

Clinically Managed Access: The Final Piece in the Permanency Planning Puzzle

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Historical Origins

Introduction

Like many of our colleagues working in the 1990's, the Treatment Foster Care Program for the Children's Aid Societies of Durham, Kawartha-Haliburton, and Northumberland struggled with the human and social cost of a generation of children for whom permanency planning had become a major challenge. Child welfare legislation of the day had favoured parental rights over child needs to the point where planning for children's permanency had become increasingly tentative. In the child population resident in the Program, symptoms associated with trauma, abuse, neglect and very often a series of failed placements tended to obscure an underlying reality - that these children had no clarity about their futures, parenting authority, or by what criterion decisions about their future would be made. In short, the children were "in limbo", which tended to perpetuate symptoms despite treatment.

The first decade of TFC's development was one of experimenting, learning, and further experimenting in the effort to find the "formula" for more consistently successful intervention with our resident children. With its relatively rich array of resources, and its generally contained clinical/ child welfare environment, TFC was in the unusual position of being able to experiment with "best practice" in children's services, and to learn a great deal about what was necessary in resolving permanency challenges for highly symptomatic children. In the first generation of experimentation, the Program focused on case and placement planning as the key to achieving permanency, with the hope that after short-term remediation work children could be discharged into long-term placements, thereby resolving the permanency planning issue, and supporting more adaptive child functioning. The solution was not to prove

to be so simple, as the following "lessons learned" demonstrate.

Resolving Limbo

Most children referred to the Program arrived with the expressed goal of reunifying the children with their families of origin, although referring workers held out little hope for that eventuality in many of the cases admitted. In actuality, less than 20% of children were ever discharged to their families of origin. In most cases the family circumstances did not change, or changed only minimally. The reasons for this varied, but it might be safely said that our child welfare clients rarely found traditional treatment services a good fit for their complex needs. Families generally attended few sessions, did not achieve prescribed goals, and most often terminated service prematurely. Because the family was unable to make use of services, the child was not able to return home as intended. However, the period required to make that determination stretched over many months - in one case over five years was required for a case to make its way through court. During the period of decision-making, children continued to experience a high degree of anxiety related symptoms, some of which had the consequence of being disruptive to the placement. In the worst cases, placement terminated prematurely despite the high level of available clinical supports.

Helping cases to "get out of limbo" became a major thrust, and the Program became adept at using assessment, planning, and parenting capacity assessment to work cases through the limbo period more rapidly. (Osmond, 2000-2001) Cases began to achieve planning resolution in a matter of months, rather than years. However, while this change did have positive benefits in terms of reducing the number of placement disruptions, individual child progress did not



improve as we might have hoped given the perceived importance of the factor of "limbo" in child development. Perhaps placement permanency was not the underlying issue?

Resolving Attachment Disruptions

When discharge home was no longer an option, discharge into foster care became the plan. It was disheartening to learn that of those children discharged to non-specialized foster home settings as a permanency plan, 100% subsequently broke down their foster home placements and eventually were placed in staff model group care settings. This was despite the fact that children placed in the Program were demonstrated to have made progress that approached statistical significance in a study of placement outcomes (Peters, 1994).

In the Program's work with Dr. Steinhauer (Steinhauer et al, 1999) it was finally understood that children's progress in TFC had been rooted in attachment relationships with their Parent Therapists, and that by "rewarding" progress by robbing the child of this important connection, we had inadvertently caused the child to withdraw their energies from any further attempt at attaching. This eventually led to a program re-design that allowed for permanent placements within the Program, and a focus on supporting attachment relationships. (Osmond, 2000; 1996) Children placed in this way tended to exhibit more progress over time than children who had been dealt with using a "short term intensive" model. However, even in those children who had clearly made significant attachment relationships, there still seemed to be something "missing" in their sense of well-being.

