CHILDREN IN LIMBO TASK FORCE | SPARROW LAKE ALLIANCE

THERE ARE NO WIZARDS:
THE CHILD WELFARE CONUNDRUM

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DEDICATION

This publication is dedicated to the memory of **Paul David Steinhauer**, child psychiatrist, educator, mentor, who died on May 27, 2000.

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

There Are No Wizards: The Child Welfare Conundrum, was seven years in creation. It is the product of countless vigorous discussions amongst the members of the *Task Force*, with input based on each person's experience and perspective.

Paul welcomed and was always respectful of diverse ideas and opinions. It is in this spirit that the contributors offer these papers, with the hope that the ideas expressed herein will stimulate further discussion and help identify some of the difficult, complex issues inherent in child welfare work.

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HOPE *for* CHILDREN FOUNDATION

CHILDREN'S AID SOCIETY *of* TORONTO

Because children depend on all of us

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I. INTRODUCTION

THERE ARE NO WIZARDS: THE CHILD WELFARE CONUNDRUM

James R. Wilkes
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The Limbo Task Force of the Sparrow Lake Alliance has two previous publications: *Children in Limbo*, 1996, and *Permanency Planning in the Child Welfare System*, 2002. The Task Force has continued to meet and discuss matters of continuity of care in the child welfare system and how best to provide children and youth with a sense of permanence.

The title of this publication stems from our discussions which frequently show up the contradictions and conflicts that beset child welfare. We refer to these as "*the child welfare conundrum*." The conundrum can be viewed from a multitude of perspectives: administrative, financial, interpersonal, educational, cultural and political, so that it might appear so impenetrable the only solution would be wizardry. The reality is *There are No Wizards* and so we are left to embrace good casework practice.

The publication reflects the discussions that take place at the Task Force meetings and as such they are not strictly academic; rather they are voices of experience from the trenches of child welfare. The voices are varied in the issues and approaches taken and reflect the particular concern of the author, but they are similar in that they are grounded in a wealth of experience with children in the child welfare system. As such it is hoped that those who are engaged with children in the child welfare system will be drawn into the material and find it useful for practice, training and research.

Throughout the Task Force discussions that led to this publication there was one guiding principle which served to give us grounding and perspective and that was *putting the child first.* It is apparent in the practice of child welfare that, when the predominant interest and energy is on following administrative requirements, the importance of the individual child and youth seems to recede. One such example has to do with continuity of care and permanency planning. When continuity and permanence are understood simply from the administrative point of view, the emphasis is on having the same personnel and having the child or youth remain in one place. These are important considerations but there is also the important matter of looking at permanence from the perspective of the child and youth. When the child is put first the key issue becomes does the child gain a sense of permanence from this plan? A sense of permanence does not grow in a child or youth from simply remaining in the same home. A sense of permanence comes to a child from the experience of belonging and being nurtured.

The work begins by identifying some of the pressing needs of children in care. These are set out in Janet Morrison's *Summary of Children's Needs* from the *Ontario Child Welfare Review* (2007). While the material refers to the Province of Ontario it is thought that it could well have bearing on child welfare practice in other jurisdictions.

The tone of the publication is set with the right of the child to be informed. The demands of child welfare are such that, at times, the need to ensure that the child understands what is going on is lost in the host of other casework demands. However this publication attests that in child welfare, as far as information is concerned, the child should be considered the CEO. Such a position means that children, while not being given the burden of the decision, whenever feasible should be adequately consulted, and should know and understand, as far as possible, the circumstances behind the realities and decisions that impact on their lives.

Such a position illuminates the conviction that a sense of permanence requires more than establishing a permanent location and caregiver; an essential component is for the child or youth to feel a sense of participation and belonging. This understanding can be found throughout this publication and it is well captured in Gitte Granofsky's paper *Life Narrative and Voice Are Children's Rights.*

Sharing information requires more than giving information to the child or youth. For full understanding, the child or youth needs to participate in the exchange. In her paper *Tell Me My Story* Mary Rella shows how caregivers can work to help a child develop a cohesive story which in turn helps them develop secure attachments and a strong identity.

The child welfare court must give approval for a child or youth to come into the care of the child welfare system. Court proceedings can be complex and difficult. In her paper *Child Protection Court Proceedings* Kristina Reitmeier describes the current court process in the Province of Ontario and points out the need to explain and the opportunities available to help clarify the proceedings for the families that are involved.

In her paper *Adoption and Contact with Birth Family: Can a Child Have It All?* Elizabeth Keshen gives insight into the Ontario perspective of whether a child involved in the child welfare system who is adopted can have contact with birth relatives, and concludes that it can only happen if there is consent on the part of both adoptive and birth families.

The child welfare practice of Native Child and Family Services gives high priority to the returning of a child or youth to his or her Native Band and Community for care. (i.e. coming "home"). At times this can lead to contention and misunderstanding with those who support maintaining a current psychological attachment to those who are caring for the child or youth. In the paper *The Foster Parent Role in Supporting an Aboriginal Child's Permanency Plan,* Landy Anderson discusses this problem and sets out some of the underlying issues from an Aboriginal perspective. Her paper may elicit strong disagreement in those who hold closely to maintaining existing attachment, but we felt it should be included in order that the Aboriginal position could be understood. It is hoped that it will promote discussion and understanding resulting in culturally appropriate plans for Aboriginal children.

Access remains a pivotal point in the success or failure of child welfare practice. In their paper *To Visit or Not to Visit: Issues Regarding Access Visits for Children in Care,* Gail Aitken, Sarah Burgess and Janet Morrison set out some of the experiences of youth who have been involved in access arrangements. They offer suggestions for optimal access arrangements. In her paper *Therapeutic Access* Mary Rella offers suggestions about how to improve parenting skills as well as help workers decide whether the child should be returned to the parent(s)' care.

In child welfare the involvement of a therapist can be beneficial. However the nature and timing of such involvement is crucial and it should enhance and not interfere with continuity of care and working toward a permanent plan. This issue is set out in James Wilkes's paper *Therapy for Children in the Child Welfare System.*

Children and youth in out-of-home care often have difficulties with separation, identity and self-esteem. In her paper *Where's My Place?* Sally Palmer addresses many of these issues and offers suggestions as to how to promote positive identity and self-esteem.

Also on the issue of out-of-home care, Jean Skelton shows the world of fostering from the inside and raises a pivotal issue for foster parents which is how to parent a child when hampered by regulations and administrative procedures. She sets this out in her paper *Parenting By Committee.*

Kinship care has become an important resource, but there are a number of issues that have to be resolved for its optimal practice. The paper authored by Lin Brough and Andrea Smart, *Kinship: Successes and Challenges,* looks at some of the difficulties and opportunities in the management of this kind of out-of-home care.

Young people who are no longer eligible to remain in care are often left without enough support to fend for themselves. In her paper *It's About Time: Rethinking Our System of Care for Youth,* Virginia Rowden looks at the need to prolong our involvement with youth and the sense of abandonment that current practices give to the lives of the youth involved.

II. SUMMARY OF CHILDREN'S NEEDS

Janet Morrison
President, Child Psychotherapy Foundation

The Crown Ward Review (CWR) is "an annual process undertaken by the Ministry of Children and Youth Services to determine if the placement, services, educational and social needs of Crown wards in Ontario are being identified and appropriately addressed" (Ontario Child Welfare Review, *Ontario's Crown Wards Including Adoption Probation, Summary Report*, 2007). The information compiled in 2007 is the latest currently available.

> *"The goal for every child in care is a permanent, loving, and safe home, and it is the responsibility of the child welfare system to make every attempt to provide the opportunity for a child to belong to a committed, safe, nurturing family. The three critical elements to achieving permanence are safety, stability, and attachment. All three elements are essential for normal and healthy child development"* (Ontario Child Welfare Review, 2007, p.18).

Despite this stated goal to provide permanence for children in care, the results are very discouraging. According to the most recent Ontario Child Welfare Review (2007):

1. The average age of children at the time of Crown wardship is 8.5 years; 44% of children had one placement since becoming a Crown ward; 20% had two placements and 36% had three or more placements. On average, the children's workers change every 21 months.

2. 82% of Crown wards have "special needs" - 49% demonstrate behavioural support needs; 47% were taking psychotropic medications and 29% were involved in psychotherapy (CWR, 2007, p. 13-14).

3. 21% of the children reviewed were of Indian or native heritage, and of those, only thirty-five percent were served by native Children's Aid Societies, down 2% since 2006. Fewer native children (-2%) were placed in or having contact with their home communities compared to 2006, and First Nations representation in case planning decreased by 3%. The total number of native children in care *increased* 4% from 2006 to 2007.

4. 11% of children in care have been charged under the *Youth Criminal Justice Act* (p. 18). According to Dr. Deb Goodman, Manager of Research, CAST, 60% of individuals in care will come into contact with the criminal justice system during their lifetime.

5. Since 2006, adoption for Crown wards has increased only very slightly from 3% to 4%. (p.19)

6. The number of adolescent Crown wards continues to increase – up 3% from 2006 to 2007, and "all areas of independence planning for youth aged 15 years or more require improvement including social development, vocational training, employment, life skills, extended care, and adult support (Ontario Child Welfare Review, 2007, p.19).

7. A large proportion of Crown wards "disappear" from the child welfare system at age 16-18 and many of these are believed to return to their family of origin.

Our intention in this publication is to make these statistics meaningful, to acquaint the reader with a picture of the individual children, the dilemmas surrounding decision making in their best interests and the systemic, logistical and attitudinal challenges we face, as those who participate in their lives.

III. LIFE NARRATIVE AND VOICE ARE CHILDREN'S RIGHTS

Birgitte Granofsky
Psychologist
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Based upon interviews with many children and youths who were or had been society wards, Senator Landon Pearson, Advisor on Children's Rights to the Minister of Foreign Affairs, stressed how important it was for them to have people who really care about them as well as to have some real control over their own lives:

> The [young people] who were doing well all told me that there were two reasons they were thriving: there had always been someone in their lives who was crazy about them; and they had always been given opportunities to make meaningful choices (Joyal, Noèl & Feliciati, 2005, p. 21).

With the *Convention on the Rights of the Child*, the United Nations provided international standards regarding children's rights and societal responsibilities towards them. Article 12, which speaks to *children's right to participation in decisions concerning them*, is particularly relevant to my argument regarding society's relationship with children in its care:

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

This paper will focus on children's right to be informed about their own situation in life and on their right to participate in decisions that affect their lives. Without ongoing information about past and present life-events, a child-in-care cannot develop a coherent sense of self. Without being met with respect as a person worth listening to, he or she can not develop self-respect and self-trust. And without a core sense of self and a sense of inner strength, it is not possible for a person to make meaningful choices and, consequently, to lead a satisfying life.

Claire Cassidy's theory of how we develop an "I" and a self-identity is useful in this regard. She postulates an "internal processor" that reflects upon the world in order to create "some understanding and in turn help shape the 'I' or identity of an individual" (Cassidy, 2007, p. 43). This development from reflection to understanding does not happen in isolation. Others communicate and interpret the world for the child and provide him or her with some of the

necessary tools for the creation of a self identity. They provide the words. As Smith says, the stories we live and tell are "bound by the words we have available to construct those stories" (Smith, 2005, p. 5). We are our stories, and we need to know our stories in order to know who we are and in order to make informed and good decisions about our lives.

When it comes to creating a positive, strong sense of self-identity, children–in-care are disadvantaged in multiple ways. If they grew up in a dysfunctional family, interactions would have been difficult to "read." It would, as Vetere and Cooper say, be difficult for a child to decipher what is going on if family members had ill intentions towards each other and towards the child or if the adults' behaviours were unpredictable (Vetere & Cooper, 2005, p. 77). At some point, the child's life with his or her family would have been interrupted and more likely than not, several moves within the child welfare system would have followed. This traumatic loss of people, of places and of memories, and any other trauma the children may have experienced, tends to compromise their capacity to regulate emotions (Joy D. Osofsky, in Vetere and Cooper, 2005, p. 76). The resulting poorly regulated emotions, chronic anxiety and hyper-vigilance would further hamper the child's capacity for internal processing. And so would the impoverished vocabulary that often, according to Smith, characterizes these children (Smith, 2005, p. 5).

All these problems are compounded when the adults involved, whether in child welfare, mental health, or the courts, do not keep children informed about their pasts or about decisions made about their lives. If they are not given information, if they do not know their often disrupted stories, including traumatic events, children-in-care end up with a fragmented sense of self. How can they possibly achieve a sense of permanency if they have not integrated their personal history? Permanency is most often discussed in terms of a permanent placement, but the development of permanency in terms of self identity is equally, if not more, important for a person. "It has got to do with psychological stability" (Koren, 1996, p. 293).

In 1990, Canada signed the *Convention on the Rights of the Child* and ratified it in 1991. Therefore, Canada obligated itself to make laws, policies and practices regarding children and youth consistent with the *Convention's* spirit and principles. The final report of the Standing Senate Committee on Human Rights (*Children: the Silenced Citizens*, April 2007) indicates that progress has been slow. According to the *Convention*, children are and must be understood as people with rights, and as important participants in society (Ibid., p.xxi). And they have a right to participate actively in the development of their own well-being (Ibid., p. 25). Only by respecting children as persons with rights do we help them to develop into full human beings capable of making meaningful and socially responsible choices (Ibid., p. 30). No matter how well-intentioned they are, adults who make decisions on children's behalf without involving them in some meaningful way, prevent those children from reaching their full potential. Consequently, accountability for any decision made regarding children's lives should be *to* them not *for* them (Ibid., p. 26). "Corporate accountability" for decisions such as taking a child into care should be to the child whose life is affected by those decisions, not to "the managerial hierarchy," as Gerrilyn Smith puts it (Smith, 2005, p. 7). On behalf of youths, Ontario's former child advocate Judy Finley said: "Don't speak about us without us."(*Children: The Silenced Citizens*, 2007, p. 57).

The *Convention* challenges all of us who interact with children in whatever capacity. We cannot sit idle and await legislative changes; instead we need to come to terms with an understanding of young people that differs from much current practice in child welfare, in the judicial system and in mental health. We must learn to understand and to interact with children and youths as subjects with their own voices rather than as objects in need of our protection. As described well by Marvin Bernstein, this means a shift in paradigm (Bernstein, 2008, p. 7). Most of us will struggle with this paradigmatic shift in the understanding of children and youth and of their role in society. Immediately, we think of what it would mean if children had to make decisions with far reaching implications such as whether to stay in an abusive home or which parent to live with. But taking children's voices seriously does not necessarily mean that adults abandon their responsibilities in terms of children's lives. Children do need to be protected and nurtured, but they interact from birth onward with their environment and form opinions about it and about their own role in the world.

Children's *participation in decisions about their lives* differs significantly from the practice that is based on adult interpretation of "what is best" for the child. The Dutch psychologist, Marion Koren, questions the entire principle of "the best interest of the child" which for decades has guided child welfare practice in Canada as well. She argues that what is in the "best interest" of somebody else is a matter of interpretation, and that there are no "checks and balances" unless the child (and the family) is directly involved or has somebody who represents him or her (Koren, 1996, p. 141). In order to further argue her case against a paternalistic approach to child welfare, Koren quotes a Dutch Ombudsman, De Langen:

> The fact that children are not yet grown up is used as an excuse by parents, social workers, teachers, judges and many other adults to follow their own interpretation of the child's best interest and to set demands and make decisions that may have far-reaching consequences for children which no one can foresee … Why are adults, who are in a much stronger position in many respects, so afraid to take children seriously and to grant them a large degree of autonomy (Koren, 1996, pp. 143, 144)?

Do we truly consider children and youths "persons"? Or are they, in our eyes, only in the process of becoming persons, and their voices, therefore, not credible? At what age might that process be complete? Does it even make sense to distinguish between adults and children as if they were fixed categories? In child welfare we often come across children who function as the most mature persons in their families and who look after the needs of their parent/s and siblings. Yes, infant dependency is a reality. Infants need to be fed and looked after, but so do many adults.

In Western culture we define childhood as a special period from birth until 16, 18 or 21 years of age depending on whether we mean the age at which a young person is no longer under the protection of Children's Aid, is permitted to drive, to drink or to vote. "In societies where you are seen as an adult when you are ten, then you are an adult when you are ten" (Cassidy, 2007, p. 172). Our current ideas about childhood were shaped by Enlightenment philosophers such as Rousseau who argued that "nature wants children to be children before they are men" (Howe & Covell, 2005, p. 23). Since then we in the West have preferred to look upon children as innocent and in need of adult protection, guidance and control. It sounds benevolent, but it also has to do with control and power. Consider the view, held as late as in the nineteenth century, of women in

the West and in many cultures still. Women were/are seen as weak, fragile and in need of protection and their needs best met by their husbands and men in power who knew/know better than they what was/is good for them.

We all know that others' expectations shape our behaviours and our opinions of ourselves. If our voices are not valued, if we are considered too young to take on responsibilities, if we are "protected" from knowing facts about ourselves, we will stay immature, irresponsible and feel ourselves to be outsiders to the "real" (adult/male) world. Piaget found that capacity for abstract thinking only developed at the age of twelve, but he has been proven wrong. As Cassidy says, children can reflect and reason from an early age and are not cognitively limited to concrete thinking. But as with any other skills, cognitive skills need both to mature and to be practiced (Cassidy, 2007, p. 163). This view is also held by the *Convention* and, consequently, it does not stipulate an age limit in terms of child participation in decisions regarding his or her life.

The Standing Senate Committee on Human Rights found that, because their voices are not heard in proceedings and decision-making processes concerning their welfare, many children and youths-in-care feel that their rights as defined by the *Convention* are being violated. The report urged provincial and territorial governments to ensure that children's voices be heard: "Children can recognize their responsibilities within the child protection system only if they feel that they have ownership over their own lives" (*Children: The Silenced Citizens*, p. 102). Independent of the child's age, adults should feel accountable to him/her for decisions they make on his or her behalf.

In Ontario, self-determination is expected to happen, almost magically, when the child turns seventeen. At 17 they can leave the care of Children's Aid, but if they want to return to care, they find the door closed. To expect young people to conduct their lives in isolation without familial or community support at that age is tantamount to abandonment. And it is even worse if society has not prepared the child for self-determination, met him/her with respect and allowed for participation in decisions about his/her life as he/she was growing up. A report prepared for the Child Protection Unit of the Canadian International Development Agency commented that "children's capacities are developed most effectively through interaction: the process of learning generates development, and children grow in competence through participation." The same report also saw a connection between mental health and participation: "It is now accepted that children who are active in decision-making, who learn from their own experience … are less prone to depression, hopelessness, and suicide" (Cook, Blanchet-Cohen & Hart, pp. 10, 12).

In order for children and youth to make meaningful choices, to be able to form views of their life situations and to state opinions regarding judicial and administrative proceedings, they *need to be informed.* The *Convention* recognizes the role information plays in the child's physical, mental, spiritual, moral and social development, and therefore, it implies a right to information. As Koren says, the child or youth first has to gather information before the forming of views is possible (Koren, 1996, pp. 357, 359). That means that the adults who care for children and youths must keep them informed. And what does "being informed" mean? For children-in-care, it must mean that they are informed about their parentage, their family history, and significant events in their lives, in a language suited to their developmental stage. But, as Dr. James R.

Wilkes argues, little details of the child's life are also important because they speak to the "colour," the nuances of his/her life (Wilkes, 2008).

Generally, being *told the truth* about their lives, being listened to, having their views taken seriously, and being actively involved in making decisions and helping to find solutions, has an immense "bearing on children's ability to cope"(Vetere & Cooper, 2005, p. 81). Children need to be kept abreast of decisions made on their behalf, whether those decisions are optimal or not, because "children adapt more readily to changes if they understand why the changes are necessary and if they are given a voice in determining those changes" (Covell & Howe, 2005, p.126).

The *manner of providing information to children matters*. Significant others must help them process that information and be prepared to retell the stories as the children grow. Adults must also listen when the children tell their own stories, so that their experiences can be validated and processed and do not remain on the blurry border between fantasy and reality. If communication is not nurtured, if the children's stories are not told to them and listened to, the children are left with the option of acting out their stories, their truth, and their feelings of loneliness, self-doubt, anxiety, anger and confusion (Trenka, 2003). If the acting out of their stories is also not "listened to" and understood as communication, the adult world might simply see and dismiss the children as disturbed (Smith, 2005, p. 10).

Children-in-care are vulnerable and disadvantaged. They have by definition been deprived of consistent attachment figures and have suffered abuse or neglect of some kind. In taking on the role of parent, society obligates itself to do the best job possible for those children. Society must do all it can to foster a strong sense of self-identity and self-respect in the children. In order to accomplish that goal, it must treat the children as persons with rights. Doing so requires that the adults keep the children informed about their stories and about legal and other matters that influence their lives. It requires that the adults listen to the children and allow them to make decisions to the extent that they are able and mature enough to do so. Adults are responsible to children and must be able to defend to that child any action taken on a child's behalf.

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IV. TELL ME MY STORY: THE TREATMENT BENEFIT OF KNOWING THE TRUTH

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What should I say to make you feel better?
Not the truth, it's far too painful.
Believe me, I've been trained and the truth makes me sad.
I'll tell you when I know what the outcome is. Then, it won't be a lie.
That will buy us both some time.
Maybe a solution will come along and fix this problem.
Maybe a judge will make a decision about this problem.
You will get older and maybe then you'll understand this problem.
I just wish you didn't believe that you were the problem.

Mary Rella

How often do we use these words to convince ourselves that protecting a child from the truth is the right course of action? Unfortunately, when it comes to children in the care of Child Protection Services (CPS) the answer is: far too often. This paper recognizes our tendency as professionals to engage in "protective" practices and challenges all of us to become engaged in *truth-telling* processes in order to help children *learn about themselves and their experiences*. Right now in Ontario, while Child Protection and Children's Mental Health service providers sit at planning tables together, sharing information and developing mutual understanding of complex issues that cut across our respective mandates like partner violence and neglect, when it comes to engaging in a dialogue about telling children the truth about why they are living in foster homes, kinship homes or group homes, we are silent. The numbers—along with the higher incidence of mental health and special needs issues—urge all of us to better understand the therapeutic implications *and* treatment interventions these children require *while in the care of Child Protection*. How do we understand *silence* to be more helpful than actively exploring, understanding and promoting the critical importance of helping children understand why they have been separated from their parents?

In this paper I will draw upon Bowlby's attachment theory which posits that every child seeks attachment to his caregiver and that he or she will adapt behaviour to maximize proximity and safety. Children who are securely attached have caregivers who tolerate the child's needs for both exploration and dependency and are reliably available when the child requires comfort, validation and/or autonomy. Through the provision of validating responses, protection, and soothing, the child not only comes to feel safe but is able to tolerate and regulate an ever expanding range of emotional states. Autonomy and intimacy are based on secure attachment whereas ambivalence and avoidance with respect to important relationships are the products of insecure attachment - the product of failed dependency needs and a lack of validation.

Attachment theory and Johnny's story will help to show that by taking a path designed to help children know and understand their *true stories*, we will be working to correct security and autonomy distortions, thus providing deeper and wider protection for children in all of their environments, not just those defined by the structure of treatment. In this regard, I am arguing that truth-telling and diligently addressing all of the associated feelings and dilemmas need to become a therapeutic priority for all children in the care of Child Protection- understood and supported by everyone in the child's circle of care. Several tools are offered to help make this process as simple and helpful as possible. After all, telling children the truth is far more important than any story we will tell each other about protecting children's feelings. Training professionals to help children understand their truth is essential. Supporting foster parents to be part of the training is likely an aspect of their role they have long awaited.

Avoiding the truth
It's not that I don't want to tell you

Right now when a child comes into the care of Child Welfare in Ontario, the Child Protection worker says that the child can be told only some parts of the truth until decisions are made about permanency. The foster parents cannot disclose what they know because they don't want to contradict the worker. These parents are often told to be silent on the matter as their point of view may be different than that of Child Protection. The Children's Lawyer is focused on obtaining information from the child. The Child Welfare lawyers are there to represent the position of the Society. Children's Mental Health workers often delay becoming involved with a child until permanency is decided. Thus, no one is taking responsibility for telling the child what the problems in his family are. Helping the child to process relevant feelings and reactions are left unstructured and therefore collectively unattended.

If I tell you, you might be sad

Perhaps we do not tell children the truth because we understand that their difficulties might result from their parents' problems, and so telling children about such problems creates even bigger ones for them. Hence, the truth is not seen as a solution for resolving their distress or as an avenue for corrective emotional experiences; instead, it is seen as adding to their burden.

Or perhaps we think that by waiting until the service direction is clear and confirmed and all the adults have a story to share that cannot be contradicted by any other adult, then at that time the child can know, too. This sounds like a reasonable conclusion, except that this process is riddled with problems and some would argue that the process becomes a contributor to disjointed family stories, poor self perceptions and an inhibitor for treatment (Wilkes & Milne, 2002).

Or perhaps it is because human suffering is intolerable, especially the suffering of children. We use our own defenses to buffer the pain: avoiding truth, postponing truth, omitting truth, sometimes even lying, to avoid delivering painful information to a vulnerable child.

Imagine the following exchange taking place between a foster parent and Johnny, a 7-year-old boy in her care, every Tuesday morning before he leaves for school:

Foster Mother: *Johnny, today is Tuesday. The teacher will tell you when it is 2:30. At 2:30 you need to go to the office and Ms. Mills (office secretary) will tell you if your driver is there to take you to see your mother. Please don't drink too much at lunch time or you will need to go to the bathroom on your ride to see your mother.*

Johnny: *O.K. What about recess?*

Foster Mother: *You'll go only in the morning. If the driver is not there that means you won't have a visit today. So go back to your classroom and wait until the end of the day and come home on the school bus.*

Johnny: *Will my mom come today?*

Foster Mother: *I'm sure she'll come if she can.*

Well meaning, to be sure. The foster mother on this occasion has much more information but cannot tell Johnny the truth about why his mother may or may not attend the scheduled visit. In fact, likely she won't make it. She was hospitalized with a drug overdose a week ago and has not been heard of since. For Johnny, lost is the opportunity for him to express any negative affect and for the foster mother to provide him with a corrective contingent response based on his affect—whatever it may be. Lost is the opportunity for Johnny to understand that his mother has unfortunately relapsed in her substance addiction and been hospitalized as a result. Lost is the opportunity for him to express his anger at her inability to take care of him and the sadness of missing her. He may believe that if only he had listened to his foster mother the night before, this would not have happened. The foster mother is equally at a loss. She knows he will be anxious all day. He has ADHD and will probably refuse the medication at lunch time. She wants to tell him why the access visit is tentative but she is told not to. She will wait just like Johnny to see what happens. The tentative visit becomes a secondary issue as the school calls the foster mother at 10:35 that morning advising her to come to the school to pick Johnny up. He has assaulted a student at recess and is in a physical restraint.

What does not having the truth about his mother do for Johnny? Is it really protective? It is exactly these questions which should guide us in exploring and understanding Johnny's needs and feelings in the present so we can support his growth into the future. Johnny's well-being and development should guide our work, not our biases regarding the concerns we have created about what he should and should not know about the present, regardless of how uncertain or temporary it is. Communication between all caregivers and service providers with the child in any Child Protection context, just as in any therapeutic environment, must include truth telling as a way to activate feelings which may be negative so that the caregiver can respond in a sensitive and contingent manner. This very process is necessary for the development of secure attachment (Cassidy, 1994).

The truth and security
You need to know

Secure attachment facilitates a child's ability to let another know about positive and negative affect. The ability to share the good and the bad parts of the self and to tell of anger, ambivalence, love, longings, fear and neediness all stem from having had the experience of a secure base and the ability to gain and maintain proximity to an attachment figure (Bowlby, 1979). *Secure* attachment is understood to be a protective factor in mental health. When it is *insecure* or *disorganized*, it is a risk factor for mental health concerns (Bowlby, 1979; Cassidy, 1994; Hughes, 2006) which may be categorized later in life as mood disorders, conduct disorders or personality disorders.

Part of the genetic tapestry of people is that we feel emotions. Some feelings are positive: happy, joy, delight, contentment; and some feelings are negative: anger, sadness, fear, guilt, disgust, disappointment. Events can dictate our feelings most of the time, and how we choose to express them can be in our control, provided, however, that we know what those feelings are. Emotional regulation starts very early and is completely dependent on having an adult organize and name the behaviours as feelings. "You must be hungry" or "You are tired" or "You are frustrated," or "Waiting for your bottle is hard." The identification of affective states is crucial for the development of affect regulation. Initially, an adult does it all for the infant, and eventually a co-regulation system is set up, i.e. adult with the child; and later a self regulation system operates effectively most of the time (Zeanah & Boris, 2000).

If an infant in distress experiences responsive caregiving—that is a caregiver who offers responses contingent to that distress—he will develop confidence in his caregiver as a protector of his emotional environment. This emotional and relational learning is crucial for brain development in the infant (Gerhardt, 2004). But, what if feelings the infant experiences are confused or misunderstood? What if Johnny's parents, for example, have misidentified his affective states? What if hating was minimized, scared was ignored, anger was considered defiance and sad uncared for? How a parent experiences the infant and receives the infant's cues for comfort is "downloaded" directly onto how the infant sees himself (Siegel & Hartzell, 2003). If the parent does not experience the child as lovable, good, special, wonderful, the child will not experience himself this way either. Instead, the infant will experience himself as unworthy of being loved and cared for. In turn the infant develops behaviours such as averting his gaze to protect himself from the harsh messages of the parent, which in turn, can then be interpreted by the parent as rejection. The experience they have together becomes flawed and distorted and the relationship is compromised.

Moreover, when a child experiences abuse or neglect at the hands of a caregiver or isn't protected by a caregiver, the child experiences trauma and develops insecure attachment systems such as *avoidant*, *ambivalent* and/or *disorganized* (Ainsworth, Main, Kaplan, Cassidy). Each classification has identifiable characteristics in the relationship that affect autonomy and hinder intimacy thus offering dilemmas to the child that the relationship is not equipped to resolve.

Whether the child approaches the parent or remains distant from the parent, the child becomes confused about his own security and develops various maladaptive emotional, behavioural and social solutions to control that security.

These are the very children that come into the care of Child Protection. This is Johnny. These infants, children and adolescents have in some form associated fear and uncertainty with the care they have received from their parents. These children have likely experienced disorganization at many levels of their development. Understandably, they have not learned to see their parents as a secure base and have often developed their own ineffective emotional regulation systems. Fear and insecurity drive the child to use negative strategies to involve the parent or avoid the parent most of the time. Unlike infants, older children have learned to hang on to their strategies longer and their self protection pathways are far more entrenched (Gerhardt, 2004). The child's capacity to develop autonomy is further impaired. Since the initial relationship with the parent has led to the development of these problems, the child has extreme difficulty accepting the positive experiences being offered by caregiver substitutes.

Negative affect in the child is generally what is most often avoided by well-meaning professionals once the child enters Child Protection Services. If negative affect is not addressed because the reasons could lead to upset feelings, where sadness is painful and anger can be destructive, the process of co-regulation of affect or organization of affect continues to be weak and vulnerable for the child. Adults tend to ask children to tell them how they feel but children who have not experienced the organization of behaviours as affective states will not know their feelings (Baradon et al., 2005). These children need to know *what* they feel and less *why* they feel it (Cassidy, 2003). Educating children to link feelings with behaviours and events will help them to know what they feel and why they feel it. Children in care placements outside of their home are filled with emotions that are painful and confusing. Talking with them about their life events provides corrective experiences regarding their feelings and most importantly explanations for such feelings. So Johnny would benefit from knowing his mother has had a relapse in her addiction.

The truth, security, autonomy and intimacy
You need help building your truth

Therapeutic interventions for children may have varying outcome goals. Some are immediate: to improve externalizing behaviours; some more long term: to improve relationship representations. It seems that improved behavioural outcomes can occur only once relationship representations are improved and not the other way around. The good intentions of foster care providers, group home staff, school support staff and parents to provide limits and structure as a way to correct behaviours and regulate emotions are not enough to combat the need for the child to control his own security. Structure without rebuilding a secure base is just plain ineffective.

Bowlby's final work, *A Secure Base* (1988), explains the function of developing autonomy as crucial to the development of intimate relationships. The exploration of the world is less risky knowing that the security of care is waiting in case the exploration suddenly becomes frightening. With this comes the ability to negotiate closeness when in need. Failure to negotiate closeness keeps the secure base at a distance and hence knowledge about when to return and

when to continue safely on the exploration path is compromised (Marvin & Britner, 2008). If the child is unable to identify a consistent path back to the caregiver where he or she is welcomed gently, their autonomy is often at risk. Moreover, as children's developmental needs to act on their own goals become more frequent and more complex, the attachment relationship expands to include the child recognizing the caregiver as supporting this increased autonomy. The child's experience of support increases intimacy with the parent. Caregiving behaviours focused on controlling autonomy and/or fast tracking autonomy compromise the child's effort at understanding the connections between his autonomy and intimacy with his parent.

Positive experiences with negotiations build later competencies. The trust that the relationship can stand the stress of negotiation—that it is not fragile and will not be destroyed—allows the child to have his wishes and preferences acknowledged. The caregiver also makes her or his wishes clear so a joint plan can be made (Marvin, 2008). The process allows for ruptures in the relationship to be understood as external to the relationship hence preventing defenses such as excessive anger, self-blame and worthlessness to become internalized or externalized. The repairs are also met with acceptance and understanding and serve to strengthen the relationship.

Many children entering Child Protection Services have developed poor strategies for negotiating autonomy and intimacy. Their strategies can include controlling behaviour, aggression and in some cases, over-compliance. So, how do you use truth-telling to facilitate a corrective experience?

Although the Child Protection team (including the placement) usually gives the child permission to talk about their feelings about separation from their family, the child must be given opportunities to explore, express and learn to negotiate proximity (i.e. intimacy) for such feelings *from a secure base*. The child cannot do it alone, and will not do it if he sees the team as silent and/or unhelpful. In Johnny's case, strategies he has learned such as using anger and control as a mechanism that will prevent him from negotiating closeness, will continue in the face of his foster mother's silence regarding the potential missed visit. Johnny's right to be sad, angry, disappointed and/or frustrated remains covert and unresolved. The experience becomes a further failure for Johnny to negotiate closeness connected to his feelings and a failure to learn adaptive co-regulation with a secure base. Although the Child Protection team may believe that Johnny would be upset to hear that his mother "took drugs" again and that he would be worried about her and may be sad, avoiding the opportunity for learning co-regulation with negative affect for Johnny, is not the solution. The most tragic aspect is that Johnny already feels sad, angry and upset. The news about his mother would only serve to help him express the feelings more truthfully. Johnny may not be able to answer the question of "why" he assaulted his school mate. The school may believe it was because he was asked to do math, a subject he does not feel competent at; the foster mother may believe it was the uncertainty about seeing his mom; the Child Protection team may understand either as possibilities and will likely ask for a review of his medication. All or none might be accurate.

The truth becomes the most significant pathway to help sew the patches in Johnny's relationship quilt. He can love his mother, and hate and be angry with her. We can accept these behaviours as organized clusters of unmet emotional needs and tell him we are sorry for his pain, angry for his loss, too. Had he known the truth, Johnny may not have gone to school that day, but he might

have learned a corrective emotional piece about negotiating closeness more adaptively. It is this experience and this learning that is crucial to his treatment, to his development.

