and valued. This has been associated with lower levels STS.[3] • Try to find things to look forward to even if they are small. • Challenge any negative internal dialogue and focus on changing negative automatic thoughts and beliefs to reflect a more positive outlook. • Pay attention to your body and mind. What are the signs that you are beginning to struggle with a patient or a patient's story?
Physical	• Drink enough fluids to stay hydrated throughout the day and eat the good quality food. • Ensure you take time to exercise and look after your physical health and wellbeing.
Spiritual	• Take time to be alone so you can think, reflect, practice grounding, and rest. • Try to spend time in nature regularly. • Build self-awareness capacities (e.g., through mindfulness, reflection practices) • Practice your spiritual beliefs or reach out to a faith leader for support.

Emotional	• Seek a mentor, supervisor, or experienced healthcare colleague who understands the norms and expectations of your work and may assist in identifying strategies that will help you cope. • Nurture positive personal and professional relationships and develop social support. Make time to communicate and spend time with friends and family. • Practice self-compassion. • Know what STS is and how to recognize symptoms in yourself. • Avoid avoidance. Ignoring or suppressing your feelings/symptoms only works in the short term. This can be necessary sometimes: If you need to put your feelings away to get through the day, do it. But make sure to create space for yourself to revisit your reactions and to deal with them regularly. If you ignore or suppress these feelings for too long, they will build up and overwhelm your capacity to cope.

By focusing on building your strengths and carrying out self-care activities, you contribute to your behavioral, cognitive, physical, spiritual, and emotional resilience.

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Professional Quality of Life Scale (ProQOL)

Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)

When you *[help]* people you have direct contact with their lives. As you may have found, your compassion for those you *[help]* can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the *last 30 days*.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

_____ 1. I am happy.

_____ I am preoccupied with more than one person I *[help]*.

_____ I get satisfaction from being able to *[help]* people.

_____ I feel connected to others.

_____ I jump or am startled by unexpected sounds.

_____ I feel invigorated after working with those I *[help]*.

_____ I find it difficult to separate my personal life from my life as a *[helper]*.

I am not as productive at work because I am losing sleep over traumatic experiences.

_____ I think that I might have been affected by the traumatic stress of those I *[help]*.

_____ I feel trapped by my job as a *[helper]*.

_____ Because of my *[helping]*, I have felt "on edge" about various things.

_____ I like my work as a *[helper]*.

_____ I feel depressed because of the traumatic experiences of the people I *[help].*

_____ I feel as though I am experiencing the trauma of someone I have *[helped]*.

_____ I have beliefs that sustain me.

_____ I am pleased with how I am able to keep up with *[helping]* techniques and protocols.

_____ I am the person I always wanted to be.

_____ My work makes me feel satisfied.

_____ I feel worn out because of my work as a *[helper].*

_____ I have happy thoughts and feelings about those I *[help]* and how I could help them.

_____ I feel overwhelmed because my case [work] load seems endless.

_____ I believe I can make a difference through my work.

I avoid certain activities/situations because they remind me of frightening experiences

_____ I am proud of what I can do to *[help]*.

_____ As a result of my *[helping]*, I have intrusive, frightening thoughts.

_____ I feel "bogged down" by the system.

_____ I have thoughts that I am a "success" as a *[helper]*.

_____ I can't recall important parts of my work with trauma victims.

_____ I am a very caring person.

_____ I am happy that I chose to do this work.

Peer Support Team

A number of child welfare agencies have instituted a Peer Support Team. The purpose of these teams is to prevent Post-Traumatic Stress and Secondary Traumatic Stress by lessening the impact of trauma.

Peer support members are child welfare staff trained in critical incident stress debriefing and provide educational information on normal reactions to a traumatic event. Ideally a peer support intervention will be provided within the first 24 hours following a traumatic event. Front line staff can call to request support at any time, or Supervisor can be encouraged to access the support for their staff. This service is provided by trained child welfare peers and is offered to all staff, youth in care, foster parents and volunteers. The service is voluntary and anything discussed remains confidential.

Research on the effectiveness of applied critical incident stress debriefing techniques in the workplace has demonstrated that individuals who are provided with Critical Incident Stress Debriefing within a 24-to-72-hour period after the initial critical incident experience less short term and long-term reactions or psychological trauma.

An Example: "While Senior Managers might not routinely avail themselves of the Peer Support Team, on one occasion a Manager in our Agency did. She had participated in a death review that was very distressing. She requested the intervention of the peer support team. A few days after the intervention, she found herself in the grocery store questioning where she was and why she was there. She later reflected that having participated in the intervention made her able in that moment to recognize the impact of the trauma on her concentration and reassured her this was in fact a normal response to her experiences."

Critical Incident Stress Debriefing from a Traumatic Event/Posttraumatic Stress following a Critical Incident

Published on February 12, 2013 by Joseph A Davis. Ph.D. in Crimes and Misdemeanors

Introduction

Caught off guard and "numb" from the impact of a critical incident, employers and employees are often ill-equipped to handle the chaos of such a catastrophic event like workplace violence. Consequently, survivors of such an event often struggle to regain control of their lives to regain a sense of normalcy. Additionally, many who have been traumatized by a critical life-changing event may eventually need professional attention and care for weeks, months and possibly years to come. The final extent of any traumatic event may never be known or realistically estimated in terms of loss, bereavement, mourning and grief. In the aftermath of any critical incident, psychological reactions are quite common and are quite predictable. Critical Incident Stress Debriefing or CISD and the management of traumatic reactions by survivors can be a valuable tool following a life-threatening event.