Resolving Emotional Issues

Findings on the Program's initial outcome study (Peters, 1994) indicated that some of the children placed in TFC actually deteriorated in terms of their emotional well-being and adaptive functioning during their TFC placements. A careful analysis of the child population experiencing deterioration highlighted that those children who had been significantly physically and sexually abused, and who were troubled by trauma-

based symptoms, were those most likely to deteriorate. The original Program design was largely behavioural in nature. While children with externalizing, acting out profiles seemed to make improvements, in effect by intervening behaviourally we had removed from these children their only means of expressing their distress without replacing it with any more effective resolution pathway. This led to a movement away from behavioural programming, towards a much more sophisticated, assessment based intervention approach, including a protocol for a residential response to treating the aftermath of sexual abuse (Osmond et al, 1998). Children being dealt with in the new model tended to demonstrate greater stability and improved functioning over time. From the model we learned the importance of surfacing underlying, unsaid conflicts and bringing them to resolution within a therapeutic milieu.

By this stage, the Program had discovered three of the puzzle pieces for supporting the development of improved child well-being - resolving limbo, a treatment approach that targeted underlying emotional issues rather than behavioural manifestations, and providing the opportunity for the development of critical attachment relationships. While these strategies went a considerable distance to supporting more adaptive functioning, it was not complete. A fourth puzzle piece was about to emerge.

Resolving Family Relationships

With rare exception, children placed in the Program continued to have ongoing access visits with members of the family of origin. Access visits were a continual source of challenge for Program clinical staff and Parent Therapists alike. Despite having achieved case planning resolution, placement permanency, and an increasing degree of insight into the relationship of their emotions to their behaviours, children invariably returned from access visits agitated and distressed. In a number of cases TFC staff began to attend access visits and to intervene clinically during a period usually not targeted for intense work. Staff's early experiences began to expose a previously untapped area of intervention, and through experimentation we discovered a "formula" that not only led to less disruptive visits, but contributed to a sense of "resolution" for children and parents about the past, present, and future of the relationship.



While it seems ridiculously obvious today, after ten years of struggling with the "permanency planning" question we had finally found the missing link in our quest... the use of access visits to achieve clinical objectives and further children's progress. It was this last piece that taught us that permanency cannot be fully achieved through a case planning process, or even through achieving a permanent placement capable of providing emotional and behavioural support. "True" permanency was not fully achieved until the child had reached some sense of closure about family relationships, and one way of gaining that closure was by way of using access visits in a clinical way. This article will set out the model of intervention developed in the TFC program that seems to hold out a great deal of promise for future development.

The TFC Service Approach

Assessment

The clinically managed access approach was developed as part of a comprehensive menu of services based on a thorough clinical assessment. Assessment was a key component to understanding the child's emotional, psychological, academic, and life skills needs. Further, it was critical to understanding how past events and family history had contributed to the cognitions and behavioural presentation of the child, and to assist in determining the intervention points most likely to lead to symptom relief. Conducted by the case co-ordinating TFC Social Worker, a developmental assessment would typically address the following:

1. A family assessment, including parental historical issues as well as current dynamics;
2. A parenting capacity assessment (or key components of such an assessment) to identify intervention points;
3. The child's developmental, placement, and academic history;
4. A life-space assessment of child's current adaptive functioning, including stress and anger management skills, social functioning, behavioural and cognitive profile, and life skills status;
5. A child-focused psychological assessment concentrating on cognitive resources, learning

style, and emotional status;

6. A clinical interpretation of the interplay of the above factors in the child's functioning, as well as an inventory of the child and family's strengths and capacities for change;
7. A child diagnosis. (Diagnosis was an important part of the TFC methodology, as it supported a scientifically based approach to treatment.)
8. A child and family treatment plan.

The assessment provided the treatment team with an understanding of the complex links between life events, learning and cognitions, behaviours, and unresolved issues that led each child to be in need of treatment. Invariably, family relationships were the key underpinning to the child's psychological and emotional reality, and was the issue that most often needed to be addressed in order to allow the child to make progress in all of the developmental areas.