The truth, security, autonomy, intimacy and adulthood
The truth will help you know you are not the problem

Let's look at Johnny as an adult. What life story has he been forming so far?

I grew up in CAS. Foster homes and then a group home or two. I was a bad kid. Angry a lot. My mother didn't look after me because of drugs, I think, I was too much for her. I tried to see her when I got older but it didn't really work out.

Adults who have had opportunities to learn with a secure base or have had opportunities to correct experiences with a secure base (Fonagy, Steele M, Steele H, Moran, & Higgitt, 1991) are more likely to understand and therefore resolve experiences that have had a negative impact on their development. Johnny could be one of these adults but he won't be unless we take the opportunity to help him understand, work through his confusions, and identify and resolve his feelings about why he was sèparated from his mother. Corrective experiences involving understanding the details of his story would provide Johnny with the opportunity to be one of these adults.

Most of the research examining how adults understand the care they received as children comes from studies using the Adult Attachment Interview (George et al., 1984; 1985; 1996). In the interview, adults are asked to recall memories of how they experienced being cared for while growing up. They are also asked how they believe such experiences have shaped their personalities. The narratives they provide are classified based on how the adult thinks about his or her life story rather than the content provided. So while the experiences presented may be negative, the understanding of the events is what really matters.

The narratives are classified as *secure/autonomous, preoccupied* and/or *dismissive,* and/or *unresolved* (George et al., 1984; 1985; 1996). The defining feature of a *secure/autonomous* state of mind is that the story told by the adult about his or her experiences is balanced and truthful. These experiences are understood to be external to the self and therefore self-blame is minimized. A narrative that is *preoccupied* with the relationship, whether idealized and/or "villainized," reflects a description of caregiving experiences that are distorted. Bewilderment, anger and/or fear permeate the narrative demonstrating a continued preoccupation. The *dismissive* narrative features examples that are disjointed where less meaning is placed on caregiving and more meaning is placed on pseudo autonomy. The adult dismisses the importance of a secure base and instead recalls a much more self-reliant model, developed in early childhood. Negotiating intimacy is minimized and dependency needs denied. The *unresolved/trauma* state of mind classification is characterized by traumatic events left unresolved and continuing to impose fear in the present. Such a classification may also include unresolved mourning of a death and pain connected to the loss that is still unbearable to think or speak about. The overall narrative is confused and is presented like a broken picture, one piece at a time, and not in any order. The effects continue to be devastating in adult relationships.

In our story, Johnny's experience of separation from his mother, coupled with confusion about his bad behaviour and the link he draws to his mother not showing up for visits, along with his inability to learn at school and form peer relationships, and his changing placements and caregivers are all *relationship trauma experiences*. Johnny does not understand that addictions are difficult to overcome. Johnny does not know that he is not the source of the problem. Likely he believes his mother doesn't want to see him because he is bad. His bad behaviour and the fact she doesn't show up is all the proof he needs.

This is where the truth really counts. Helping the child with painful content will provide opportunities to rearrange the forming defenses to combat the child's painful realities. Correcting such distortions must be understood by the Protection team—and everyone in the child's circle of care for that matter—as a treatment priority. Statements and variations on "I don't know that," "I can't talk to you about that," "You need to be in a safe place," "I'm here to keep you safe," etc., only add to an incoherent story that the child has formed and is already building emotional defenses for. It is the duty of all involved with children in care—including CAS teams, foster homes, group homes, Children's Mental Health and courts—to help the child develop and create a cohesive understanding of his or her experience with the parent, the foster or substitute care placement and all of the feelings that follow. Johnny must *know* the content of his story so he can process the distress as the story unfolds. Children are much better at sadness and anger than adults believe them to be. Exploration and empathy would validate Johnny's feelings and help him to better understand shameful feelings and hence his sometimes outrageous behaviours. It becomes essential to help the children understand the reasons they developed the behaviours they act out.

With or without his mother as a caregiver, Johnny—developmentally—needs a secure base. Providing positive and healthy physical care for a child is certainly a corrective experience and a contributor to a secure base. But it is not enough on its own. Truth telling as a corrective experience is equally important. The tension between what Johnny understands is unsafe about his mother's ability to care for him, and what he experiences, "I love my mother and I hate my mother," culminates in conflicting mental representations of care, intimacy, autonomy, and security. These representations should not be ignored or further confused once a child comes into care. Secure attachment is fundamentally based on validating the truth of the child's experience. Validating negative affect and/or confusion about past and present experiences *is* the first step in the corrective experience. The foster parent, the Child Protection team and the courts, for that matter, are responsible for ensuring that Johnny has a secure base in order to have corrective emotional experiences. Expressing negative affect will help Johnny to develop a more truthful narrative which in turn will help him on his path to becoming an *autonomous* adult. Moreover, such experiences will help him develop his own capacity as a future parent by teaching him the importance of providing a secure base for his future children.

What *could* Johnny's life story be so far?

I grew up in the care of the CAS. I missed my mother terribly but she had a drug problem and couldn't look after me. I lived in a couple of foster homes. I was a real handful – very angry and sad a lot of the time. I lost touch with my mother at times but I always knew she couldn't look after me. Drugs are terrible that way. They really got in the way of her showing me she loved me

even though she said it. I'm sorry I missed growing up with her but my life would have been a mess if I had.

The concept of permanency for a child comes from knowing and understanding where the child will grow up, as well as psychologically understanding where he or she belongs (*Permanency Planning in the Child Welfare System*, 2002, and *There Are No Wizards*, 2010). Helping the child develop a coherent story about the reasons for being separated from a parent and the reasons for placement outside the home contributes to psychological permanence about his or her place in the world (Palmer, 2010). Johnny, and every other child, needs a secure base to facilitate that process.

At this point I would like you to think about a child that you are working with and how you can use questions—some that you create or perhaps some of the ones offered in the following questionnaire—to help facilitate a conversation with that child. The real work begins when we tell the truth and we remain present, attuned, curious, and emotionally responsive when the child experiences pain and other feelings and is supported over and over again, to know and understand his or her own story…as it is developing…so far.

Informing the Child

What a guide could look like and what professionals in Child Welfare, Children's Mental Health and the Courts could be talking about at community tables and through consultation and training.

- Tell the child why he or she is in care, provide information about what has happened to their family.
- Initiate when child enters care and continue to tell child at every access visit.
- Help children understand and process the content of their stories.
- Give children information to help process negative affect.
- Help child understand that going home might take a long time.
- Provide a process that helps children recognize the resources they have to process information and feelings, i.e. expand process to include the foster home/group home.
- Clarify reasons for care with specific content.
- Identify the fantasy children have developed to resolve the reasons they believe they are in care.
- Understand the process of helping children to recognize parent limitations and the reasons such limitations are a problem for care.
- Repeat this process over and over.

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 cannot 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 questions 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 question(s) I want to ask are

.....

The questions I want to ask you are .....

The best way for me to remember the reasons I'm in Care are .....

If I forget I can .....

These questions help me because .....

My other question is .....

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V. CHILD PROTECTION COURT PROCEEDINGS: INFORMING AND INVOLVING THE CHILD

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This paper was initially conceived as an outline of the stages in a child protection court case, written by a lawyer to provide an overview for clinicians struggling to understand a system that appeared, to them, not to focus on the child at all. How, they asked, can children be protected in a process which, although well-intentioned and necessary, is ill-equipped to provide for the children's needs for information?

In the course of the discussion, questions about the place of the child in the complex rules and processes and comments highlighting best practice procedures which could assist the child in knowing her story were superimposed by the clinicians on the steps in the court case. The resulting paper is something of a dialogue – it sets out what is, and suggests how to make it better for the child.[1]

Pre-court

Child protection court proceedings in Ontario[2] begin either as a result of the removal of a child from their family (commonly referred to as an "apprehension") or a decision to seek a court order without first removing the child (most often an order of supervision with conditions to address a specific identified need).

Amendments to the Child and Family Services Act (CFSA) which were proclaimed in force on November 30, 2006, and new Child Protection Standards which took effect at that time have emphasized the importance of strength-based responses, engagement of the family in planning and finding solutions, and have enshrined the need to consider Alternative Dispute Resolution mechanisms prior to commencing a court application.

In order to be able to give the child the information the child needs, it is important that the worker attempt to gain the birth parents' co-operation in placing children in care. Sometimes this can be done by way of a family meeting or conference. If possible, a Family Group Conference may be convened, including extended family and others who may contribute to planning for the child's ongoing care. The child must be informed in an age appropriate manner at the time that the parent is informed, preferably by a social worker, of any decisions that have been made. Concise, accurate information (the truth) should be provided to the child.

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[1] The comments in italics are from a children's mental health perspective. They advocate the principle that the child should be properly informed and involved with the court process.

[2] Child protection in Canada is governed by provincial laws, which vary from province to province. While the specific details differ, there are substantial similarities in the process involved which enable the reader to generalize the comments to other jurisdictions.

In an ideal world, if a child must be taken into care, the separation from parents should happen at home, and with the parents' reassurance of the child and preparation in advance. Not all situations permit this kind of planning. The child's possible emotional reactions should be anticipated and a plan should be made to address them: e.g. if a disclosure from the child preceded the removal, the child may want to retract. Other emotional reactions from the child may be guilt because the child feels to be the cause of the disruption in the family; shame because it will become common knowledge that the family is dysfunctional; anxiety because of the unknown; because of possible parental anger and rejection; worry that parents cannot function without them or that younger children will not be looked after; anger at self, at the Children's Aid Society (CAS), at parents.

In cases where an application is made to court without the child/ren first being removed, the child should be spoken to directly – preferably with the parents' participation to ensure that everyone gives the same message to the child. From the child's perspective, it would be preferable to have the parent accompany the child to the foster home, provided there are no safety issues if the parents are aware of the location of the child's residence. This would set up communication between caregivers about the child.

First Court Appearance (within 5 days after apprehension)

The CFSA requires that when a child is brought to a place of safety, the CAS bring an application before the court within 5 days after the event. The parents are often told by phone where and when to attend, and might only receive the court papers at the courthouse. The "court papers" include information about the order the Society is seeking, as well as considerable detail about the allegations that led to the Society's intervention and/or the removal of the child.

Best practice would suggest that the worker should communicate with the parent(s) directly, explain the reasons for intervention, and talk about how they might inform the child about what has taken and is going to take place. In an ideal situation, a visit between the child and the parent(s) would be arranged during the 5-day period. The lack of contact between parents and children right after placement is likely to add to a child's insecurity.

The CFSA requires that children age 12 or older receive notice of the proceeding. If a lawyer is appointed for the child, then subsequent documents are given to the lawyer. Most children, prior to having a lawyer appointed, are given a copy of the court documents – the Protection Application and the worker's Affidavit which sets out the evidence on which the Society is relying.

It would be preferable that the child be provided with information in a manner that makes the reason for CAS action more clearly understood, given the child's age and stage of development. A face-to-face telling of the story by a worker, in the presence of the parent or the substitute caregiver would be more beneficial to the child than a copy of the court documents. Those preparing documentation for court should be mindful that the materials will be read by the child.

Sometimes, giving formal notice to a child is delayed until counsel for the child is appointed – so that the child's lawyer can give the explanation. *This can be problematic when the circumstances surrounding the child's placement in care are unknown to or not clearly understood by the child; there may be clinical repercussions to the child of being told the story, and the lawyer is unable to provide support to the child that can meet his or her clinical needs. Although the lawyer should be the one to explain the court process and the legal documents to the child, it may not be best for the child for the lawyer to explain why the child's situation resulted in him or her coming into care.*

The first court appearance almost invariably results in an adjournment – and if the child has been removed from home, he or she is most often placed in temporary care and custody of CAS on a "without prejudice" basis for the length of the adjournment. "Without prejudice" means that the court has not yet adjudicated the merits of the claim and will treat the case on the next occasion as if the "without prejudice" order had not been made.

Parents now have to prepare their case – there may be expectations set for them to change some of their behaviour and parenting practice etc., which may be explained by the worker, or perhaps recommended by their lawyer. It would be important that the child be made aware of what the parents were told. From a clinical perspective, it is essential that the significance of "without prejudice" be explained to the child and parents, ideally together.

The issue of access during the adjournment period is of utmost importance to the child, but may be only an "afterthought" at this early stage for the worker focused on making sure the child is physically safe.

There are also a variety of practical issues which come into play for the child at this stage following a placement in care: How will my teacher and my friends know what happened and why I am not there? Who will look after my pets?

The child needs to know the reasons for being taken into care and the plans for the immediate future. Preferably, the parents are involved in telling the child. The parent/s may be too upset to cooperate and the child might then need help with the interpretation of parental reactions. Also questions, such as: Why can I not stay at home? When will I see my Mom? ...my house? need to be addressed.

Possessions such as toys, photos, school work, favourite clothes, blankets (for infants something that smells of familiar person) are extremely important for the child to take along in order to support his/her sense of self and as "transitional objects," i.e., links to attachment figures (however insufficient these may be).

The court will consider appointing independent representation for the child in some circumstances, and may send a direction to the Office of the Children's Lawyer (OCL) in Ontario. The CFSA outlines some circumstances in which the court must consider whether independent legal representation would be beneficial for the child. On occasion the CAS – or counsel for a parent – makes the suggestion to the presiding judge.

Parents should be told about this possibility prior to court. Workers, lawyers and judges should be aware of the possible impact of such a decision on the parent's sense of autonomy and control. Parents need to have an understanding of the role of child's counsel, which is to independently represent the child's interests in court.

CAS will give the Children's Lawyer full disclosure, and this is most often exercised by the assigned lawyer coming in to read the CAS file. *Parents should be made aware that this will be the case – so they do not learn about it from the child's counsel or their child.*

At the first appearance, most of the time the judge has only the CAS "papers," and doesn't have time to hear from parents of child. The child is very rarely present. A temporary placement decision is made on the basis of protecting the child from (usually physical) risk. The judge gives brief verbal reasons for the decision, and often sends a message to the parents about the need to make changes or put forward a plan for the child's care.

Most often, the only party with a lawyer at this stage is the CAS. Parents will have an opportunity to apply for legal aid (if they qualify) and retain counsel during the adjournment. If a direction for independent legal representation for the child was made, the Office of the Children's Lawyer will receive a referral package from the court on the basis of which a lawyer will be assigned. Child's counsel are experienced lawyers, and the OCL provides training and has guidelines about how their work gets done. Parents have choice of counsel, and there is nothing to require them to retain someone with experience in child protection law.

The order made on the first appearance is intended to be for the very short term. The court is acting on incomplete information. Sometimes the CAS investigation is not fully completed.

When further investigation is contemplated, the child and family should be properly informed as to the nature (process and timing) and reasons for the further investigation. It is not always clear where the responsibility for such explanation lies: with the court or with the CAS.

An access order is usually made (except in the most blatant situations of risk) but it is often a cookie-cutter "1 hour per week, supervised at the CAS office" approach. In many cases, there is not enough known at this stage for a meaningful approach to access.

Access planning is a major element of casework planning and strategy. The CAS must always have an opinion as to the optimal access plan. Quite often access can be used as a means of assessment and if so the details of such a process should be provided or at very least the intention to use access in such a way should be identified.

Access visits which ignore the current court situation are confusing to the child. The child will wonder "what is going on here? I can see my parents but I can't live with them; how do they feel about this? what has to happen for me to be able to go home? Do my parents know all this?" These and other questions arise when the child does not have full information about his or her circumstances. Without information, the visit may become a ritual in which everyone maintains silence about what is going on and instead eats pizza and plays with toys.

Access orders should take into account developmental issues. Weekly access is, for example, not sufficient for an infant or a young child to sustain an attachment to a parental figure. Older children will want answers to why they can't see parents more often, or why they might not be able to phone. It is important to give children reasonable answers to these questions.

Visits should be long enough to meet their purpose: to sustain a relationship, or provide opportunity to make meaningful assessments about the child, the parents and their relationship.

Questions at this point will be many: Why am I not at home? When will I return? Who decides and when? Am I a bad child? Is this why I am not at home? What changes does my parent have to make? Why are my parents reacting the way they are? Why are my parents late for appointments? Why are they angry? Who decides about me, my foster parent or worker or judge?

Temporary Care and Custody/Access Hearing

Once the parent(s) has/have retained counsel and prepared their side of the story in affidavit form, the court holds a temporary care and custody and/or access hearing to determine which temporary orders should be made until a full hearing of the issues can be held. This may be the 2nd or subsequent appearance; timing varies. The Timetable under the Ontario Family Law Rules says this hearing is to happen within 35 days of start of the case. In many cases, temporary care and custody is determined on consent or by default (parents have no alternative to foster care to propose). In some cases the contested hearing happens much later.

It is important that information about the timing of this hearing be given to the child, and that the reasons for any delay be made clear to the child, because if no information is given the child

tends to blame him/herself for any delay. Explaining the delay offers the opportunity to explain the whats and whys of the upcoming court process.

Changes in court plans should be immediately explained to the child (for example, hearings that are going to be adjourned). The child should know that the parents have the same information.

During the adjournment period, the Society has a better opportunity to set up family group conferencing or mediation with the family than was possible in the initial 5 days. Again, this should be done as soon as possible before the family closes ranks and the child gets used to living elsewhere. Especially with older, difficult children, the family may feel relieved by placement and lose some of its commitment/sense of responsibility for the child. Family group conferencing is an opportunity to identify extended family and friends who may be willing to take the child or at least play a constructive role in the child's life.

How much information is the child/youth given about the material that parents and other pre-intervention caregivers present to the court? Where a child is represented by counsel, counsel would receive the information presented by the parents.

Counsel will decide what to share with the child, and how to do it. Child's counsel at times objects to CAS workers providing information related to matters before the court to their child client. *Where the child has a lawyer, then the lawyer, and not the worker, should review the court documents with the child, as age appropriate, and elicit the child's preferences. If counsel is slow to meet with the child, workers should intervene to facilitate a meeting as soon as possible in the process. Where a child is not represented, the worker should make the child aware of the nature of the information provided to the court by the parent, in a manner that the child can understand.*

The temporary care and custody hearing is supposed to determine where the child will be until trial. The onus is on the CAS to demonstrate that there is a risk that the child would likely suffer harm if returned to the care of the parent, and that a supervision order either with the parent or with another person would not be sufficient to protect the child. Where return home would place the child at risk of likely harm, priority is given to placements with a member of the child's extended family or community.

The opinion of the CAS is key to this process. Workers should explain their assessment clearly to the parents and child, as well as to the court. Ideally, from a clinical perspective, parents and their child would hear it together, with their lawyer(s). They would have an opportunity to discuss it and react to the information. It is common for children to want the judge to hear their opinion, and a child should know if their opinion will be given in evidence to the court. If the child has a lawyer, the lawyer will provide the child's views and wishes to the court.

The order made can be varied, but the party who wants the change will have to satisfy the court that there is a change in circumstances.

How clearly is this understood by the child? In every case, there should be a plan for who will be responsible for seeing that the child understands both the outcome and how or why it might change in the future. If the child has a lawyer, the lawyer will explain the court decision as well as the next steps in the court process, in an age appropriate manner. *The child should know that the parents also understand this. Often the child thinks that it is the CAS which is behind everything that is taking place when in fact the way is open for change if the parents would only take it.*

The temporary care and custody hearing is usually scheduled only after everyone is represented and Respondents (parents or other pre-intervention caregivers) have filed responding material answering CAS allegations. At the hearing, the judge reads Affidavits (sworn statements in writing) from the parties and hears submissions (argument) from the lawyers or unrepresented parties. Child's counsel, if any, makes submissions, but usually does not file any evidence in support of the child's position.

For some children, it may be important to know their views were put before the court, and that the judge understands what the child wants. Courts have generally allowed the child's views to be provided to the court by the lawyer, during submissions. The lawyer can assure the child that the court will know what he or she wants, but that the final determination is up to the judge.

If the primary issue is where the child will be (in care, with parents, with relatives) until trial, access may once again appear as an after-thought. In other instances, access is the only issue in dispute.

Access is a key casework decision; if it is not properly thought out it can be disruptive and confusing. CAS must have a clear position on access in each case.

Access should be based on the long-term plan and if there is no plan in place then access is used as a means of obtaining information necessary in making the plan. The focus of the decision must be on the best interests of the child and not on a contest between the participants. When there is no long-term plan in place then access visits without supervision or a means of assessing the quality of the interaction can simply prolong limbo.

Access should be discussed with families before court. Ideally it should be set up with family at the time of first placement. Often placements are handled as emergencies because it is less painful for workers to do them quickly, rather than using a long drawn-out process of negotiating or mediating with the family. This can mean that child doesn't see parent until after

the court appearance and we are hearing from Crown wards that this can be very distressing for them – parent is cast as an adversary and child/parent relationship is further strained. For younger children, sudden cut-off from parents is psychologically traumatic except in cases of severe abuse.

Adjournments and Further Court Conferences

There may be a number of court appearances over the life of a case, often called "conferences."

Each court appearance deserves the same attention as far as explaining the situation to the child/youth. There may be a tendency to think that the child/youth is familiar with what is going on and need not have further explanation. This overlooks two important considerations. First, the child may have matured and have a better capacity to understand what is happening. Second, it gives the child/youth the opportunity to process the issues again and express his/her current feelings. Here again, the child/youth's opinion as to what he/she wants to happen should be canvassed and the position that the child's counsel and CAS are to take should be explained to the child. This is done by the child's lawyer, if counsel has been appointed.

Whenever possible, judicial continuity should be maintained. If the particular jurisdiction practices what is known as judicial Case Management, all the court appearances will be in front of the same judge. If there is no Case Management, there may also not be judicial continuity, and a different judge might be presiding at each appearance. This complicates the situation as it raises questions about how this new judge will perceive what has transpired to date. Counsel will have to consider how much to emphasize some of the past issues. *The implications of the new judge ought to be shared with the child and parents.*

The purpose of these sequential appearances is to organize the case, try to reach a resolution on consent, and failing agreement, to narrow the issues that the court will ultimately have to decide through a trial.

As the situation is clarified it ought to be explained to the child/youth. The clearer the issues become the better the child/youth is able to process what is happening. While the issues are being clarified, it is important that the child/youth understand which issues are relevant to the court and which are not. For example, the child/youth may be experiencing some problems with the new school or with the foster home and this may be foremost in the child/youths mind; however this is of little importance to the judge in a situation where his parents are on drugs and not following a treatment plan.

At each court date, another court date will be set.

The child/youth is to be informed. It may be helpful for the child/youth to mark the date on a calendar. Again the issues to be raised at this hearing should be reviewed and discussed.

Parties and their lawyers are generally required to attend each appearance, but if one party knows in advance that it will be requesting an adjournment, it is encouraged to let others know in advance or file an adjournment "form" to save everyone time.

The worker, in consultation with child's counsel if any, should inform the child/youth and be open to considering discussion as to how all parties are feeling about the adjournment. Whether the child/youth asks or not it is likely that he/she will be wondering about what parents and worker think about this delay.

Judges should recognize the impact of delay and uncertainty on children. When the case does not move forward (i.e., nothing "happens" at a court appearance) an explanation must be given to the child. Foster parents/group home staff often do not understand the technicalities and complexities of the court process, and there is little in the way of systems to ensure that the child's caregivers are advised of what happened. What kind of support can be provided in these circumstances?

Whoever is the child's primary caregiver (i.e., group home staff or foster parent) should undertake to have the situation properly explained to the child/youth. Depending on the age of the child, the child's lawyer can assist by explaining to the child or the primary caregiver the fact of and reason for an adjournment. If there is no lawyer for the child, this can be done by the CAS worker with assistance of CAS counsel. The matter should never be shrugged off.

Lack of information provided to child caregivers has the effect of making the court seem more powerful – children report feeling that their lives are "on hold," at the mercy of someone (judge) who doesn't know them. Clarity and opportunity for processing are of paramount importance.

Assessments as Part of the Court Process

Ongoing assessment by CAS workers is a constant in child welfare practice. The nature of casework is such that parental performance is always being assessed along with what supports and help may be put in place to improve the parenting capacity. When a matter is before the court, the information obtained in the course of casework becomes evidence.

With regards to formal assessment by psychologists, psychiatrists, etc. of the child, parents or proposed caregivers or access parties, the relevance of such assessments for the issues before the court must be demonstrated. Assessments undertaken for reasons other than those before the court may be of little or no benefit, e.g. the fact that an assessment on a child shows that child to

be mentally disturbed may suggest the need for treatment, but not that the child should be taken from his/her parents. On the other hand if it shows the necessity for parenting which is beyond the capacity of the parents, then it may be relevant.

Assessments can be costly and time consuming and if not properly conducted not only are they of little or no benefit they can cause unnecessary delay and perpetuate limbo. At best, an assessment is an intrusive measure and should not be undertaken lightly.

The Regulations which accompanied certain amendments to the CFSA provision regarding court-ordered assessments which took effect February 28, 2007, have codified best practice procedure to ensure that:

i. The purpose of the assessment is clearly stated.
ii. The questions that the assessor is to address are clearly articulated, including the questions that specifically require recommendations.
iii. The assessment is completed in a timely fashion.

The Regulations also prescribe the content of assessment reports, and require that the following information be included:

i. The assessor's resume, including professional qualifications and credentials, and the number and type of assessments previously conducted by the assessor;
ii. A summary of the instructions received, a list of the questions on which opinion was sought and the materials provided and considered;
iii. The methodology used, including any instruments or tests applied;
iv. The reasons and factual basis for conclusions drawn by the assessor;
v. Direct answers to the questions posed or the reason why an answer cannot be provided;
vi. Recommendations sought, or the reason why a recommendation cannot be provided.

Those who conduct assessments advise that the more particular the questions posed the better – vague or general questions are to be avoided. It is suggested that there be a pre-assessment conference, involving all parties and child's counsel, in which the expectations for the assessment and the procedure to be followed are set out.

Assessment should not be done as a matter of course. When a child is brought into care is not the time to do a general assessment, as the child is under stress and results therefore cannot be extrapolated to more "normal" times. Also, assessments are usually stressful for children and cause them to think that there is something wrong with them. But assessment can still be extremely useful in order to address specific issues or help those looking after the child understand how to work with him/her.

Attempts at Resolution

There are a variety of mechanisms available, both with the court process and as alternatives to court, for resolution of the issues that brought a child protection case to court, including

- Settlement conference at court;
- Use of mediation;
- Family group conferencing (especially where there are competing family plans);
- Assessment as vehicle for identifying issues and narrowing the options.

Mediation and Family Group Conferencing are prescribed methods of Alternative Dispute Resolution (ADR) in accordance with 2006 amendments to the CFSA. Both have been shown to be valuable in enhancing family commitment and in involving more potentially supportive people in the child's life. If these options have not been tried early on in the process, or have previously not resulted in settlement, they may be tried at any stage.

From the perspective of the child there are principles that apply to all four of these possible means of resolution.

i. *The child is made aware of these possible means of resolution, whether they were explored, and why the decision was made to use them or not to use them.*
ii. *Consideration is given to having the child (and support person) present.*
iii. *If the child is not present there is a means of having the child's wishes or opinions presented to the meeting.*

Motions/Variations

A motion is simply a request to the court to make an order – usually one that is not "final." As the circumstances in a case change, any party can bring a motion asking the court to change an order, e.g. CAS may bring a motion to have a child remaining home under supervision ordered into care. A parent (or CAS) may bring a motion to change an existing access order, or to discharge a child to a parent or other person.

The child is often unaware that a mechanism for changing the legal status exists. The idea is given that the decisions made in court are set in stone. The child should know that these avenues are open and why they are being pursued or not pursued as the case may be. This can be explained by child's counsel.

Evidence in support of a motion is presented by Affidavit (i.e., sworn statement in writing). Oral testimony is rarely permitted at this stage.

Information on the court process should be provided to the child as age appropriate. This can be done by child's counsel.

Courts are disinclined to decide the ultimate issue on a motion – because that is reserved for trial: a proceeding in which the judge can assess the credibility of witnesses and parties appearing in person. So, cutting off access to a parent in advance of a trial is challenging. Courts don't like orders which would prejudice or disadvantage a party – particularly a parent, who has less power than the Society. The child is not a party, but in practice children, even when represented by counsel, rarely bring motions to change court orders.

The most common motions are about varying access. *As has been stated repeatedly, the CAS must have a position on access. The reason for the access decision must be explained to the child and if there is disagreement then the areas of disagreement should be made clear.*

The Trial

If the case has not been resolved on consent, it will be set down for trial. A trial is a proceeding in which witnesses are called to give oral testimony. Documentary evidence may also be filed. A trial is an adversarial proceeding. Each party has the opportunity of cross-examining the witnesses for the other parties, with the goal of discrediting the witness and undermining the credibility of his/her evidence.

The mechanism should be explained to the child and consideration given to having the child (with supportive person) present. The CFSA contains a presumption that children 12 and older may be present, unless the court is satisfied that this would cause the child emotional harm. Conversely, a child under 12 cannot be present, unless the court is satisfied that this would NOT cause the child emotional harm. The parties would have to agree to have the supportive person present, given that child protection proceedings are closed to the public.

The court may encourage the parties to prepare affidavit evidence from some witnesses in an effort to shorten the trial. If the proceeding is a Protection Application, the trial will decide first whether the child is "in need of protection," and second, which of the available protection orders would be in the child's best interests (known as the disposition).

Children are rarely called as witnesses. Child's counsel routinely opposes any request to have the child testify, as the wishes can be relayed to the court by counsel. Most judges are reluctant to have the children be witnesses, or to even conduct judicial interviews in chambers. If the child has counsel, the lawyer will explain that the judge will know how the child feels as the wishes are told to the judge by the lawyer.

If the matter proceeds to trial, child's counsel, after receiving authorization from the Children's Lawyer to attend, participates fully. Child's counsel will take a position, call evidence to support the position if not called by the parties, cross-examine witnesses, and make submissions on any issues that arise during the trial as well as closing submissions at the end of trial.

In coming to a position, child's counsel will ascertain the child's views and preferences, if any. If the wishes are independent, strong and consistent, those wishes form the basis for the position. Child's counsel will inform the court of the child's wishes, and will ensure that evidence of the context is before the court, so that the court is able to make an order that is in the child's best interests. Child's counsel will, subject to the child's interest and level of understanding, discuss with the child the position that will be taken and keep the child informed about what has happened at court.

It is open to the parties to call expert witnesses who provide their opinion evidence to the court. *Whether the child needs to know the details of who is called as a witness and the nature of the evidence depends on the age of the child, and whether the information could be emotionally harmful to the child.*

The court is limited to the orders set out in the statute. For example, in Ontario the court cannot make an order for adoption and access to birth family (although a new type of order permitting "openness" after adoption is available if everyone consents).

Whatever the court orders, someone should take the care to properly explain the reasons to the child. When the child has a lawyer, child's counsel should provide the reasons from a legal perspective. *The child's caregiver should know and understand what was told to the child. Explaining the reasons may involve acknowledging that there was a difference of opinion and giving the merits of the losing side. The outcome should not sound as if it were obvious when in fact the decision was difficult.*

In the case of an infant the reasons should be kept for the child to understand when older. Judges might consider writing separately to the child to explain the judgment.

The Court may make an access order with every other order, whether temporary or final in nature. An order for Crown wardship terminates existing access orders, and there is a presumption that there will be no further order for access unless certain specified criteria are met.

Status Review Applications

When the court makes an order that is time – limited (e.g. supervision order or Society wardship) the CAS is required to bring the matter back to court before the order expires, to be reviewed.

On a Status Review, the court can make a further order (supervision, Society wardship, Crown wardship) or terminate CAS involvement. CAS may also bring a Status Review application at any time. "Early" status review applications may be the result of apprehension from an order of supervision, for example.

A Responding party or the child may bring a Status Review Application 6 months after an order is made, or if the CAS is not complying with a material aspect of the plan the court implemented with its order. If a child is a Crown ward and has been in a foster home continuously for two years, the parents need permission to bring a Status Review.

Crown wardship orders can be reviewed. Access can be reviewed without putting the wardship in issue (although if CAS moves to reduce or terminate access, the parent often counter-seeks a return of the child to his/her care).

The child needs to know what is available and the reasons for proceeding or not proceeding with such applications as the case may be. If a supervision order or a Society wardship order is being reviewed, and the child had a lawyer, then that lawyer is automatically authorized to represent the child on the status review application, and to discuss with the child the possibility of bringing an early application before the order expires. If a child wants to bring a status review application of a Crown wardship application, and had counsel, the Office of the Children's Lawyer should be contacted, so that the Children's Lawyer can authorize counsel to meet with the child and discuss the matter. If someone else brings the status review application, the court can be asked to make an order for legal representation of the child in this new proceeding.

Appeals

The CFSA permits parties and the child to appeal as of a right (no permission is needed and there is no threshold test). There is a 30-day time period after a decision for giving notice of appeal. When an appeal is commenced in respect of an order for Crown wardship that has no access order attached, it means the child cannot be placed for adoption until the appeal is decided. Many appeals started by parents which are served on CAS are never pursued. CAS may not bring a motion to dismiss the appeal in a timely fashion.

It is difficult to know what to tell a child about an appeal because it's not clear what may happen. Children should know that a parent cares enough to appeal a decision, just as they should know that the parent contested the Society's recommendation for Crown wardship in the trial stage.

Appeals are decided on the basis of the record created in the court of first instance, but if there is new information, "fresh evidence" may be allowed on appeal.

The same principles of informing the child apply. The child should be aware, as age appropriate, that appeal is a possibility and the reasons for appealing or not appealing as the case may be. Some of the difficulties in telling arise here because the child has not been adequately informed all along. When there has been little information shared then it is necessary to review the entire matter from the beginning and present the positions and actions of the various parties involved.

Best Practices Procedure

Throughout this paper the point is made repeatedly that children who are the subject of child protection proceedings must be properly informed and involved in the court process.

Best Practices Procedure suggests that informing a child involves three key elements:

1. **The information given is complete and accurate** – i.e., the person giving the information has a thorough grasp of the facts and does not withhold key elements.
2. **The child is in a position to hear what is said,** i.e., the circumstances of the telling of the information must be geared to facilitate the child hearing it. Written material for the child to keep can be helpful. The child is given opportunity to ask questions. The child's principal caregiver is present to ask appropriate questions. If necessary, (child is too young, unavailable, indisposed), the information can be given to the child's principal caregiver and put on record for later perusal and understanding.
3. **The child has opportunity to process and integrate the information,** i.e., the child can talk the issues over afterwards with principal caregiver or think up questions about what has been told. To some extent this relates to the second point above because a person who was present during the information sharing should be available for later processing. Optimally this will be the principal caregiver.

VI. ADOPTION AND CONTACT WITH BIRTH FAMILY: CAN A CHILD HAVE IT ALL?

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In Ontario, it had long been established law and practice that adoption severed all ties a child had with the birth family, and a new family, with no ties to the past, was formed. It was considered critical that the adoptive family be allowed to function autonomously, without interference from the birth family, to ensure stability and permanence for the child. For example, the Ontario Court of Appeal stated:

> It is hoped that adoption will ensure a safe and secure environment for the child, the stability and continuation of which should not be immediately threatened by access granted to the natural parents. The new adoptive parents on their part are given security from such upset and interference by the secrecy provisions of the [Child Welfare] Act. Such applications for access, if permitted, would set the secrecy provisions of adoption orders at naught and render them meaningless. The adoption order creates a new family; the natural parents cease to be parents of the child and the past history of that relationship is expunged.[1]

There were situations where adoptive families did maintain some contact with the birth families: where the birth parent was known to the adoptive parents; where this was a stepparent adoption; or where the adoptive parent felt that, in the particular circumstances, for example an older child, it was in the best interests of the child to have some sort of relationship with the birth family.