Since the mid- 1980s, following many high-profile events tied to the United States Postal Service, the need to provide victim assistance to employees in the workplace setting has received more positive attention than ever before. This prevention and intervention movement has gained a lot of momentum with the passage of state and federal legislation designed to protect, provide resources and services to those who are physically or emotionally traumatized in the workplace.

As part of a corporate Human Resources Division strategy, an HR administrator can employ, train and deploy trauma specialists to provide direct, face-to-face contact or phone contact as part of an overall Crisis Response Teams (CRT) program. This integrated team acts to off-set risk, mitigate fall-out and enhance recovery and sustainability in the event of an acute or short-term man-man or natural workplace stoppage. Additionally, trauma specialists can be identified in nearby locations if not on site who can respond quickly be being placed on-call or on "stand-by" (ready alert) regardless of the situation. This is an absolute must legally, ethically and morally should a catastrophic event occur.

What is a Critical Incident?

The author defines examples of a "critical incident" as a sudden death in the line of carrying out his or her day-to-day duties, serious injury from a shooting, a physical or psychological threat to the safety or well being of an individual, business or community regardless of the type of incident. Moreover, a critical incident can involve any situation or event faced by emergency, public safety personnel (responders) or employees that causes a distressing, dramatic or profound change or disruption in their physical (physiological) or psychological functioning.

There are oftentimes, unusually strong emotions attached to the event which have the potential to interfere with that person's ability to function either at the crisis workplace scene or away from it at home (Davis, 1992; Mitchell, 1983). This is what the author calls "dosage exposure". The closer the employee or victim is to the critical incident (primary, secondary, tertiary or quaternary) the stronger or weaker the reaction (biopsychosocial and cultural) they will have to the event.

Clinically, traumatic events and their impact on individuals are fairly predictable. When a person has been "exposed to a critical incident, either briefly or long-term, this exposure can have a considerable impact on their global functioning. Historically, some of the first documented cases of traumatic stress or what used to be called "transient situational disturbance" (TSD) can be traced to military combat.

In time, researchers began to find evidence that emergency workers, public safety personnel and responders to crisis situations, rape victims, abused spouses and children, stalking victims, media personnel as well as individuals who were exposed to a variety of critical incidents (e.g., fire, earthquake, floods, industrial disaster, and workplace violence) also developed short-term crisis reactions.

Trauma Reactions

Trauma personnel refer to short-term crisis reactions as the "cataclysms of emotion" where feelings and thoughts run the spectrum and include such diverse symptoms as shock, denial, anger, rage, sadness, confusion, terror, shame, humiliation, grief, sorrow and even suicidal or homicidal ideation. Other responses include restlessness, fatigue, frustration, fear, guilt, blame, grief, moodiness, sleep disturbance, eating disturbance, muscle tremors or "ticks", reactive depression, nightmares, profuse sweating episodes, heart palpitations, vomiting, diarrhea, hypervigilance, paranoia, phobic reaction and problems with concentration or anxiety (APA, 1994; Horowitz, 1976; Young, 1994). Flashbacks and mental images of traumatic events as well as startle responses may also be observed. It is important to consider that these thought processes and reactions are considered to be quite normal and expected with crisis survivors as well as with those assisting them. Some of the described symptoms surface quickly and are readily detectable. However, other symptoms may surface gradually and become what the author calls "long-term crisis reactions." These responses can be masked within other problems such as excessive alcohol, tobacco and/or drug use. Interpersonal relations can become strained, work-related absenteeism may increase and, in extreme situations, divorce can be an unfortunate by-product. Survivor guilt is also quite common and can lead to serious depressive illness or neurotic anxiety as well (APA, 1994; Mitchell, 1983; Young, 1994).

What is Critical Incident Stress Debriefing (CISD)

Debriefing is a specific technique designed to assist others in dealing with the physical or psychological symptoms that are generally associated with trauma exposure. Debriefing allows those involved with the incident to process the event and reflect on its impact. Ideally, debriefing can be conducted on or near the site of the event (Davis, 1992; Mitchell, 1986). Defusing, another component of CISD, allows for the ventilation of emotions and thoughts associated with the crisis event. Debriefing and defusing should be provided as soon as possible but typically no longer than the first 24 to 72 hours after the initial impact of the critical event. As the length of time between exposure to the event and CISD increases, the least effective CISD becomes. Therefore, a close temporal (time) relationship between the critical incident and defusing and initial debriefing (i.e., there may be several) is imperative for these techniques to be most beneficial and effective (Davis, 1993, Mitchell, 1988).

Research on the effectiveness of applied critical incident debriefing techniques in the workplace has demonstrated that individuals who are provided CISD within a 24–72-hour period after the initial critical incident experience less short-term and long-term crisis reactions or psychological trauma (Mitchell, 1988; Young, 1994). Subsequently, emergency service workers, rescue workers, police and fire personnel as well as the trauma survivors themselves who do not receive CISD, are at greater risk of developing many of the clinical symptoms the author has briefly outlined in this article (Davis, 1992; Mitchell, 1988). From the author's perspective, when applying debriefing techniques, an appropriate and effective standardized protocol must be followed when assisting responders and employee crisis survivors of any critical incident (more on that matter later or in future commentary). Most approaches to CISD incorporate one or more aspects of a Seven Part (7) Model. The model that the author suggests here consists of several key points that should be followed as a general guideline when addressing responders and/or employee-survivors who are involved in man-made, natural, accidental or industrial disasters.