Clinical Context

All children placed in the TFC Program received milieu based intervention as part of the model. Milieu-based treatment involved a complex array of life-space counseling, cognitive and behavioural interventions, life and social skills training, and academic support. The Program has a particular expertise in working with traumatized and attachment resistant children, which underlies the clinical approach (Osmond et al, 1998). Residential treatment was provided by specially selected and trained Parent Therapists, supported by a multi-disciplinary clinical team.

The team consisted of Child Care Consultants (senior social workers with a background in child and family treatment), a full-time Clinical Manager, a contract psychologist and psychiatrist, and a part-time Art Therapist. A Behaviour Consultant specializing in Applied Behavioral Analysis was also part of the clinical team. This team served 32 cases in 16 foster homes (totaling over 150 children in a 10 year period), allowing a maximum caseload size of 8, carried by four Child Care Consultants. The Consultant provided about one-half day weekly of direct instructional supervision; other program components included a 24 hour clinical hotline, monthly training, and a monthly support group for Parent Therapists. These program elements are typical



of the model as described by TFC Standards (FFTA, 1999).

As identified in the developmental assessment, children placed in the Program might be also be referred for individual psychotherapy, psychopharmacological intervention, group therapy, or any other clinical support seen to be appropriate to meeting the child's needs. Typical of the TFC model, these interventions were viewed as supplemental, not substitute services. Milieu based intervention was the primary service in each and every case, with other services being well integrated and coordinated using a team approach overseen by the assigned Child Care Consultant.

Services to Families

The absent service in the TFC configuration had always been "family therapy". In the original program design it was anticipated that child welfare family intervention would be an appropriate option. As the Program matured, it became evident that something more intense would be needed. Various options were tried, often without much success. Referrals to outside agencies led to a fragmentation of clinical approach, necessitating an enormous investment in communication and problem solving. Further, traditional children's services centers had a difficult time adjusting their service approach to the highly pragmatic, supportive, long term strategies our child welfare clients required. Services were almost always terminated prematurely when outside services were involved. Another option was to contract services on a case by case basis. While less time was invested in problem solving, and services were better integrated, our clients continued to require a "different" kind of service, one that was designed around their complex, multi-problem presentation, lack of internal and external resources, slowness to trust, and suspicion towards service providers.

Meanwhile, the Program's Child Care Consultants and Parent Therapists began to work directly with families in an attempt to deal with critical issues that affected the child's daily progress. Three main approaches developed: Inclusive Foster Care; Parent Mentoring; and Clinically Managed Access. While none of these approaches resemble the services typically provided by

a child and family treatment center, for our child and family population they seemed to provide the most flexible and workable options to achieve clinical goals. Two of the three approaches are described in some detail in other publications (Osmond et al, 2000), but are summarized here:

Inclusive Foster Care - a model in which the child's parent is included in the child's day to day care while in out-of-home placement. Inclusion might be limited to participation in a Plan of Care meeting, or be extended to active participation in all aspects of the child's life, including attending school meetings, accompanying the child to appointments, haircuts, clothing, shopping, etc. In its most functional form, inclusive foster care is a partnership between two sets of parents, each with his or her own expertise and resources, on behalf of the child.

Parent Mentoring - A form of direct service to client families delivered by the Parent Therapist. The parent receives guidance, teaching, and coaching in the techniques and tasks required to care for their child. The foster parent provides such coaching by acting as a "mentor" to the parent/ child relationship. The relationship is an informal one. It is not mandated, and cannot be imposed, but requires as its basis a relationship between parent and milieu-based therapist that develops positively over time. The client comes to view the Parent Therapist as an ally, and as a safe person who has their best interests at heart; he or she believes that the Parent Therapist is providing excellent and healing care to their child, and yet does not feel threatened by this. With the guidance of the clinical team, the Parent Therapist will have found a way to empower and include the parent in the process, and the parent in turn becomes willing to learn the special skills and knowledge required to parent their child successfully.

Clinically Managed Access - Based on a thorough assessment of the family's strengths and needs, clinically managed access uses the parent/ child access visit as the vehicle for achieving identified goals. Therapeutic interventions are targeted to resolving outstanding familial issues and fostering the development of more functional attachment relationships through the structure of well-supported



access visits.