Times have changed. Whether because some young parents who have decided to relinquish their children no longer feel shamed by having had a child, or because some adoptive parents feel that their child may wish to have some connection to his/her biological parent and know his/her roots, the laws have changed in Ontario to allow for both contact with and knowledge about the birth family after adoption. This article will set out these changes and explore how they are currently being applied. The focus of this paper will be children involved in the child welfare system who are placed for adoption. These children may have been relinquished at birth to a child protection agency (a "Society") by a parent who decided at the outset to have the child raised by an adoptive family, or may be Crown wards whose permanent plan is placement in an adoptive home. This paper will address permanency planning through adoption and the impact on access, ways in which adopted children can maintain contact with the birth family, and the challenges in accomplishing these goals. It will be seen that a child can have it all, both a "forever family" and

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[1] *C.G.W. v. M.J. et al.* (1981), 34 O.R. (2d) 44, at p. 49. Note that the *Child Welfare Act* has been replaced by the *Child and Family Services Act,* R.S.O. 1990, c. C.11 ("*CFSA*").
Note that legislation and case law often uses the term "natural" instead of "birth" or "biological" parent, and the terminology has been used throughout this paper as it appears in the original source.

contact with birth relatives, if important people involved with the child, and the child in certain circumstances, agree that this is in the child's best interests.

Permanency Planning through Adoption

Permanency Planning for Crown Wards

When a child is made a ward of the Crown, that child stays in care until age 18.[2] It is the duty, however, of the Society to make all reasonable efforts to assist the child to develop a positive, secure and enduring relationship with a family through either adoption, a custody order or, for an Indian or native child, a plan for customary care.[3] Therefore, the focus is on finding a permanent, long-term placement for every child made a Crown ward. Once adopted, a child is no longer a Crown ward, and becomes instead part of a new family.

When an order of Crown wardship is made, it is presumed that there is no access to the birth family, including birth parents, grandparents and siblings. The court cannot make an access order unless the relationship between the person and the child is beneficial and meaningful to the child, and the access will not impair the child's future opportunities for adoption.[4] A recent amendment to the law permits the Society to allow some contact or communication to take place, if in the child's best interests.[5] This informal contact can only continue as long as the child is a Crown ward; once adopted, the child's adoptive parents make decisions about contact.

What Does Adoption Mean?

The effect of an adoption order is to legally extinguish all relationships between a child and the birth family, and to establish the adoptive family as the child's family. The terminology used is that the child ceases to be the child of the birth parents, and becomes the child of the adoptive parents. Therefore, the wording of the law perpetuates the notion that the new family is a complete substitute for the birth family, which is at odds with the current trend towards openness.

Legally – What Has to Happen to Access Orders before a Child Can be Adopted?

A child cannot be placed for adoption by a Society until any order of access to the child made by the child protection court is terminated.[6] Some courts have held that a child can be adopted if there is an existing access order, provided it is an order for access by the child to another person.[7] In a recent case, the court ultimately determined that it was not in the child's best

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[2] The Society may provide extended care and maintenance to a child beyond age 18, even though the order of Crown wardship has ended: *CFSA,* s. 71.1.
[3] *CFSA*, s. 63.1.
[4] *CFSA,* s. 59(2.1).
[5] *CFSA,* s. 59(4).
[6] *CFSA,* s. 141.1.
[7] *A.G.(Re),* [2009] O.J. No. 2875 (S.C.J.); *Children's Aid Society of the Niagara Region v. J.C.,* [2007] O.J. No. 1058 (S.C.J., D.C.).

interests to continue a sibling access order, as the adoptive parent said she would not continue with the adoption if there was court-ordered access, and preferred to allow the siblings to have informal contact as the adoptive parent considered appropriate.[8] This case indicates that, in certain circumstances, the court will allow an order for access to a member of the birth family to continue, provided it fits strictly within the wording of the relevant section (i.e. access by the child to another person), and that continued contact is in the adopted child's best interests.

At the time the adoption order is made, the court cannot make a new order for access to the child by the birth parent or a member of the birth parent's family.[9]

Adoption and Contact with Birth Family

Can an Adopted Child Maintain Contact with the Birth Family?

Contact with the birth family can run the spectrum from pictures, to letters, to phone calls, to visits. The law does not allow for the court to make an order for access by a member of the birth family to a child who has been adopted[10], but the adoptive family may allow the child to have contact in an informal arrangement. The Ontario laws have recently been changed to allow for contact by way of openness agreements[11] and openness orders.[12] There are three ways an adopted child can maintain contact with the birth family.

(a) Informal Contact

Once a child is adopted, the child is the child of the adopting parents, as if they were the natural (biological) parents.[13] Unless there is an agreement or court order specifying a person's right of access to a child, the adoptive parents make decisions about who may see the child, and what format the contact takes.

The Ontario Court of Appeal has recognized that the adoptive parent has the right to determine who has access to the child:

> The granting of an access order after adoption would hamper the relationship between an adopted child and the adopting parents. It would put that relationship on an unequal basis with that of natural child-parent relationships, because a judicial or administrative official would determine who had access to the children, rather than having that determination made within the family unit.[14]

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[8] *A.G.(Re), supra.*
[9] *CFSA*, s. 160(1).
[10] *CFSA*, s. 160(1); however, if the child establishes or maintains a relationship with a member of the birth family post-adoption, that person may be able to apply for access under the *Children's Law Reform Act*, R.S.O. 1990, c. C.12 ("*CLRA*"), s. 21 as "any other person".
[11] *CFSA*, s.153.6.
[12] *CFSA*, ss. 145.1, 145.2.
[13] *CFSA*, s. 158(2), *CLRA*, s. 1(2).
[14] *Catholic Children's Aid Society of Metropolitan Toronto v. S.(T.)*, [1989] O.J. No. 754, at para. 27 [69 O.R. (2d) 189 at p. 201].

...

> In adoption cases a new family is created and that family got protection under the C.W.A. [Child Welfare Act] and now gets it under the C.F.S.A. Between its members decisions are made, as in any natural family, as to who may come into the home and who may not.[15]

An adoptive parent may voluntarily choose to allow the birth family to have contact with the child, and, as previously stated, the contact can run the gamut from pictures, to letters, to face-to-face visits. Similarly, the adoptive parent may unilaterally decide to end contact. The birth family member can then apply to court for an access order under the *Children's Law Reform Act*.[16] A court may conclude that the birth family member has established a new relationship with the child in the post-adoption period, and has status to bring an application for access. A decision will be made as to what contact, if any, is in the child's best interests, and may even include access over the objection of the adoptive parents.[17]

(b) Openness Agreements

The *Child and Family Services Act* provides statutory acknowledgment of agreements for post-adoption contact between birth family and adoptees. For the purposes of facilitating communication or maintaining relationships, an openness agreement may be made, either before or after adoption, by an adoptive parent and a birth relative, foster parent, member of the child's extended family or community, adoptive parent of a birth sibling, or a member of the child's band or native community (if the child is Indian or native). The agreement may include a dispute resolution mechanism. The child's views and wishes, where they can be reasonably ascertained, must be considered before the openness agreement is made.[18]

Openness agreements are by their nature purely voluntary. Courts cannot order individuals to enter into such agreements. The most courts have done, where contact with the birth family seems to be desirable for a child whose best interests are served by an adoption, is to order the Society to consider making recommendations to the adoptive family to consider an openness agreement.[19]

It is not clear that, even though openness agreements have statutory recognition, they would be legally enforceable if access were denied to the birth family. Any agreement, if an application were brought to court, would likely be subject to the child's best interests. At most, openness agreements reflect an intention by the parties, at the time the agreement is negotiated, to continue contact between the birth family and the adoptee.

(c) Openness Orders

The purpose of an openness order is to facilitate communication and maintain a relationship between the child and a birth relative, a person with whom the child has a significant relationship

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[15] *Ibid.*, at para. 35 [p. 204].
[16] *CLRA*, s. 21.
[17] *A.L. v. B.A.M.*, [1993] O.J. No. 2068 (O.C.J., G.D.), at para. 15.
[18] *CFSA*, s. 153.6(4).
[19] *Children's Aid Society of the Niagara Region v. S.C.*, [2008] O.J. No. 3969 (S.C.J.).

or emotional tie, or a member of the child's band or native community if the child is an Indian or native person.[20] Openness orders are possible in very limited circumstances. If a child is a Crown ward, adoption is planned, and there is no access order in effect, the Society may apply to court for an openness order before the adoption. Notice of the application is given to the child if twelve or older, to every person who will be permitted contact if the order is made, to the prospective adoptive parent(s), and to any Society that will supervise or participate in the arrangement. The court may make an openness order if it is in the child's best interests, if the order will provide for the continuation of a relationship with a person that is beneficial and meaningful to the child, and if the Society, the person who will be permitted contact, the prospective adoptive parents, and the child if twelve or older all consent.[21]

Accordingly, there are several factors that limit the use of openness orders as a mechanism for maintaining contact between a child and birth family:

1. The child must be a Crown ward. Therefore openness orders are not available when there has been a private adoption.
2. Only the Society can bring the application. The Society may be reluctant to stay involved with the family once the adoption has been finalized.
3. There must be an identified adoptive home.
4. The application can only proceed on consent. The court will still determine whether the requirements for an order have been met, but if one party decides to oppose the openness order, the court cannot make an openness order even if it is clearly in the child's best interests.

The openness order may give the adoptive family complete discretion to determine contact. For example, in a recent case, the court ordered that the child have contact with his birth parents in the discretion of the adoptive parents, with their prior express consent.[22]

Openness orders may be varied or terminated if a material change in circumstances has occurred and if a variation or termination is in the child's best interests. For a variation, the proposed order would continue a beneficial and meaningful relationship, or for a termination, the relationship is no longer beneficial and meaningful to the child.[23]

Therefore, although at the time the openness order is made, everyone involved must consent, when an application is made to vary or terminate the order the court must adjudicate the dispute. The court also has the option to refer the parties to alternative dispute resolution.[24]

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[20] *CFSA*, s. 136(1).
[21] *CFSA*, s. 145.1(3).
[22] *Re S.M.*, [2009] O.J. No. 2907 (O.C.J.) at para. 263.
[23] *CFSA*, ss. 145.2, 153.1.
[24] *CFSA*, ss. 145.2(7), 153.1(10).

What Happens if the Child and Birth Family Want to Reconnect?

Ontario has also made recent changes to its adoption disclosure provisions, so that adoptees and birth families have avenues through which to find out both identifying and non-identifying information about each other. This reinforces the legislative intent to support openness between adoptees and birth families in appropriate circumstances.

The Adoption Disclosure Register allows adoptees and certain birth relatives to apply to have their name included on the Register. If people are looking for each other then identifying information is released.[25] Adoptees and certain birth relatives can also obtain copies of adoption orders and information from birth registrations; however, anyone can file a notice asking that there be no contact, or specifying a preferred manner of contact, and it is an offence to initiate contact contrary to the notice.[26] Finally, a search can be done for adoptees and birth relatives in particular cases of serious medical need; however, identifying information is only released if the person who is found consents to such a release of information.[27]

Post-adoption contact achieved as a result of the adoption disclosure provisions is, again, predicated on consent. Although some identifying information is available when consent is absent, an individual still retains control over whether or not contact occurs.

Conclusion

The Ontario legislation and practice sets the groundwork for contact between adoptees and their birth families. It is all predicated on cooperation. Informal arrangements will happen if everyone agrees. Openness agreements are evidence of intentions at the time of negotiation, but legal enforceability is not guaranteed and will always be subject to the child's best interests. Openness orders can only be made if the Society and certain individuals consent, and can be changed at any time by the court. If there is insufficient cooperation and a birth parent brings an application for access under the *Children's Law Reform Act* as "any other person", or an application is brought to enforce an openness agreement or order, the court will determine whether access is in the child's best interests.

It is possible, therefore, for an adopted child to have it all: a "forever family" that will legally be responsible for his or her care, and, in appropriate cases, a connection to the biological family so that the child may take comfort in knowing his or her roots. This will only happen, however, if the adoptive and birth families can work together to ensure that the contact occurs with everyone's goal being the child's best interests.

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[25] *Adoption Information Disclosure,* O. Reg. 464/07, ss. 9, 10.
[26] *Vital Statistics Act*, R.S.O. 1990, c. V.4, ss. 48.1, 48.2, 48.3, 48.4, 48.5, 56.1.
[27] *Adoption Information Disclosure, supra*, ss. 16, 17, 18.

VII. THE FOSTER PARENT ROLE IN SUPPORTING AN ABORIGINAL CHILD'S PERMANENCY PLAN

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Preface

The general role of foster parents is to support a child's permanency plan by helping children transition from their home in a positive manner. Most foster parents develop a unique skill set in this area, given that foster care by nature is temporary and foster parents quickly learn how to help children move on. They play a critical role in the child's transition plan and the process/outcome of a child's transition plan usually mirrors the foster parent's attitude towards it. If a foster parent agrees with a child's plan to move on, most likely the transition will run smoothly. Generally speaking, when the foster parent contributes to a child's service plan in a positive manner, there is less conflict in the service team and the goals are more likely to be achieved. When a foster parent does not agree with a service plan, he/she can directly or indirectly have a negative impact on the child's plans. A foster parent may even thwart the permanency plan, depending on the length of time a child has lived in their home.

For example, if a foster parent has cared continuously for a child for TWO (2) years, the foster parent has a legal right in Ontario to oppose the child's removal from their home and request a Board Review of this decision, if they do not believe it is in the child's best interest to be moved [*Child and Family Services Act*, R.S.O. 1990, c.C.11 (CFSA), 61 (5) (b) Rights of Child, Parent and Foster Parent, 61 (7)(Notice of Proposed removal and 61 (7) (1) Application for review].

There may be many compelling reasons for a foster parent to exercise this right of appeal to the CFSA Child and Family Services Review Board (CFSRB); however, for an Aboriginal child, this is a lost opportunity for an Aboriginal child to be raised in their own culture. Furthermore, the historical pattern which has threatened the Aboriginal culture and destroyed the lives of thousands of Aboriginal families and children is re-lived. The implications for interfering with an Aboriginal child's permanency plan harkens back to the historical paradigm that destroyed Aboriginal culture in the first place.

Today, in Ontario's Aboriginal child welfare community, we are working collectively to heal the abuses of the past. This work includes the formation of Aboriginal child welfare agencies and is facilitated by sections of the CFSA that speak to the inherent rights of Indian children, families, Bands and communities. Part of the core mission of these agencies is to ensure that where Aboriginal children cannot remain with their birth parents they nonetheless have an opportunity to be raised in a family of their own culture and community.

Aboriginal History and Relationship to Child Welfare

The following is a brief summary of the historical factors that have contributed to the overrepresentation of Aboriginal children in Canada's child welfare system. It is important to understand the history of Residential School in order to understand why it is detrimental to stand in opposition to an Aboriginal plan that is being developed for an Aboriginal child.

This is a cursory glance at decades of history. It is briefly compiled in a few paragraphs to help the reader understand the complexity of working with Aboriginal children in care and to reinforce the need to support an aboriginal child's permanency plans in every way possible. This historical summary is barely scratching the surface and I encourage anyone working with the Aboriginal community to pursue this subject in further detail.

During this dark period of Canadian Colonization and Residential School, the Church and State systematically set out to destroy the Aboriginal people by removing children from their families and communities and assimilate them into European culture. The children were raised in Residential Schools, where they were forbidden from speaking their native language and they were not allowed to practice their spiritual beliefs or learn their cultural traditions. In some situations, the children were subjected to deplorable living conditions, severe emotional, sexual, and physical abuse and died as a result of poor health, neglect, disease and murder.

Today we are experiencing the terrible impact of these tragic errors in our child welfare system and other aspects of our Canadian society. The Residential School system began in 1874 and remained in effect until most of the schools closed in the mid-70's with the last school in Canada (Saskatchewan) closing in 1996. This left a legacy of Aboriginal people who were victims of physical, mental and sexual abuse.

The following excerpt reflects the thinking of the time that set the stage for decades of damage:

Annual Report of the Department of the Interior (1876)
Our Indian legislation generally rests on the principle that the Aborigines are to be kept in a condition of tutelage and treated as wards or children of the state... It is clearly our wisdom and our duty, through education and other means, to prepare him for a higher civilization by encouraging him to assume the privileges and responsibilities of full citizenship.

During early Colonization there was a perceived need to deal with the Aboriginal "problem." The Church orchestrated the spiritual destruction of the Aboriginal culture and developed Residential Schools that were designed to destroy the Aboriginal way of life. Aboriginal people were viewed by the European conquerors as "Savages."

At the time, the Eurocentric motives to bring the "Savages" up to a higher knowledge was considered admirable, but the results were catastrophic as the intent was to systematically annihilate Aboriginal culture to achieve this goal.

This Eurocentric belief system has created a legacy of brokenness affecting Aboriginal individuals, families and communities in today's society. This piece of history is known as Colonization and is also considered Genocide or Identity Genocide of Children.

Genocide

The United Nations Convention on the Prevention and Punishment of the Crime of Genocide, adopted by way of Resolution 260 (III) in the United Nations General Assembly on December 9, 1948 defined "Genocide" as follows:

Genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such:

- *(a) Killing members of the group;*
- *(b) Causing serious bodily or mental harm to members of the group;*
- *(c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;*
- *(d) Imposing measures intended to prevent births within the group;*
- *(e) Forcibly transferring children of the group to another group.*

Identity Genocide of Children

On February 9, 2009 in an Ontario Superior Court of Justice a Class Action Law Suit, Marcia Brown and Robert Commanda, was commenced. This law suit represents 16,000 Aboriginal people who were in the care of an Ontario Children's Aid Society within the period of December 1, 1965 to December 31, 1985.

The "60's Scoop" is a term coined by Patrick Johnson in his book *Native Children and the Child Welfare System* (1983). The 60's Scoop refers to the phenomenon beginning in the 1960's to 1980's of unusually high numbers of Aboriginal children apprehended from their families for reasons such as: substance abuse, physical abuse, sexual abuse, economic hardship and neglect.

The Feb 9, 2009 law suit claim is a result of the "60's Scoop" and is based on the Ontario and federal governments' failure to honour and ensure that specific constitutional obligations were upheld for Indian children who were in care during the identified period. The law suit claims that the government was responsible for the Identity Genocide of Children, defined in the law suit as:

Identity Genocide
The damage or harm caused by the deliberate creation and implementation of policy, program and practices that systemically attempt to eradicate the particular culture, social, linguistic, customs, traditions and spirituality of the child's indigenous family, extended family and community

An illustration of the effects of identity loss as a result of previous child welfare involvement is described on Page 9 Paragraph 27 in the law suit as follows:

Commanda experienced anger and ambivalence about the mainstream community that had led him to his predicament. He experienced distance and awkwardness with the Indian community with whom he had little or no connection in respect of the traditions, language, customs, heritage, spirituality and culture. He could not settle into ordinary relationships with Indian and non-Indian persons. He experienced depression and suicidal ideation.

Culture and tradition are essential to Aboriginal survival. In a 1997 *First Nations and Inuit Regional Health Survey*, approximately 10,000 adults responded and over 80 % agreed that it was a good idea to return to traditional ways to promote community wellness (Svenson and Lafontaine, 1999).

Therefore, in our current child welfare practice, when developing permanency plans for Aboriginal children, if there are Aboriginal options to choose from, the cultural match must take precedence in lieu of all other options.

Should a non-Aboriginal caregiver prevent an Aboriginal child from returning "Home," this begs the question: How can a non-Aboriginal parent support a culture that they inherently do not respect? And more importantly: How can a non-Aboriginal parent truly replicate Aboriginal culture?

It has been argued that exposure to Aboriginal culture from within a non-Aboriginal family can address the identity needs of Aboriginal children; however Kenn Richard , Executive Director of Native Child and Family Services of Toronto writes:

Casual and superficial exposure of an Aboriginal child who has been brought up outside his or her birth culture to Aboriginal life, such as attending a pow wow once a year can serve to exacerbate identity formation problems. Such exposure may enhance cultural literacy – leaving few words of language or skills in certain crafts – but fundamentally, they are estranged from their heritage and may be viewed as tourists in their Aboriginal land. (Kenn, 2007).

The issue of how a child forms their identity is inextricably linked to their culture. The issue of identity may not be a primary consideration when the child is young, but identity is crucial during adolescence and on to adulthood.

In the Native Child and Family Services of Toronto *Aboriginal Healing and Wellness Strategy Repatriation Report* (1999), the report cites a study where 18 adult Aboriginal adoptees were interviewed. These Aboriginal adoptees were raised in non-Aboriginal homes. The study concluded overwhelmingly, whether the adoption was successful or not, that: **loss, isolation** and **identity confusion** were predominant themes among all adoptees interviewed.

More of these same sentiments that echo the experiences of Genocide survivors and are prevalent in today's Aboriginal community are illustrated in the following excerpt from the *Royal Commission on Aboriginal Peoples Report* (1996):

A Northern Community Leader writes:
Social maladjustment, abuse of self and others and family breakdown are some of the symptoms prevalent among First Nation baby boomers. The "Graduates" of the "St. Anne's Residential School" era are now trying and often failing to come to grips with life as adults after being raised as children in an atmosphere of fear, loneliness and loathing.

Overrepresentation of Aboriginal Children in Care

It comes as no surprise that Residential School children raised in such horrific circumstances cannot be productive parents. Unfortunately, as the Residential School survivors began having children themselves, without any positive parenting experience and a lack of meaningful relationships in their lives, these Survivors began parenting their children, with a lack of knowledge, lack of community support and overall a lack of parenting skills.

For the Aboriginal parent, having a broken and fragmented sense of self contributed to this whole dysfunction, with the end result of an overrepresentation of Aboriginal children in Canada's child welfare system as evidenced in Trocme, Knoke and Blackstock (2004) report that approximately 40% of children and youth living in out-of-home care in Canada in 2000-2002 were Aboriginal. Additionally, Aboriginal children are taken into the child welfare system in disproportionately large numbers – at least five times greater than the rate of non-Aboriginal children (Trocme et al, 2004).

The shocking reality of the devastating effects of Colonization and this tragic part of our history has manifested itself in our day-to-day work in child welfare here in Ontario. For children who were historically raised bankrupt of Aboriginal culture, for today's Aboriginal child to be raised in a non-Aboriginal home, in essence, we are: replicating aspects of our past, perpetuating the effects of Residential School and contributing to the effects of Intergenerational Trauma, defined by Eyaa-keen Centre Inc., Manitoba as follows:

Intergenerational Trauma
Intergenerational or multi-generational trauma happens when the effects of trauma are not resolved in one generation. When trauma is ignored and there is no support in dealing with it, the trauma will be passed from one generation to the next.

Perpetuating the separation of Aboriginal children from their Aboriginal families is the underpinning of Intergenerational Trauma. Therefore we must do everything that is within our power to mitigate and reduce the negative effects of Residential School and work collectively to preserve Aboriginal existence. This is why it is so important to connect an Aboriginal child to their Community, Band, and Identity and whenever possible to return our children "Home" by supporting their transition plans.

"There's No Place Like Home"

Most caregivers understand and support the concept of returning a child to their biological family when it is safe to do so. However a broader definition of "Home" that goes beyond the

Aboriginal child's immediate birth parents, may not look like the definition that most caregivers are familiar or comfortable with.

Returning "Home" means many different things for an Aboriginal child. It may come in the form of having the Aboriginal child form a relationship with their Band, members of their community, helping them understand Aboriginal history, actively involving the child in events in the Aboriginal community, supporting and embracing their spiritual practices, participating with them in ceremonies, engaging the child in traditional dance, drumming, helping them learn to speak their Indigenous language and most importantly and literally — supporting the child's plan to return "Home" to their Indian reserve or First Nations community.

In the Aboriginal community it is a tribal worldview by which the child's family is broadly defined to include Band members and community members as part of the child's family. In the interest of preserving an Aboriginal familial structure, the best interests of the child and family are not mutually exclusive. Because the best interest of the child and family are a mutually intrinsic value to the Aboriginal way of life, it is incumbent upon us to try to develop an approach to permanency planning that addresses the fragmentation from the past. There needs to be a holistic change in our new paradigm that addresses the disintegration of the Aboriginal soul.

The Child and Family Services Act, R.S.O. 1990, c. C.11 (CFSA) legally affirms and protects the Aboriginal notion of family to include extended family, Band and community and speaks to the right of "Indian" children to be returned to their Aboriginal community when removed from their biological parents care. Sect 57(5) directs the court to consider the following when removing an Aboriginal child from the biological family:

Sect 57 (5)

Idem: where child an Indian or a Aboriginal person

(5) Where the child referred to in subsection (4) is an Indian or a Aboriginal person, unless there is a substantial reason for placing the child elsewhere, the court shall place the child with,

(a) a member of the child's extended family;

(b) a member of the child's band or Aboriginal community; or

(c) another Indian or Aboriginal family. R.S.O. Child and Family Services Act, 1990, c. C.11, s. 57 (5).

Additionally, while an Aboriginal child is in the legal care of a child welfare organization, an Aboriginal child's permanency plan may be developed by the child's Band or community. The CFSA also requires consideration of the child's cultural background in Sect. 136 (3) and Best Interest in 37 (4) defined as:

Sect. 136 (3) and 37 (4)

Where child an Indian or Aboriginal person

Where a person is directed in this Part to make an order or determination in the best interests of a child and the child is an Indian or Aboriginal person, the person shall take into consideration the importance, in recognition of the uniqueness of Indian and Aboriginal culture, heritage and traditions, of preserving the child's cultural identity.

Determining how to return a child "Home" can be a complex, labour intensive and an emotionally challenging process. Because we all want what is best for the child, everyone around the table is focused on their interpretation of what a child's best interest should look like and members may not agree on the permanency plan because they have a different opinion of what is in the child's best interest.

Despite the legal definitions and the legal authority that exists to support and protect the inherent rights of Indian children, we continue to run into real life problems about defining what is in the best interests for an Aboriginal child. As a result, the reintegration plans for Aboriginal children continue to be challenged and sometimes compromised. This is illustrated in the following case example:

A young Aboriginal child was placed in a European foster home. This child was raised as an infant in the European foster home for over two years and was beginning to learn and understand the first language of the family. After the agency obtained Crown wardship, permanency plans were developed for the child to be returned to an Aunt on her Indian Reserve, where other extended family members also reside. For a variety of reasons, the Aunt never visited the child before and the child did not have a pre-existing relationship with the Aunt prior to the permanency plan being developed.

The foster parents viewed the Aunt as a "stranger" and argued and legally appealed to the Child and Family Services Review Board [CFSA 61(5) (b) Rights of Child, Parent and Foster Parent, 61 (7) Notice of Proposed removal and 61 (7) (1) Application for review] that it was in the child's best interest to remain in their home. In the end, the agency was able to successfully place the child with her Aunt.

The CFSRB recognized that the Aunt was a member of the child's family in accordance with the tribal world view and concept of family and returned the child "Home," preserving the Aboriginal connection between the Aboriginal child and Aboriginal community.

The Importance of an Aboriginal Child's Permanency Plan

A child's permanency plan may come in many different forms and doesn't have to be adoption. An Aboriginal child may move to another Aboriginal foster home, kinship placement, customary care plan or Band/community plan. There needs to be a paradigm of care developed where Aboriginal culture is left intact.

When placing children in non-Aboriginal permanent plans, there is a risk of perpetuating the effects of Residential School and the pattern of the "60's Scoop."

There may be more permanency options to consider for Aboriginal children, given the emphasis and legal authority to develop Aboriginal plans for Aboriginal children. The repercussions of this is that while agencies are actively pursuing Aboriginal plans with Bands and the child's community, given the complexity of permanency planning, delays in court cases, change in service plans, there is a greater risk that permanency plans for an Aboriginal child may be delayed. Therefore, the longer a young child remains in a foster home, the harder it may be for

the foster parent to let the child go. This is a tall order for any caregiver, to allow a child to leave their home under the best of circumstances. The circumstances of the child's permanent plan may not always be suitable to the foster parent for reasons that may appear prudent and practical in their view of the child's best interests.

No matter how well intentioned, the alternate plan of leaving a child in a non-Aboriginal home on a permanent basis should only be considered after all efforts have been exhausted to return a child to their own family or place the child with his Band or community. This continues to be a challenge for child welfare because a significant number of children have been placed in non-Aboriginal homes, which in some circumstances have had dire if not tragic results. Without the proper education, support and guidance, there is an increased likelihood that the foster parent may oppose a child's permanency plans. Because a significant number of Aboriginal children are placed in non-Aboriginal foster homes, it is imperative that the child welfare agency, service team and Aboriginal community help these caregivers understand their role in an Aboriginal child's life and the implications of their decision should they decide to interfere in an Aboriginal child's permanency plan.

Despite the best recruitment efforts of Aboriginal child welfare agencies and mainstream Children's Aid Societies, there continues to be challenges in recruiting and maintaining Aboriginal foster homes, resulting in the majority of Aboriginal children being placed in non-Aboriginal homes.

Given the over-representation of Aboriginal children in care and the lack of Aboriginal foster homes, this means that child welfare is heavily reliant on non-Aboriginal foster parents to care for Aboriginal children. The implications of this have yet to be fully understood or measured. This is why it is essential that any foster parent who cares for an Aboriginal child must embrace, support and facilitate the cultural identity of the aboriginal child in their care. This includes the likelihood of moving the child from their home into another Aboriginal home or community plan, with which they may not agree.

Foster Parent Role in an Aboriginal Child's Permanency Plan

A foster parent who does not support an Aboriginal child's permanency plan or attempts to prevent the child from being removed from their home, in essence is perpetuating the Residential School legacy. Ultimately, the foster parent is responsible for their decision to interfere with an Aboriginal child's permanency plan, although the problem is essentially systemic. There are a variety of factors such as: community awareness/involvement, child welfare societies (Aboriginal and non-Aboriginal), legislation, media, death, public inquiry and scrutiny and politics that have contributed to this dilemma. To prevent these situations from occurring, a new paradigm of care needs to be developed where the skills, knowledge, attitudes and values of non-Aboriginal foster parents match Aboriginal culture. Furthermore, at this point, there needs to be a fundamental understanding, perhaps contractual agreement, before a foster parent accepts the placement of an Aboriginal child, where they commit to returning the Aboriginal child back to their community.

If a foster parent truly believes in the principle of best interest of a child and supports a child's Aboriginal identity, regardless of the emotional strain or hardship which may result to allow the child to move on, they must not stand in the way or make any efforts to subvert the permanency plan. Truly supporting a child's Aboriginal heritage includes allowing them to return "Home."

Not only are we legally bound to support a child's heritage through our Ontario legislation and foster care licensing standards (Government of Ontario, *Ministry of Child and Youth Services Policy Directive*, 2008-02 and 0202-6), it is our moral and ethical obligation as substitute parents, that we do everything within our power to ensure that a Aboriginal child is connected to their community and understands their Aboriginal identity with the guidance and support from the Aboriginal child welfare agency or Aboriginal community. While the legislative and regulatory frameworks exist to compel us to support children's culture, at the end of the day we are reliant on the child's caregiver to properly execute these expectations in a child-friendly and sensitive manner.

While it is a foster parent right in Ontario under the *Child and Family Services Act*, R.S.O. 1990, Chapter C.11 to go before a Child and Family Services Review Board to appeal an agency's decision to remove a child from a foster parent's care after TWO years, preventing an Aboriginal child from returning "Home" is contributing to the effects of Residential School. I would therefore challenge all foster parents to carefully consider their position before they oppose an Aboriginal child's permanency plan.

Any caregiver who has an Aboriginal child in their care must be committed to upholding the principles articulated in Part X of the CFSA that requires us to do our utmost to plan inclusively with Bands and to ensure the rights of Aboriginal children to their Aboriginal community, culture and identity.

Often, where an Aboriginal child is concerned, the preferred permanency options parallel the following in descending order of priority:

1. Return to Biological family (Family)
2. Extended family members in First Nation communities
3. Extended family members within the family/child's city
4. Extended family members outside the family/child's city
5. Close friends of the Biological family within the family/child's city, i.e. members of the immediate "family network"
6. Friends of the family outside of the family/child's city
7. Other Aboriginal families within the family/child's city
8. Other Aboriginal families outside the family/child's city
9. Non-Aboriginal families within the family/child's city
10. Non-Aboriginal families outside the family/child's city

Therefore, it is essential for foster parents to support an Aboriginal Child's permanency plan that has been endorsed by the child's service team. Foster parents are key players in the child's transition and their role is crucial to a successful transition.

The Foster Parent role in supporting an Aboriginal child's permanency plan is as follows:

- ✓ Give permission for the child to move
- ✓ Actively participate in the child's transition plan
- ✓ Understand and promote the child's Aboriginal heritage
- ✓ Embrace the principles of Aboriginal healing, wellness and restoration
- ✓ Work as a collective member of the Aboriginal community and service team

In conclusion, without a caregiver's compassion and commitment to a new paradigm of care that helps the Aboriginal child understand and embrace his Aboriginal heritage, the effects of Residential School will continue to survive in the next generation and the damage will continue to cycle through the child welfare system.

Glossary

(Definitions from: *Health Canada. A Statistical Profile on the Health of First Nations in Canada: Determinants of Health, 1999-2003; Indian Act*, Revised Statutes of Canada, 1985.)

Aboriginal Peoples (*Health Canada*)
The descendents of original inhabitants of North America. The Constitution of Canada recognizes three groups of Aboriginal peoples – Indians, Métis and Inuit. These three separate peoples have unique heritages, languages, cultural practices and spiritual beliefs.

Band (*Indian Act*, R.S., 1985, c.I-5)
"Band" means a body of Indians

(a) for whose use and benefit in common, lands, the legal title to which is vested in Her Majesty, been set apart before, on or after September 4, 1951,
(b) for whose use and benefit in common, moneys are held by Her Majesty, or
(c) declared by the Governor in Council to be a band for the purposes of this Act

Bill C-31 (*Health Canada*)
The pre-legislation name of a 1985 amendment to *Indian Act*. The amendment was designed to eliminate several discriminatory provisions from the *Indian Act* concerning the unjust removal of First Nations people from the Indian Register, such as the removal of an Indian woman and her children if she were to marry a non-Indian. The major impact of Bill C-31 has been the restoration of Indian status to people who lost it under the Act's unjust provisions. Approximately 105,000 people have regained or acquired Indian status since the passage of the bill in 1985.
For further information please see <http://www.johnco.com/nativel/bill_c31.html>

First Nation (*Health Canada*)
A term that came into common usage in the 1970's to replace the word "Indian" which many people found offensive. Although the term "First Nation" is widely used, no legal definition exists. Many Indian people have also adopted the term "First Nation" to replace the word "Band" in the name of their community. Both Status and Non-Status Indian people in Canada are referred to as "First Nations People(s)."