A Crisis Intervention Response Specialist must lay the constructive groundwork for an initial "assessment" (audit) of the impact of the critical incident on the employee survivor(s) and support personnel by carefully reviewing their level of involvement before, during and after the critical incident (Mitchell, 1988,1986•, Davis, 1993).

As a general guideline, the author suggests incorporating the following seven (7) Key Points into the debriefing process when providing assistance to employee-survivors or to emergency rescue responders. They are:

1. Assess (audit) the impact of the critical incident on support personnel and survivors;
2. Identify immediate issues surrounding problems involving "safety" and "security;"
3. Use defusing to allow for the ventilation of thoughts, emotions, and experiences associated with the event and provide "validation" of possible reactions;
4. Predict events and reactions to come in the aftermath of the event;
5. Conduct a "Systematic Review of the Critical Incident" and its impact emotionally, cognitively, and physically on survivors. Look for maladaptive behaviors or responses to the crisis or trauma;
6. Bring "closure" to the incident "anchor" or "young" support personnel and survivors to community resources to initiate or start the rebuilding process (i.e., help identify possible positive experiences from the event);
7. Debriefing assists in the "re-entry" process back into the community or workplace. Debriefing can be done in large or small groups or one-to-one depending on the situation. Debriefing is not a critique but a systematic review of the events leading to, during and after the crisis situation.

First, the "debriefer" assesses individuals' situational involvement, age. level of development and degree of exposure to the critical incident or event. Consider that different ages of the individuals, for example, one may respond differently based on their developmental understanding of the critical event (Davis, 1993).

Second, issues surrounding safety and security surface, particularly with children. Feeling safe and secure is of major importance when suddenly without warning, families, and employees' lives are shattered by tragedy and loss.

Third, ventilation and validation are important to individuals as each, in their own way, needs to discuss their exposure, sensory experiences, thoughts and feelings that are tied to the event. Ventilation and validation are necessary to give the individual an opportunity to emote.

Fourth, the debriefer assists the employee survivor or support personnel in predicting future events. This involves education about and discussion of the possible emotions, reactions and problems that may be experienced after traumatic exposure. By predicting. preparing and planning for the potential psychological and physical reactions surrounding the stressful critical incident, the debriefer can also help the employee survivor prepare and plan for the near and long-term future. This may help avert any long-term crisis reactions produced by the initial critical incident.

Fifth, the debriefer should conduct a thorough and systematic review of the physical, emotional, and psychological impact of the critical incident on the workplace and on the employee survivor or survivors. The debriefer should carefully listen and evaluate the thoughts, mood, affect, choice of words and perceptions of the survivor of a critical incident and took for potential clues suggesting problems in terms of managing or coping with the tragic event upon impact and in the near future.

Sixth, a sense of closure is needed. Information regarding ongoing support services and resources is provided to survivors. Additionally. assistance with a plan for future action is provided to help "ground" or "anchor" the employee survivor during times of high workplace adjustment and stress following the incident.

Seventh, the debriefer and the use of debriefing assists in short-term and long-term recovery, as well as assisting the employer and the employee-survivor re-entry process. A thorough review of the events surrounding the traumatic situation can be advantageous for the healing and recovery process to begin.

Strong Reactions to Trauma are Not Always Immediate

As with any man-made, natural or accidental catastrophic event, many experience and do suffer from short-term crisis reactions. Others, depending on their "dosage exposure" may need attention for a psychiatric disorder called "posttraumatic stress disorder or PTSD. PTSD as a disorder can be difficult to diagnose as its onset can be acute or delayed. Without detection, the prevailing symptoms can be chronic. Furthermore, it can involve a host of other symptoms (syndrome) such as sleep disturbance, anxiety, acute reactive depression and phobic disorder just to name a few. Some employee-survivors and their families cannot be left alone because of overwhelming fear, loss of personal control over their environment, their community, their lives and livelihood. Almost everyone in a close, tight-knit business community will know someone who has been affected, hurt, seriously injured or perhaps who might have died. PTSD can be obvious in some employee-survivors and in other cases; PTSD can also exist at a more subtle level only surfacing when a memory or some

sensory stimuli triggers it. It is something a specialist must look for and assess frequently when a critical or catastrophic incident occurs in the workplace or nearby community.

Summary

A human resource corporate officer, business manager or director must consider all of the implications of a workplace related critical incident due to legal, ethical and moral reasons. Furthermore, it has been demonstrated that Critical Incident Stress Debriefing or CISD and its close cousin, Critical Incident Stress Management or CISM is an effective way to intervene and reduce (mitigate) employee survivor reaction to crisis.

It is highly recommended as part of an overall "risk management" strategic business plan for sustainability purposes; human resource officers must consider CISD and CISM as an integral part of doing business on a day-to-day basis in the event of a critical or catastrophic work stoppage situation.