Techniques OF CLINICALLY MANAGED ACCESS VISITS

Phases of Access Intervention

This form of intervention has four active clinical phases, as follows: the pre-work stage; contracting; preparation phase, and active visiting. Debriefing is a task of active visiting.

The **pre-work** phase consists of assessing both the child and family's needs and strengths, as already discussed. It is in this phase that the family is engaged in a cooperative journey on behalf of their child. By being provided with an opportunity to share their story, and to receive support and feedback to see how the events of their lives have affected their own beliefs and thoughts, as well as the beliefs and thoughts of others in the family, the family is introduced in very concrete, easy to understand terms the targets for change in the family's functioning. The essential stance early in intervention is to avoid feeding into any existing feelings of guilt, inadequacy, or failure. Instead, a simple, honest, emotionally neutral approach is often the best way to approach clients with a long history of service failure. While not all clients respond to this approach, the act of gathering the family story, ensuring it has been captured accurately, and mutual exploration about how life's events have shaped current reality often acts as a positive platform for working through resistance and opening up the possibility of cooperation on behalf of the child.

The **contracting** phase includes the parent and child in determining the direction of their future together. Mutual identification of the key issues that get in the way of a successful relationship, a "starting point" for change, and contracting for successful access visits - goals, behaviours, expected outcomes, consequences - take place in a series of sessions conducted by the Child Care Consultant.

Preparation for successful visiting entails a complex, thorough set of tasks aimed at enlisting full parental cooperation, and beginning the long process of modeling a more productive communication and

problem solving style. Preparation visits with parents focus on updating the parent on the child's progress this week (in very concrete terms), identifying the parents' progress in the week, mutually determining what issues, facts, events the parent wishes to communicate to the child, and rehearsing a strategy for delivering the message. Time is spent on making a plan for fun, anticipating the child's response, and rehearsing solutions or teaching moments. Finally, the Child Care Consultant checks in on the perceived level of support in the helping relationship, as the week's plan is finalized.

Preparing the child for access visits is usually done by the Parent Therapist in collaboration with the Child Care Consultant. It is important that the child recognize that a team is collaborating closely, and that all parts of the access visit are being planned as carefully as possible. This message provides the child with a sense of safety around access visits, and some sense that what can be done for the parent, is being done for the parent. This is a critical piece; children who do not feel as if their parents have the appropriate level of care and support are very reluctant to take a chance on communicating more forthrightly or changing their behaviours within the relationship. If, on the other hand, they feel that someone is working as supportively with their parents as with them, they are much more inclined to take risks within the access structure.

Similar to preparing the parent for visits, the child is prepared by: being updated on the parents' progress during the period in between visits; identifying the child's own progress; determining what issues, facts, and events the child wants to share with the parent; and rehearsing a strategy for delivering the message. Planning for fun and anticipating challenges and rehearsing solutions supports the child through the transition to visiting.

Structuring the Access Visit

Pre-planning and structuring the access visit is an important aspect of developing it to meet clinical goals. The goal early in the sessions is to move the family away from its usual interactive patterns, and to move in a supportive, mutually agreed on way towards a more satisfying, enjoyable visit. Some of visit time is used for



dealing with issues, but this is by way of "clearing the air" and alleviating mutual anxiety more than it is to focus on talking through issues. In this approach, "doing and being" is much more pragmatic than "talking and thinking", and the sooner the family can move on to the desired behaviour and experience the positive benefits of more enjoyable time together, the more likely the desired behaviour is to be repeated.

Structuring visits is based on an important assumption. Parents often do not have the basic skills required to play comfortably, talk to children in a developmentally appropriate way, recognize the child's behavioural cues, or offer supportive and corrective input. It is this lack of skills which sets up the difficulty within the relationship, and prevents the child from taking the risk of being open or behaving differently. Carefully constructing access visits to offer a well-supported level of challenge, and ensuring the highest degree of mutual satisfaction possible, tends to foster in both parent and child a sense of trust in the process and the clinician, and sets the stage for later ventures into more emotionally difficult content.