Indian (*Health Canada*)
A term that describes all the Aboriginal people in Canada who are neither Inuit nor Métis. Indian peoples are one of three groups recognized as Aboriginal in the *Constitution Act of 1982*. The Act specifies that Aboriginal people in Canada comprise Indians, Inuit and Métis people. In addition, there are there are three legal definitions that apply to Indians in Canada: Status Indians, non-Status Indians and Treaty Indians.

Indian Act (*Health Canada*)
Canadian federal legislation that sets out certain obligations of the federal government toward First Nations people. It regulates the management of Indian reserve lands. The Act has been amended several times, most recently in 1985.

Indian Status (*Health Canada*)
An individual's legal status as an Indian, as defined by the *Indian Act*

Inuit (*Health Canada*)
An Aboriginal people in northern Canada who live above the tree line in Nunavut, the Northwest Territories, north Quebec and Labrador. The word means "people" in Inuktitut, the Inuit language. The singular of Inuit is Inuk.

Non-Status Indian (*Health Canada*)
An Indian person who is not registered as an Indian under the *Indian Act*

Reserve (*Health Canada*)
Land set aside by the federal government for the use and occupancy of an Indian group or Band.

Status (Registered) Indian (*Health Canada*)
An Indian person who is registered under the Indian Act. The Act sets out requirements for determining who is a Status Indian.

Treaty Indian (*Health Canada*)
A status Indian who belongs to a First Nation that signed a treaty with the Crown.

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VIII. TO VISIT OR NOT TO VISIT: ISSUES REGARDING ACCESS VISITS FOR CHILDREN IN CARE

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Introduction

In this paper we discuss access visits for children in care, distinguish between access for Temporary and Society wards vs. Crown wards, and offer some suggestions to improve these visits. The guiding criteria should be whether access visits promote "safety, stability, and attachment" (*Ontario Child Welfare Review*, p. 18). It is important to understand whether and in what circumstances access visits might have a negative impact on a child's placement and sense of permanence.

"The goal for every child in care is a permanent, loving, and safe home, and it is the responsibility of the child welfare system to make every attempt to provide the opportunity for a child to belong to a committed, safe, nurturing family. The three critical elements to achieving permanence are safety, stability, and attachment. All three elements "are essential for normal and healthy child development" (*Ontario Child Welfare Review*, 2007, p. 18). Despite this stated goal to provide permanence for children in care, the results are very discouraging. According to the most recent *Ontario Child Welfare Review* (CWR), the average age of children at the time of Crown wardship is 8.5 years; 44% of children had one placement since becoming a Crown ward but 20% had two placements and 36% had three or more placements. On average, the children's workers change every 21 months. More needs to be done to provide the children with the security and permanency essential to their healthy development, and improving policies and practices regarding access visits may assist us to reach that goal.

Background

In Ontario, the number of children in care having access visits with their birth families has grown in the past decade. Temporary and Society wards of 53 provincial child welfare agencies have access visits with birth parents as do a large percentage of our 9,272 Crown wards (*Ontario Child Welfare Review*, 2007, p. 4). In 2007, the Ministry of Children and Youth Services reviewed the files of 5,548 Crown wards. Seventy-five percent of those reviewed had access orders and an overwhelming percentage of those (85%) experienced access to their immediate or extended families (*Ontario Child Welfare Review*, 2007, p. 21). When access with siblings is included, 95% of Crown wards experienced some form of access with family members *(Ontario Child Welfare Review*, 2007, p. 21).

Note: Currently the authors are involved in a qualitative research study (Strauss & Corbin, 1998) regarding access issues, in collaboration with Dr. Faye Mishna of the Factor Inwentash Faculty of Social Work, University of Toronto, and supported by a grant from the McCarthy Tetrault Foundation. Treatment Foster Care in Cobourg, Ontario, and four Children's Aid Societies are also collaborating in this project. Interviews were conducted with 24 children between 8 and 12 years old who have access visits with birth family members; focus groups were conducted with four groups of foster parents caring for children who have access visits and four groups of child protection workers with experience supervising access visits. Some information in this paper has been taken from those interviews.

With the full implementation of the *Ontario Child and Family Services Statute Law Amendment Act*, 2006, there will likely be a further increase in the number of access visits for children in foster care and group homes. Access may also increase for those children and youth in various kinship care and guardianship arrangements or in adoptions with openness (*Ontario Child and Family Services Act*, 2003). In many instances, research has indicated the positive and beneficial effects of access visits with birth family members for children in care (Palmer, 1995; Rella, 2006). However, there are also children who experience high levels of distress before and after access visits (Haight et al., 2002). The concerns about current practices relating to access visits are not new but seem to be intensifying as the number of access visits increases (Aitken, 1995, 1996).

Defining Access

Access is "court ordered visitation between non-custodial parents and their children" (Osmond, Perlman, Dale, & Palmer, 2002, p. 59). Conditions are generally not specified for children who are placed voluntarily in out-of-home care through an arrangement between the parents and a child protection agency. However, when the child's removal is court sanctioned, access orders may indicate the conditions of contact including the frequency, duration, location, participants and the extent of supervision (Osmond et al., p. 59). Generally, the term "access" is used to mean visits with family members and the term "contact" is used to indicate less direct communication such as phone calls or the exchange of letters. At one time, it was argued that court orders did not adequately specify the degree of contact, from frequent and direct, to infrequent and indirect (Bernstein, Caldwell, Clark, & Zisman, 1992). Now, however, it is commonly argued that judges are too specific and give too little discretion to Children's Aid Societies to set or vary the terms of contact or access.

Recent Research on Access Visits

Recently, Deborah Goodman of the Child Welfare Institute, Children's Aid Society (CAS), Toronto, and her colleagues conducted a survey research project involving 3,469 children in 39 agencies experiencing family access (Goodman, Tuyl, Filippell, & Pickett, 2007). They found that 87.5% of all access is court ordered, 61% of access for Crown wards occurs and 54% of those cases are given some form of supervision (Goodman et al., 2007). Half the children and youth in Crown Ward Unit workers' caseloads have access visits, and 75% of Crown wards with access are children over age 12. "Out-of-care" children (those children in kinship care and those removed from the custody of one parent as a result of domestic violence situations) totalled 23% of all children who required access arrangements. These access visits place enormous strain on resources because there is no worker assigned and no financial help with transportation.

Among the conclusions of the survey were that regular access is a large part of all casework activity, and that greater frequency of access and supervision of access creates more workload and resource issues. Factors which were found to contribute to quality access were "available and adequate staffing to support and carry out access plans; worker training on effective ways to carry out access plans; available and consistent transportation for all children who have access with family members; access environments that are more 'home-like,' and the availability of flexible and suitable access programs such as the Therapeutic Access Program and Child Access

Program as alternatives to regular access visits." Among what were deemed "Key Learnings" from the survey were that "agency infrastructure to support access is a hugely overtaxed 'house of cards,'" workers are concerned with the "inflexible nature of many access arrangements" and workers view access as NOT serving the child's best interests in 1/3 of access visits" (Goodman et al., 2007, p. 32.)

The Goals of Access Visits

There are diverse goals or purposes with respect to access visits and these often depend on the expectations regarding family reunification (Beyer, 1999). The *Ontario Children's Law Reform Act*, s. 24(1), states that the judge should make access orders in the child's "best interests," citing considerations such as "the emotional ties" between the child and interested individual, "the views and preferences of the child" and the "plans proposed for the care and upbringing of the child." While the paramount consideration in all decisions related to children is their "best interests" (*Ontario Children's Law Reform Act*, s. 24(1)) there is a presumption that, while in the temporary care of the Society, children should have contact with their parents. There are a number of reasons why this is so. For children under Temporary Care Agreements, (i.e. in temporary care and custody of the Society), and even for Society wards, access visits are often used as assessment tools to gauge the prospects for successful family reunification in the future. Visits also allow for continued communication and relatedness in the event the children will be returned home. Generally, the younger the child, the more frequent the contact needs to be in order to maintain and strengthen the relationship. Therapeutic access is a special form of access which "is designed to promote secure attachment and build parent-child relationships;" the goals of therapeutic access are to "assess parenting risks" and "help parents improve their parenting skills and their relationship with their children" (Rella, 2006, p. 7). Trained workers attempt to understand the parents' past histories, especially the parents' relationships with their own parents, and to work from within the parents' experience to bring about change. For example, parents who have been severely abused are often confused when their parenting behaviours are described as abusive or rejecting because they believe they have corrected or improved upon their own childhood experiences (Rella, 2006, p. 9).

When child welfare authorities make the decision that parents are unlikely ever to be able to care for their children, the children become Crown wards. In Ontario, 8.5 years is the average age of children at the time of Crown wardship (*Ontario Child Welfare Review*, 2007, p. 3). When a Crown wardship order is made, all existing access orders cease and there is a presumption that no other order for access will be made. The court can only make an access order to a Crown ward in circumstances where the relationship between the child and the person seeking access is meaningful and beneficial to the child *and* the access will not impair the child's future opportunities for adoption. Both prongs of the test must be met (*Ontario Child and Family Services Act*, s. 59(2)). Birth parents may apply for access after the child has been declared a Crown ward if they provide evidence that the child will not likely be adopted as a result of age or disability, and would suffer harm as a result of having family access permanently severed. (Access to siblings or grandparents may be sought even if access to birth parents is denied). There is currently concern among child protection workers and foster parents that access orders are too frequently granted after Crown wardship orders are made and that continued family

access after Crown wardship does, in fact, reduce children's opportunities for adoption (Mishna, Cook, Aitken, & Morrison, 2007-2009).

For children who are to be made Crown wards without access, access visits are occasions are for the purpose of grieving and saying good-bye. For those who are to be adopted, the plan is often to continue some level of access until an adoptive home is found. This is permissible under a no-access order, as CAS, considered the parent of a Crown ward, has discretion to decide who may visit with the child. Since November 2006, the legislation allows for openness agreements and orders, (adoption with some form of access) but these are not in widespread use. Frequently prospective adoptive parents do not want the child to maintain a relationship with the birth parents, siblings or grandparents. The objection to the child maintaining contact with siblings seems to be stronger in situations where the siblings live with the birth parents. Both agreements and orders for openness after adoption require the consent of the adoptive parent(s).

Children who are made Crown wards have experienced great instability and/or trauma in their young lives and a very large percent have experienced some form of abuse by a family member. In the last *Child Welfare Review*, it was determined that 82% of Crown wards have "special needs" and 49% demonstrate behavioural support needs (*Ontario Child Welfare Review*, 2007, pp. 13-14). Given these circumstances, the goals or purposes of access visits for Crown wards become somewhat uncertain (Bailey, 1999). Some say the goal is to allow children to understand their histories and "stories," to develop a coherent narrative of their life; some say it is to preserve happy memories; some say it is to fulfill judges' orders; and some say it is to maintain connections because the children will likely return to their biological families, eventually (Mishna et al., 2007-2009). In many instances workers, foster parents and children say they don't understand the goal of access visits or why access is structured as it is, particularly with respect to frequency and duration. Too often, access will continue on the same schedule that was established prior to the child becoming a Crown ward. The goals of access should modify as the child develops and circumstances change, but the new goals and the reasons for the new goals ought to be understood by all persons involved in access visits.

The perception that children who are Crown wards often return to their families of origin when they reach the age of 18 seems to provide a rationale for these children to have access visits (Mishna et al.). There is no evidence that this is the case, however, and even if there were, this seems like faulty logic to those in child welfare circles who see young people looking for support and alternative possibilities. Better transitional supports for youth leaving care are essential to assist them, wherever they are going. The most recent *Child Welfare Review* (2007) notes that the number of adolescent Crown wards is increasing and that "all areas of independence planning for youth aged 15 years or more require improvement including social development, vocational training, employment, life skills, extended care, and adult support" (*Ontario Child Welfare Review*, 2007, p. 19).

Determining Access Visits

Despite the fact that the law requires the child's "best interests" be the overriding measuring stick for custody and access decisions (*Ontario Children's Law Reform Act*, s. 24(1)), there are many instances in which child protection workers, judges and lawyers all have competing

perspectives on what constitutes the child's "best interests" (Bailey, 1999). Adding to these difficulties is the fact that the family service worker may have different viewpoints and priorities than does the child protection worker. It is common for family service workers to develop positive relationships with the parents of children in care and to view the failures in their parenting abilities in a somewhat sympathetic light. The child protection worker, on the other hand, may be more closely attuned to the child's developmental difficulties and attribute them to the parents' failures. Although the family service worker is the case manager and instructs the Society's lawyer, a disagreement between the child protection worker and family service worker may slow the decision-making process or affect the information provided to the judge and hence the judge's decisions. Ideally, family service workers would be directly involved in the evaluation of access in order to allow them to better prepare for court; to better put forth the best interests of the child. Finally, there is a concern about pressure within the system to allow access visits in order to gain the birth parents' agreement to their child becoming a Crown ward, thus saving the considerable costs of a trial. All of these factors make the directive to do what's in the child's "best interests" somewhat complicated.

The *Ontario Children's Law Reform Act,* s. 24(1), states that the judge should make access orders in the child's best interests, citing thirteen considerations. However, from comments of various workers in a number of agencies it is evident that workers do not always understand the rationale from which judges make decisions. Perhaps in some instances judges might give greater attention to offering the agencies explanations for their judgements. It has been suggested that although each child and birth family is unique, it might be possible to develop some broad guidelines concerning access with respect to a) the age of the child, b) the mental health concerns, c) the presence of trauma or post traumatic stress disorder, d) the willingness of family members to accept the child's placement in care, e) the family member's mental health and stability, and f) the degree of disruption and distress caused to the child by family visits (Mishna et al., 2007 -2009).

A comprehensive assessment of the child's needs and the benefits of family contact is very important at the time of Crown wardship. "Comprehensive assessment is the cornerstone of effective permanency planning, particularly as it relates to facilitating the development or strengthening of attachment needs" (Steward & O'Day, 2000, p. 150). Society workers need to work closely with their legal counsel in order to ensure that the proper evidence is placed before the judge charged with determining what contact would be appropriate for the particular child. The paramount concern should be to make decisions that will best assist the child to establish psychological permanency - safety, stability, and attachment.

Varying Access Visits

Decisions about altering arrangements for access visits are made by various persons in individual circumstances; again there are no established criteria as to when the visits ought to be changed, by whom, and how. Who should decide that it is not in the child's best interests to continue to have access visits or to have them increased or decreased? Sometimes judges give wide discretion to agencies to monitor and adjust access according to the child's needs. Increasingly, however, judges are leaving little or no latitude as to the form and frequency of access and it can be difficult to modify an access order. The Society worker needs to prepare evidence that

demonstrates how the access is negatively affecting the child. The foster parent's messages about a child's behaviour, the parents' behaviour, the child's expressed wishes, observations made by the worker or access supervisor, or the child's lawyer should all be before the court when the agency requests a change in access. Careful documentation will avoid the worker being perceived by the judge as uncertain or alternatively, as punitive. The clearly articulated goal should be the avoidance of harm to the child and the furtherance of the child's treatment and developmental needs. Anecdotal evidence suggests that it is not widely understood that access orders can be varied without reviewing the legal status of the child and that workers tend to avoid going back to court regarding access out of concern that the parents will seek to have their child returned.

Implementation of Access Visits

"Contact or access can be helpful or destructive to the welfare of the child and much depends on how thoroughly the various issues have been explored before the access and contact plan was formed" (Wilkes, 2002, p. 6). The frequency, format, and length of visits should be determined by the goal of the visits, the age and special needs of the child, the relative cooperation of the family member, and the amount of disruption to the child's schedule. The goals and other considerations should be reviewed and reassessed on a regular basis as circumstances alter and as the child's developmental needs change. Unfortunately, the goals are often vague and the arrangements are often determined by practical imperatives rather than by the requirements of the particular child. The locations and arrangements for visits vary widely from agency to agency, and even within agencies. Frequently, decisions are made on the basis of the availability of staff or volunteer drivers, without sufficient emphasis on consistency or continuity of contact for the child.

Supervision of Access Visits

People who supervise access visits frequently have few guidelines and inadequate training. There are no provincial training requirements for the supervision of access visits, or even what constitutes supervision. The extent of preparation for this very important role varies greatly. Some workers attend excellent workshops on therapeutic access sponsored by the province or individual societies but many do not have this opportunity. Some agencies have considerable training and well-articulated policies about access visits, while others have neither training nor comprehensive policies. Even within agencies that have well trained staff, there may not be a sufficient number to supervise more than a small percentage of the visits. Although there are agencies that do their utmost to have a child's access visits regularly supervised by the same worker, in many cases the access visits are overseen by many different workers who may not know the child or the family. Frequently, supervision is carried out by part-time protection workers hired to facilitate weekend visits. At many access centres, the family visits take place in a room with other families so there is no privacy or opportunity to address confidential or sensitive material.

Supervision of access visits can involve proactive interventions by a skilled and knowledgeable protection worker addressing painful but important family issues, or, at the other end of the spectrum, it can involve a relief worker sitting outside a closed door, who assumes that his or her

only role is to call security in the event of a disturbance. Many workers believe access visits should be "happy" occasions, free from difficult or contentious subjects, such as why the child is in care, or why mom or dad was recently in jail or hospital. Too often supervision is viewed as monitoring the conversation to prevent "inappropriate" topics from arising when it is very important for children to know what is happening in their family's lives and to express their concerns. When visits are supervised by workers who are inexperienced or who do not know the family, they may ignore or misinterpret highly charged interactions. For example, an apparently innocuous exchange might signal significant past events, events which trigger traumatic reactions in a child. The notes taken during access visits can be influential in decisions about future access or even returning the child home. It is essential that workers have adequate training for supervising access visits, that there be continuity of supervision and that, in their supervisory role, workers attain a degree of comfort with taking a proactive, "therapeutic" role. For example, workers supervising visits may intervene when parents engage in "rejecting", "inconsistent," or "insensitive" behaviours, and actively promote "parenting behaviours that foster the child's confidence in the parent as protector" (Rella, p. 12).

If children are to understand their stories and histories they need to know why they are in care, why they have been made Crown wards, and why, for example, their parent didn't come to the last scheduled visit. Even when the child has been made a Crown ward, there is the potential for an improved relationship and for the parent(s) to increase their understanding of and responsiveness to, the child's needs. These needs are not addressed by food or gifts. Following are examples of appropriate, meaningful goals for access visits for Crown wards: the child benefits when the parent reassures the child that he or she is loved and important to the family and is not responsible for the family situation; the child is assisted when he or she is given permission to attach to his or her foster parent; the child is also assisted when progress in care is discussed in such a way that there seems to be cooperation and continuity among foster parents, birth parents and protection worker. When it's not possible for these things to happen, the impact on the child must be acknowledged and the child's resulting distress validated. .

Foster Parents' Role in Access Visits

Too often, the important role of foster parents in access visits is overlooked. The foster parent may be instrumental in transporting the child, and as well preparing the child for the visit and dealing with its aftermath. The foster parents rarely, however, get detailed information about what took place at the visits. Whether the visits are happy or stressful events, the foster parents need to be informed in order to provide continuity for the child's experience and for the development of their relationship. When family visits are upsetting, it usually falls on the foster parent to console the child, for example, when a parent failed to show up, arrived without the promised treat, or came with unwelcome news of another partner or pregnancy. Sometimes, a child may have experienced confusion or rejection or an unsettling memory but is not able to articulate what happened. Without a thorough debriefing from an experienced supervisor who participated in the visit, neither the child nor the foster parent is able to make sense of the child's distress. When the foster mother and other members of the foster family experience anger and distress associated with these occasions, they in turn may anticipate access visits negatively or resent them. Consequently, a whole new layer of conflict and confusion is introduced within the

child. Research suggests that there is considerable tension, uncertainty and apprehension among all parties with respect to visits (Haight et al., 2002).

Frequently, foster parents do not take children to and from visits because they do not wish to have contact with the biological families or because they are inconvenienced by the visit's time and location. Transportation to and from visits may be done by a variety of volunteer drivers, which increases the uncertainty and discontinuity of the experience. Ideally, foster parents or the children's worker would drive them to and from their family visits but failing that, at least having the same person take them for each visit would provide some continuity.

Preparation and Debriefing for Access Visits

The process of preparing and debriefing a child before and after an access visit is essential but it may not happen at all or it may be unplanned. Sometimes preparation or debriefing takes place on the ride to and from home, but often it occurs only in response to the child's negative reactions. In response to the child's distress, the foster parent may call the child's worker who, in turn, may call the worker who supervised the visit. It may be days before the foster parent finds out what took place at the visit; or the foster parent may not get any helpful information at all. If the child does not react negatively, information about the visit is rarely provided.

According to several Societies' access visit manuals, there is a great deal of focus on the workers' requirement to plan visits. However, it is not clear that the workers should articulate the goals of the visit to the child or understand the child's expectations, expectations which may be completely different than the worker's goals. Nor is there any focus on the need to debrief the child after the visit to determine if the goals or expectations have been met. Finally, although there appears to be considerable agreement on the need for communication between all adults in the child's circle of care, the time and resources are inadequate to address this need. It is extremely important that the reason for the access visit be discussed before each visit in terms the child can understand. In addition, the child's expectations and desires need to be explored and responded to by someone who knows him or her well, can put the particular visit in context and will be available to evaluate it in terms of the child's hopes, wishes and fears.

With appropriate training, the foster parent, the child's worker or the supervising worker could all potentially be the person who prepares and debriefs the child with respect to access visits but it should be the same person each time. Whether the foster parent is doing the debriefing with the child or not, she needs to know what happened at the visit so that she can understand the child's experience and in turn, assist the child to understand the experience. If the foster parent is to become the child's permanent caregiver it is essential that she/he have this information, because she/he is central to the child developing permanence, both physical and psychological. If the foster parent is frustrated and resentful about the access visits, it could undermine the child's placement and that should be a real concern. Foster parents not only need information about what transpired at each visit but also training to understand the goals of access, and how to talk to the child about the family member involved. They also need support to tolerate the stresses induced by the access visits. Recent interviews with foster parents suggest that they want to be better informed and receive training with respect to access visits (Mishna et al., 2007 - 2009). Other

research has indicated that training and support for foster parents resulted in more investment by the foster parent in sustaining the child/birth parent connection (Sanchirico & Jablonka, 2000).

Two years ago the Ministry instituted a province wide 27-hour training program called PRIDE (Parent Resources for Information, Development, and Education) which all new foster parents and adoptive parents must complete. Recently, there is an option for experienced foster parents to take the training as well. Among other things, the course assists foster and adoptive parents to understand the significance of the cultural, socio-economic and abuse histories of the children they are fostering or adopting. It is also intended to help parents of children in open adoptions and foster parents of Crown wards with access to understand the rationale behind communication with the biological parents and to encourage a variety of options from the occasional note with news of the child, to phone calls, to driving the child to access visits, to supervising access visits depending on the wishes of the biological parents and the comfort level of the foster or adoptive parents. Less experienced foster parents are not encouraged to take on the same role as more "seasoned" foster parents. There is now widespread recognition that children are best served when there is communication and a level of comfort between the parents who gave birth to them and the parents who are raising them and this is particularly true when the children are in regular contact with their biological parents. It is now an "expectation" that some form of communication will take place.

The Children and Access Visits

There is little research about Crown wards' perceptions of the purpose of their access visits, or what expectations arise as a result of continuing contact with birth family members. Many workers and foster parents, however, think that the children are confused by the visits and view them as an opportunity for treats or as a prelude to going "home," to live with their birth parent. Most children who are made Crown wards have family visits with a parent who subjected them to some form of neglect or abuse – physical, psychological, sexual. In most cases, they begin and continue to have visits without the benefit of family therapy or "therapeutic access" and without the opportunity for the child or youth to tell the parent how they feel about the abuse, and the harm they have suffered as a consequence. This is especially concerning when these children have access visits supervised by someone who actively opposes the mention of anything unpleasant or "inappropriate." In recent interviews, several workers have said that the definition of a good visit is a visit when "no one cries" (Mishna et al., 2007-2009). Although no one wants a child to suffer distress during a family visit, there are many instances when dealing with a difficult topic can be beneficial. For example, children might be helped by having a chance to ask their parent about the circumstances surrounding their apprehension, obtaining validation from the parent or supervisor about their experience, or expressing feelings of anger, sadness or fear. Suppression of their emotions can lead to frustration and can be an impediment not only to their developing a healthier relationship with the parent, but also to their gaining self awareness.

There has been little evaluation of the impact of access visits in order to know which children benefit and which may be further harmed. Some are re-traumatized each time they visit with an abusive parent who brings a gift, saying something like "I love you so much and want you to come home." Similarly, there has been little evaluation of different access and supervision

arrangements to determine what is best for which children. One essential question is whether contact promotes or impedes children's acceptance of their current living arrangements and attachments with their current caregivers. Being unclear about the goal of the access visits could easily lead the child to think he was going back to live with the birth parent and undermine any motivation to attach to the foster parent. This in turn would likely interfere with the child's sense of permanence – both physical and psychological. On the other hand, if the child perceives the birth and foster parents to be cooperating, the child may be able to attach to both, just as a child of cooperative divorced parents is able to attach to both.

A large percentage of children in care who have access visits have significant mental health problems associated with earlier traumatic relationships with their primary caregivers: fetal alcohol syndrome, and other developmental impediments (*Ontario Child Welfare Review*, 2007, p. 14). The 2007 *Child Welfare Review* indicates that 82% of the Crown wards reviewed were identified as "special needs" children, 47% were taking psychotropic medications and 29% were having psychotherapy *(Ontario Child Welfare Review*, 2007, p. 13.) Working with these children and meeting their needs requires skill and training, as well as support currently not always available to workers and foster parents.

It is not clear what, if any, consideration is given to these mental health and developmental problems when making decisions about contact with their families of origin. Workers, lawyers and judges might benefit from understanding how depression, anxiety, attachment disorders, fetal alcohol syndrome, post traumatic stress disorder, learning disabilities, and developmental delays variously affect children's perceptions and ability to comprehend the all important decisions being made for and about them. In most cases, without skilful observation and intervention, the conversations and explanations about access go entirely unheard and unprocessed and it is only the feel of the car ride, the tension of the wait at the access centre, the taste of the hamburger, or the looks on the faces of the birth parent, foster mother or worker that register. What does this mean for the children and how can we improve their understanding and experience?

Conclusions

Every aspect of decision-making, planning, conducting and varying access visits needs investigation in order to determine how better to serve the needs of our children in care, especially our Crown wards. In particular, the goals of access visits must be explored, established and revisited with all who are involved, including the child. Whether or not children benefit from access visits, which children benefit and under what circumstances, must be determined. This kind of research could be a helpful tool for assessment and an invaluable source of evidence when requesting a change in access at court. The experience and wisdom of foster parents who are charged with the responsibility of providing care should be an important part of the information provided to the court. So, certainly, should be the perceptions and wishes of the children, whose healthy development depends greatly on their being helped to understand themselves and their stories (Haight et al., 2002; Hess, 1988). Also, it is essential that adequate and consistent training be provided for all workers who supervise access visits and for all foster parents who care for children having access visits. Certainly, practices need to be established to promote better communication between workers and foster parents and to ensure that there is

planned preparation and debriefing of the child at the time of each visit. Proactive supervision by experienced workers could not only lead to greater understanding of the impact of access visits on children but could significantly improve the quality and outcomes of access visits (Rella, 2007).

Only by thoroughly scrutinizing all policies and practices regarding access visits can we adequately fulfill our responsibilities to the children. According to Deborah Goodman et al. (2007) this will "take time and resources, expertise, and commitment from board, senior management, front-line staff and supervisors." Examining every aspect of contact between children in out-of-home care and implementing an integrated child-focused practice is crucial to these children's healthy development and sense of permanence –"safety, stability and attachment." (*Ontario Child Welfare Review*, p. 18)

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IX. THERAPEUTIC ACCESS: FROM SUPERVISING ACCESS TO BUILDING PARENT-CHILD RELATIONSHIPS

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A new approach to "supervised access" has been unfolded in Ontario over the past four years. Developed by the author in her work at the Intensive Family and Community Resource Program (INTERFACE) at Thistletown Regional Centre and in conjunction with the Children's Aid Society of Toronto and others[1], the model takes advantage of traditional supervised access opportunities and uses them to actively engage child welfare workers and parents in working together to build secure parent-child relationships, while teaching parenting skills.

"Therapeutic Access" is an innovative teaching and intervention program that trains child welfare protection workers to change their role in relation to supervised access. Workers are taught to assess parenting risks in the context of the parent-child relationship during supervised visits. This focus provides a road map for developing interventions to help parents improve their parenting skills and their relationships with their children. The normally *silent* worker—one who observes and takes notes during supervised access visits—becomes the *proactive* worker—one who serves as an available and valuable resource to educate parents and help them to better know and respond to the needs of their children. This new approach recognizes that parents provide significant information about the parenting skills they learned (or did not learn) from their own experiences of being parented. Grounded in attachment research and theory, Therapeutic Access empowers and supports parents to gain understanding about their own experiences of being parented, apply this new insight to their current parenting, learn new skills, reduce the risks that resulted in the placement of their child or children in the first place, and whenever possible, work towards permanency and/or reunification. By conceptualizing parenting behaviours as *rooted in past experiences* that can be *changed today*, workers and parents can work together to shift the focus away from a parent's "love" for the child or "desire" to be a better parent to one of concrete skill-building and behaviour change. The approach also provides a framework for the court system so decisions about permanency planning can be achieved more expediently.

This paper describes some of the limitations in current supervised access practice, provides a brief review of attachment theory and research, and presents Therapeutic Access as an alternative intervention model for supervised access. Grounded in attachment *and* the realities of child welfare practice, Therapeutic Access is designed to promote secure attachment and build parent-

[1] INTERFACE has worked to implement this model with the Children's Aid Society of Toronto (CAST), Catholic Children's Aid Society of Toronto (CCAS) and Children's Aid Society York Region. In particular, North Branch CAST has implemented the model in an organized manner and hired a coordinator as the key worker in developing Therapeutic Access plans. The program has recently been granted core funding as it successfully moved from a pilot to a program.

child relationships. The paper concludes with a brief description of how the model is unfolding in Ontario.

Why change supervised access practice?

Established under the authority of the *Child and Family Services Act* (CFSA) in Ontario, Children's Aid Societies (CAS) act to protect children from harm. Most of the children who come into contact with CAS require intervention as a result of parenting behaviours that place children at risk of emotional harm, physical harm and/or sexual abuse. Efforts to help parents use more adaptive parenting skills have tended to focus on helping parents learn instrumental care skills (i.e., supervision, feeding, etc.) rather than emotional care skills. However, *the child-parent relationship itself* is emerging as the target for most effective intervention and prevention efforts in infant mental health research (Clark, Paulson & Conlin, 1993; McDonough, 1993). Focussing on the relationship *between parent and child* and how the caregiving pattern affects both instrumental and emotional care as well as how it contributes to abuse behaviours, is critical to assessing risks and the potential for reunification.

In most situations, children are protected without being removed from their homes. However, in those cases where the risk to a child is deemed to be so significant that she or he cannot remain at home and be protected from harm--and in its goal to reunite children with their families where possible--CAS uses a service called supervised access. This means that parents can have direct contact or visits with their child or children in the presence of a CAS worker. Most often, this involves the worker observing the visits and making notes of his or her observations. When changes are observed, be they positive or negative, the worker recommends changes to the access arrangements. The observations and recommendations are shared with the parents and submitted to Family Court where judges make decisions to maintain or change access arrangements.

While supervised access appears to offer all of the necessary ingredients for change to occur—the parent and child are present along with a worker who can teach and provide feedback to the parent in the moment—workers and parents (as well as the courts) are well aware of some longstanding issues and challenges. Some parents, for example, attend and behave in the access visit in ways that are similar to the behaviours that promoted child welfare involvement in the first place: they continue to miss cues for attachment from their children; they neglect instrumental and emotional needs; and, sometimes, continue using harsh punitive strategies to discipline their children. At times, the views of CAS workers and parents are at odds. On the one hand, parents believe that their interactions with their children are appropriate and therefore expect CAS to recommend that a child be returned home, to their care. On the other hand, CAS believes that the necessary changes have not been made, that the children continue to be at risk and that they cannot make a recommendation for the child to return home. While workers may offer parents "support" to change their parenting behaviours, often parents refuse this support believing that it comes only with an admission of guilt on their part and an acknowledgement of purposeful abuse. Despite "parenting group" attendance, parents continue to manifest problematic behaviours with their children. Although attending groups is often a condition for reunification, and parents do attend, the positive effects predicted by their attendance are not

visible in access visits. Access visits therefore can remain stagnant and unproductive with respect to reunification and/or permanency planning.

Making infant-parent or child-parent relationships the centrepiece of evaluation and intervention for families involved in child welfare and in child welfare settings raises a number of challenging issues for workers, families and the courts. For example, can assessing the relationship between parent and child provide evidence that simultaneously illuminates the risks identified and clues to help change the relationship? Can identifying adult attachment representations provide crucial understanding that can be used to minimize current parenting risks? Can parents be taught to identify, respond, plan and act on their children's signals for distress differently from the ways they learned when they were being parented? Can supervised access provide sufficient opportunity to strengthen a parent's position as a consistent protector in the eyes of their children? Our experience, to date, is showing that all of these challenges can be addressed through Therapeutic Access, an approach that is grounded in attachment research and theory and conceptually *designed* to function therapeutically unlike current supervised access practice.

With increasing numbers of children coming to the attention of child protection and a desire for the system to provide tailored and flexible support to meet the needs of vulnerable children and families, child welfare service providers, families and communities need to use every opportunity to build practices that support parents, foster healthy child development and well-being, and prevent abuse and neglect. Therapeutic Access is emerging as one such practice squarely aimed at changing passive and repetitive sequences of supervised access visits into proactive learning and practice windows that can advance the development of healthy relationships. With the high number of children in CAS care and the consequent number of visits that occur in CAS offices, the current situation is ripe for improvement.

Therapeutic Access is grounded in attachment

The behaviours of parents and their children are well understood when they are situated and explained through attachment research and theory. The works of Bowlby, Ainsworth, Main, Zeanah, and Crittenden, for example, offer indispensable insight into the behaviours that unfold in families everyday and that child welfare workers witness in families' homes and later in supervised access visits.

Between 10-20 months, the child's symbolic representation of the attachment system develops. The child develops a representation of attachment through repeated experiences of the parent via the ways the parent attends to cues of distress (fear, illness, physical pain) from the child. Such cumulative experiences form the child's understanding of how his or her parent will respond consistently to their cues for proximity.

Often, problems in parenting are rooted deeply in attachment representations and take the shape of abuse and neglect which comes to the attention of child welfare. Anecdotal evidence suggests that parents who become involved with child welfare and participate in supervised access fall in the dismissive and/or preoccupied fearful/angry state of mind. These parents are most often difficult to engage as they are either angry and externalize their feelings towards CAS workers, fearful and compliant without making changes, and/or dismissive of their involvement with

CAS. However, the story regarding parenting styles and interactions with infants and developing children which is critical to our understanding of how to intervene in repairing and changing those patterns, began long ago.