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The CENTER for VICTIMS of TORTURE

Progressive Muscle Relaxation

Introduction

Our bodies and brains communicate with each other through chemical and electric signals. This means that when we feel stressed our muscles can tense up. The tension in our muscles then sends signals back to our brains that they are tense, which can increase our level of mental stress. We can break this cycle in the mind using mindfulness, visualization or grounding exercises, or we can break it in the body with exercises like breathing, stretches or progressive muscle relaxation (PMR).

	Start in your feet. As you inhale, curl your toes and push them forward and down, feeling the tension in your arches and even in your ankle. Hold your feet like this for 5 seconds while you count slowly. Now release your toes and let your foot relax as you breathe out.
	Next, inhale and pull your toes up and back towards you and tense your calf muscle. Hold this tension for 5 seconds. Now release your foot and let your calf relax as you exhale.

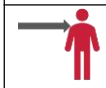
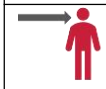
It can be difficult to tell your muscles to relax, sometimes even difficult to tell where your body is tense. Progressive muscle relaxation is an exercise where we tense each muscle group in our body in turn and then release it. This relaxes the muscle group and also helps you to recognize the difference in how it feels for those muscles to be tense or relaxed. For this exercise we want to tense each muscle group gently and then release it. At no point should your muscles feel strained. If you have an injury or intense pain in an area of your body, you may want to skip that place until it is healed, or the pain feels less intense.

Progressive muscle relaxation is an exercise where we tense each muscle group in our body in turn and then release it.

Steps

PMR can be practiced standing, sitting, or lying down on your back on a firm mattress or other comfortable but supportive surface. It can be a particularly good practice to do right before bed to help you sleep. It can help start by grounding briefly or taking three deep breaths.

As you practice, it is important to breathe normally throughout this exercise; do not hold your breath. It can be helpful to match the tensing of your muscles with an in-breath and the relaxing of your muscles with an out-breath. Pay particular attention to the feeling of the muscles releasing. You can even visualize the tension leaving your body as you exhale.

	Next, inhale and tense your thighs. You can do this by pushing the back of your knees towards the ground. Hold this tension for 5 seconds. Now release your thighs and feel them relax as you breathe out.
	Next, inhale and tense your buttocks. Hold this tension for 5 seconds. Now release your buttocks muscles and allow the area to relax as you exhale.
	Next, inhale and tense your stomach and abdominal muscles by pulling your stomach inwards and backwards. Hold this tension for 5 seconds. Now release your abdominal muscles and allow them to relax as you exhale.
	Next, tense the muscles in your back and shoulders by pulling your shoulder blades together and arching backwards slightly as you inhale. Hold this tension for 5 seconds. Now release your shoulders and allow your back muscles to relax as you exhale.
	Next, tighten your hands into fists and tense up all the muscles in your arms as you inhale. Hold them tight like this for 5 seconds. Now release your hands and relax your arms back down to your sides, letting them hang loosely as you exhale.
	Next, tense your shoulders and neck muscles by bringing your shoulders up to your ears as you inhale and holding them there for 5 seconds. Now release your shoulders, letting them relax back down away from your ears as you exhale.
	Next, tense the muscles in your face, clenching your jaw, pressing your lips against each other, and squeezing your eyes shut tightly, as you inhale. Hold this tension for 5 seconds. Now let the muscles in your face release and relax, allowing your jaw to loosen so that your mouth is slightly open as you exhale.

	Finally, tense your entire body by pulling your arms and legs in together and tightening into a ball as you inhale. Hold this tension throughout your entire body for 5 seconds. Now exhale and release your body and let your limbs relax out. Allow your whole body to relax and feel as though it is melting into the floor or chair or mattress. Feel the tension slowly leaving your body. Pay attention to the feeling of relaxation. Notice how your body feels different now that it is allowed to relax. Stay with this feeling for at least 10 seconds.
	If you are not going to sleep, begin to move your body slowly, taking a moment to feel your muscles waking up. When you feel ready, stretch your arms and legs and if your eyes have been closed, open them now.

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Therapeutic Family Care Program
Support for Children, Youth and Caregivers

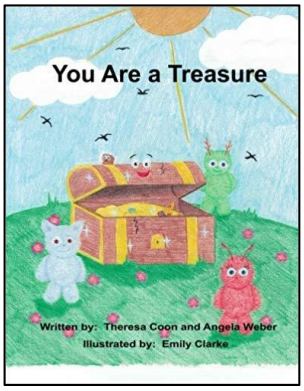
Storytelling is part of childhood. When a safe and caring adult sits down and shares a story with a child, it creates opportunity to develop curiosity, acceptance and empathy for difficult experiences and big feelings. Children's storybooks are filled with accessible language and engaging narratives that help a child make sense of their world.

Here are some helpful titles that we have discovered in our therapeutic work with families. We have organized the books by theme, however several of these titles will overlap. Most of these books can be found on Amazon.ca or Indigo.ca.

Children's books to help adult and child understanding of:

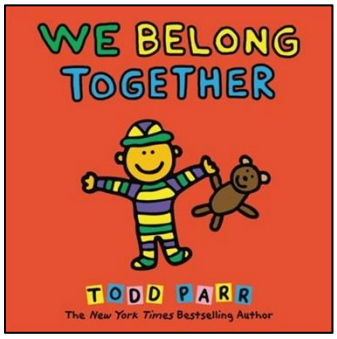
Child Welfare & Alternate Caregiving

Alternate caregiving can include any home outside of a child's family of origin or birth family. This can include foster caregiving, kinship caregiving (grandparents, aunt/uncle, etc.) or adoptive home.