There are four broad levels of structure in clinically managed access, high, medium, low, and no structure. The level of structure shifts as family comfort and functioning develops. Optimally, the family is made aware of concrete criterion for decision-making about movement through the various levels of support, and is provided with regular feedback about how they are progressing. This allows decision-making about access visits to be well informed, and even collaborative between all family members and the clinician.

Highly structured visits are agency based and take place in the presence of a facilitator. No independent time is offered, and the visit closely follows a pre-arranged script.

Medium Structure visits begin with high structure, then move to some independent time, and ends with a highly structured exercise. The level of independence is adjusted progressively, as the family achieves goals and demonstrates progressively stronger role behaviour.

Low Structure visits involve a check in, but the visit itself proceeds without intervention. At the end of the

session there is a debriefing check in. This level of structure is that most commonly provided in the normal course of supervised access in child welfare agencies.

No Structure is the final level of intervention, with the family member making arrangements directly with the Parent Therapist to pick up child at pre-arranged point. It is required that the parent check in with caregiver before and after each visit. The clinician checks in by phone, and holds family problem solving meetings on an as needed basis in addition to regular Plans of Care sessions. In this latter stage, support and planning functions falls to the Parent Therapist, under the supervision of the Child Care Consultant, working on goals established in the Plan of Care. It is from this level of intervention that the Parent Mentoring role first begins.

Role of the Facilitator

The role of the facilitator for clinically managed access developed experimentally, over time. Ongoing visit related problems were causing grave clinical concern, as children returned from access distressed, anxious, and struggling with memories and unresolved issues, all of which were manifested behaviourally in the treatment milieu. While milieu based interventions provided some stability, it was obvious that something was required in the visits themselves to be more supportive to the children concerned. Child Care Consultants entered visits to observe the family dynamics, and as clinicians are wont to do, began to intervene clinically within the family visits. When initial forays into this arena proved promising, a more organized approach developed, which could eventually be taught to Contract Child and Youth Care workers, as well as other qualified visit supervisors.

As the role emerged, it took on the following tasks:

- * Conducts parent preparation sessions
- * Coordinates/ instructs caregiver's child preparation sessions
- * Books visit transportation and location
- * Ensures access location is comfortable, has available equipment
- * Welcomes child and family
- * Conducts check in session - most clinically active time
- * Acts as support during activities - provides guidance



and structure, role modelling, comments on key | developments or accomplishments, intervenes as necessary to support family's identified goals. During appropriate times, is as unobtrusive as possible

- * Conducts debriefing session - punctuates major accomplishments, highlights how certain problems were solved, identifies issues to be carried through on next time
- * Assists family in preparing the plan for next session, including a range of activities and snacks
- * Attends (or in the case of the Child Care Consultant, chairs) Plan of Care sessions to establish goals, outcome indicators, communication strategies, and a framework for decision making
- * Works as part of a well-coordinated clinical services team, ensuring that information from access progress is made available to all other service providers, and incorporating into access work those themes and issues which emerge in the other clinical environments.

A Typical High Structure Visit

High structure visits are held in a safe and neutral place, usually the Society offices. Considerable effort goes in to selecting a space that is child and family friendly. If such a space is not available, the facilitator will need to be creative to provide a conducive setting.

The child is usually brought to the visit by the Parent Therapist, who uses the driving time for preparation work. The facilitator is available at the access location to greet the child and family, and ensure safe movement from door to visit location. Planning the first greeting, and ensuring a successful transition can be a challenge in a busy Society office, but is important to contain if the family is to be able to make best use of the structure without reverting to their normal interactive patterns.

The first half hour or less is the facilitated session. In this period, the week's news is exchanged, any issues are surfaced and worked through according to the agreed upon plan, and the facilitator acts in the role of "family therapist" during this brief "talking therapy" period. Initially families find this session challenging, as they are unaccustomed to using their time together for positive problem solving and issue resolution. Early sessions are helpful in establishing the rhythm, and in

developing a level of trust that issues can successfully be worked through in this format. Later, when the pattern is well established, family members can use these times to surface the underlying issues which may interfere with a successful contact.