Bowlby, for example, found that all infants are biologically predisposed to maintain proximity to caregivers. However, he also recognized that children differ in the ways they achieve this goal by virtue of their experiences with their caregivers. Through repeated experiences with caregivers, infants and children develop expectations—"Working Models" or cognitive/emotional representations of their interactions with primary caregivers—which serve as guides for future relationships. A lack of a consistent strategy for coping with threats to security explains the link between disrupted attachment to the caregiver and subsequent developmental, social, emotional and cognitive difficulties in the child (Zeanah & Boris, 2000).

Bowlby (1969,1982) emphasized the development of a "goal-corrected partnership" between infant and caregiver. The behaviours of the infant are organized around the goal of maintaining proximity to the mother hence establishing security. When the attachment system is activated by a potential threat (i.e., physical pain, fear, illness) the infant attempts to increase signals to communicate proximity to the caregiver, retreating for a sense of safety and reduction of stress. The concept of goal-corrected attachment behaviours provided the foundation for Ainsworth's identification of the three patterned subtypes of the organization of infant-parent attachment behaviours: secure, avoidant, and ambivalent/resistant, each characterized by a distinct strategy for the achievement of proximity that becomes apparent by the end of the child's first year (Ainsworth, Blehar, Waters & Wall, 1978). In their work with parent-child relationships, Main and Solomon (1990) later identified the disorganized/disoriented subtype.

Infants who have *not* had their needs met consistently and appropriately by caregivers either minimize emotional displays (avoidant) in an effort to reduce the risk of future disappointments, or heighten their expression of negative emotions (ambivalent/resistant) in an effort to engage an inconsistently responsive caregiver. Both relationship patterns pose risks to the dyad. Mothers of avoidant-insecure infants are more covertly rejecting of their babies, especially when the infant expresses negative affect, and show a narrow range of emotional expressiveness (Ainsworth et al., 1978; Malatesta, Culver, Tesman & Shepard, 1989). Mothers of ambivalent-insecure infants are "unavailable" in the home environment. For example, parents miss cues for distress and/or act on their own feelings thereby failing to respond to the internal state of the child (Crittenden, in press). These patterns are observed throughout the development continuum.

With respect to disorganized infant-mother attachments, Main and Hesse (1990) proposed that infants have been exposed to frightening experiences or frightened parents who themselves continue to experience unresolved complex trauma. As a result of these traumas, parents behave in ways that are confusing to infants and therefore frightening to them. An infant frightened by a parent's behaviour will be in conflict with respect to seeking proximity (for security) and avoiding proximity as a result of fear. Simultaneous needs promote disorganization.

Lyons-Ruth, Bronfman, and Parsons (in press) expanded the above based on observations of mothers and infants in which the mother had documented unresolved trauma. The two types of disruptions in maternal affective communications were: 1) "failure of repair" and 2) "competing

strategies." "Failure of repair" is characterized by unresponsiveness to the content or intention of the infant's communication. The mother responds with hostility, intrusiveness, withdrawal, or parent-infant role-reversal. In the absence of a minimal level of appropriate parental responsiveness, infants have difficulty activating attachment strategies leading to fear and a breakdown of organized behavioural strategies. "Competing strategies" refers to fear-based contradictory caregiving behaviours that both elicit and reject infant attachment behaviours thereby confusing the infant's ability to form a coherent attachment strategy. Such mothers provide infants with contradictory messages and respond inappropriately or not at all to communications by the infant. These mothers also engage in more negative intrusive behaviours and role confusions (Lyons-Ruth et al., in press). Hence, mothers who continue to be significantly confused about their own self-worth promote confusion in the attachment relationship. Current caregiving behaviours towards their children include rejection, role reversal and intrusiveness.

Many parents who have harmed their children or increased the risk of harm have often been puzzled when child welfare characterizes their behaviours as negative or abusive. They report that their own care experiences were far worse and they believe that the corrections they have made are sufficient. As well, continued research suggests that parent *intentions* to keep their children safe from harm, for example, do not necessarily translate into *protective behaviours.* Instead, they find their behaviours being evaluated by child welfare as either physically or emotionally abusive (Crittenden, in press). Without intervention, these parents would likely continue to believe that their "improved" or "well-intended" approaches are sufficient while failing to recognize the limitations and the continuing need to learn how better to protect their children.

There is growing evidence that infants in high risk families characterized by maternal depression, neglect, abuse, alcoholism, or domestic violence are especially likely to be classified as disorganized. Moreover, violence or abuse in the mother's childhood increased the tendency for insecure attachment to take *disorganized* rather than *avoidant* forms of attachment. Different types of childhood experiences appear to be associated with different patterns of maternal caregiving. Violence or harsh punishment was associated with more hostile-intrusive maternal behaviour, whereas abuse including sexual abuse was associated with maternal withdrawal. (Lyons-Ruth & Block, 1996). All such behaviours are observed in the child welfare office during supervised access.

According to Cassidy (1994) and as evidenced by the work of Main, Kaplan and Cassidy (1985), parents' "working models" of relationships influence all relationships including those with their children. Mothers who are dismissing of attachment relationships convey this orientation to their children, whereas mothers who are preoccupied with their attachment convey their preoccupation. Each develops a parenting model, behaviours affecting parenting and subsequent attachment relationships that can promote risks to their children in the form of neglect and abuse and become a focus for child protection intervention. Given that many parents who become involved in the child welfare system have experienced both trauma as well as early relationship disruptions, it stands to reason that current caregiving behaviours are seen as increasing risks to their children. It also confirms that parents generally continue to do what they have learned to do with their children in access visits.

The most disruptive parent/child relationships occur when the parent is both the source of security and the source of terror for the child. In such relationships the parent makes affective errors, for example, by responding inconsistently or with contradictory behaviours to cues for proximity, or is non-responsive or inappropriately responsive. The child experiences disorientation from the parent as the parent responds in a confused or disorganized manner. The child experiences the parent's behaviour as intrusive (verbal or physical), frightening, withdrawn or frightened of the child (verbal or physical) (Lyons-Ruth & Jacobvitz, 1999). While the absence of an appropriate attachment figure is apt to negatively impact the social and emotional development of the child, the parent who is present to provide protection yet absent in the ability to do so because of inconsistent and disruptive caregiving efforts promotes more devastating effects in the attachment representation for the child (Lyons-Ruth & Jacobvitz, 1999). Understanding the significance of such relationships may provide clarification regarding the efforts required to promote positive change for the child in access. Clarifying the ability of the parent to change the above noted behaviours is crucial to the permanency plans for children.

Unresolved complex trauma and/or unresolved loss in the parent promote a continued lineage with respect to child maltreatment over generations. For example, in two separate studies disorganized attachment was found to be a factor in 82% of maltreated infants (Ward & Carlson, 1995) and 55% of maltreated infants. The disorganization of the attachment relationship was found to be a central mechanism in the emergence of many of the disturbances associated with child maltreatment (Lyons-Ruth & Jacobvitz, 1999). Children cooperate in maintaining their parents' state of mind by creating their own psychological distance thereby behaving avoidantly, or by continuing to engage in power struggles in an attempt to engage the parent, thereby behaving ambivalently/resistantly, and/or developing a number of unsuccessful strategies that attempt to avoid and engage the parent simultaneously. These behaviours appear to promote risks to children in that avoidant children are at risk of neglect and resistant children are at risk of abuse including failure to thrive.

On the whole, children come to understand from repeated experiences with their parents and caregivers that a pattern exists in their interactions. The parent's past experiences produce a present day ability (or disability) to respond to their child's negative affect. Hence, while a parent may learn better *what* to feed the child, the manner in which the parent feeds the child is very important. The content may improve, however, helping the parent to recognize negative affect while feeding, and teaching the parent to respond sensitively and consistently would also address the emotional health of the relationship.

Bringing attachment knowledge and parenting strengths into practice

Understanding maternal and paternal caregiving patterns may by helpful in determining interventions and treatment to lower current parenting risks as well as increasing secure attachment possibilities. To be effective in altering parenting behaviours related to insecure and/or disorganized attachments, the research tells us that clinicians, mental health workers and child welfare workers need to understand parent events in childhood prior to determining treatment and planning interventions regarding their current parenting. Given that specific patterns of maternal (and paternal) caregiving affect the nature of the infant's attachment strategies, it stands to reason that most of the dyads identified as at risk in the child welfare

spectrum have experienced various forms of difficulties that are manifested in poor parenting, neglect, abuse, failure to thrive, and/or behaviour problems in children.

How does one weave this knowledge into child welfare practice and specifically into access visits? An obvious implication of the research and findings is that in order to promote the development of secure attachments and to alter insecure attachments in infants and children, it is necessary to change the behaviours of the primary caregiver. In addition to its grounding in attachment, Therapeutic Access is similarly rooted in recognizing and harnessing parental resources of strength, coping and resilience.

The concepts of strength and empowerment have been used with a wide variety of clients and in a broad range of situations including mental health (Rapp, 1992), people with disabilities (Mackelprang and Salsgiver, 1996), people suffering from substance abuse (Miller & Berg, 1995), children exposed to trauma (Aldwin, 1994; Poertner & Ronnau, 1992), homeless women with children (Thrasher & Mowbray, 1995), and adults dealing with stress and coping (Saleebey, 1996). According to this literature, strength can be conceptualized using a number of overlapping and related approaches such as cognitive and appraisal skills, reframing parenting experiences, practicing behaviours, and direct hand-over-hand teaching. Therapeutic Access is based on the derivates of the above noted approaches to change while focussing at all times on the overall significance of changing attachment relationships to build secure patterns of engagement with the child and consistent appropriate responses from the parent.

Use and timing of Therapeutic Access

While Therapeutic Access is designed to address parent-child relationship problems and give parents an opportunity for reunification with their children, child safety and healthy development are central to decisions concerning the use and timing of the intervention. For example, interventions to protect children and support secure attachments must minimize the amount of time infants spend in foster care and the frequency of caregiving disruptions. This necessitates an expedient *and* thorough understanding of children's risk factors in their home and a similarly expedient and thorough understanding of whether parents can change their maladaptive behaviours towards their children. If parents refuse to participate, or if therapeutic access is found to be ineffective, permanency planning is essential.

If Therapeutic Access is offered and parents decide to participate, the planning begins shortly after the child is placed in care. With a focus on learning relationship-based skills and practicing adaptive parenting skills, each session is longer in duration (e.g., two - four hours) than typical supervised access. Because the sessions are intended to bring about demonstrable behaviour change, the CAS worker prepares documents for court that concretely stipulate what the parents need to learn and demonstrate, as well as the amount of time offered to help them learn. For example, "the mother will attend four hours of therapeutic access, twice a week for a period of six weeks. This period of time will provide the mother with forty-eight hours in which to learn about the instrumental care of her child, (feeding, supervision, structure, routine) and the emotional care of her child, (sensitivity, responding to cues for distress, delighting in play activities)." This kind of clear understanding regarding the risks and opportunities provided to

reduce those risks is helpful to parents, lawyers and judges in making decisions to continue or terminate therapeutic access.

Therapeutic Access in action

Setting the stage

In Therapeutic Access, the parent assumes all parenting responsibilities for the child. The time with the child becomes **"parenting"** the child rather than **"visiting"** with the child.

However, Therapeutic Access planning and joint work with the parent begins well before an actual structured visit takes place. The desired changes can perhaps only occur while providing the caregiver with the opportunity to make the changes in a secure environment, thereby fostering the parent's ability to accept negative and positive affect from their children while learning how to recognize and respond to it differently in themselves. The work of van IJzendoorn (1997) suggests that attempts to facilitate changes in parenting relationship be considered carefully and systematically. This is very important when parents are engaged with child welfare. Attempting to increase sensitivity in the parent/child relationship in light of poverty issues and/or addictions and/or mental health issues may not be possible. It is also likely that such relationship changes towards the infant by the parent are not possible given the internal insecure and/or dissociative state of mind of the parent. However, attempts at assessing the nature and extent of these problems should always be considered and recommendations regarding reunification can be made during access.

Information gathered about the parent's past and the formulation developed allows the worker to begin to predict with the parent the areas of concerns that may be observed in the access visit, as well as to plan interventions to help the parent recognize their behaviour and change the outcome. The worker and the parent plan together to reduce the risks identified and agree that they are both able to evaluate the improvements identified.

Assessment

The case history provides an understanding of the risk factors already identified: the parental risk factors, unique characteristics of the child that place him or her at risk, extended family risk factors and community risk factors. Given this information, the assessment process focusses on clarifying the child's exposed difficulties that require treatment and the skills parents need to learn to reduce the risk factors.

Assessing adult representations of attachment relationships is done primarily by using the Adult Attachment Inventory (AAI) (Main, Kaplan & Cassidy, 1985). A history of the parents' recollection of their own childhood experiences including a description of: the *immediate family*, *relationships with parents as a young child*, *five adjectives for relationship with mother/father and memories for each*, a *description of closeness in the relationships*, an *account of care at times of illness or fear*, *physical pain and a description of rejection* (minimized or promoted) in the relationship, *parental threats*, *discipline*, *losses*, and *current relationships with parents.* Scoring is done on the basis of coherence, quality of information (i.e. believable without

contradiction), quantity of information, (i.e., too much, too little), relevance (i.e., answers the questions asked), and manner (i.e., answers questions in clear language). The outcome of the questionnaire provides a formulation of the individual's state of mind regarding representation of relationships in general. The "state of mind" scales are classified in four categories: **Balanced**: a coherent state of mind characterized by a valuing of relationships; **Dismissing**: characterized by a deactivated attachment system therefore dismissive of the task of attachment representations; **Preoccupied**: characterized by a preoccupation with past attachment relationships either angry or fearful as past experiences contribute greatly in the present; and **Unresolved/Disorganized**: characterized by lapses in monitoring of reasoning, changes in mood, content, lapses specific to talking about trauma or loss.

The AAI is a tool used in individual therapy and requires specific training to score accurately and reliably. However, for the purpose of Therapeutic Access, key relationship questions modified from the AAI are useful. For example, we learn to mother from our mothers and father from our fathers. What did you learn from your mother/father? Describe your relationship when you were young. How did your mother care for you when sick/scared/hurt? What did you learn about trust, conflict, and rejection? What did your mother do when you were hurt? How did your father show you affection/rejection? What did you learn from your mother about mothering? What are the things you are repeating in your own mothering?

Hence while the AAI is not the tool used to obtain a history of relationships, key components can help identify and clarify a learned style of engagement from the parent.

Risks are then re-evaluated once skills have been learned to the best of the parent's capacity, and reduction of risks promotes recommendations regarding permanency. For example, has the parent increased her or his capacity to act as a protector for the child and hence move towards a secure attachment relationship? The focus on increasing the parent's ability to be the *protector* and increasing the child's confidence in the parent as protector has significant implications in all areas of care for the child--both instrumental and emotional.

The sessions

The goal of Therapeutic Access is to determine whether parents can increase sensitive behaviours towards their children, reduce rejecting behaviours, decrease inconsistent parenting behaviours promoting confusion for the child and eliminate frightening, frightened or dissociated atypical behaviours in the parent. Interventions in the sessions are aimed at helping parents eliminate parenting behaviours that contribute to the child's view that the parent is ineffective, frightening, inconsistent and rejecting, and aimed at helping parents increase parenting behaviours that foster the child's confidence in the parent as a protector, thereby promoting the secure attachment relationship.

The parent arrives fifteen minutes early to meet with the worker and plan the time together. The parent is responsible for bringing a meal to eat with the child as well as other things the child would require. If the child is an infant, the parent is responsible for bringing a diaper bag that contains formula, diapers, blanket, toys, etc. If the child is older, the parent brings food that is prepared by them. This is particularly significant in that it demonstrates the parent's ability to

plan ahead, organize and meet the needs of the child. It also places the parent in the caregiving role with the child thereby emphasizing the role of parent as protector for the child.

Therapeutic Access involves structuring the supervised access from "hello" to "goodbye." Parents are encouraged to join with their children, meet their unique needs, plan and practice playtime, prepare meals/snacks, communicate, demonstrate listening skills, prepare for the separation, and plan for the next access. All of the essentials that we would want to see any parent provide for their child are brought to life in a Therapeutic Access visit.

Most children in access are old enough to have the parent explain to them the purpose of the Therapeutic Access time. With support the parent is asked to explain to the child the reasons they have supervised access as well as the purpose of the parent's learning. For example, "I'm here with you because I am learning better how to take care of your feelings when you get upset," or "I'm learning how not to use physical punishment when I get angry with you," or "I'm learning how to keep you safe and make sure I know what to do when you get scared." Such statements promote feelings of security for the child as feelings of responsibility for the foster care placement shifts away from the child and on to the parent. Further it prevents children from making up their own inaccurate stories about what is happening to them (Wilkes & Milne, 2002).

Part of the session allows for "unstructured activity" that provides an opportunity for the parent and child to experience free play. The worker observes the tone of the relationship, mutual engagement, scaffolding opportunities for the parent to teach affect regulation, cognitive development, social reciprocity, sensitivity and responsiveness. The worker intervenes at different times providing feedback in areas the parent needs to change and positive feedback in areas of strength. Such feedback is always provided in the context of improving the relationship between parent and child and with a reminder that the parent may not have learned the skills in their own experiences growing up.

The worker remains involved with the parent during access and does not assume any care responsibilities for the child. The message to the parent is that parenting their child requires all their attention and that the child would like to see the parent assume that role in their relationship. The role of *protector* is always encouraged for the parent so as to increase security for the child. Hence corrective experiences begin to reshape previous attachment representations.

Workers need to understand the organization of parental actions in order to help parents reorganize their actions to include adaptive parenting skills. The parent's own childhood experiences can help the worker clarify distortions and/or errors the parent makes in their relationship with the child. The greater the risk the more correction the distortion requires; the greater the correction the greater the involvement from the worker in access. Treatment is directed towards reducing distortions by allowing the parent to learn to see themselves as protective and safe to their child. This framework is carried through in all areas of care the parent provides.

The parent also learns the language of the child's behavioural expressions addressing feelings rather than unsuccessful behaviour management. This would be particularly important for the parent who has been physically punitive with their child and the child who has learned to express

their anxiety either by non-compliance or over-compliance. The access time serves to create a corrective narrative for the child regarding past abuse experiences. The child learns through repeated experiences that their parent is learning to be a "*protector*" thereby strengthening the relationship between the dyad.

Participation in parenting groups or other interventions should become relevant in the child/parent relationship in the session. In other words, the positive effects of learning how to control anger in other programs (or child management skills, depression management, etc.) should be evident in the care parents provide to their children.

The access time incorporates opportunities to correct greetings and goodbyes between the parent and child, to strengthen the position of the parent to recognize cues of distress from their child and learn how to respond to the cues by assuming proximity in a safe and gentle manner. The parent learns to help the child with feelings associated with the transition of returning to the foster home while remaining in relationship with them. This is particularly helpful for avoidant attachment relationships.

After the sessions

The parents and the worker debrief, reflecting on what happened and what the parents found helpful, identifying parent strengths and continued learning goals and looking at ways parents can continue to build their learning outside the access visit setting. The debriefing segment with the parent provides significant opportunity to evaluate the positive changes in the relationship as well as the instrumental care provided to the child.

Documenting the work

The notes of the access session are reviewed by the parent and signed, and the next access is planned. A Therapeutic Access plan is written by the worker. It is designed to help the parents and the courts identify learning areas, time frames for learning, and review dates once the learning begins. Recommendations regarding any changes to the access status (from supervised to semi- or non-supervised) are made when learning and behaviour change demonstrate that the risk factors are lowered.

Unfolding the model in Ontario

Therapeutic Access is becoming a useful tool in current child welfare reform efforts in Ontario to meet growing needs and the complexity of families coming to the attention of child welfare. This model is helping to promote understanding, shift the thinking of workers, and appears to expedite permanency planning.

Over the past three years, CAS workers across the province of Ontario have been trained to use the model. Training has focussed primarily on helping CAS professionals to structure access in a manner that produces organized information regarding parenting changes. Although training has also included helping workers to learn to bridge adult early care experiences with current

parenting practices, participants have identified that they require more opportunities for concrete learning.

Looking forward, this model may also come to be used with families who are involved with child welfare, but whose children remain at home in the care of their parents. Further, an exciting emerging application of the model involves using Therapeutic Access with parents who have a child or children in care, but who also are parenting other children outside of this arrangement. In other words, parents involved in co-parenting another child or who have had a recent baby may soon be actively supported to carry over their therapeutic access learning into their other parent-child relationships. With respect to new infants, for example, they'll have access to learning early attachment signals with their infants from the very beginning stages of development thereby reducing risks from the start.

Thus far, the courts appear to applaud the efforts made by workers utilizing Therapeutic Access. Feedback from CAS workers themselves is twofold: on the one hand, they like the notion of returning clinical practice to their work; on the other hand, the process can be daunting because a decade of risk assessment tools aimed at evaluating risks have to a large extent overshadowed and diminished the clinical skills required to do this work effectively. Workers who would like to use Therapeutic Access as a viable alternative to supervised visits are still being constrained by high caseload numbers and ongoing time constraints.

As a promising approach for tackling the difficult and deeply entrenched issues in providing quality protection services for children, Therapeutic Access provides a proactive movement toward more dynamic and responsive supervised access designed to achieve better outcomes for children and vulnerable families. It equips child welfare protection workers with tools to provide effective prevention, permanency, protection, and family preservation services. By training child protection workers to understand the complexity of attachment relationships and by helping them to teach parents to increase their parenting capacities essential to meeting the needs of their children, Therapeutic Access facilitates a greater likelihood for reunification of children and their parents whenever it is possible and may prevent recidivism in the child welfare system. Thus, Therapeutic Access has a potential for tremendous cost savings as well. In situations where reunification is questionable, Therapeutic Access is still considered as an approach that improves permanency planning for children, delivered in a manner that is planned and evaluated.

Summary

In summary, while each access visit is but one snapshot in time, it provides an opportunity to understand the risks in the family and those in the parent-child relationship. The greeting, feeding, play and goodbye structure provides ample opportunity for the parent to learn and/or demonstrate capacity for nurturance, social interactions, and sensitivity to a child's cues. The parent's ability to assist in all areas of regulation, child's readability, and the child's strategies to engage or avoid the parent, or confusion regarding both, are observable and thus provide opportunities for learning.

The process allows the parent to articulate the relationship he or she wants to have with their child and the manner in which to have that happen successfully. The reflective process of

utilizing the narrative of the parent's past care experiences, their resulting internal representation of relationships, and parenting style is helpful in enabling the parent to reweave their parenting quilt with their child and provide more adaptive parenting.

If the parent has learned that physical force and punitive punishments are essential to obtain compliance, it is likely that in their attempts to teach their children respect they would promote fear in their children and recreate a disrupted relationship. It is also likely that the parent who experienced fear and threats in his or her own childhood and learned to hide away, dealing with their own fear and uncertainty, learned that adults were not protective in the resolution of such emotional dilemmas. As a result, they continue to avoid engagement with their own children.

Therapeutic Access works to construct the bridge necessary to help parents understand their past experiences, their current behaviours, their effects on their children and the parent-child relationship.

Understanding a parent's developmental process and how they have made meaning from their childhood environment helps to explain the process by which parents organize their behaviours towards children. Therapeutic Access can focus on supporting parents as well as providing corrective interventions for the purpose of change thereby possibly breaking the lineage of disrupted attachment relationships and minimizing risks to children.

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X. THERAPY FOR CHILDREN IN THE CHILD WELFARE SYSTEM: WHY? WHEN? and WHAT?

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In child welfare practice therapy is a frequent consideration. This may be for a number of reasons, common among them are difficult behaviour, traumatic past events, or ongoing stressful issues.

This paper argues that unless the matter of therapy is carefully considered it is possible that instituting therapy will promote confusion and uncertainty in the child's life. All therapy takes place in the context of what is happening in the life of the client involved. This is certainly true for children and youth in the child welfare system where therapy that does not help in understanding the current circumstances is a diversion at best.

There is a cartoon which shows a man fallen through the ice and on the shore nearby is his loyal dog. The cartoon caption reads, "Rex get help." The next picture shows Rex lying on a psychiatrist's couch. The cartoon is a good reminder that it is important if one is requesting help to be sure to understand and specify the type of help wanted before it is requested.

In the often confusing and troubled world of child welfare it is rare to find a situation that doesn't require help of some kind from others outside of Child Protection Services (CPS). There are often so many needs to be dealt with in any particular situation that there is a natural tendency to look for help wherever it can be found. The problem is that if such help is sought precipitously, without thinking it through, the casework can be hindered rather than helped. More particularly, when the word "help" is loosely translated to "therapy" then the likelihood for confused casework is heightened.

When thinking of the needs of a child brought into the child welfare system it is helpful to think of the hierarchy of Mazlow. There is little point in considering the niceties of traditional therapies for a child if the child is insecure about how the child's basic needs are to be met and maintained. Issues of abuse, neglect and uncontrollable behaviour may be compelling, but until a child has a sense of being properly cared for there will be little or no capacity to deal with them.

If "help" means something as general as, "make it all better," then seeking help becomes an exercise set up to fail. Child welfare work is always repair work, making the best of a less than ideal situation, and reducing the exposure to harm to the child. To do this properly the plan has to be specific and detailed. If therapy is sought there should be clearly defined objectives. To help clarify requests for therapy it is helpful to ask why? when? and what? Why do we think this treatment will be of benefit? Is this the right time to be seeking this therapy? And what is the goal of this therapy?

The two essential casework goals:

There are two equally important and essential casework goals in child welfare: one, establishing continuity of care; two, helping the child know his/her story. These are really two sides of the same coin. Continuity of care not only means stability of placement and caregivers, but also clarity of the direction of the long-term plan. The child's story involves both the past history as well as the present circumstances. If the child does not know his story he really has no way of appreciating continuity. Telling the story will involve helping the child understand the reasons for CPS decisions, why the present arrangements (including current access plans) are as they are, and what is planned for the future. If these two goals are to be adequately met it is essential that the child's principal caregivers (foster parents and therapists) are also aware of the essentials of the child's story. This is because children cannot have a sense of belonging if they are aware that those caring for them really do not know much about them. The attainment of these two important goals may well be therapeutic and on occasion even require the assistance of mental health professionals, but in themselves these goals fall outside traditional therapeutic models. If therapy is introduced before sufficient attention and effort is given to these two goals then it is likely to be a disrupting and confusing experience for the child.

The following are examples of seeking therapy without having given adequate attention to these two essential goals. The first overlooks the importance of continuity, the second overlooks the importance of the child's story.

> *Sarah, age 10, came into foster care at age 7 because of her mother's inability to end her cocaine addiction. She left the foster home when she was adopted at age 9. The adoption did not work out as the adoptive mother was unable to tolerate Sarah's lack of warmth and her continuing references to her birth mother. At this juncture the agency felt that she could not be adopted until she had therapy and she was placed in a foster home. Missing from this recommendation was the understanding that Sarah's lack of warmth and continued references to her birth mother was in large part a reflection of her non-acceptance by the adoptive mother and the sense that she didn't belong in that home. A reinforcing negative cycle was being established. The case work ought to have been directed at helping the adoptive mother understand the interaction and the reason for Sarah's behaviour. If this could not be worked out it wouldn't necessarily mean that Sarah wasn't suitable for adoption in another family.*

It is ironic that children with troublesome behaviour have their continuity disrupted by being moved when a significant reason for their behaviour is the lack of continuity that such management causes.

Information sharing with the child and with principal caregivers is an essential component of good casework practice. As the following case illustrates instituting therapy when this is ignored will lead to confusion and alienate children and youth further from their caregivers.

> *Albert, age 15, was referred to a mental health clinic for anger management. He had recently been placed in a foster home and the foster caregivers were*

concerned about his lack of respect and angry retorts to their suggestions. The therapist was having a difficult time because Albert refused to engage and sat in stoney silence. On reviewing the case it became evident that he had two younger siblings placed elsewhere. His father had a criminal record and while maintaining some contact was unable to adequately parent. His mother was dead. The decision was made to bring Albert and his siblings together with their caregivers and their father and review the involvement that the child welfare agency had with the family from the very beginning. Shortly after the child protection worker had begun the review Albert and his sibs began to interact together: "do you remember...", "that was the place where the drug lady lived...", "that was where they had the knife fight...", and so on. Albert told of an occasion when, out of the apartment window, they had seen the police coming for his father. Albert ran with his father to the elevator but his father told him to go back and look after his brothers.

The point here is that at the clinic Albert was placed in front of a therapist who had no knowledge of the material that came out in the above session. Albert was aware this person knew little or nothing about his life and experience. The anger he had been showing in the foster home, which in large part was understandable in the light of his experience and lack of nurture, was only intensified by such a thoughtless and inadequate intervention.

Good therapy is integrated into the reality of the situation. A therapist is not a wizard. The therapist needs the facts. This being said a competent therapist would not begin the therapeutic process in a child protection case without first addressing, with the child's worker, the child's story and the agency's plan. The therapist would also make sure that the child has been fully informed of both. The therapist might well have a role in helping to ensure that the material is properly processed.

Prior to seeking therapy:

From the moment a child is brought into care the casework plan must ask what is the long-term plan, and what has to take place in order to achieve this plan? As well, attention must be given to orienting the child to what is going on, both in terms of the concrete aspects of the child's daily living as well as in the ongoing planning and arrangements for the future. This involves a clear explanation to the child in developmentally appropriate terms as to why the child is in care, as well as a clear picture of what should take place in order for the child to return home. In helping the child it is important to let the child know who makes the decisions that affect the child's life and this includes being clear about which decisions can be made by foster parents and which have to be made by the Children's Aid Society (CAS). The consideration of therapy has to await these measures.

There is no doubt that skilled casework is required in handling these issues and in some cases benefit could be derived from consultation with a mental health professional as to how best to process these matters with a child. A mental health professional might help in assessing the situation and making suggestions in the casework planning. An important question in this regard

is whether or not more information is needed or is it that we simply have to organize and think through the information already at hand.
The point to be made is that the help of the mental health professional is primarily sought to assist the child and the child's principal caregivers to understand what is happening in the life of the child. This is a necessary step before considering therapy.

In many instances the child welfare staff should be able to handle such a process on their own. An important participant in these proceedings is the foster caregiver who is able to act as a support for the child. The caregiver can ask questions that the child could well be thinking. "How long will it be before Billy can visit his parents at home?" "Why did Sally's mother do that to her?" The caregiver is also able to help the child process the information in the days and weeks that follow explanations. In this way, when the opportunity presents itself, the caregiver is able to deal with how the child might be thinking. It is important that the caregiver have adequate support and access to consultation with the child welfare staff in addressing such issues with the child.

Often children in care have conditions that do not lend themselves to traditional therapy. Children with foetal alcohol effects or major attachment problems are examples of children who need special support and care. A therapist might be helpful in explaining the child's behaviour to the caregivers and supporting them, but a series of individual sessions with a therapist are not likely to be of much benefit.

Why therapy?

Ideally therapy is sought because that particular intervention is judged to be of benefit to a clearly defined problem.

The following are common situations in child welfare. Children in these situations may benefit from the understanding that a mental health professional can provide but this does not necessarily mean that a course of therapy is required.

- **Problem behaviour:** A child in care often exhibits difficult behaviour because of the current situation. If the child is drifting in limbo the child is likely to demonstrate the attendant emotional stress by exhibiting troubling behaviour. The premature addition of therapy, without adequately processing the limbo situation simply adds another layer of confusion and promotes the child's sense of impotence and abandonment. Beginning therapy without dealing with the limbo situation can deepen the sense in the child that he/she is bad and that is why children's aid is involved.
- **Experienced psychological trauma:** Often children who are brought into the care of CPS have been exposed to situations of abuse, catastrophe or bereavement and this seems, in itself, a compelling reason to seek therapy. Such therapy should not be initiated without first working to establish continuity of care and adequately addressing the child's readiness to undertake that therapy. All of the child's emotional strength may be directed toward dealing with the limbo situation so that there are no resources left to deal with the trauma. Therapy can be considered once some continuity has been established. It may also be the case that once continuity of caregiving occurs for the child, therapy is no longer indicated.

- **Unclear casework plan**: There are a host of variables which come into play when trying to work out the best plan for a child. Unstable parents, shifting circumstances, conflict between key relatives, absent resources, long waiting lists are examples of the many issues that make it difficult to plan. When circumstances are unclear the child often shows difficult behaviour and the principal casework goal can shift away from establishing a coherent plan to finding the child therapy to deal with the behaviour. While therapy might be helpful it should not take the place of the main casework effort which is to end limbo and establish continuity of care.
- **Save the placement:** There are situations in which there has to be some change or the placement is likely to be ended. In such situations any therapy that is sought must deal with the context of the child's placement. It does not help to seek therapy that is largely independent of the current caregivers. When a placement is at risk, therapy is likely to be futile that does not deal with the interaction between the child and the caregivers and help the caregivers understand the child.

Readiness for therapy:

Before therapy is undertaken it is helpful to be assured of the following:

- **Stable placement:** A child will not have the capacity to engage usefully in a therapeutic process if the child is caught up in dealing with a recent change in placement. If the placement is unstable then that becomes the central focus of the casework and the involvement of the mental health professional must be directed toward that issue.
- **Supportive caregiver in place**: A child needs to have a sense of security and support in day to day living. A therapist may be helpful, but is not a substitute for a nurturing caregiver.
- **Child has sufficient emotional and cognitive capacity**: Involved in this consideration is the method of therapy being sought. A cognitively compromised child or a child who exhibits thought disorder is unlikely to benefit from insight-oriented therapy.

When the decision is made to undertake therapy, child welfare staff should consider the following:

- Will the therapist work to help the child integrate the child's present circumstances and past experiences?
- Will the child's principal caregiver(s) be assisted in supporting the child to deal with issues arising from therapy?
- Can there be a working relationship between the therapist and the principal caregivers?
- What consideration has been given to involving member's of the child's family?

Medication:

Some children will benefit from medication. This is a separate consideration and a full discussion is beyond the goal of this paper. Some children have emotional difficulties to the point that they are unable to adequately perceive and understand what is happening around them and their behaviour cannot be managed with the support of medication. Before a child is medicated there has to be an assessment by a physician, often a psychiatrist. Such an assessment can take place early in the proceedings of managing a child in care. If the decision is made to

give medication the specifics of what is expected from the medication should be clearly understood by the child (bearing in mind cognitive limitations) and by those caring for the child. The target symptoms and intended outcomes should be identified. Regular assessments of the efficacy of the medication are essential.

Summary:

Therapy can be a useful help and support for children in the child welfare system, but it is important that it not be put in place without first assuring that the child or youth is fully informed of the current circumstances and the measures in place to provide continuity of care. It is never a substitute for a nurturing, stable, caregiving environment. There need to be clear target goals with regular review of the child's progress including need for therapy if and when it is initiated.

XI. "*WHERE'S MY PLACE?*": HELPING CHILDREN IN OUT-OF-HOME CARE WITH SEPARATION, IDENTITY, AND SELF-ESTEEM

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Introduction

The struggle to find our place in the world begins at birth; but some events push us to redefine ourselves in relation to those around us. Tommy, aged two, watched his parents put his three-month-old brother in their car and drive off to a wedding, giving Tommy a cheerful goodbye as they left him in the care of his grandmother. Tommy looked at the empty car-seat beside the baby and said, almost to himself, "Where's my place?" His grandmother explained that children weren't invited to the wedding, but the baby had to go because his mother was his only source of food.

