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FEATURES

Miranda is the first daughter of Hsiang Fei Lu,
Supervisor of Training at OACAS.

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Message From the Executive Director

As the fall season begins, our minds turn to the public awareness campaign to prevent child abuse, recognized across the province during October.

The Ontario Association of Children's Aid Societies (OACAS) and its member agencies are preparing to build awareness and educate Ontarians about child abuse prevention through October's Child Abuse Prevention Campaign, using the *Use Your Voice* theme and the purple ribbon symbol. This year, the public is reminded that "Abused children don't always look it," because child abuse isn't always obvious.

Ontarians can learn more about child abuse, how to recognize the subtle and obvious signs of abuse and how to report it at useyourvoice.ca or parlezpoureux.ca. Useyourvoice.ca is the focal point of this education campaign and provides information on identifying and reporting abuse.

The purple ribbon, symbol of October's Child Abuse Prevention Campaign, is in its fifteenth year and will be seen all over Ontario. Ontario's Children's Aid Societies participate in the bilingual provincial campaign and promote the message and the purple ribbon symbol in their local communities with purple ribbons, wristbands, pins and buttons.

In the last few months leading up to our education campaign, we saw the passage of Bill 165 which gives Ontario an independent Child Advocate reporting directly to the legislature ultimately enhancing advocacy efforts on behalf of children. We saw government provide youth in care with better educational supports such as more tuition grants, application fee subsidies and a new initiative to support Crown Wards so they can succeed through high school to post-secondary education and training. Based on our advocacy efforts, we are glad to see that the government is acting.

In this edition of The Journal, we offer articles on supervision in child welfare, culturally competent practice, understanding risk in youth, the Looking After Children approach, the changing demographics of families and understanding the children we serve.

As the October election approaches, we encourage everyone to wear the purple ribbon, wristband, lapel pin or button during October to show your support for the well-being of children and to create awareness about child abuse prevention.

Jeanette Lewis

Youth in Care and Deliberate Self Harm: Furthering Our Understanding About Risk

By Connie Cheung and Deborah Goodman

Introduction

Deliberate self harm (DSH) for the purpose of this article is defined as: *the deliberate destruction or alternation of body tissue without conscious suicidal intent resulting in injury severe enough for tissue damage.* Internationally, DSH among children and youth (youth) is a growing mental health concern (Laye-Gindhu & Schonert-Reichl, 2005; Owens et al., 2002; Reith et al., 2004). Some common behaviours of DSH include self-cutting/ wound picking, burning/ scalding, self-battery, self-poisoning, self-hanging, head-banging and other self-inflicted injuries that place the youth at risk.

Around the world, suicide is among the top three causes of death for both males and females between ages 15 to 44 and DSH is an established risk factor for suicide (Hawton et al., 2003,). Further underscoring the importance of this link a recent study found the year after DSH about 16% will repeat and 2% will die by suicide (Owens et al., 2002). An important risk factor for DSH includes childhood maltreatment. Since DSH significantly predicts an increased likelihood of self-harming behaviours and suicide in later life (Gratz, 2003, Reith et al., 2004) and it is estimated that 5% to 10% of youth in care engage in DSH (Goodman, 2005) it is therefore critical to better understand DSH in a child welfare population and the risk and resilience factors associated with it. Increasing our knowledge advances our ability to detect, evaluate, treat and ultimately prevent this growing mental health issue.

Towards that end, the Children's Aid Society of Toronto (CAS-Toronto), a mandated child welfare agency serving approximately 30,000 youth a year (of which nearly 2,100 are in care at any point in time), has been conducting a longitudinal study of its youth in care with a DSH incident (includes harm or threat of harm). Study aims are: 1) to describe the frequency of DSH behaviours of youth, 2) to describe the risk and protective factors associated with DSH, and 3) to explore treatment strategies that are effective in reducing the number of DSH episodes in youth in care. This article presents the study's longitudinal analysis and preliminary study data and results as well as highlights potential implications and suggests areas for future exploration.

Frequency of Deliberate Self Harm

Perhaps one of the most extensively studied areas of self harm is its prevalence. A considerable amount of the research has employed clinical samples (e.g. hospitals, treatment and in-patient data) with often over a third of the sample noting DSH. A number of factors can influence the prevalence rate such as the type of DSH included (e.g. harm

only vs. harm and threat vs. requires medical attention) or the breadth of the DSH definition employed (e.g. only cutting vs. including a variety of methods) or the variation in the study's methodical approach. Recent prevalence studies of DSH in more normative, community-based samples, set the estimate at between 7% -35% youth having engaged in some form of deliberate self harm (Evans et al, 2005; Laye-Gindhu et al., 2005; Gratz, 2001, 2006). Overall, there appears to be consensus amongst mental health professionals and related researchers that that DSH is a flag of mental health concerns and the prevalence of DSH in children and adolescences seems to be rising (Gratz, 2003). So how frequently are youth in care engaging in DSH? Do males differ from females in the frequency of DSH events?