At the conclusion of this session, the day's plan is reviewed, and the pre-set goals for that day punctuated ("we decided to concentrate on having fun today", or "remember taking turns is our goal today, let's see how we do with that"). The agreed upon activity is begun, with the facilitator moving into a relatively low-key position unless he or she is needed to highlight some issue. Modelling, praise for demonstrating a desired behaviour on the part of parent or child, supporting positive communication, or helping family members practice new behavioural strategies are all part of the activity period. The focus is on helping parent and child maximize their time together, and enjoy each others' company.

The first activity is followed by a snack. Either the parent or the child can plan and bring a snack. Working with food, and preparing to eat together is an opportunity to give and receive nurturing, as well as work on adaptive life skills. Facilitators will need to find ways to help snack time feel normalized and productive, rather than hurried or perfunctory. Snack is followed by a second activity, and finally clean up.

Each of the above-described visiting tasks is a rich source of clinical data. Difficult or particularly successful moments will have been experienced, old patterns repeated, new behaviours tried, and non-verbal messaging will have played a role. In some moments the facilitator will have needed to intervene directly. These experiences and observations can be shared during the debriefing section of the visit, when family members share which each other "how it went", whether their goals had been achieved, and what they would like to continue to work on. Ideas are generated for the next session's activities and snack, and the visit nears its close.

Goodbyes are often a trying moment for all during the visit. Rehearsing parting behaviours ahead of time may be helpful. Another facilitator strategy is to act as the "voice" to the parting process, providing a running



commentary about each person's thoughts and feelings, and how those were manifested ("I notice Sarah is holding on extra tight today. It has been a good visit, and it is hard to say goodbye. But Sarah knows that mother will be back, and that next time we will be making popcorn together. So now it is time for Sarah to have one big last hug, and then to go and see Mrs. Jones, where she can talk some more about how today went, and what was good and not so good about it. Mrs. Jones is right outside, and we can go and see her together".) In order for clinically managed access to be as useful as possible, the sensitive management of the strong feelings at the end of a visit, and modeling of vocalizing these feelings rather than acting them out in some way, thereby creating a bridge to further progress, is essential.

PRINCIPLES OF CLINICALLY MANAGED ACCESS

The importance and role of ongoing child and family contact have been well established in the literature (Osmond et al, 2000, 2001; Palmer, 1995; Pine, 1993). Ongoing work on understanding how best to achieve productive contact generated the following ideas, which have proven to be central to developing access as a positive clinical tool. The child caregiving team will all need to adopt these notions - foster caregiver, therapists, and child protection workers - in order to foster the delicate shifting of methodology away from traditional access and towards something more clinically useful in nature.

Clinically managed access:

- * Is respectful of the family
- * Gives permission for more effective parenting
- * Provides effective modelling for good parenting
- * Provides active teaching towards modifying parenting behaviour
- * Focuses on helping the parent and child learn to enjoy one another
- * Accentuates the positive, eliminates or reduces the negative
- * Helps and encourages the family to find other services
- * Focuses on the family's ownership of their own issues, and their responsibility to deal with those issues as directly and forthrightly as they possibly can
- * Assumes that resolution of relationships is the critical

- feature, and that no structural or legal change can take the place of appropriate resolution and closure
- * Does not require "perfection", but focuses on "good enough" progress to achieve a comfortable resolution
- * Is fluid and responsive to changing circumstances and dynamics.

Case Example

In the following case, clinically managed access was a critical tool in assisting the child to make progress, the mother to come to terms with her limitations, and for an appropriate permanency plan to be constructed.