You Are a Treasure
Author: Theresa Coon & Angela Weber

- Story that creates metaphor for children to understand the not being able to live with biological parents and being in the child welfare system
- Explores: alternate caregiving, emotional experience and safety



We Belong Together
Author: Todd Parr

- Story of openly defining family, importance of belonging
- Explores: alternate caregiving, adoption, foster caregiving

TFC
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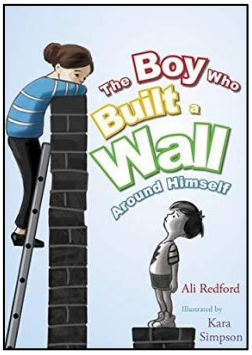
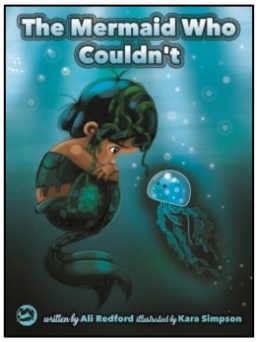
Developmental Trauma

Developmental trauma is the impact early hurtful life experiences has on a child's emotional, social, physical and mental development.



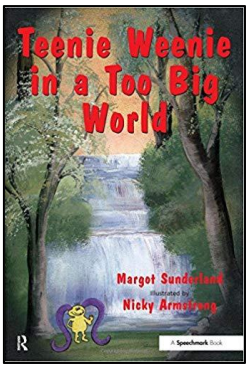
The Boy Who Built a Wall Around Himself
Author: Ali Redford

- Story of a little boy who pushes others away to keep himself safe and healing from hurtful experiences
- Explores: relationships, understanding impact of trauma, safety-seeking behaviours, blocked trust



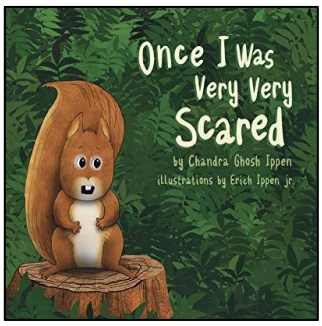
The Mermaid Who Couldn't
Author: Ali Redford

- Story of a mermaid child who experiences the social and emotional impacts of early childhood trauma
- Explores: safe & caring relationship, impact of trauma, feelings of shame, healing



Teenie Weenie in a Too Big World
Author: Margot Sunderland

- Story that creates new language and understanding of fearful experiences, importance of connection
- Explores: relationships, seeking safety, impact of trauma



Once I Was Very Scared
Author: Chandra Ghosh Ippen

- Story that normalizes and helps children understand different behavioural responses to scary or hurtful experiences
- Explores: impact of trauma, safety, behaviours, coping

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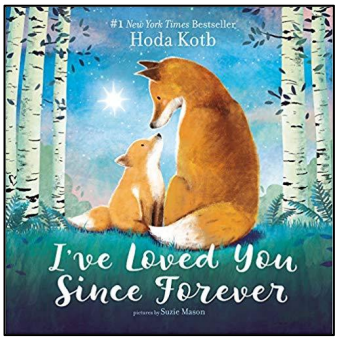
Support for Children, Youth and Caregivers

Attachment & Relationship

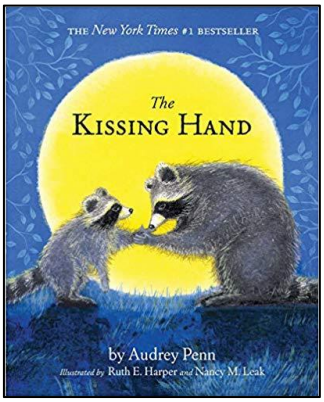
The Invisible String
Author: Patrice Karst

- Story about an invisible string that illustrates connection and relationship even when person is separated
- Explores: loss, separation, attachment, emotional experience of relationship



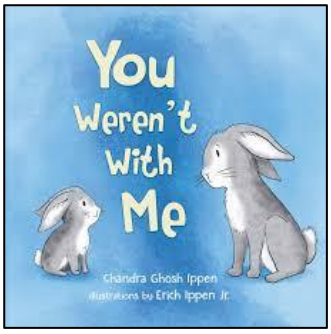
I've Loved you Since Forever
Author: Hoda Kotb

- Story of claiming a child, attachment and taking delight in child
- Explores: adoption, parent-child relationship



The Kissing Hand
Author: Audrey Penn

- Story of a child experiencing distress with being separated from parent, illustrates relationship helping with change
- Explores: parent-child relationship, attachment, coping with changes and transitions



You Weren't With Me
Author: Chandra Ghosh Ippen

- Story of understanding a child's emotional experience after a parent-child separation
- Explores: attachment disruption, understanding feelings, blocked trust