Tommy seemed to accept the above explanation; but children who have to leave their parents to be moved into a completely strange environment have the same basic question: "Where's my place?" And the answer is not as simple. To respond therapeutically to children in out-of-home care, it is important to explore their reactions to separation from their birth family, and to give truthful answers to their questions, in a way that helps them to maintain their identity, and does the least possible damage to their self-esteem. With this in mind, caregivers and social workers can help children to grieve their loss, to work toward integrating the past and present, and to move toward a positive self-concept despite this crucial disruption in their lives.

Separation Theory

Separation related to out-of-home care can be broadly defined to include children's loss of family, their understanding of the reason(s) for placement, and their ongoing relationship with their family while they are in out-of-home care. The seminal work on children being separated from their families was done by Bowlby, an English psychiatrist, beginning in the 1950s (Bowlby, 1961; Bowlby, 1973). He and his colleagues studied children placed in institutions, as well as those in more normal situations such as children placed with a caregiver when their mothers entered hospital for a few days to have a new baby (Robertson & Bowlby, 1952).

Phases of Reaction to Separation in Children/Youths

When they are separated from parents, children's reactions will vary according to their psychosocial development, the family situation leading to the separation, and the way the separation is carried out. There are common patterns, however, as documented by Robertson and Bowlby (1952), cited in Lieberman (1987). In the days and weeks following separation from their mothers, very young children (approximately 12 to 36 months) have been found to progress through the phases of protest, despair, and detachment. With older children, who have more evolved defence mechanisms, the sequential phases are likely to be: numbness/denial, followed by attempts to regain the lost parent/bargaining; disorganization/despair; reorganization or detachment. These phases are similar to those normally experienced by adults who suffer a significant interpersonal loss.

Numbness/denial. At the stage of numbness/denial, the child's loss is too great to admit to consciousness. This was illustrated by Charlene, 5, who lost both parents in a car accident (Steinhauer, 1980). She was in the car with them but was not injured. The police removed her parents' bodies almost immediately, but Charlene continued to look for them in the back seat of the car, where they had been thrown by the impact of the collision. Almost immediately, Charlene repressed her feelings and did not want to talk about the accident or even admit that it had occurred. Her feelings gradually emerged over weeks of play therapy with Dr. Paul Steinhauer. Most children in foster care are not given an opportunity to work through their feelings in a therapeutic relationship; consequently, they are likely to repress their feelings, which will impede their ability to form close attachments as they move into adulthood.

Attempts to regain the lost parent. After the initial shock, children generally move into a stage of bargaining for their parent's return, which includes seeking contact/connection. A child who has been moved several times may have given up openly showing distress, but the need for connection persists. Children/youths may need permission to talk about their birth families.

> Caroline and Frank Rogers were treatment foster carers for four 11- and 12-year-old boys. They had all been moved several times, because of difficult behaviour, and the Rogers home was designated as "treatment foster care". As had been their habit, the boys called Caroline and Frank "Mom" and "Dad". None of them mentioned their own families, or revealed any feelings about being in out-of-home care. The Rogers began to doubt the wisdom of using parental titles, when one of the boys greeted four different foster care couples as "Mom" and "Dad" at an agency picnic. In discussion with their worker, they learned that the birth parents of children in care tended to feel rejected when they heard foster carers being called "Mom" and "Dad" by their children. As a result, the Rogers decided to invite the boys to call them by their first names. In the month following this, all four boys behaved in ways that suggested Caroline and Frank had opened the way for them to acknowledge their own families. Each of them did this in different ways: asking questions about their families; trying to contact them; or reaching out to other family members.

Disorganization/despair. Young children in this stage are likely to show their despair about the loss of family in a range of ways, such as withdrawal from new caregivers, frequent crying, other regressive behaviour such as bedwetting, or defiance. Older children may reach this stage earlier, because they realize sooner that they cannot control their return to their family. Thus, they may demonstrate hopelessness from the beginning of placement, by withdrawing or acting out their resentment.

Reorganization or detachment. Children's ability to negotiate the above stages, and the support they receive, determines whether they can reorganize their sense of self and learn to accept a new environment. One aspect of this support is children's sense that their two families can cooperate. As with children whose parents have separated or divorced, if the people who represent caring in the child's life are "at odds," the child is left with the burden of divided loyalties. When parents are able to set aside their differences and focus on the needs of their children, however, this has been found to reduce children's anxiety and confusion.

Children whose development was compromised prior to the placement, or those who do not get support in handling separation, may deal with their feelings by detaching themselves emotionally from the people around them. To the extent that they are detached, they tend to isolate themselves, or form superficial relationships. Sometimes they are viewed as manipulative, as they focus on meeting their own needs, rather than allowing themselves to become attached to either foster carers or social workers. Some children tend to fantasize about eventual reunion with their families, while denying or minimizing the problems in their pre-placement lives.

In extreme cases of detachment, the child has never experienced a secure attachment to a caregiver. These children have been defined as "unintegrated" by Balbernie (1974); they lack an adequate "primary experience" of reliable nurturing from a parent figure. Thus they have not been able to internalize the sense of well-being that enables other infants to cope with separation. Without this capacity, unintegrated children act out their anxiety, cannot identify with the feelings of others, do not show guilt, and fail to value themselves. Without intervention, these children may remain unable to experience or express their underlying emotions. This, in turn, compromises their ability to form attachments at all stages of their lives, unless they receive some helpful intervention.

Effects of Separation Reactions on Child's Behaviour in Foster Care

Children who have not been too compromised by their earlier experiences and their separation from families will begin to adapt to their new environment over time. One way of adapting is to regress by resorting to earlier behaviour. This also serves the purpose of testing the tolerance of their new caregivers, i.e. whether regressive, sometimes oppositional, behaviour will lead to them being moved again. This testing behaviour may be perceived by the new caregivers as a reflection of how the child feels about them; but it is much more likely to be related to child's normal separation reactions.

Ideally, caregivers can communicate with children's birth families to ask about the child's usual behaviour and how parents have handled this. If no relationship has been established between the two sets of caregivers, the communication may have to be done through a social worker. Direct communication is best, however, for the child in out-of-home care: knowing that their present caregivers are in positive communication with their parents is likely to add to their sense of security, and to reduce their sense of divided loyalties. Often children's problem behaviour is fear-related—they are afraid they may never go home again and believe themselves to have been the cause of the family breakdown. Ongoing contact with birth family members can help to minimize their fear. As for understanding the reasons for the family breakdown, children may be helped through access visits in which a caregiver facilitates communication between parents and children, as well as coaching parents to become more responsive to the child's needs (Osmond, Durham, & Palmer, 2002).

Suggested interventions to modify separation reactions

Ideally, caregivers and social workers will do everything possible to prevent further moves after children have been taken away from their birth parents. This includes: helping children with their separation reactions from the beginning of the placement process; encouraging/allowing parents to be allies in supporting their children in the placement (Osmond et al., 2002); and ongoing support by social workers to help caregivers deal with children's problems before they reach a crisis point.

Early research about children being separated from parents showed that their anxiety could be lowered if they had supports such as a familiar person; a familiar place; a familiar possession; and control over returning to their parents (Bowlby, 1973). Providing a familiar person and place can be done in foster placement by preplacement visits, so the child or youth has a chance to process the impending move before being taken to live in a strange home. Parents should be encouraged to accompany their children on preplacement visits. The importance of parental support to young children in strange situations was shown years ago in a laboratory study by Ainsworth, Blehar, Waters, and Wall (1978). They tested the behaviour of children ages 1, 2, 3, and 4, for their ability to tolerate different stages of unfamiliarity and aloneness. The children were placed in an unfamiliar room under varying conditions—with or without their mothers, and with or without an unfamiliar adult. Generally, the younger children showed distress at the disappearance of their mother, which was reduced somewhat by a comforting stranger. Under stress, they decreased their exploratory behaviour in the unfamiliar surroundings. Three-year-olds were more readily consoled by a stranger than were younger children; four-year-olds were the least distressed by the separations and tended to maintain their explorations under a range of conditions.

From the experiments by Ainsworth et al. (1978), we might expect that children would benefit from having a parent accompany them to an unfamiliar home when they are being placed in foster care. In today's legally-oriented Child Protective Services environment, however, inclusion of parents in their children's placement is not the norm (Palmer, 1995). Workers tend to discourage parents from accompanying their children to a new foster home, and even from communicating with new caregivers. Workers often explain this as wanting to control the interactions of difficult birth parents with foster carers, who are a scarce resource. From the viewpoint of the child's adaptation to the new home, however, this limit on parental involvement is counterproductive.

With respect to the familiarity of the environment, a new placement would ideally be close to the child/youth's own neighbourhood; this provides for continuity in the child's life, and prevents the extra disruption of changing schools. Some agencies arrange for transportation so that older children can finish the school year in their own school.

As for familiar possessions, workers can ensure that children can bring transitional objects with them. For very young children, this may be a blanket, or stuffed toy, and a picture of their family. For older children, pictures are also important, along with other significant belongings. Finally, control over returning to parents can be done through regular visits with birth family members.

Some pioneering work has been done with treatment foster carers, where they used parent-child visits as an opportunity to teach parents how to respond constructively to their children's questions and handle their difficult behaviour (Osmond et al., 2002). This approach could be useful in regular foster care, but does not seem to be used; rather, workers often try to protect foster carers from contact with parents, beginning with the placement of the child, where parents are usually left behind. We should revisit the theories of Bowlby (1973) about children being separated from their families, constructed and tested many years ago, and use them to guide our present practice.

Identity Theory

Identity is our fundamental frame of reference—how we define ourselves, especially in terms of our roles and relationships. It may be used interchangeably with the term "self-concept" and includes: a sense of being a distinct individual apart from one's family of origin; an understanding of society's

expectations and one's ability to meet them; a sense of belonging: to a person/family, a group (e.g. ethnic), or a community. Identity is closely involved with the capacity for attachment: we need a secure sense of self to risk becoming attached to another person (Erikson, 1963).

Conditions that Promote the Development of an Independent Identity

Several conditions in the lives of children/youths are necessary to give them the security to move toward an independent identity: a basic sense of belonging to a family or community; continuity of life experience; the opportunity to move toward independence gradually; and role models. All these conditions are threatened when children are placed in out-of-home care.

Sense of belonging. The child's sense of being part of a family or community is compromised by being moved away from their birth families. Over time they may develop a sense of belonging in their new home; but often they are uncertain about their status. For children/youths, the main source of belonging is being part of a family. Youths in care do not belong in the foster home in the same way as the foster carer's own children: for example, Vivian, 18, had lived from infancy with one foster family, and was adopted by them when she aged out of care; but she often told the foster carers of her longing to be like Kate, their birth daughter. The importance of being part of a birth family was described by David, another teenager.

> David had come into care at 13 when his maternal grandparents died. At 18, he was reunited with "long-lost" relatives on his paternal side, and wrote about this to his social worker: "I never felt that I belonged anywhere. After this [meeting his other grandparents and relatives] I feel as though I belong now, and that I am somebody, and that is the best feeling anyone could have in this situation." (Laird, 1979, p.186).

Continuity of life experience. Our sense of continuity depends on having knowledge of our personal history, without which it is difficult for us to imagine our future. As Erikson (1964) stated: The young person, in order to experience wholeness, must feel a progressive continuity between that which he has come to be during the long years of childhood and that which he promises to become in the anticipated future; between that which he perceives himself to be and that which he perceives others to see in him and to expect of him (p. 91). Most children in out-of-home care have gaps in their knowledge of the past. They lack the opportunity to talk with someone who has always known them, who can answer their questions as they arise about their family and their place in it.

Gradual move toward independence. Providing children, and especially youths, with the opportunity to move toward independence gradually is a challenge for caregivers and social workers. Ideally, youths can move toward independence from a secure base of attachment with their families, who continue to protect them while the youths take the risks associated with growth and development. Youths also need a home environment that makes minimal psychological demands; this allows them to conserve their emotional energy for the challenges of school and peer relationships, and to regress when they are feeling overwhelmed. Finally, children/youths will benefit from family structures that are flexible enough to allow them increasing independence, while providing some external limits to help them develop internal controls.

Role models. Beyond the above conditions for identity development, role models are also important. Successful graduates of child welfare reported that they were helped by having adults whom they could emulate (Silva-Wayne, 1995). Normally, children use their parents as adult role models. If their relationship with a parent has been overwhelmingly negative, children may react by trying to be different from their parents; but this is a complicated process if they have no positive model to follow. Children who have little contact with parents may imagine them in ways that can be quite different from reality. They may idealize parents and view themselves as having been "kidnapped" from parents who are wanting to have them return. Or they may focus on the negative aspects, building on what they have heard or experienced.

Difficulties for Youths in Care Attempting to Form an Independent Identity

Most youths living in out-of-home care are lacking the conditions that facilitate the development of an independent identity. They may be unable to trust or attach to parent figures; they may lack knowledge about their families; they may belong to an oppressed racial or ethnic group; they have been separated from their families abruptly; and they may feel guilt about being in care.

Inability to trust or attach to parent figures. Some children entering out-of-home care have not had the important early experience of being able to trust a parent to care for them, so their ability to form intimate relationships is likely to be compromised. Others who may have been attached to a parent or other family member have experienced a disruption in this relationship and have not been helped to resolve their separation reactions, as described earlier. These conditions are likely to cause children to withdraw from relationships, or to act out their negative feelings—confusion, sadness, frustration, and anger—in their new homes. These children lack a secure base from which to test out their independence. As mentioned earlier, the work of Balbernie (1974) showed that children whose development has been compromised in this way are likely to remain unintegrated in terms of formulating their experiences into a secure identity.

Lack of knowledge about family. Often the people around them, such as social workers and foster carers, have a negative view of children's parents, and communicate this to children, openly or in more subtle ways. This is bound to have a negative effect on the child's development of identity. The difficulty is aggravated by the child's lack of opportunity for a continuing experience through which they can evaluate their family's lifestyle and values. To fill this void, they may try to recreate their parents' lives: "...in prolonged placements, the child may be even more prone to duplicate destructive family patterns in his or her own adult interpersonal and family relationships" (Laird, 1979, p.191). The less information an adolescent has about his family, the more likely he is to try to recreate them, and to "act out destructively in a way which reflects the few facts he may have about his hidden or lost parents, or even worse, on the basis of his fantasies about the lost object" (Laird, 1979, p. 185).

> Barbara, a First Nations girl, was adopted at about seven years of age by a Caucasian family. She was apparently a model "daughter" until age 15. Then she began to drink and become involved in casual sex, in keeping with what she had been told of her older sister's behaviour. Her adoptive parents could not cope with Barbara's behavior; at 17 she was admitted to psychiatric hospital, and the adoptive parents were unwilling to have her return to them.

During Barbara's four month stay in psychiatric hospital, a social worker spent time discussing her memories of the frightening events in her family that led to her admission to care at age three. In Barbara's memory, no one had ever attempted to discuss her past, which included witnessing her sister murdering an abusive boyfriend. After discharge from hospital, Barbara moved into a community group home and returned to school; when seen a year later, she appeared to have stopped acting out her past family experiences, and was doing well. It was important for Barbara to set herself free from repeating what she knew of her family's past. To do this, she needed help to develop her narrative history, to decide which parts of her family identity she could retain, and how she might develop her own unique self.

Belonging to an oppressed racial or ethnic group. As with Barbara, children and youths in care often come from groups that experience prejudice and oppression, such as First Nations people and Caribbean Canadians (Palmer & Cooke, 1996a). Some of these children/youths may try to ignore or reject the racial aspect of their identity, denying that they are different from peers who do not share their minority status. This is especially likely for those who have little ongoing contact with their own racial or cultural group.

Arlinda, 11, was taken from a First Nations community and placed in a small town an hour away where there were no other visibly First Nations people. She was attractive, athletic, and made friends in the community; but she experienced racism in the foster home. Recalling that she was teased and mistreated by the foster carers' sons, who called her "a dirty Indian," Arlinda reported that she didn't even know what an 'Indian' was. On leaving foster case, she made contact with her mother, who had lost all her children to a child welfare agency. When the author met Arlinda at age 24, she had left the small community for a large city, and was recovering from addiction to alcohol. She was trying to move ahead with her life, and had formed some supportive connections with other aboriginal people.

Abrupt separation. Children who are separated from their own families do not have the luxury of moving gradually toward an independent identity. As described under **Separation Theory**, they are often moved to an unfamiliar place, without preplacement visits, and without arrangements for ongoing contact with their families.

Guilt about placement. Many children/youths who come into care blame themselves for the breakup in their families (Palmer, 1990). This is partly related to the natural egocentricity of children—believing that they are at the center of everything that happens to them, and partly a denial that there are conditions over which they have little or no control. Consequently, added to the pain of separation is the belief that they have caused it. This may be reinforced by parents having complained about the child or youth's behaviour, or requested the placement.

Another contributor to guilt may be that children have been "parentified", i.e. taken on adult responsibilities in their birth families, because of family conditions related to poverty, parental substance abuse, or parental absence. Parentified children/youths often become emotionally enmeshed with the parent who depends on them, and this connection is likely to persist when they are separated (Palmer, 1990). Attempts to encourage them to focus on their own lives may be ineffective with children who may feel guilty about having deserted a parent who needs them (Ibid.).

Suggested interventions to promote a positive identity

Belonging. Children's sense of belonging to a family can be strengthened through knowledge of their own history. Ryan and Walker (2007) have done considerable work with children to help them reclaim their family histories. In their work, they came to a number of conclusions:

- "When children are moved away from their families, their past may be lost, much of it even forgotten" (p. 3).
- When children lose track of their past, they may find it difficult to develop emotionally and socially.
- If adults cannot or do not discuss their past with them, it is reasonable for children to suppose that it may be bad.
- Children separated from their families need to sort out why the separation occurred and (over time) why various adults have been unable to care for them.
- Life Story work gives children a structured and understandable way of talking about themselves; it can produce clarity where there are dangerous or idealized fantasies.

Too often, the Life Story books created by child protection agencies have little content about birth families, but focus on the child's life after placement. Ideally, a resource person can be identified to help get information about the child's birth family; it is often necessary to seek out extended family members to get information, pictures, and small mementoes for the book. The benefits of helping youths to connect with their past was shown by a year-long Life Books project in a Hamilton group home for adolescent girls who presented serious behavioural challenges. Over the year, the girls spent an hour per week in a guided group devoted to working on their scrapbooks, and each had a resource person to help her locate material about her family. The girls' behaviour showed a significant improvement during the year of working on the books, when compared with the year prior to the beginning of the project (Sykes & Palmer, 2003).

Continuity. As mentioned earlier, continuity for children is enhanced when they are placed near their own homes and schools. A familiar neighbourhood also helps them to maintain their identity, and makes it easier to have ongoing contact with their families. The disruption is much more abrupt for children who do not have easy access to their previous homes.

Role models. Ideally children/youths can find some positive characteristics in their parents with which they can identify. Even children with negative relationships can be helped to understand their parents' behaviour through knowledge about the hardships faced by their parents, including neglect and abuse in the parents' early lives. This knowledge may help children/youths to understand the gaps in the care they received from their birth families, and the reasons they have to be in out-of-home care.

Another source of role models can be a particular racial or cultural group to which the child or youth belongs. Often children in care have little contact with their own racial or cultural group; if this is an oppressed group, they may have negative stereotypes about it that inhibit them from identifying with others like themselves. It is important for youths, in particular, to be given opportunities to become familiar with others of similar race or ethnic origins, in a way that will promote understanding and pride in their heritage.

Reducing guilt about placement. Techniques such as life history grids and scrapbooks can help children/youths to understand that they had little control over events that led to their placement. A life history grid is a simple diagram, in which the years of a child's life are written in a vertical column (e.g. age 1, 2, 3) at the left of the grid, and the important aspects of the child's life are listed as headings across the top of the grid. The latter may include: location of home, people living in the home, health of family members, events related to school, and friends. The following example of a grid covers only three separated years—in actuality, all years up to the present would be covered.

EXAMPLE OF LIFE HISTORY GRID

Age of Child	Where I lived	Who lived there with me	Health & family problems	School
1	Dundas	Mother & father	Father alcoholic	None
6	Toronto	Mother, two brothers & boyfriend Tom	Mother depressed	Ryerson P.S.
11	Hamilton	Mother, three brothers & boyfriend John	John abused me	North Hamilton P.S .

Often the grid reveals that there have been many changes and moves, as well as health and family problems, that have contributed to the child/youth being moved away from the family. A record such as this can help children to realize that they have not been responsible for the breakup of their families.

Self-esteem Theory

Self-esteem can be defined as how good we feel about ourselves—one aspect of identity.

Sources of self-esteem

We derive our self-esteem from reflected appraisals, social comparisons, our sense of competence, and sense of belonging (Rosenberg, 1979). The last point has already been covered under "Identity."

Reflected appraisals. These may be defined as: how significant others view us; how we believe others view us; and the attitude of the community as a whole (Rosenberg, 1979). For children/youths, significant others are usually parents, and children/youths who are living away from home have two sets of parents about whom to be concerned. The situation leading to placement may include rejection by birth parents, especially with children/youths who have been difficult to manage in their own homes. The second dimension, how children believe others view them, is also complicated by placement: children/youths who have been abused or neglected by parents may believe they are not valued, and may have little opportunity to correct this view through an ongoing relationship with their parent(s). Clinically managed visits, described below, can be used to address this problem.

The attitude of the community as a whole is another area that may contribute to low self-esteem. Adults may have sympathy with children in care, but not with their parents. If the child's family is criticized or

not respected by caregivers and the wider community, children/youths are likely to feel diminished; they may try to dissociate from their families, to avoid being similarly classified. Or they may defend their attachment to families by acting out, as with Barbara, the First Nations girl discussed earlier.

Social comparisons. Children/youths tend to compare themselves with others in their immediate home and school environment. Compared to the foster carers' own children, they are less secure in the family, and (initially at least) have no sense of belonging to the community. At school, they may have difficulty keeping up, partly because of earlier disruptions. Moreover, they know they are different from other children who are living in their own homes, and they may be stigmatized because of their foster care status. Pat, 20, a Carribean Canadian, recalled students at her high school calling her a "foster home hippie."

Competence. A sense of competence is important to self-esteem: for developing children/youths, this comes mainly from success in negotiating the world around them. Children/youths in out-of-home care may feel they have failed in their own families, especially if their parents requested their placement or acquiesced to it. Competence is also adversely affected by the tendency of placed children/youths to regress in their developmental tasks. Their emotional energy is being diverted to the task of adapting to a totally new environment, and their functioning is likely to suffer accordingly. For children who have grown up in care, questions of identity are likely to emerge when they reach adolescence, and again absorb emotional energy that is then not available for other developmental tasks.

Children who have been assuming adult responsibilities in their families have probably thereby gained a sense of competence, which they risk losing when they are placed in care; consequently they resist their change of status. This has implications for the training of foster carers and group home staff.

Other youths coming into foster care may have achieved a sense of competence as part of a peer subculture, and will probably lose this when they enter care. They may try to reunite with their group, join another antisocial peer group, or create their own new antisocial subculture, especially if they live in a group environment.

As mentioned earlier, children/youths from oppressed racial/cultural groups may be at risk when they enter care, because they lose touch with others of their own race who provided some protection from being oppressed. For example, people of colour may be singled out in a school where there are few others like them, while they may have been protected by numbers in their original home environment.

Suggested interventions to promote self-esteem

Social workers and foster carers can help to promote children's self-esteem by addressing the questions children have at the time of placement honestly, but framing the information in a positive light. Ideally, the original placement should include: open discussion of the reasons with parental involvement; at least one preplacement visit to new home, accompanied by a family member or other familiar person; and clear plans for the continuation of family attachments. These steps should help to minimize children's tendency to self-blame, as well as lowering their anxiety about the separation. It will also maximize the chances of an ongoing relationship between the two families, with the related benefits to the child/youth (Osmond et al., 2002).

Most placements are not carried out in the ideal way discussed above, so the gaps should be addressed as soon as possible, although later intervention is better than none at all. As early as possible in the process, social workers and foster carers should talk to children/youths about their experiences of separation and dislocation, and help them to process their feelings and memories. Again, sharing the family's history can help children to understand that a range of conditions and events, mainly out of their control, have contributed to their placement. If child's or youth's difficult behaviour contributed to placement, adults can help to reframe this as a reaction to changes in the family or other stressful conditions. Birth parents should be included in these discussions whenever possible: children are much more likely to be reassured about the past by their parents than by someone who was not part of their lives prior to placement.

Life history grids and scrapbooks can be very helpful in this process. As Ryan and Walker (2007) point out, Life Story work can increase self-esteem for children/youth living in out-of-home care. Many of them are vulnerable to feeling worthless and unlovable if they think they have been abandoned, neglected, or injured by family members, and this is never discussed. The life history grid usually shows children that their family breakdown was caused mainly by conditions outside anyone's control.

In terms of the "competence" aspect of self-esteem, social workers and caregivers should bear in mind the energy required by children/youths care to negotiate a strange setting, often with a background of negative family relationships. They can help children/youths to be more self-accepting by acknowledging the hurdle of adapting to a complete change in environment, and the limitations on their energy for addressing other tasks such as school.

Children/youths who feel guilty about having a poor relationship with parents can be helped through clinically managed visiting (Osmond et al. 2002). This gives the social worker an opportunity to encourage the positive aspects of the relationship, to work on interpersonal conflicts that have contributed to the breakup, and to help children and families come to terms with their past and plan their future. It is good for the child's self-esteem to know that their birth families are involved in planning for their ongoing care. Social workers and foster carers can promote this by: enlisting birth parents in helping foster carers to understand the child; discussing mutual goals for the care of the child; and encouraging birth parents to take some responsibility for their child. Sometimes there is a good reason for not including birth parents, or other extended family, in the child's life: if so, this should be explained to the child, ideally with the parent present to minimize the child's sense of rejection.

Ongoing help with "finding a place" in the community

As mentioned earlier, children who are part of an oppressed racial/cultural group should be helped to have a positive view of the group to whom they belong. Ideally, they will be placed with caregivers from the same race/culture. When caregivers are not from the same group, they should try to facilitate some contact for children with other people who may give them a sense of belonging, and act as role models for them.

Sadly, children/youths may themselves experience oppression in out-of-home care because they are "different". It is important for them to be prepared for this: social workers and caregivers should talk to them about racism in society, about safeguards against this (in the education and justice system) and suggest some ways they can counter racist approaches that others may make to them (Palmer & Cooke,

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XII. PARENTING BY COMMITTEE

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When applying to become foster parents, our understanding of our role was that we would make all parenting decisions for a child placed temporarily in our care, just as we did for our biological children. The social worker, we thought, would work mainly with the child's parents, check in on us now and again, and let us know when the child would be returning home or joining an adoptive family. Although training for new foster parents informed us that the work of foster parents and workers was not as parallel as we had first imagined, it did not fully prepare us for the role confusion that we would sometimes experience.

I became a foster parent seventeen years ago when my youngest child entered junior kindergarten. I wanted to remain at home full-time until my children were just a little bit older, at which time I planned to return to work. A former neighbour who fostered babies triggered the idea. I had always loved babies and the thought of helping to care for ones in need of a home excited me. My husband was very supportive of the idea, but extended family members were immediately concerned. Did I know what I was getting into? Had I thought this through? My Dad, never one to interfere, expressed concern that I was setting myself up for a lot of heartache, but I was not worried. I had a plan.

My goal was to foster only newborns. This way, I could avoid seeing distraught children separated from their families or have to listen to them recount stories of abuse or neglect. They would come to me unscathed and before they were ready to walk or talk, would return to their families or join a permanent adoptive family. Fostering newborns seemed to be an ideal way to do very meaningful work without getting too involved with the politics of the child welfare system. Everything went according to plan. The first newborn placed in our care joined a wonderful, loving adoptive family before her first birthday. Her future seemed bright. Seventeen years later, this beautiful, vibrant young woman continues to thrive with her family.

Our second placement, however, did not go as I had imagined. Circumstances in this child's family were very complex and the placement lasted much longer than anyone could have anticipated. There were criminal charges against a parent, lawyers hired and fired, court dates often adjourned, plans presented from different family members and the complication of siblings in different foster homes who needed to stay connected. I often felt like I was on an emotional roller coaster, one day preparing myself for the impending separation from this child and the next day planning to include him on our next summer vacation. Finally, just shy of his sixth birthday, he was placed in an adoptive home. The separation was excruciating and I remember thinking that my Dad was right.

During this placement and in the years that have followed, I have encountered many unavoidable confusing, competing and contradictory constraints to parenting within the child welfare system. These constraints sometimes appear just as confusing to the child or youth in care as to the foster parents, causing the child to question where their place is and whether they are really a part of the family.

Not Having Complete Control Over Child Rearing Decisions

One constraint of parenting within an administrative/bureaucratic system is that I do not have complete control over child-rearing decisions and feel that I must sometimes justify my decisions to workers who are not involved in the daily job of parenting. This can be a frustrating experience. For example, I once had a youth in my care who needed to be held accountable for stealing from a member of our family. Just before Christmas, the worker suggested that I reduce the amount of money spent on this particular child's gifts and use the difference to pay down the child's debt. While I shared the worker's desire to ensure that this child was held accountable for his actions, I was worried that his receiving considerably less than others would upset him, leaving the rest of the children in the house feeling uncomfortable or awkward. Quite simply, this was not an atmosphere I wanted to create on Christmas morning. Ideally, a worker who does not agree with parenting decisions made by a foster parent would do well to remember that foster parents have to consider how decisions not only affect the child in question, but other members of the family as well. To this worker's credit, she supported me in making the final decision around gift gifting, even though we did not agree on what that was.

Whether parenting biological children or children in care, weighing the child's right to make his own choices against the parent's responsibility to set reasonable boundaries is a constant balancing act. When parenting children in care, however, I am sometimes required to explain and defend those boundaries. For example, a youth in our care decided that he wanted to attend a high school which was an hour's commute from our home. He was not on track behaviourally or academically, and we were concerned that he would not persevere with the daily commute by public transit, which would have meant that he changed schools mid year. The worker stated that she believed that the child had a right to make his own choices and learn the natural consequences of those choices. While I agreed with the worker in principle, we also wanted to minimize the already high stress level of parenting this child on a daily basis, particularly because we had one other child in our care. I was concerned about having to put another child on hold – whether in helping her with homework or driving her to extracurricular activities. Luckily for us, the child ultimately decided that he wanted to attend our local high school. Nevertheless, having to justify the boundaries I set to those who do not do the daily parenting adds an extra layer of frustration to parenting children placed in out-of-home care.

My favourite positive example of how a worker empowered me to have control over child-rearing decisions concerned a very young teen in my care who wanted to dye her hair. While I was keenly aware that the time was near when she would do what she wanted without feeling that she needed to ask for my approval first, I was trying to delay the inevitable because I thought she looked beautiful the way she was. When her worker visited, this child asked her for permission to dye her hair. The worker simply said, "That's between you and your foster mom. I'm not here to discuss the colour of your hair. I'm here to make sure that you're safe, you're happy, you're in school, you're healthy - things like that. The rest is between you and your foster mom." It wasn't long before this youth dyed her hair and also pierced a few things and, of course, there was nothing I could do about it. Nevertheless, I think that this is a wonderful example of how a worker can help to minimize the level of frustration that foster parents sometimes feel because we are parenting within a system that, for many reasons, cannot give us complete control over child-rearing decisions.

Without question, however, the biggest frustration I have experienced due to a lack of complete control over child-rearing decisions has been around placement decisions. For example, recently it was decided that a youth in my care, who had been removed from my home for an assessment, amongst other things, needed the around-the-clock supervision that a group home could offer. The confusion for me is that while he may be more closely monitored in a group home setting, this setting does not appear to be meeting his emotional needs or giving him a sense of his place in this world, as evidenced by his recent question to me, "Whose kid am I anyways?" Later, answering his own question, he stated, "I am a group home kid." His words were an indication to me that he saw himself not as a child who was living in a group home setting, but rather that his living situation was something that he had "become."

This is an example of a "conundrum" in foster child care. Unfortunately, I am unable to suggest what the optimum conditions would have been to return this child to our care. His case is very complex. We were a cross-cultural/racial foster placement and this child tried to hide from others in the community. He is an adolescent with a history of trauma and rejection, who refused to participate in any type of therapy or mentorship relationship or take needed medication. I struggle to make sense of whether returning him to our care, despite what surely would have been continuing challenges, would have been any worse an alternative to the group home solution, particularly because he is a child with whom we have had a lifelong connection.

Underlying Tensions/Animosity Between Workers and Foster Parents

Another constraint of parenting within an administrative/bureaucratic system is that there sometimes appears to be an underlying tension/animosity between foster parents and workers. From a foster parent perspective, the source of such friction can include things like poor communication, a perceived lack of support, as well as differences of opinion about what is in the best interests of the child. From the worker's perspective, I am not clear what the root of this tension is, but whatever the cause, the tension exists.

One tension rarely discussed openly is a worker's perception of a foster parent's motivation to foster. It is my sense that this tension could be related to the number of children that a foster parent cares for and, subsequently, the amount of per diem that a foster parent receives. Perhaps workers are concerned about the amount of time and attention that the children in their charge do or do not receive, or perhaps it is related to traditional notions of motherhood and the belief that parenting is something that one does for love and not for money. For example, a worker once told me that a child for whom I cared for years earlier was currently being placed in a "good" foster home, and not one that "just does it for the money." This was an indication to me that she believed that money was the motivation for many foster parents. I have to admit that I, too, have sometimes wondered why some foster parents choose to provide care for three or four children - many of them special needs - in addition to caring for their own families. I also have to emphasize that some of the foster parents that I most admire are those who have been managing large families for many years and appear to be doing an excellent job of it. Many have also adopted children they once fostered.

It must be remembered that although foster parents may be very committed, they may not be in a financial position to adopt or parent a child without the accompanying per diem. This limitation does not mean that the foster parent is not committed to the child. Also, because of the work involved with fostering, some (most?) foster parents might see this like any other career path. Practically speaking, most people can not do the job they want to do unless there is an income attached. Historically, fostering might have been based more on volunteerism, but I am uncertain that in today's economic climate, mothers can be expected to stay out of the paid work force in order to foster without some financial compensation.

Like all unresolved tensions that initially appear to be just between adults, it is our children who often feel the brunt of our discord. For example, the youth previously in my care and now living in a group home setting recently told me that he informed a staff member at his group home that he was certain that he could come to live with me if he left care. He said the staff member reminded him that we were foster parents and asked him if he had any idea how much money we made. For me, these words were stinging, particularly because I pick this child up every other week to bring him to our home for a weekend visit on a volunteer basis. As well, if I thought that taking legal custody of this child would solve his problems, I would not hesitate to do this. The bigger concern, however, is the impact that these words had on this youth. I fear that a lack of sensitivity around discussing this issue with children in care might leave them feeling confused about a foster parent's commitment to them and unable to understand that foster parents need the per diem in order to care for children. I see this as another "conundrum" of the child welfare system and a compelling reason for opening up the dialogue on this seldom discussed tension between workers and foster parents.

Foster Parent as a Member of the Team (Inclusion/Exclusion)

When parenting within an administrative/bureaucratic system, the goal is for a foster parent to always feel included as a member of the child's team. For me, a sense of inclusion is characterized by things like an open and respectful exchange of information and opinions between a worker and a foster parent, regardless of whether or not there is complete agreement on any given issue. This kind of discussion always leaves me feeling empowered to use my judgment to parent the children in my care on a daily basis and to build relationships with their families. I have, thankfully, experienced a sense of inclusion throughout the vast majority of my fostering experiences.