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

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

Child Protective Services (CPS) were drawn in by the school, because Katrina's behaviour there was increasingly out of control, and she had bruises after a fight with her mother. Katrina was placed in Care. The CPS workers found working with Pat very draining. When she was 'up', she was constantly harassing the worker, making demands about her daughter's care. When she was 'down,' she wanted to talk at length to workers about her illness, and her complaints about family members, the agency, and the community. Her workers were always relieved to transfer the case. At no time in her 'cycle' was Pat ever able to admit that her



mental illness affected her capacity to parent; thus no decisions were being made for Katrina's future—everyone felt trapped in mother's cycle.

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

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

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

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

against a problem that was outside all of them, and against which mother and daughter had shown considerable strength.

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

Pat was genuinely proud of her daughter's behavioural and emotional gains. The therapist reinforced this, praising her for supporting Katrina in 'getting off the roller coaster.' She framed this as Pat "parenting the very best she could" by making decisions that were good for Katrina. With help, Pat gained awareness of her moods, and decided to keep visits short during manic periods in order to spare Katrina.

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

Pat contacted Katrina's father, from whom she was estranged, and offered to work with him towards assuming custody. Over the next six months, the TFC worker helped her to develop a co-parenting



relationship with Katrina's father and his wife. Katrina eventually felt safe and well cared for in her father's home, and she was discharged. She is still there several years later.

Conclusions

Because of the complex configuration of clinical interventions available within the Program, outcome research conducted in the TFC Program (Osmond, Palmer, Durham, 2001; Peters et al, 1994; Osmond, Dorosh, 1993) has never been able to clearly link the practice of clinically managed access with more positive case outcomes. However, clinical experience has shown repeatedly that other clinical methodologies in the absence of attending to the issues in the family dynamic, rarely result in the kind of improved child functioning that other remedial services combined with clinically managed access produce.

The reasons that this tool has been so powerful, experience suggests, are as follows:

1. In most cases, the parent was highly motivated to attend access visits, whereas he or she may have been considerably less motivated to attend other forms of intervention. The desire to have contact with the separated child in some form, whatever the underlying reasons, continued to be the most important factor promoting parental participation in this format.
2. Successful intervention during the visits led immediately to more satisfying, successful visits. When the parent could experience immediate gratification and a reduction of stress, it tended to reinforce continued effort.
3. The clinician's role was pragmatically helpful, in that it was focused not on dealing with problems, but on dealing with learning to have fun and relate positively. When the perceived outcome of an intervention is so closely in tune with the parent's own desires, the clinician is much less likely to encounter defensive behaviours. The emergence of defensive behaviours in this format may be used as a signal that too much is being attempted, or insufficient supports have been offered to ready family members for a particular piece of work. Taken in small increments and focusing on

pragmatics at least in the beginning stages, tended to maintain parents as active partners throughout. Later, more emotionally-laden material could be addressed, when greater trust had been established.

4. When positive relationships and a positive focus between parent and clinician had been established, it was much easier to "slip in" a key piece of structural work around the parent/ child relationship. It became "part of" the dynamic of interacting positively, and not a separate formal process. This experience seems to "fit" with other research on child welfare interventions with complex, multi-problem families, where programs that concentrated on immediate, instrumental, and pragmatic issues were perceived by clients as more helpful overall, and were more likely to be able to successfully incorporate intervention at an emotional level.

5. Success was experienced by the family members almost immediately. The flow and process of the visit becoming more satisfying. This became the platform on which more complex interventions could be constructed. Perhaps most importantly, it allowed children to gain a realistic appraisal of the parent's strengths, limitations, and capacity for change. In the most successful cases, children achieved a level of acceptance of the family circumstances, and developed an appropriate place for the family member in his or her emotional life. This final task is recognizable as one of the key steps for successful mourning, and ultimately for relinquishing a past-oriented focus in favour of a more future oriented life stance. (Worden, 1991; Osmond, 1996). In short, resolution had been achieved, and "limbo" was over.

Over time, the access visit became one of our most reliable and positive clinical tools, more productive than any other family-based intervention for our child welfare clients. Further research of this and other methodologies is current underway through the Child Welfare Centres of Excellence initiative; it is hoped that a better understanding of the role of this important contribution to the Program's work can be achieved in the process.



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