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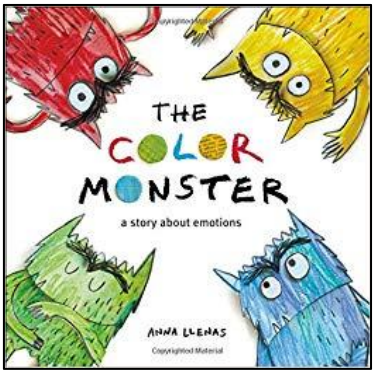
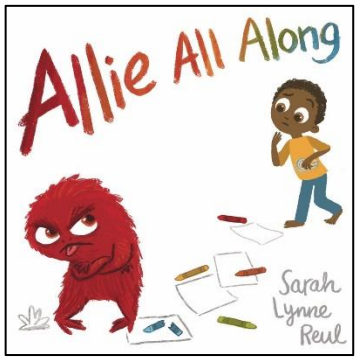
Support for Children, Youth and Caregivers

Identifying and Understanding Big Emotions



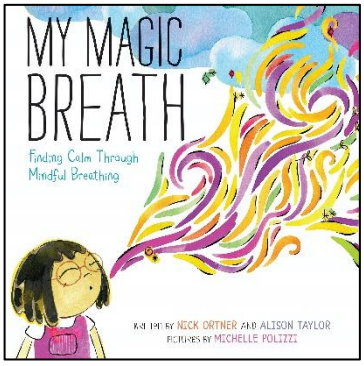
The Color Monster
Author: Anna Llenas

- Story of naming and recognizing different emotional states, normalizing different feelings
- Explores: feeling identification, acceptance, organizing experience



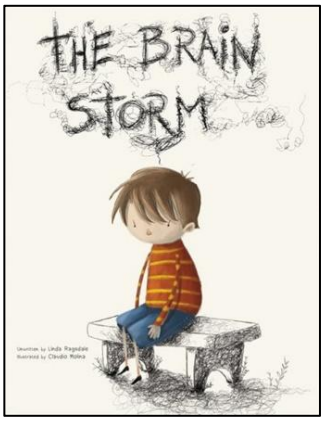
Allie All Along
Author: Sarah Lynne Reul

- Story of understanding emotional experience underneath behaviour
- Explores: Co-regulating strategies, acceptance, reducing shame and blame



My Magic Breath
Author: Nick Ortner & Alison Taylor

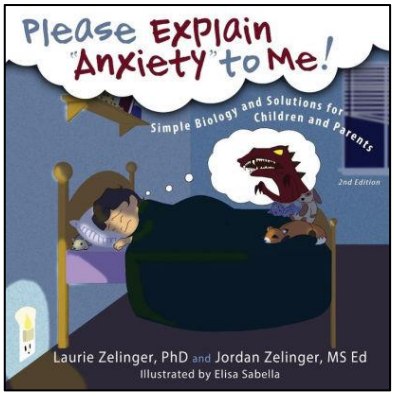
- Interactive story that introduces mind-body awareness of emotional experience, using breathing strategies
- Explores: coping with big emotions, mindful breathing, bodily awareness, acceptance



The Brain Storm
Author: Linda Ragsdale

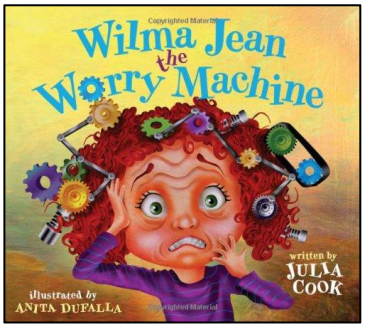
- Story with no words, only pictures, that invites children to be curious about emotional experience
- Explores: curiosity, acceptance, social-emotional experiences

Understanding Anxiety and Strategies



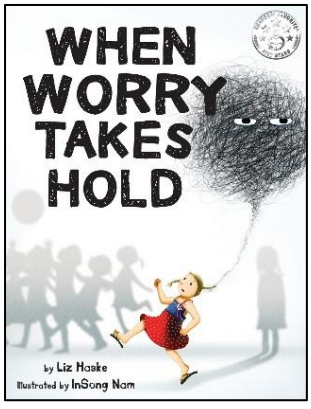
Please Explain 'Anxiety' to Me!
Author: Laurie & Jordan Zelinger

- Story that explains physiological experience of anxiety using dinosaurs and easy-to-understand brain science
- Explores: Brain-body connection, strategies



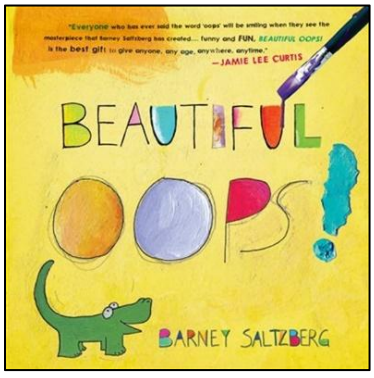
Wilma Jean the Worry Machine
Author: Julia Cook

- Story of a little girl who has lots of worries about school, friends and other circumstances
- Explores: self-mastery, control, racing thoughts, practical ideas and strategies



When Worry Takes Hold
Author: Liz Haske

- Story of a child who experiences anxiety, normalizing experience and addressing feelings
- Explores: Coping, courage, relationships

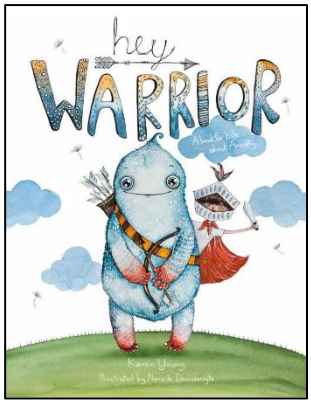


Beautiful Opps
Author: Barney Saltzberg

- Story of reframing mistakes, fear of failure into opportunity and creativity
- Explores: being flexible, adaptable, creativity