Unfortunately, I also know what it feels like to *not* feel fully included as a full member of a child's team. For example, although a decision pertaining to a change of placement for a child in our care was technically made at a particular meeting on a particular day, my sense was that this meeting was just a formality. It seemed clear to me that members of the child's team had reached a decision well before the meeting, and that I was not to be a part of that consultation. As such, a sense of exclusion can occur gradually and it can be insidious.

A sense of exclusion can also be rooted in things like role confusion or in structural issues. For example, once it was determined that the youth who left our home for an outside assessment would not be returning to live with us, the worker was unable to include us in the full sharing of information, citing issues of confidentiality amongst other things. This was difficult for us

because we still *felt* very much like the child's parents. Continuing to voluntarily take the child for regular weekend visits meant that he sometimes shared information with us that his worker could not. This proved to be problematic because his confused perspective on issues often left us feeling concerned about whether or not his voice was being heard, especially with respect to his right to visit with biological family members.

I can contrast this experience with another youth who left our care prematurely against our wishes, leaving school halfway through her final year. This youth's worker maintained regular phone contact with us over the course of a year, followed up on my concerns, and openly shared information with me about the girl's current living situation. While our change of role with each youth was difficult, I attribute the second worker's liberal style of communication sharing as that which facilitated this youth's eventual return to our home a year later to plan to pursue a post-secondary education. This is a good example of "best practice" when workers keep up an open communication with foster parents who are trying to build and maintain life-long connections with children and youth after they have left their care.

I see this as another conundrum of fostering. We are asked to attach to children and become members of their team, but we are also expected to step back, disengage as a team member and change roles when that job is done. Sometimes, the ability to change roles can be exacerbated by confusion around when, why or how our roles have changed. Also, confusion can be magnified by a foster parent's frustration over the fact that they do not yet feel ready to "give up." Thus, it is critical that foster parents are included in all discussions pertaining to role changes in a timely and transparent manner and, to the extent that it is appropriate, they are made to feel validated for the contributions that they have made as a member of the child's team.

Barriers to Good Communication

In my experience, good communication between all members of the child's team makes for a positive fostering experience. Some of the obstacles to good communication that I have experienced include things like constraints on everyone's time, the use of jargon, a lack of open and timely information sharing, workers who compare how I parent my biological children with how I parent children in care, as well as a lack of worker contact with foster parents who have committed to maintain life-long connections with their former foster children.

The constraints on everyone's time is evidenced by early morning and late evening e-mails between foster parents and workers, as well as workers who return phone calls while driving or while waiting to be called into court. However, the time pressure that workers are under really became evident to me when one complained that she did not think that she should be expected to call me every other day. While this was not my expectation, I understood that my phone calls had left her feeling under pressure to respond to all the demands that I and others placed on her. While these time constraints can usually be worked around, others are more problematic.

For example, I once asked a worker if she could arrange an appointment for me to speak with the mental health professional who had recently assessed a child returning to my care. I had been feeling concerned that I had not been invited to attend the child's yearly psychological assessment, even though the child had spent part of the year living with me. I had hoped that

speaking with the doctor directly would give me an opportunity to not only ask questions about the best way to manage this child, but to also get a sense about what he thought the long-term outcomes for this child might be. The worker told me to tell her what I wanted to know and said that she would ask the questions for me. While she may have been worried about the scarcity of appointments and the lack of time and resources, this defeated the purpose of what I wanted to achieve.

Another thing that I view as a barrier to good communication is the use of jargon. While most of us are accustomed to using it from time to time, it can be problematic if workers use it as a means of addressing specific concerns with a foster parent. Expressions like, "*None of us is doing this for a medal*" and "*This child doesn't need a rescuer*" are examples of jargon used by a worker that left me feeling confused about what exactly her concern was. From the worker's perspective, the use of clichés may have felt like a less confrontational way of expressing concerns. However, this kind of vague communication did not leave me with an opportunity to understand or respond to her perceptions of me.

Another thing that I have heard many foster parents cite as a barrier to good communication is a lack of open and timely information sharing about things like court proceedings, for example. In cases where a court date has been adjourned, a worker may feel that there is no reason to phone a foster parent. However, foster parents still have to explain court delays to children who are anxiously awaiting news of a proceeding, thus, open and timely information sharing is critical.

Another barrier to good communication that I have experienced is a worker who compares how I parent my biological children with how I parent children in care. This type of comparison sets a worker and foster parent up for conflict because the two parenting experiences are incomparable in many ways. For example, I once had a worker ask me whether I would have allowed my biological children to visit "questionable" family members in the community, as the child in my care had done. This made me feel that the worker believed that I felt less concerned about children in care than I did about my biological children when in truth, the children in my care have always given me much greater cause for concern than either of my biological children ever did, which is understandable given the great degree of adversity that many of them have faced.

The fact of the matter is, however, that there are many differences between what I feel empowered to do as a biological parent and what I feel constrained in doing while parenting within an administrative/bureaucratic system. For example, my biological children were not able to call a lawyer or threaten me with changing homes when they were very upset about something. I also did not have to worry about them visiting "questionable" family members in the community because they generally respected my parenting authority, so "no" meant "no". This was simply not the case for this particular child, who exhibited controlling and manipulative patterns of behaviour. In parenting this adolescent, I preferred to talk to him about a plan for keeping himself safe, including when, how and who he would call if he felt unsafe. My goal was for the child to remain open and honest with me about what he was doing, where he was going and who he was seeing, even if he was visiting "questionable" family members that a worker has cautioned him not to see. I saw this as making the best of an imperfect situation. The issue of agency liability versus trying to avoid driving an adolescent's defiant behaviour underground is yet another example of the conundrum of parenting within the child welfare system.

Also a barrier to good communication is a lack of worker contact with foster parents who have committed to maintain meaningful long-term connections with their former foster children. In my experience, this is problematic for several reasons. First, not knowing where the child is or how the child is faring leaves me feeling anxious. Second, for youth who have been moved several times and may also be feeling anxious, I very much want to reassure them that no matter how far away they have moved, we are still here for them.

Another important reason for maintaining contact with foster parents who have committed to maintain life-long connections with their former foster children is that sometimes, children share information with us that they may not share with group home staff. For example, a child recently shared with us that a relative had been diagnosed with tuberculosis. We had knowledge that when this child was living in a previous group home, he had contact with this family member, so we were able to relay this information to a staff member from his current group home. We then made a point of calling the person in charge of the group home, who indicated that this was the first he was hearing of it. In this example, regular worker contact with foster parents would benefit both the worker and the child, but foster parents may be reluctant to initiate worker contact if it does not feel encouraged or welcomed.

How Agency Encourages/Discourages Relationship Between Foster Parent and Child's Biological Family

For me, one of the most rewarding parts of fostering has been working with the families of the children in my care. Over the years, the agency for which we foster has done an excellent job of encouraging and respecting these relationships, and foster parent training has often included discussions about the many ways in which foster parents can build on these relationships for the benefit of the children in their care. In my experience, children settle faster and are more trusting when they know that their family can phone or visit with them in our home and when they see that I have a positive relationship with their parent(s).

For example, I once cared for a young girl who was unexpectedly taken into care from her kindergarten classroom. Her mother was in the end stages of AIDS and there were no other extended family members who were able to continue to care for the child. The experience was very traumatic for her, and I suspect that the child sensed that her mother was much more ill than she admitted to being. Prior to coming into care, the child had been visiting regularly with her mother who was in the hospital. It was early in the placement and the worker had not yet had an opportunity to arrange access visits. At my home, this child was anxious and screamed all night long. After one particularly difficult night, we asked our resource worker to approve an impromptu visit so we could take the child to the hospital to see her mother. The change in her when she returned from this visit was dramatic. She slept soundly each night and kept telling me how smart my husband was because he knew how to find her mother.

Parenting within an administrative/bureaucratic system, however, means that foster parents are also expected to end relationships with children's birth families. Such was the case with an adolescent who was in our care when he was little, but no longer had legal access to his mother. Despite direction from his worker not to do so, he made contact with her, stating that this was his

family and he had a right to know her. The worker, aware of my past positive working relationship with this mother, directed me now not to have any communication with this mother. For me, the issue was a little more complex than that. I understood that the agency's position was grounded in problems of liability, but I was also worried about the impact that this message was having on this adolescent's emotional well-being and sense of identity, which was already weak. In addition, it was difficult for me to process with him how he was feeling about these events because I was concerned that I would be viewed as condoning the visits.

I am not sure how my about-face looked to this adolescent. For years, I had been telling him that his mother was a nice lady who loved him very much, but was unable to parent him. Now I was expected to deliver a very different message. Complicating this was the fact that I was not privy to the full sharing of information about his family. This is another example of the conundrum of parenting within an administrative/bureaucratic system. A relationship that an agency at one time views as an asset and encourages a foster parent to develop can be seen as a liability years later because of changing circumstances.

Fostering a Positive Sense of Identity in a Cross-cultural/racial Foster Care Placement

One of the biggest challenges I have faced as a foster parent is how to help a child who is living in a cross-cultural/racial placement develop a positive sense of identity. My experience has been that especially around adolescence, such a placement can cause a child to feel awkward in the community, sometimes compelling him/her to invent stories about how we are actually biologically related. This, of course, can be the experience of any child in care who simply wants to blend in and not feel different, but blending in is not as easy for a child who has been placed cross-racially, for example.

Certainly, agencies always try to place children in homes that are culturally and racially similar and, when this is not possible, to place them with families that respect diversity and are culturally sensitive. My understanding is that there have been continued efforts to recruit resource parents that are culturally/racially diverse, make greater use of kinship care placements, and to educate foster parents about important issues pertaining to cross-cultural care-giving. I am, however, uncertain whether all of these strategies can completely alleviate the sense of difference children may feel when placed cross-culturally/racially, especially during adolescence.

For example, I recently heard from a young adolescent who was in my care when she was a small child. She told me how strange it felt to be living in a group home outside of Toronto where she is one of the few black students in her high school. She stated that her worker told her that there were no other available placements in Toronto that met her needs. As such, a lack of diversity in communities where children are being placed may be another challenge to meeting the cultural needs of some children and youth in care.

Once again, this is another example of the conundrum of raising children in an administrative/bureaucratic system. Although everyone tries to do the best they can, it is difficult, if not impossible, to replicate a child's culture outside of the family of origin. As such a continued focus on the prevention of children being placed in care in the first place seems critical.

Advocacy

As a foster parent, I have always felt encouraged to advocate for the children in my care so that their voices are heard. There are many mechanisms through which advocacy can be done, including regular Plans of Care, High Risk Conferences, Placement Planning Meetings and completion of the *Looking After Children* assessment. All of these mechanisms facilitate my ability to discuss a child's concerns, offer my opinion about what I believe a child in my care needs and affords an opportunity to ask questions about matters that do not make sense to me, including issues related to school, permanency planning options or a child's visits with biological family members.

However, advocating for youth no longer in my care and living in a group home placement is much more challenging. This is problematic because advocacy is equally important for children in group homes and should not stop once they are out of foster care. It is important that they feel that there are adults in the community who continue to be concerned about their welfare but, unfortunately, what a foster parent views as advocacy can sometimes be interpreted by a worker as interfering in matters that are not the foster parent's concern.

For example, a child with whom we share a life-long connection is now living in a group home setting. We decided that we would continue to be an active part in his life and speak up on his behalf if it appeared to us that decisions were being made that were not timely or in his best interest. This felt like the right thing to do, particularly because a lack of timely decision-making during his earlier years in care resulted in emotional trauma from which he never fully recovered.

Late one spring, it became evident that this youth would need to attend a school that was better suited to his style of learning. Worried that this child was already behind in his credits, I asked his worker a few times over the summer if a decision had been made about where the child would be attending school in September. A picture of indecision and disagreement emerged. Conversations with group home staff during the first few days of school indicated that they were confused about which school this youth would be attending. To complicate things even further, the child insisted that he would only attend schools that appeared to be beyond his learning capability. In addition, some staff at various schools that were being considered disagreed about which school this youth should attend.

Four weeks into the new school year, the child was still not in school and we were losing patience by the minute. No doubt, our questions about why these matters had not been attended to during the summer months (vacation time? too many other emergencies to attend to?) must have left the worker feeling like we were just one more headache she had to deal with. Fueling my frustration, the worker advised me that in the grand scheme of things, whether or not this youth was yet in school was not his biggest problem.

In the meantime, my husband asked a friend of his, who is a high school principal, how it could be that school personnel were in disagreement about which school a child could attend. His friend advised him to tell the appropriate people to simply call their school board trustee, guaranteeing that this would ensure that a child got registered somewhere immediately.

Frustrated, my husband called the group home staff and told them that this child needed to be in school and suggested that if they could not register him, they ask for assistance from the trustee.

A later phone call from my resource worker indicated that the child's worker had called her to complain that my husband had been trying to "bully" the group home staff with his phone call. Although admitting to feeling totally frustrated and helpless watching this child wasting weeks of his school year, my husband was adamant that his level of frustration was no different from that expressed by group home staff themselves.

Months later, I had occasion to read an article about a study that was conducted in a hospital setting. It discussed, amongst other things, the experience of fathers advocating for their sick children and the willingness of fathers who were feeling protective of their children to be unpopular with health care providers when difficult issues needed to be raised (McNeill, 2004[1]). The study concluded, amongst other things, that clinicians would do well to understand the protective role that fathers assume while advocating for their children, lest they be perceived as "...unreasonable, difficult, hostile, (or) angry" (McNeill, 2004, p. 532).

Shortly after reading this article, I asked my husband what he was feeling the day he had the conversation with the group home staff about calling a trustee to help with registering the child in school. Consistent with the protective role assumed by some of the fathers in the study who were advocating for their children, my husband said, "I felt like people were not properly looking out for him and if I didn't speak up, then who would?"

While there are those who might say that our advocacy was unnecessary because there were workers, agency staff and other mechanisms in place to ensure this youth was not falling through the cracks, our past experience was that despite all of these things, he *had* fallen through the cracks. Left in our care from infancy to five years old without a permanent plan or an understanding of where he would grow up, I have no doubt that this prolonged state of limbo, amongst other things, compromised his ability to successfully transition to an adoptive home, resulting in an adoption disruption and a return to the foster care system.

There is nothing we can do to change the past and I have long grown weary of carrying the weight of guilt and regret for not having adopted the child when he was little. Although months of counseling have helped me to put things into perspective and recognize the many structural issues that were at play in this child's life that I could not control, it is frustrating to know that one of the barriers to advocating for him is that it may not always be welcomed or received in the well-intentioned manner in which it is meant.

Suggested Measures

We need to be mindful of the ways in which the constraints of parenting within the child welfare system contribute to children and youth living in a state of limbo. In order to persevere parenting a child who is exhibiting very challenging behavior, it is critical that I feel empowered to make daily parenting decisions. Without this, the capacity of foster parents to carry on through

[1] McNeill, T. (2004). Fathers' experience of parenting a child with juvenile rheumatoid arthritis. *Qualitative Health Research,14* (4), 526-545.

difficult times is compromised, and children and youth then bear the stigma associated with being uprooted and moved from one home to the next, causing them to question whose kid they really are.

One suggested measure is that foster parents be included as part of the ongoing consultation about whether a child will remain in their care or will return to their care. To join a meeting where it seems that decisions have already been made and then be asked where I believe the child should be placed does not feel like meaningful consultation. In addition, the minutes from such a meeting will not really be accurate because although foster parents may technically have been consulted and agreed not to have a child return to their care, what may not get flushed out is whether or not they agreed because they believed the decision had been already been made and they were unsupported in their desire to have the child return. Providing foster parents with copies of all Plans of Care minutes might be one way that all team members can feel more included. My understanding is that this is not routinely done across all agencies.

In addition, it is important that workers have conversations with past and current foster parents about the kinds of supports that would encourage them to care for youth formerly or currently in their care. This is particularly important for youth who are experiencing ongoing placement instability. At the same time, workers need to remain realistic about what a foster parent can achieve. In situations where a child has suffered emotional trauma or abandonment, is acting out and is not ready to accept therapeutic help, perhaps maintaining that child in the same home and getting them to school each day should be considered a successful placement. In this situation, a child would at least preserve continuity of peer and family relationships and would grow up with the knowledge that they mattered enough to someone to keep them. Hopefully, such a child would also always have a place to call home.

Another suggested measure is that youth who are visible minorities should be given advance notice when they are being moved outside of the multicultural city where they have grown up. There may be a dozen reasons why this was not done, but my concern is that youth who feel out of place in their community may start agitating to move, which exacerbates placement instability.

In the same way that it would be highly inappropriate for separated parents to tell a child that the other parent's contact with a child was motivated by anything other than caring so, too, is it for social workers and staff. And, in the same way any parent would expect to speak directly with the mental health professional who was assessing or treating their child, foster parents expect the same and the children in their care deserve no less. Communication that is relayed through a third party reduces the importance of the foster parent role in understanding and helping children with mental health issues. A mutual respect for each other's role is needed.

Access Orders for Crown wards that were made years ago should not necessarily preclude them from connecting with biological family years later. In situations where a level of risk is evident, but a youth is determined to see biological family regardless, I would argue that monitoring the contact and developing a plan of safety may be a reasonable thing to do because in forbidding contact, we risk driving the contact underground where it can not be monitored. In addition, for youth who have been raised in the foster care system, we have a responsibility to help them

navigate relationships with their families before they age out of care because this may be where some youth return once they turn 18 and No Access Orders no longer prevent them from seeing biological family.

The youth that I have been writing about has expressed his intention to reunite with family members once he is 18 and legally allowed to do so. Once he ages out of care, I expect that it will be we, and not social workers, who support him as he tries to renegotiate these relationships and form safe boundaries. I also expect that it will be to us that he returns to live if relationships with biological family members do not unfold as he expects. As such, another suggested measure when asking foster parents to sever relationships with a child's family would be to consider why foster parents may feel uncomfortable doing this.

Lastly, unless advocacy is recognized and welcomed in all its forms, then children and youth may not have the comfort and security of knowing that there is always one consistent adult that they can depend on. Whether questions about a child in care come to a social worker from their direct supervisor or from a concerned adult in the community, such concerns should be received and answered to the best of the worker's ability with an equal degree of openness. My hope is that every adult in the community is made to feel that children in care are their concern.

In this paper I have suggested just a few ways in which the many confusing, competing and contradictory constraints of parenting within the child welfare system can negatively affect children. We all have to do better for children and youth in care who do not deserve to live their lives in a state of limbo.

XIII. KINSHIP: SUCCESSES AND CHALLENGES

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For generations families of various cultural and ethnic backgrounds have privately made alternate arrangements for their children when they have been unable to care for them. These private arrangements might be with extended family (kin), friends or neighbours (kith) or community members (i.e. faith community), and may be short term or on a more permanent basis. This type of planning enabled children to grow up safely while retaining ties to their family of origin, their cultural heritage and their community. Stories about their lineage, traditions and beliefs could be shared with them by their direct caregivers, as well as those in the community. This allowed children to maintain their sense of identity, and gave them an understanding of the story of their life and the people in it.

Although the Children's Aid Society of Toronto (CAST) has always supported this view of keeping children with kin, kith or community whenever possible, how to achieve this had not been formally developed until a two year pilot project commenced from June 30/03 to June 30/05. The Kinship Care Program defined kinship care as "Any living arrangement in which a relative or someone else who is emotionally close to the child takes primary responsibility to raise the child."

The philosophy behind this initiative was the belief that children who maintain important family, cultural, religious and community relationships, are more likely to have positive outcomes from this sense of love and belonging in a safe setting. It was hoped that being cared for by extended family would reduce the trauma of being separated from their birth family and community and would eliminate or at least decrease the number of placement changes that the child would experience. Working with extended kith and kin networks to develop safe, nurturing plans for children was seen as a more strength based way to develop more positive working relationships with families and also a way to reduce the sense of limbo that children feel during protracted litigation.

During this two year period, 83 children were placed with 57 kin families and their ages ranged from less than one year to ages 16 to 17 years of age. Of the children admitted into care, 74% were for neglect with the balance including physical, emotional and sexual abuse. Placing children with kin families resulted in 92 – 100% cultural/racial match and 60 – 100% religious match. From this group, 66% remained in their kin placements, 19% returned to care, 10% returned to parents, 4% were adopted from the kin home and 1% were adopted by the kin home. These results were seen as very positive and a plan for rolling out the results, training staff and reinforcing the benefits of this initiative was developed.

On April 4 & 5, 2006, a Kinship Care Symposium, sponsored by the Ministry of Children and Youth Services and Child Welfare Secretariat was hosted by The Children's Aid Society of Toronto, the Catholic Children's Aid Society of Toronto and the Ontario Association of Children's Aid Societies. For two days, the audience was educated, challenged and enlightened while listening to passionate supporters of kinship care from Ontario and the United States. Keynote speakers Mattie Satterfield spoke about "Valuing Family Relationships," Dr. Joseph Crumbley spoke about "Assessing Families for Kinship Care" and Dr. James Gleeson spoke about "Kinship Care and the Child Welfare System." These very informative and sometimes humorous discussions were followed by front line staff and supervisors talking about their experiences, challenges and hopes for the future. Mollie Sitwell, a kin provider, gave a very heartfelt description of her experiences during the assessment phase and how she and her family were enjoying the wonderful new life they had with the inclusion of her nephew into their family. She reminded everyone in the room that "the apple doesn't fall far from the tree" is not an accurate or objective way to view potential kin families.

The *Child and Family Services Act* (CFSA) in Ontario provides the legislative framework for Societies to pursue their search for kin homes for children who are deemed to be or found to be in need of protection. The kinship program's philosophy is consistent with the paramount purposes of the CFSA which (among other things) recognize the integrity of the family unit and promote the consideration of the use of the least disruptive course of action available to a Society in assisting the child.

The CFSA compels the court to consider whether a placement with a child's family or within the child's community would be in the best interests of the child. When the child is native, the Act directs the court to place an Indian or native child with the child's extended family, a member of the child band or native community or with another Indian or native family unless there is a substantial reason for not so doing.

The child's legal status will affect the manner in which a kinship placement for a child is secured. If a child is in the care of the Society then a kin's home must be deemed to be "a place of safety" and a certain set of standards is applied to meet this designation. If the child is not in the care of the Society, then another set of criteria is relevant to ensure that the placement is appropriate. The term "Kinship Care," relates to community/extended family placements for children who are in the Society's care. The term "Kinship Service," relates to community or extended family placements for children who are not in a Society's care.

The regulations under the CFSA provide the requirements that are to be followed for kinship placements to be approved. Part 1 of Ontario Regulation 206/00 deals with the designated "Place of Safety Prior to Placement" requirements for children who are already in the care of a Society. Part 11 of Regulation 206/00, which came into force in February 2006, provides direction to Societies on the requirements for the assessment of plans proposed for the care of a child by a member of the child's extended family or community where the child will not be in the formal care of the Society - that is – Family and Community placements.

Kinship service placements were intended to be safe placements for a child or children, generally on a temporary basis until a permanent plan could be developed. However there would be times when the permanent plan would in fact be the kin placement. The standards would be applied

until such time as the child was no longer in need of protection, and they would guide the expected level of service for Children's Aid Societies to ensure that the agreed upon outcomes for the child were reached.
"When families fail, children, our next generation of citizens, workers, and leaders, all too often fail as well. The costs of not taking steps to strengthen families are enormous. We must develop strong families and kinship care is a key component" (Satterfield, 2006). The field of child welfare has always known that having a child in care is generally not the best option, but assessing kin had not been formally expected and there was no systemic plan for finding and assessing possible kin family. With the success of the pilot project, CAST continued to move forward to find kin placements to keep children out of care, or lessen their time in care.

The six following case examples are either currently active on the child protection supervisor's team or have been recently closed. She is very familiar with each family situation, and has focused on the information that is directly relevant to understanding the potential or actual kin placements and the differing levels of success. Including all of the information known about each family is not necessary or within the scope of this paper. Each case example was chosen to highlight different types of success or challenge, and to suggest questions that might be considered before making final decisions.

Teddy's situation highlights the ambiguity that some extended family members feel when their role with the child is permanently altered. Blake's situation demonstrates that even when the initial plan does not succeed, positive change and a good outcome can come about. Ariel's situation highlights the delay and limbo that can result when potential plans for young babies are very slow in being presented. Matthew's situation again highlights the potential delay and limbo for a baby when the kin's expectations are unrealistic. Veer and Daya's situation highlights a very successful temporary kin placement and family reunification. Sherri and Shawn's situation demonstrates how two children from the same family can have very different kin experiences and outcomes.

TEDDY

Kristi and her son Teddy (8 years old) had been living with her mother Gwen when her file opened in August 2006. Kristi was a 30-year-old woman with a history of drug use, undiagnosed mental health, violence and transciency. After a physical altercation between Kristi and Gwen, Kristi left with Teddy. Given Kristi's vulnerabilities and lifestyle, she and Teddy had spent a good portion of his life living with Gwen, so the risk to Teddy was heightened when Kristi fled with him. She and Teddy ended up in a shelter, where staff described her as anxious and erratic. Although Kristi eventually agreed to a psychiatric assessment, she was arrested by police for harassment and breach of her conditions before this could happen, and Teddy came into care in October 2006.

Before her incarceration, Kristi made an allegation that Gwen had sexually assaulted Teddy. An investigation was conducted and this allegation was not verified. At that point, CAST began the process of completing a home study with the hope that Teddy could be placed with Gwen. Teddy also had bi-weekly overnight weekend access with his father Teddy Sr. CAST also made many attempts to talk with Teddy Sr. about having his son live with him. Although Teddy Sr. did not say no, he would continually change his telephone number or disconnect the number so that workers and Teddy were often unable to contact him.

During the home study process, the Kinship assessor learned that Gwen had some health problems and suffered from depression for many years. She was also the sole care provider for her sick husband and mother who all lived together in the family home outside of Toronto. Although Gwen clearly loved Teddy, she saw herself only as his grandmother and a support to Kristi, not as his sole caregiver. The home study process became quite protracted as Gwen struggled with very mixed feelings about what she was willing and able to do for her grandson. She talked about feeling completely overwhelmed with the daily care of her sick husband and mother while she also battled her own depression. She was also very angry with Kristi for putting her in this position.

Teddy began going to Gwen's house on weekends for access. These visits would alternate with weekends with his father Teddy Sr. Gwen and Teddy Sr. had a cordial relationship, and she did try to persuade him to take Teddy to live with him. As Gwen became more insistent, Teddy Sr. withdrew more and more frustrating both her and her grandson.

During one weekend visit with Gwen, Teddy did not want to return to his foster home and he refused to get in her car. She called her worker who drove to her house to assist. When the worker arrived, he offered many suggestions as to how Gwen might persuade Teddy to do what she was asking. She was not willing/able to follow those suggestions. It took approximately two hours before Teddy was willing to get into the car and return to his foster home.

One of the biggest challenges that Gwen faced was the role change from grandmother to mother/decision maker. Even though Teddy had spent a good deal of his life living with her, she was a quiet woman who maintained her role as grandmother, deferring all decision making to Kristi. One of the conditions of Teddy living there would be that Kristi could not live there. That would leave Gwen with sole responsibility for Teddy's day-to-day care as well as making all decisions to ensure his safety and well-being.

Time continued to pass while Gwen struggled with her decision. Kristi was not doing well and was often homeless or back in jail. When she was out of jail, Kristi would sometimes call her worker or her mother, but it was clear that she was not able to care for Teddy. On the few occasions that Kristi would show up for access with Teddy at CAST's office, she would cry and whisper to him that they were both victims. Teddy became very anxious during these visits and would have a very difficult time for a few days after.

Finally, almost five months after the home study process began, Gwen agreed to have Teddy placed with her in May 2007. The transition for Teddy was also very difficult. He was used to his grandmother doting on him and giving in to him to make him happy. Gwen really struggled with rules, structure, consistency and consequences and Teddy took full advantage of this. Just getting him to go to school became a huge battle. There were many challenges and times Gwen thought of giving up, but she did persist and they eventually settled into a routine.

Dr. Joseph Crumbley talked about this struggle at the Kinship Care Symposium. He explained that when you are assessing kin, you are assessing whether they can change pre-existing roles and relationships. If the kin member is not able to do this, the placement is not likely to be successful. He further stated that it is important to assess whether past history would cause negative feelings and interactions between the kin and birth parent. Although Kristi had been

missing for quite some time, eventually she did surface again and she still struggled with the same issues. Quite likely Gwen's anger at Kristi would resurface each time Kristi returned and criticized her mother's care of her son.

During a more stable period, Kristi moved to the same area as Gwen, which was outside of Toronto. This family's file was then transferred to a sister agency to continue to monitor. The hope was that Gwen would seek legal custody of Teddy to ensure his safety and well-being as he grew up, and his mother would still be a part of his life.

This situation demonstrates the challenge that extended kin face when they are considering changing a pre-existing role and relationship. Although committed to Teddy, it took her a very long time to think this through. She really struggled with changing her role from doting grandmother to sole care provider and decision maker for Teddy. She was also quite concerned that her obligation to care for her ailing husband and mother and her own history of depression already left her feeling quite overwhelmed and depleted. Wanting to do the right thing for her grandson and really considering the drastic shift it would have in her life resulted in her feeling a great deal of ambiguity around making a decision.

BLAKE

Twenty-seven-year-old Terri had two children – Blake 7 and Carrie 1. Terri, Blake and Carrie lived with Carrie's biological father Danny who owned and operated a tattoo parlour. Terri also worked at the tattoo parlour, so Blake and Carrie also spent a good deal of time there as well. Terri reported that Blake's father had been quite violent and Blake had witnessed this violence.

Terri's file opened in June 2007 when an anonymous caller reported that a mother was heard swearing at Blake saying "you little mother fucker, I wish I never had you." The mother also told Carrie to "shut the fuck up, I'll pick you up when I'm good and ready." The caller was concerned that the mother was abusive to her children and that the son had behavioural problems and had been suspended from school for hitting a teacher.

Terri admitted to yelling and swearing at Blake, but said that he also swore at her. She denied speaking this way to Carrie. Blake had been diagnosed with ADHD and ODD and he had a great deal of difficulty talking about his feelings or engaging in any conversation. Blake identified himself as a bad child.

During this time, Terri and Danny were also experiencing money and relationship problems, so there was a great deal of tension in the family home. Terri was very stressed and did not seem willing or able to provide Blake with the structure, routine and predictability that he needed. When he upset her, she engaged in verbal power struggles with him, and would then give herself a "time out" so that she wouldn't hit him. Blake was a very angry child who experienced a great deal of rejection from all of his family members when his behaviour became defiant.

Although there were many conversations with Terri about using other family members as support or respite when she felt she couldn't manage, she consistently said there was no one who would help. When Terri finally reached her breaking point, she requested that Blake be admitted into care under a Temporary Care Agreement in September 2007. When Blake learned

what was going to happen, he refused to leave his home, kicking, yelling, screaming and cursing. When all efforts were exhausted to get him safely into the worker's car, the police were finally called to assist with transporting him.

While in care, Blake was friendly, played with other children and really enjoyed the verbal and physical attention from the adults in the home. However, he continued to use extremely foul language. He didn't understand that this was inappropriate and that it hurt people's feelings. When this was explained to him, he responded quite positively. Although Blake did demonstrate a caring sensitive side, when he was in a bad mood or upset, he could be very violent to the things and people around him and the cursing would begin again.

Blake continued to be very angry with his mother for putting him in care. He refused to attend any access visits with her, and their telephone conversations consisted of the two of them yelling and cursing at each other.

Terri had a very acrimonious relationship with her mother Theresa and she described being raised in an abusive home that resulted in her long history of depression. Shortly after Blake's admission, Terri began seeing a psychiatrist who prescribed medication to help alleviate her depression. A Family Centered Conference was then held and the family decided that Theresa would plan for Blake. The home study was completed and although there were some concerns, Theresa's plan was approved. The biggest concern was that Theresa had never cared for Blake for more than four days at a time and she didn't really understand what his needs were and how challenging his behaviour could be. Given the abuse that Terri alleged to have experienced from her mother, there was also concern about Theresa's parenting knowledge, skill and level of patience.

Blake was discharged from care and placed with Theresa in November 2007. It did not take long for Theresa to see some of Blake's more challenging behaviour. In spite of knowing his diagnoses, she continually struggled to provide him with the structure and routine that he needed, and it was reported that she once told him that when he became 12 she would be able to beat him. Many supports were put in place for Theresa, but she refused them all and indicated that she was going to return Blake to his mother. She was not able to alter her parenting style to meet Blake's needs in spite of the numerous interventions that were attempted.

Another Family Centered Conference was held and Terri reported that she was planning to leave Danny and she wanted her son returned to her. Terri moved into her own apartment in the same building as Theresa, and Blake was returned to his mother in March 2008. The separation from Danny seemed to have a very positive affect on Terri. She was much happier, calmer and more patient with Blake. She was also more able to maintain some structure and routine for both of the children. Terri was just beginning to understand how her upbringing had influenced her parenting style and she worked hard at correcting the mistakes that she had made. Having her mother in the same building also gave her some limited support as Theresa was willing and able to care for Blake for brief periods.

Although Blake's stay with Theresa was not successful in the long run, it did help bring the family a bit closer together, and Blake got the clear message that his family would do what they

needed to do to have him home. That was the first time that this family was able to come together and support and cooperate with each other, even though in a limited way. Without this bridge, it is very unlikely that Terri would have been able to make the necessary changes to safely parent her son.

Dr. Crumbley talked at length about legacies and how powerful they are. He called them "rights of passage" from one generation to another. It took some time, but Terri finally began to understand that she had learned how to be a mother from her mother, which was not a very positive or safe time for her. Terri was committed to learning new ways to parent Blake that would not include yelling and cursing at him. She was trying to free herself from the family legacy, while Theresa remained firmly entrenched in her past parenting style.

Even though the placement with Theresa was not successful, this break did give Terri time to assess and end her relationship with Danny, and begin to deal with her own issues. Her psychiatrist prescribed medication for her depression and once she was feeling more capable and in control of her life, she was able to really look at her parenting style and see that she was replicating what she had experienced as a child. This was hard work, and did not always come easily to Terri, but she was determined to repair her relationship with Blake and become the mother that she had always wanted to be.

ARIEL

CAST received a call from a hospital in July 2007 reporting that Jenny had just given birth to a baby girl. Baby Ariel was born at 30 weeks and weighed 4 pounds 6 ounces. Jenny admitted to using crack cocaine throughout her pregnancy, the last time being two days before Ariel was born. Jenny also admitted to not having any prenatal care as she was fearful that her baby would be taken away. Jenny said that Ariel's father Jason was in jail and she also had a 9-year-old son Adam who lived with his father Ryan in London, Ontario.

Ariel had meconium and hair testing, both of which came back positive. The drug tests also confirmed that Jenny's usage of crack was quite frequent throughout her pregnancy. Ariel was brought into care and placed in a foster home.