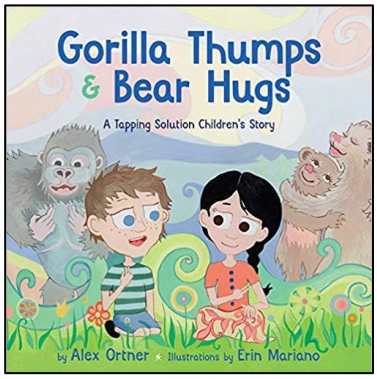
Therapeutic Family Care Program
Support for Children, Youth and Caregivers

Understanding Anxiety (and other big emotions) and Strategies



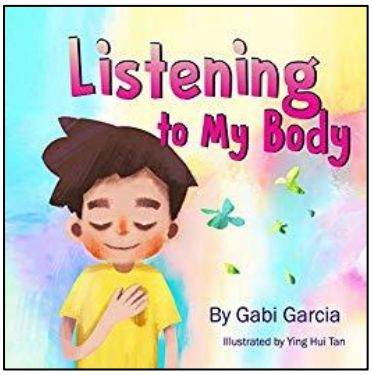
Hey Warrior
Author: Karen Young

- Story that normalizes and explains the parts of the brain and body that work together when we experience anxiety or stress
- Explores: empowerment, brain science, strategies for soothing



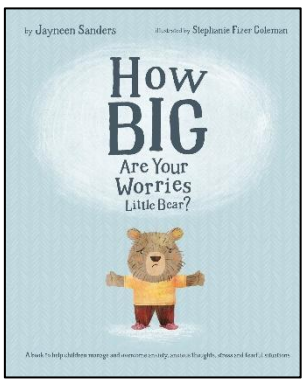
Gorilla Thumps & Bear Hugs
Author: Alex Ortner

- Story that introduces the 'tapping' technique that helps children soothe anxiety and overwhelming emotions
- Explores: Confidence, practical strategy, affirmation



Listening to My Body
Author: Gabi Garcia

- Interactive story that helps create body-mind awareness of feelings and sensations
- Explores: Emotional resilience, practical strategy



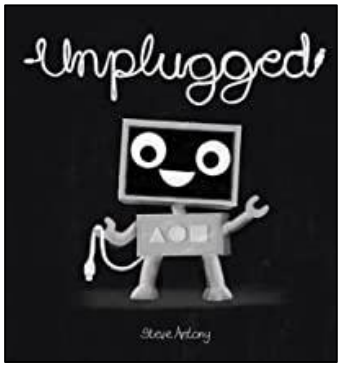
How Big Are Your Worries Little Bear?
Author: Jayneen Sanders

- Story of a bear who learns to soothe big fears and worries with caring adult
- Explores: relationships, safety, fear, coping

Therapeutic Family Care Program
Support for Children, Youth and Caregivers

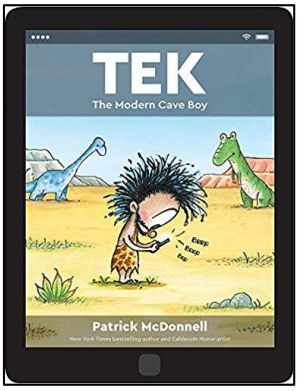
Screen Time

These books help adults and children start conversations about creating balance with screen time and online safety.



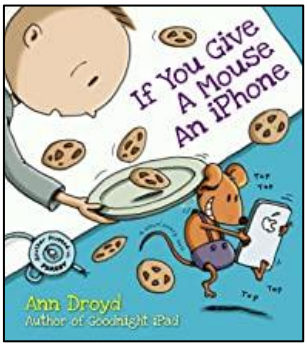
Unplugged
Author: Steve Antony

- Story of a robot who discovers that there are fun activities both with a computer and outside with friends
- Explores: creating balance with screen time



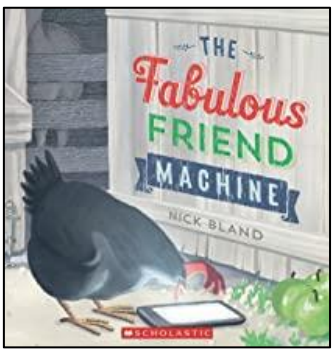
Tek
Author: Patrick McDonnell

- Story of cave boy who misses connection, adventure and relationship when focused on his gadget instead
- Explores: balance, relationship, impact of technology



If you Give a Mouse an iPhone
Author: Ann Droyd (David Milgrim)

- Playful story of a mouse who becomes preoccupied with a new cell phone
- Explores: impact of technology, balance



The Fabulous Friend Machine
Author: Nick Bland

- Story of a chicken's introduction to social media
- Explores: online safety, balance, impact of technology

Therapeutic Family Care Program
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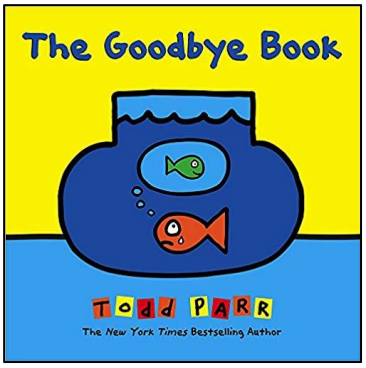
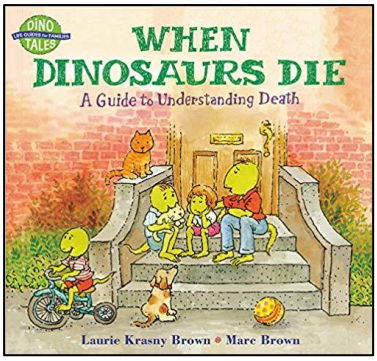
Grief and Loss

These books explore different ways to organize feelings of grief and loss for a child. These feelings do not just occur when someone dies, but also when a child has experienced any kind of loss, ending or goodbye.



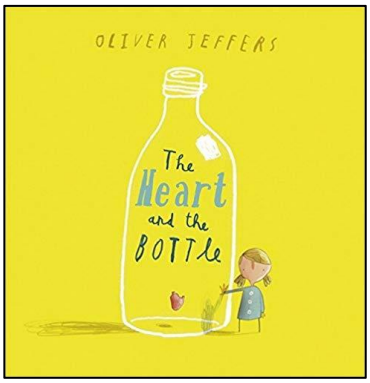
The Goodbye Book
Author: Todd Park

- Story of fish who narrates the emotional experience of loss and saying goodbye
- Explores: Coping, relationship, experience



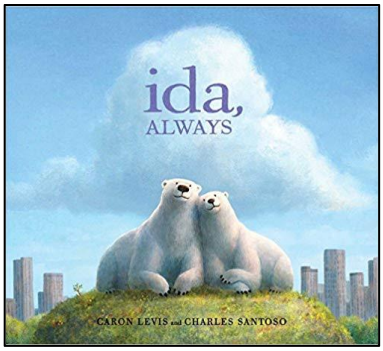
When Dinosaurs Die
Author: Patrick McDonnell

- Story that creates simple & clear language about death and loss using dinosaur characters
- Explores: death and grief, coping, experience



The Heart and the Bottle
Author: Olivia Jeffers

- Story of a child who experiences loss and protects her heart
- Explores: Impact of loss, coping, relationship



Ida, Always
Author: Caron Lewis

- Story of two polar bears who experience friendship, love and loss
- Explores: death after illness, emotional experience of loss

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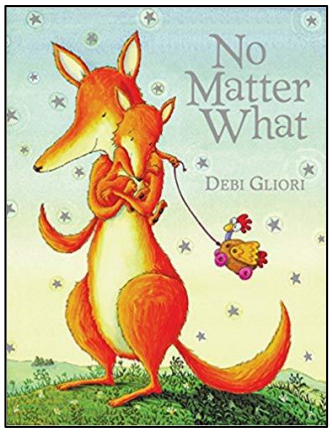
Support for Children, Youth and Caregivers

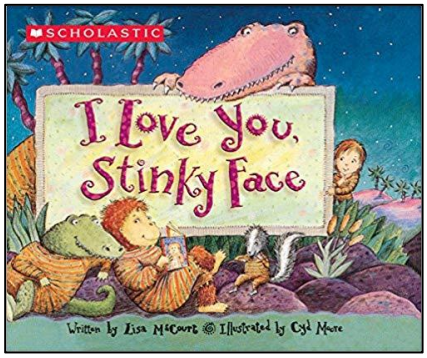
Permanency & Attachment

Children who have experienced multiple transitions or caregivers can often feel uncertain about love & stability. These books help create shared experiences of certainty and connection.



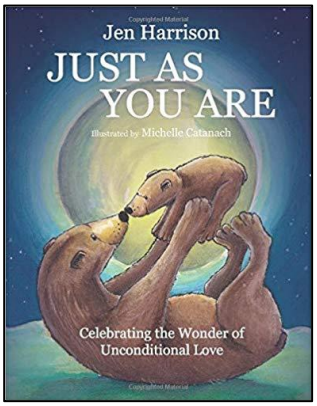
No Matter What
Author: Caron Lewis

- Story of fox family who playfully explore boundaries of love, care and devotion
- Explores: taking delight in child, unconditional love, attachment



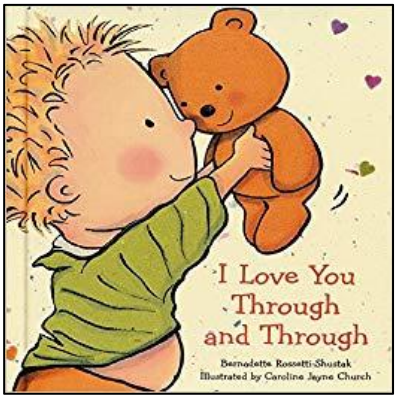
I Love you, Stinky Face
Author: Lisa McCourt

- Story of child who explores whether his mother will still care for him in outrageous humorous situations
- Explores: unconditional love, permanency



Just As You Are
Author: Jen Harrison

- Story of bear family who expresses love regardless of mistakes, behaviours and challenges
- Explores: worthiness, unconditional care and love, permanency



I Love You Through & Through
Author: Bernadette Rossetti-Shustak

- Playful story of loving child in all form and through all feelings
- Explores: taking delight in child, unconditional love, attachment