Once Jenny was released from the hospital, she disappeared and CAST was not able to locate her. At first she called a few times and access visits were set up for her. However she did not attend any of the visits and then she stopped calling without leaving any thoughts about who she would like to raise Ariel. Jason spent most of the next year in jail, so he did not have any access with Ariel either. The worker went to jail to see Jason a few times to find about any family on either side who might be able to plan for Ariel, but he consistently denied knowing of anyone. When the worker tried to find out names or areas where extended family or friends lived, Jason refused to give any information.

The worker then called Ryan in London to see if he would plan for Ariel as she was Adam's half sister. Ryan was sympathetic but there was too much going on in his life and he wasn't able to plan for her. He also said that he didn't know anything about Jenny's extended family or how to reach them.

Without any potential plans, CAST recommended Crown Wardship no access for purposes of adoption for Ariel. However in April 2008, Sharon, the paternal grandmother unexpectedly came to Toronto from Nova Scotia to plan for Ariel. Sharon explained that once Jason really understood that Ariel would be adopted, he contacted her to adopt his daughter. Until Jason's phone call, Sharon did not even know that Ariel existed.

The child welfare agency in Nova Scotia indicated that it would take six to eight months to complete the adoption study for Sharon. Given the lengthy timeframe required, a decision was made to complete a Kinship assessment of Sharon. During CAST's discussions with the Nova Scotia agency, they reported that they had been involved with Sharon in the past and that they believed that some of the concerns still existed. Nova Scotia began the Kin assessment, but shortly thereafter Sharon withdrew her plan. Sharon explained that Jason had been released from jail in Toronto, returned to Nova Scotia, was critically injured in a shooting, charged with several offences and would likely be incarcerated again. She then said that she felt overwhelmed by the prospect of caring for Ariel and was not prepared to take on this additional responsibility.

Jason put Sharon in a very difficult situation. When he asked her to adopt Ariel, she hadn't even known of Ariel's existence, and there was very little time for her to consider this very big change in her life. Clearly she was torn between wanting to help her son by caring for her granddaughter and taking on more responsibility when her own life situation was already quite challenging.

Without any other plans, Ariel was made a Crown Ward no access for purposes of adoption.

CAST was obliged to consider any plan that Sharon presented, even though there were early signs and the social work team's collective instinct that Sharon's plan would not materialize. Fortunately, Sharon withdrew her plan early but one could imagine a scenario where a lot more time could have passed while the Nova Scotia plan was being assessed, only for it not to have passed muster. If someone else popped up to propose another plan, it too would have to be assessed. Meanwhile, Ariel continued to be in limbo and might likely have lost opportunities for a permanent plan.

MATTHEW

CAST received a call in March 2008 from Laura's Ontario Works worker who reported that Laura was pregnant and due in August and was using crack cocaine. Laura had two other children 19 and 8 who were being raised by other family members because she had a 19-year history of substance abuse. Allan, Matthew's father, also had a history of being addicted to crack cocaine. Although he reported that he was clean, he stated that he was not able to care for his son.

Matthew was born in August 2008 and while in hospital he was in CAST care. Upon discharge from care, he was placed with his maternal grandmother Iris when he was approximately one week old. Iris was prepared to care for Matthew for six months while Laura attended drug treatment. Iris was convinced that within that short time frame Laura would be drug free and able to safely parent her son.

Just eighteen days later, Iris called CAST to report that she could no longer care for Matthew as Laura had resumed her drug use and her behaviour put them both at risk. Matthew was brought back into care and placed in a foster home. Laura was incarcerated.

Matthew's paternal aunt put forward a plan to care for him. CAST's Kinship Department was just about to approve her plan when she withdrew stating that her family was too worried about Laura's interference in their life if Matthew was living with them.

When Laura was released from jail in January 2009, she again persuaded her mother to put forward a plan for Matthew. CAST Kinship Department conducted a home study focusing on what had changed since September 2008, and Iris's willingness and ability to care for Matthew long term if Laura was not able to remain substance free. Iris found this process very difficult and intrusive. She had a great deal of difficulty answering the questions posed to her as she kept repeating that she was his grandmother and she loved him.

Given that Matthew had already moved three times in six months, CAST was reluctant to move him again when Iris took such offence to answering these very important questions. The process took a very long time, however her plan was finally approved with the paternal aunt as her back up, and Matthew was placed with Iris again at the end of March 2009.

There are very important questions to ask about this kin placement, which is still in its early days. Is this really a permanent plan for Matthew? Should Iris's plan have been considered again having regard to all that we know about Laura, her drug abuse and her relationship to Iris? Would it have been best for Matthew if CAST turned away from the family and sought adoptive home with no ties to the biological family? The legislation imposes an obligation on Societies to explore family and community placements. However, in the case of babies and young children, should there be an emphasis on finding permanency quickly as opposed to seeking out family members no matter how long the process takes? Remember Ariel? What if it took nine months for the Nova Scotia plan to be processed and at the end of it grandmother was denied or withdrew her plan then?

Dr. Crumbley talked at great length about the kin caregiver's loyalty to their child, the birth parent. If there is a co-dependant relationship between the grandparent and the birth parent, the grandparent lives with fantasies and tries to rescue the parent. In spite of Laura's 19-year history of using crack cocaine, Iris had a fantasy that Laura would miraculously be drug free in six months. When asked what gave her this hope, what signs did she see – she had no answer.

Iris never intended her plan to be long term, so if Laura did not fulfill her mother's fantasy, what would happen to Matthew? The second plan included the paternal aunt as back-up, but if Laura continued to use drugs, the aunt's concern about Laura's interference in her family's life would remain. Past history shows that when Laura is using drugs, she steals from her family and lands on their doorstep to sleep, eat and clean herself up until she goes back out and uses again. If Laura does not remain drug free, will this type of behaviour break down the family placement and Matthew be admitted into care again for the third time?

Even if/when Laura stops using, she still has never parented any of her three children. One cannot automatically assume that she has the knowledge, skills, patience or resources to successfully do this even if drug free.

Iris did not have a realistic view of her daughter and how she would be drug free and able to parent in six months. Her rescue fantasy falls into Dr. Crumbley's description of a co-dependant relationship. If Laura continues to use drugs, will Iris once again ask CAST to come and take Matthew? If so, he will have moved four times. The hope, of course, is that even if Laura continues to use, Iris will commit to him and present a permanent plan. If our hope is misplaced, we have put this baby though a great deal of upheaval in his very young life.

VEER and DAYA

Twenty-five-year-old Sakari and 32-year-old Hasin were the parents of two children, 2½-year-old Veer and 6-month-old Daya. CAST received a call from a family physician in June 2007 who reported that the parents brought their daughter Daya to see him. They explained that Daya had fallen off a broken swing two days before and she appeared to be well after. However after two days, her leg was swollen. X-rays identified a fracture and the family was referred to The Hospital for Sick Children.

Daya had a body scan at the SCAN Clinic at Hospital for Sick Children which identified three fractures at various levels of healing. There was a femur fracture which parents said occurred from the fall in the broken swing. When asked about the fractures to her radius and ulna, they said that Daya had rolled off the couch at 2 or 3 months of age. The physician at SCAN stated that developmentally it was unlikely for this child to roll off a couch and sustain these injuries. Further she stated that these injuries would not likely still be visible on an X-ray of the child taken almost four months later.

Based on these findings, there was concern that the injuries may have been intentionally inflicted. There was also some concern about Daya's lack of weight gain while in her parent's care. At birth Daya's weight was above the 10th percentile, but by early June 2007 it had dropped to below the 3rd percentile.

Given their very young ages, both children were admitted into care June 8, 2007, and Daya's weight immediately began to increase. Both Daya and Veer did well in care and their parents attended access visits consistently and on time.

The maternal grandparents arrived in Toronto from India on a visitor's visa early in July 2007 to present a plan to care for their grandchildren. CAST encouraged them to seek an extension to their visa so that a Kinship home study could be completed. Although it did take some time, they were successful, and their visa was extended until July 2008. The Kinship home study was approved and the children were placed with their grandparents in December 2007.

The maternal grandparents were very loving and diligent in caring for Veer and Daya. They ensured that all the children's medical and religious needs were met, and they made full use of community programs to enhance their social interaction in the neighbourhood. The grandparents also supervised Sakari and Hasin's access with their children for eight hours weekly in the family home.

While the children were living with their maternal grandparents, Sakari and Hasin attended a parenting program and Sakari had a mental health assessment which reported that she was stable. They then began attending CAST's Therapeutic Access Program to provide them with an opportunity to practice the knowledge and skills they had learned from the grandparents and the parenting program. Mid-June 2008 the children were returned to their parents under a supervision order. Sakari and Hasin continued to strengthen their parenting skills and increase their awareness of risk to ensure the safety of their children by remaining connected to resources in their community. In October 2008, CAST closed the family file.

While the cause of Daya's injuries were never conclusively ascertained, with the commitment and support of the maternal grandparents, Sakari and Hasin demonstrated a new understanding of how to parent their children to meet their physical, emotional and social needs. During the sixteen months that this file was open, having the maternal grandparents involved ensured that the children spent most of that time being cared for by family who were able to maintain all of the cultural, religious and community connections that are so important for children. Sakari and Hasin were also much more willing to accept teaching and guidance from the grandparents. With this support, they were able to better understand what was being taught to them in the parenting programs that they attended, and they felt more comfortable trying out their new skills.

These parents were relatively young and alone in Toronto. They had no one to normalize their feelings and worries, offer them support or make suggestions. Without kin to offer all of this and care for their children, the outcome could have been much different. This situation is a true success story and the entire family was extremely grateful that things worked out the way they did.

SHERRI & SHAWN

Cheryl is the mother of five children ages 23, 19, 16, 14 and 6. CAST has had numerous openings since 1997. The most recent occurred in August 2005 and remains open. The concerns include a consistent pattern of neglect of the children's physical and emotional needs and

inadequate supervision. It is suspected that Cheryl has undiagnosed mental health issues that may contribute to her inability to meet her children's needs and keep them safe.

In August 2005 the police reported that 11-year-old Sherri was home alone with 3-year-old Shawn, there was no food in the house, the house was extremely cluttered with boxes and the stench from the cats, dog, rabbit and bird was nauseating. When the police finally located Cheryl, she returned home and immediately began yelling and challenging everything that was being said.

Over the next year the Society had a very difficult time meeting with the family, and it was believed that Cheryl was actively avoiding any contact. On the rare occasions when the worker did connect with her, Cheryl presented in very odd ways. She would laugh at very inappropriate times and jump up and leave the room, or be argumentative and aggressive. During this time Cheryl also began denying that Shawn was her son. Sometimes she would deny that he was present when the worker in fact saw him in the home. Other times she would say that he was a neighbour child just visiting. The older children all confirmed this same message.

Given our long involvement with this family, our inability to see the children to assess their safety, especially in light of Cheryl's odd presentation and denial of Shawn being her son, we went to court to seek a supervision order in September 2006. When the Judge read all of the material, he ordered Cheryl to produce Sherri, 12, and Shawn, 4, so that they could be admitted into care.

When it became clear that the children could not be returned to their mother, and the two fathers of these children were not prepared to care for them, the Kinship Department earnestly searched for alternate family members to plan for them. Donna and Rayna, who were maternal aunts, were assessed.

Donna was married and had two teenage sons at home. She was prepared to care for Sherri, but not Shawn. The assessment was completed when Sherri was 13 years old and had been in care for 13 months. Given her age, Donna thought that she would fit into her home and that Sherri would be somewhat self sufficient. Sherri was placed with Donna and her family at the end of October 2007 against Cheryl's wishes.

Rayna was a single mother with two children, both with special needs. Careful consideration was given to her plan as she had past involvement with the child welfare system. However she worked hard to address the issues and her plan to care for Shawn was approved. While he was in care Shawn was seen by a psychologist who reported that he had significant delays in all areas of his development. Rayna demonstrated an understanding of his needs and a commitment to caring for him. Shawn was placed with his aunt when he was 4 years old against Cheryl's wishes.

It soon became very clear to Rayna that Shawn was not used to any structure or routine and he resisted her efforts to provide any. Most of his speech consisted of mumbling that she was not able to understand and he was not able to play or share with other children. Out of frustration he would kick and bite other children necessitating a very high level of supervision at all times.

It took a great deal of time, patience, consistency and caring, but Rayna was finally able to convince Shawn that she was committed to him for the long term. Although there were numerous setbacks, he began to blossom in her care. His speech improved dramatically, he was able to play with other children and he felt loved by his aunt. His mother had given him the message that he shouldn't listen to anyone else, and it took a long time for him to trust Rayna and believe that he was safe with her.

Initially Sherri did well living with her extended family. She got along with family members, fit into the routine of daily life and attended school. However, as time passed, Sherri's demeanour and level of cooperation changed. She began skipping school, hanging out with a tough crowd and using drugs. During this time Sherri also had consistent contact with Cheryl who made it very clear that she did not want Sherri to be there. Although the Kinship Support Worker met regularly with Donna and Sherri to try and ease the tensions and help put things in perspective, this was not successful. In May 2008 Donna called to say that Sherri could no longer stay in her home, and Sherri was brought back into care.

Immediately Sherri began asking to go live with her Aunt Rayna and her brother Shawn. There were many discussions, and the service team and Rayna were concerned about whether this change would compromise her ability to meet all of the children's needs, especially since Cheryl was not supporting this placement either. It was finally agreed at the end of August 2008 that Sherri would be placed with Rayna and Shawn.

It did not take long for the challenges that Donna experienced to begin happening in Rayna's home as well. Although she tried very hard to deal with Sherri's behaviours, it was putting a real strain on her ability to manage her own two children and Shawn. There was discussion again about Sherri coming back into care. Although Sherri was part of the planning, she ran away in October 2008. When Sherri was found a few days later, she was placed with her initial foster mother where she remains to date.

Why has Shawn been able to have such success living with Rayna while Sherri has not been successful in two kin placements? There are a few quite obvious differences. Sherri was 12 when she was admitted into care in 2006, so she had experienced many years of chronic neglect. This included lack of food, living spaces so cluttered that there was little space for the family to live, excessive use of physical discipline, parent-teen conflict between Cheryl and her oldest son, lack of appropriate supervision and Cheryl's verbally abusive behaviour with the school or CAST when recommendations or suggestions were made. It is also very important to remember that Cheryl did not support this placement and reminded Sherri of that whenever they had contact. Because of Sherri's age, she frequently had telephone contact with her mother, and all of her caregivers have noted that her attitude changes and becomes much more negative after these conversations.

Cheryl views the world as a hostile place where no one outside of the family can be trusted and she has passed this legacy down to Sherri. It was clear when Sherri first came into care that she too had that belief, and she has really struggled with trusting that this view could be mistaken. Given Cheryl's beliefs, she has not taught Sherri whom to trust or how to make or sustain friendships that are positive and supportive to her. With the number of moves Sherri has made, it is quite likely that she feels very alone and out of step with her peers and the rest of the world.

Since Shawn was only 4 when he was admitted into care, he had not experienced the years of chronic neglect that Sherri had. Although he has been diagnosed with delays in all areas of his development, some of them appear to be environmental as he has made significant gains in Rayna's care. Cheryl did not attend for scheduled access visits with Shawn, so he did not receive the ongoing message that his mother did not want him to live with Rayna.

Shawn has learned over time to trust Rayna and he knows that she plans to care for him while he grows up.

Although both of these kin placements met all of the requirements to be designated suitable kin homes, CAST was well aware that Cheryl did not support either one of them. The guiding principle in placing both of these children was that their experience away from their mother would be more positive with family rather than in care. Should CAST have made that assumption given Cheryl's very clear statements that she did not support either placement? Of course the hope was that she would change her view and see that her children were doing well with family. This very clearly did not happen with Sherri. Because of their ongoing contact in person and by phone, Cheryl was quite persistent in criticizing and undermining both Sherri's kin placements. In focusing her efforts on Sherri, Cheryl did not visit or keep in touch with Shawn by phone. This lack of interference is very likely what saved his kin placement and resulted in Shawn learning to trust his aunt and make gains in the areas in which he was behind.

There are many benefits to placing children with kin rather than keeping them in care. Knowing their child is with kin reassures a family that they will stay connected, reinforces the child's sense of cultural identity, creates a sense of stability for the child, and allows the continuation of lifelong family traditions and memories. The case examples for Teddy, Blake, Veer and Daya, and Shawn show different ways how these benefits were achieved.

Even with Gwen's reluctance to take the legal steps to make Teddy's place with her more permanent, she took him into her home and cared for him, something his birth father was not willing to do. This was a very positive message for Teddy, who was too young to really understand the legal situation. Being with Gwen also meant that Teddy would be able to maintain his relationship with his mother.

When Blake was discharged from care, he moved to his grandmother and then back to his mother. His stay with his grandmother was not a very positive one for him, but he did see that his mother took steps to get out of a negative relationship, take care of her own health, and welcome him back home. Terri worked very hard to change her way of relating with Blake and alter her parenting style. Blake is a very bright child who began to blossom with these changes. Although there were setbacks, he felt better about himself and was reassured that his mother would fight to keep him.

When Veer and Daya were brought into care, their parents contacted the maternal grandparents who were able to come from India to care for the children. This time together allowed the grandparents and grandchildren to form a very strong relationship, much different from the one they would have developed during occasional visits. The grandparents were able to reassure the children that they would be safe while teaching and encouraging the parents to learn new skills. It also gave the whole family the ability to remain very connected to their culture, community, and religion. Although the circumstances that brought them all together were not very positive,

the result was. When the grandparents left to go back to India, they were all left with memories of the time they shared.

As discussed in Shawn's case example, he has enjoyed a stable placement with his aunt, and he views her and her children as his family. Because he was young, and Cheryl did not actively sabotage his placement, he has learned to trust that he is loved and will remain with Rayna as he grows up. This sense of safety and security has also allowed Shawn to make great gains in overcoming some of the environmental delays that he displayed. The only down side is that he has very little contact with his mother and other siblings. Although Rayna has attempted to maintain contact with at least some of the siblings, this contact comes with interference from Cheryl. Rayna is torn as she understands the importance of Shawn staying connected to his siblings, but she is also very protective of him and does not want his placement with her to break down as Sherri's did.

Sherri's outcome was very different from Shawn's. She experienced many more years of neglect, and both of her kin placements were actively sabotaged by Cheryl. As soon as CAST began to look at the first kin plan, Cheryl repeatedly told Sherri, CAST, and the court that she would never support it. At 13 years old, Sherri was very vulnerable to her mother's influence, and she said very little about what she wanted during the kin study. Although CAST was obliged to look at the plan, if everyone was aware that Cheryl would never give her daughter permission to succeed there, should that information have been given more weight than the fact that the plan was approved? When that kin plan did break down, Sherri asked to live with Rayna with the same result. Unfortunately for this child, she has been rejected by two family members, and this has taken a very large toll on her self esteem. There is no doubt that her behaviour was problematic in both placements, but Cheryl was constantly in the background fueling the fire.

Ariel's case example highlights what happens with very young babies when families do not provide information until the very last minute. Even though the worker made genuine and persistent efforts to find family for her, and a recommendation of Crown Wardship no access for purpose of adoption was before the court, CAST was obliged to look at the paternal grandmother's plan late in the process. Both CAST and our sister agency in Nova Scotia had very real concerns about whether this plan would actually be approved, but everyone had to proceed with the process while Ariel sat in limbo. Had Sharon not withdrawn her plan, the process would have continued and Ariel would have been in care even longer. If the plan was not approved, she would have remained in care many more months with no positive outcome.

Matthew's case example highlights somewhat similar concerns. Although he had been placed with Iris very soon after his birth in September 2008, she returned him to CAST care after only eighteen days when her daughter's behaviour put both of them at risk. In January 2009, Laura convinced Iris to once again put forward a plan for Matthew. During the kin study, nothing had changed. Iris kept repeating that she was Matthew's grandmother and he should be with her. However, she was still not prepared to plan for him long term because she was convinced that Laura would be drug free and able to parent in six months. No one was suggesting that Iris would not be able to parent Matthew safely; but should he have been placed with her again when her expectations were so unrealistic? If Laura does not meet Iris' expectations, will she again ask that he be placed in care? Matthew is a baby who does not know who his birth family is. He is a healthy baby boy who would be very easily adopted, and yet there is a possibility that he may be back in the foster care system in limbo, without a permanent placement.

The legislation sets out the obligation for child welfare to look for kin placements so that children do not remain in care. However, there is sometimes a difference between what is clinically best and legally possible. When a kin placement is approved, should a child always be placed there? Should Matthew have gone back to the same situation that lasted only eighteen days? Should Ariel have been expected to stay in limbo while a sister agency completed a study that was not looking like it would materialize? Should Sherri have been placed with kin when her mother was so determined to make it fail? By following a legal requirement to place with kin, did the field of child welfare make things worse for Sherri?

Although CAST is obliged by the current legislation to actively search for and consider all kin plans for children in care, some of the examples above highlight that this legal requirement does not always support the clinical realities in some family's lives. Is it enough that a kin family passes an assessment that indicates that they are a place of safety and they have an emotional connection to a child? When a social work assessment uncovers information or a set of dynamics that appear likely to undermine this plan, should it still be put in place?

These are important questions from both a legal and clinical perspective. Can there be some flexibility built into the legal system to ensure that seeking out kin placements does not undermine the child's chances of finding a permanent home in a timely manner?

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XIV. IT'S ABOUT TIME: RETHINKING OUR SYSTEM OF CARE FOR YOUTH

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There's a billion people on the planet. What does any one life really mean? But in a family, you're promising to care about everything. The good things, the bad things, the terrible things, the mundane things... all of it, all of the time, every day. You're saying 'Your life will not go unnoticed because I will notice it. Your life will not go un-witnessed because I will be your witness'."[1]

Our kids need a witness.

In **1985** the *Child and Family Services Act* (CFSA) introduced the concept of "extended care" which gave CASs the mandate to provide services to "former Crown wards" up to the age of 21 years.

That was twenty-four years ago. At that time it may have been reasonable to think that youth would be ready to be "launched" on their own. I remember being a front-line worker with a caseload of youth and worrying about where they would find room and board, where they might get a job, who might "look out" for them. The 1985 CFSA amendments were a positive change; they allowed a continuation of support for those youth who had left foster care and still maintained a connection to the Children's Aid Society (CAS). The changes also provided some opportunity for youth to continue with school, as long as they were also able to set up their residence, establish credit sufficient to get a phone and pay utilities. And while the CASs could do this, there was no policy to require them to offer this to youth.

In **1994** the Extended Care and Maintenance (ECM) policy was introduced by a policy memo to ensure that all youth were offered the opportunity of extended care. It also was to provide an alternative to welfare, and later when the Conservative government cut welfare rates, the ECM rate was preserved to provide an incentive for connection to the CAS rather than the local welfare office. The program best supported those who were continuing with education. Youth who had found employment could only receive ECM if their income fell below minimum wage, and if it exceeded this amount the ECM rate was clawed back. Youth who needed to complete their high school education were required to do so from a base of "independent living."

Youth have been advocating for changes to the care system for over 20 years. Their common position has been – **treat us as you would your own kids**. More recently they challenged the government and CASs to revisit policy and programs for youth in care, using one key overriding principle "**What would a good parent do?"** When they were asked recently about services that would assist their transition out of the care system, youth pushed back and stated categorically:

[1] From the motion picture "Shall We Dance," 2004. Miramax Films. Note adjustment "family" rather than "marriage."

"You are asking the wrong question! Don't ask how to better prepare for termination, ask us what we need to help us grow up."

In **2006**[2] over 300 youth in care told government and CASs about the things that most worried them. The fear of leaving care was the most predominant concern. Financial, emotional and educational support were at the top of the list, but in the words of a very wise young person "if you don't deal with the issue of age, there is little point in making other changes. We're just not ready."

Since 2006, many CASs listened to the recommendations of youth. Changes have been made to financial support, and more resources have been made available by government as well as CASs to post-secondary support. A number of agencies have also changed service models in an attempt to provide better emotional support – largely through Independence Workers and peer support programs. The fundamental issue is still not addressed. It's not about planning a better system for discharge, it's about providing the best support possible to grow up.

It's time to deal with the construct we are using to fashion our "system of care" - it's an antique system and by its design it creates uncertainty, anxiety, dysfunction, inability to form relationships and is just hurtful. For kids who come into CAS care for the long term, they are clear: the child welfare system has nothing to do with permanency – it is about preparation to be terminated, detached, ejected, rejected ... and WAY before they are ready to leave.

The ages that define "independence" date back to 1897, when revisions to the *Children's Protection Act* made Children's Aid Societies the legal guardians of all girls under age thirteen, and the new age limit for commitment to the Refuge was set - for girls - at between 13 and 18 years.

From the Archives of Ontario:

... the Industrial Refuge for Girls opened in 1880 as a separate unit of the Andrew Mercer Reformatory for Women. Although separate from the Reformatory, the Refuge was administered by the same Superintendent and Assistant Superintendent, and shared the Reformatory's accountant, surgeon and school-mistress. Responsibility for the inspection of the Refuge, as well as for providing rules and regulations with respect to its management, discipline and policing, rested with the Ontario Inspector of Prisons and Public Charities.

The Industrial Refuge for Girls closed in 1905. At that time, homes were found for a majority of the girls, while others were placed with relatives. A few were transferred to various other custodial institutions.

This appears to be when the age of 18 surfaced, and it continues to guide our system of care. Also from this era:

- The start of the Klondike Gold Rush
- Charles Tupper became Prime Minister, and also Wilfred Laurier in the same year!

[2] Youth Leaving Care: An OACAS Survey of Youth and CAS Staff, April 2006.

- Ford's Quadricycle – which pre-dated the automobile
- Nicholas II of Russia's coronation in Moscow
- The premiere of Puccini's *La Boheme* in Turin
- Oscar Wilde's play *Salome* which premiered in Paris
- The First Modern Olympics since the Roman emperor Theodosius I banned the Ancient Games in AD 393 as part of the Christian campaign against paganism, and
- The "Yes, Virginia, there is a Santa Claus" letter was published in the *New York Sun*.

And women did not have the vote.

It is time to deal with "age" in the statute (CFSA) and there are a number of Ontario precedents for doing so (drivers licensing, mandatory school age, smoking, drinking, consent to sexual activity). Ontario also needs to step up and align with the *UN Convention on the Rights of the Child* regarding the age of protection. We should be supporting kids until they finish school, rather than rushing them out the door before they are ready. While we can hold out for legislative change, it may not come, and even if it does, it may be years away. There is so much we can do in the absence of amendments.

Essentially we have a sequence of "encouraging get ready to leave care" otherwise felt by children and youth as a steady and consistent push over a series of steep cliffs. Not only should the ages of protection and extended care be changed but we need to change the philosophy of care. It is possible to move to a policy of treating long-term foster care as a permanency option for those children and youth who are not likely to go on to adoption. It is possible to proceed with adoption after Crown wardship ends. This requires a change in philosophy and eliminating "programming detachment."

It would mean a shift:

From	To
At 16 years ... Children and youth are advised (or find out) that they can leave care at 16. The **message to youth**: "You're 16. You need to get ready, in less than 2 years you have to be out on your own." OR: If they do leave at 16, and terminate wardship they CANNOT re-enter the care system (which	The concept of "emancipation" is not introduced. Young people stay with their foster family for at least another 5 years. If youth leave care, then the door is open to return. As it would be in a family. The liability of having a youth "out of control of the Society" is acknowledged, but is not the rationale for terminating wardship. **The message to youth:** Your place is with family. Focus on your studies, get a part-time job that will give you work experience, some spending money and hopefully help you decide what you want to do when you finish school.

From	To
they could if they left at 18). The **message** to youth who "check out": if you leave now you can never come back. Sorry.	If you mess up, you can come back.
"I thought I was part of the family, and then my worker told me I had to go to Independent Living Program. Why? All of a sudden I realized it wasn't really MY family – none of the "bio kids" had to go away to learn life skills. It was weird – I felt like I didn't belong anymore." Youth, 19-years-old. *"I knew Jenny wasn't ready to be on her own, but she was really challenging and testing everyone. She moved in with her mom and the wardship was terminated. It was not good - very chaotic – the mom was still dealing with addictions and health problems. Jenny ended up dropping out of school to take care of her mom. We'd like to help her, but we don't have a mandate anymore." Child and Youth Worker*	
At 17 years … Children and youth are recruited into independent living programs that "program" them to get ready to be out on their own by 17 years or certainly before their 18th birthday. The **message** to youth: "Learn fast about how to manage on your own. You can't stay here beyond your 18th birthday."	Child welfare programs are **not** about preparing for leaving care. They **are** about relationships – family, peers, and other positive relationships. Supports need to be provided to maintain the family-based placement. If in foster care, the foster parents are the "responsible adults" charged with caring. As it would be in a family. In terms of milestones, the future focus is not about transitioning out of care, it's about educational achievement. **The message to youth:** Focus on school, balance work and studies. You are part of our family – be a contributing member. What can we do to help you succeed? Help with school? Dealing with relationships? With finding a part-time job?
"By 17, I was in grade 10 - two years behind because of all the moves. I had to move out, get a place to stay, pay rent, buy food, pay all my bills, do my laundry, buy food, cook, clean. I had to get a part-time job to survive. I couldn't cope with school. I dropped out. I'm trying to get back – maybe I can finish at alternative school." Youth, 20-years-old. *"I wasn't ready to be on my own – I needed someone to kick my butt." Youth, 19-years-old.*	

At 18 years .... ECM allowance at $900+ becomes an incentive to disengage at 17 or 18 years old, if they have not done so already. Youth who continue to live with foster parents must negotiate a rate. The foster parent faces a significant reduction in their monthly allowance and youth often feel they are left begging to stay. Those that do are subjected to police reference checks. For youth ECM rates are a mix of "freedom," but also being pushed out. Seems like a lot of money, until they are out trying to manage rent, food, transportation, utilities, laundry, etc. The research shows that when youth stay in foster care until 21, they do better – in school, jobs, health, relationships.[3]	Life in the family-based setting continues uninterrupted. As it would be in a family. You don't move because you had a birthday. Foster parents continue to get the foster care rate, because they continue to parent. Youth are <u>not</u> offered ECM rates, and the idea of independence is not introduced while the youth is in high school. It's about finishing basic education and exploring options for post-secondary, including trades, apprenticeship, community college or university. The foster family plays a role in helping the youth to complete school, and plan for a more independent lifestyle - as it would be in a family. The concept of ECM is not completely eliminated, but is not the primary model of service. **The message to youth:** It's important that you stay at home until you are ready to move out. At a minimum, this is your home until you are 21. At 18, the status of Crown wardship no longer exists. For many youth in care, the "access" with biological family prohibited adoption. At 18 years of age, this barrier no longer exists. At age 18, **adoption is an option.**
When I was 17 I thought it would be amazing to be on my own, and that it would be easy to manage on $900 a month. I was shocked. The only apartment I could afford was in a very bad part of town, I was afraid to be there – it was dirty, had bugs and scary neighbors. I couldn't even afford that. I had to work part-time, at night. I was exhausted and could not concentrate on my school work. It was just too much for me to cope." Youth, 20 years	
18 - 21 years ... Few youth in care live in foster care while they attend post-secondary because most have already "aged out." Only 42% of youth in care have graduated by the age of 20.[4] The small number of youth on ECM who do attend post-secondary "figure out" how to apply to post-secondary on their own and have few if any family contacts and/or supports during the	In the spirit of "family", young people in care should be supported to go to school in the same way as they would be if they were in a family. If they attend college or university in their home town, the expectation is that they live at home (foster home). Foster parents would support their foster child (youth) at home. It would NOT be reasonable for the youth to have an apartment paid for them in the same town or city (most families could simply not afford that). If youth go to school out-of-town and the cost and time of commuting is prohibitive, then foster parents would help the youth find a place to stay, and the ECM allowance would help pay the student's living expenses. HELP – not completely pay. Before leaving home – just as in a family

[3] See: When should the state cease parenting? Issue Brief, Mark E. Courtney, Amy Dworsky and Harold Pollack, Chapin Hall, December 2007.

[4] Gateway to Success: OACAS Survey of the Educational Status of Crown Wards, March 2008.

school year, and during the holiday period.	– the parents would help the student work out a budget, find an apartment, get a part-time job, and would help with applications for university, for Ontario Student Assistance Program (OSAP), etc. **The message to youth:** Education is important, as is learning to balance work and school. Education is very valuable. As a youth from the child welfare system, you have special help now through OSAP, and we will continue to support you. It is not entirely a "free ride": you have to contribute, too.
It was great being in residence, but then at Christmas they closed for the holidays. I had nowhere to go. All the other kids went home to their families. Youth, 20 and attending community college.	
Money became an incentive to leave care: $663 - 950/mo ECM and another $3300 through the Ontario Child Benefit Equivalent program (OCBE). While it sounds like a lot of cash, it's hardly enough to survive.	The OCBE leaving care allowance is put in trust until the youth is finished high school and starts to plan their move to a more independent lifestyle. **The message to youth:** It's a Trust Fund, as if it was created by a benevolent aunt or uncle to help open doors to new opportunities.
I think the OCBE will be a great support to youth when they leave home. I thought the ECM would be enough, but I had no money to set myself up. Even though I'm on my own, I still don't have a bed. Youth – comments on new Ontario Child Benefit Equivalent Program.	
21 = I have no support.	The family relationship is established, firm and lasting. Twenty-one is not termination. The door is open and youth can plan a semi-independent lifestyle. Part-time job, school, contributing to the family. And, at 21 adoption is an option.[5] **The message to youth:** We are your family, we will support you. The door is open.
I worry – who will be there at my graduation, when I get married, have my first baby? There is no one.	

The basic approach would be to change the message – one that currently is of cumulative rejection.

Children and youth in care fear the milestones that others celebrate. We start worrying them with "independence training" in their early teens. Youth tell us that they are preoccupied with these terminations, and fearful of being on their own. This interferes with them getting on with school, making friends, building positive connections. One way to control life is to take charge – and many youth do this by leaving on "their terms," almost always too early.

Another helpful analogy ….

Imagine you have just been hired. Your employer says

[5] See: Patrick O'Brien, You Gotta Believe http://www.yougottabelieve.org/

"Welcome aboard. We're a tight team here – we do great work, we value you and we look forward to you giving us your best – and we will give you great opportunities. But by the way, you have a 4-month contract. And even if you are the best person we have ever had at our company we WILL be terminating your employment after 4 months. Yup – that's right – we want 110%. And we will terminate you."

Your reaction? Dismay, despair, panic, anger, and … start looking for your next job NOW! Detach!!!

So here are some radical thoughts.

- What if we eliminated ECM as the primary program for youth in care, and used it only as a last resort?

- What if we freshen up other aspects of foster care?

  - We treat the fostering situation as the "permanency plan" and have young people stay in family based care (the SAME family) until they are finished school.

  - We assume that most are not finished high school until 20 (which is a bit optimistic based on current statistics which tell us that less than half have completed high school by the age of 20).

  - If youth need to do the "victory lap"[6] like many other kids, they are still at "home" and not struggling to survive.

- What if we consider that adoption is an option – for older teens, and for young adults?

For a 14-year-old in care, the idea of staying at home until 21 is a lot different than having to become independent at 17. Let's think about **what a good parent would do.**

The legislation does not prescribe how CASs provide extended care -- it just says they **may** extend care. Let's focus on the "caring."

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[6] Term used to describe taking an additional year in high school to earn additional credits, repeat courses or improve grade average. Some young people also use the extra time to explore education and career options.

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