Study: Part I – Longitudinal Analysis of DSH Events

To begin to try and answer the many questions associated with DSH, from 2004 forward CAS-Toronto data from the Ministry of Child and Youth Services (MCYS): Serious Occurrence Data (SOR) form related only to a DSH event or threat of DSH is inputted into a statistical database (SPSS). When examining prevalence of DSH in a child welfare population, longitudinal analyses (2004-2005-2006) finds much consistency, such as with the average number of DSH by gender, age range of youth, and the ratio of youth with a single DSH to youth with multiple DSH [See Table 1]. Analysis of five Societies' 2003/04 SOR data found between 6%-10% of youth in care had a reported self-harming incident (Goodman, 2005). Our examination finds very few youth (less than 10%) with a DSH event in one year repeat DSH in the following year. Furthermore, the analysis of the SOR data finds a small number of youth typically account for a significant proportion of the total number of DSH events. On the face of it, this seems somewhat counterintuitive given the many risk factors youth in care often present with.

Examination of the 2005 SOR-DSH data does provides greater insight regarding the profile of youth in care with at least one DSH incident in a year. The 2005 data set involved a total of 90 youth between 7 to 21 years-of-age (*M* age=15 years). Both the age range and mean age is consistent with other years' data, where a youth with one or more DSH events is typically between 14 to 16 years of age. The 2005 SOR data found the 52 boys and 38 girls were roughly matched in age. Between-group differences (single DSH event vs. multiple DSH events) were examined. Of the total sample, 80% (n=72) engaged in one DSH episode whereas 20% (*n*=18) had multiple DSH incidents. Again, this is similar across years where of the DSH youth, 75%-80% will have a single DSH event and 20%-25% will have multiple DSH events (Goodman, 2005). Analysis did not find evidence these two groups differed in terms of gender, age or ethnicity. More importantly, these two groups also did not differ in the amount of self-harming threats or attempts. Within-group differences of youth with multiple DSH incidents were found.

Specifically, differences between genders emerged. With repeat DSH incidents, girls were more likely to engage in more then two DSH episodes, whereas boys were more likely to engage in only two DSH events, ($F(1,17) = 8.15$, $p=.01$).

Longitudinal analysis further supports this finding where DSH males average 1.3 to 1.8 events per year versus females at 2.8 to 3.0 DSH events.

These results suggest for youth with multiple DSH incidents, the chronicity of self harm may differ across genders, where girls in care may experience more chronic forms of DSH. For the multiple DSH youth analysis did not find significant differences in cultural background or age.

TABLE 1: Longitudinal Analysis of 2004, 2005, 2006 CAS-Toronto DSH Data

	Single DSH Event	Multiple DSH Event	Total Youth DSH Event	Average # DSH/ Youth	Single DSH Youth to Multiple DSH	Single DSH Events to Multiple Events
2004	**DSH Age Range:**					
Male	43 males with 1 DSH	14 males with 61 DSH	57 males with 104 DSH	1.8	75%:25%	33%:67%
Female	33 females with 1 DSH	11 females with 98 DSH	44 females with 131 DSH	2.9		
TOTAL	76 youths with 1 DSH	25 Youth with 159 DSH	101 youth with 235 DSH	2.3		
2005	**DSH Age Range 7 to 21**					
Male	42 males with 1 DSH	10 males with 52 DSH	52 males with 94 DSH	1.8	80 %: 20%	35%:65%
Female	30 females with 1 DSH	8 females with 84 DSH	38 females with 114 DSH	3.0		
TOTAL	72 youths with 1 DSH	18 youths with 136 DSH	90 youth with 208 DSH	2.3		
2006	**DSH Age Range 8 to 19**					
Male	10 males with 1 DSH	4 males with 9 DSH	14 males with 19 DSH	1.3	77%:22%	34%:66%
Female	21 females with 1 DSH	5 females with 52 DSH	26 females with 73 DSH	2.8		
TOTAL	31 youth with 1 DSH	9 youth with 61 DSH	40 youth with 92 DSH	2.3		

Study: Part II-Examine Risk and Protective Factors Associated with DSH

There is emerging evidence to suggest that the development of DSH is in part facilitated by traumatic childhood experiences that occur within the family context. For instance, childhood sexual abuse, physical abuse, emotional abuse and neglect have all been found to be correlated with later instances of DSH. Poor attachment and childhood separation and loss have also been found to be related to subsequent instances of DSH behaviours (Gratz, 2004). So why, with in care youth, many with a multitude of risk factors, does the DSH rate appear to be more similar to what is found in the community setting versus the higher rate of DSH found in clinical samples? Are specific protective factors in place that promote resiliency for youth in care so they do not engage in self-harming behaviours? If so, what are they? Are the most potent resiliency factors child specific or are they fostered by the environment? To begin to explore these compelling questions and untangle the risk and resiliency factors associated with DSH or the absence of it, CAS-Toronto is conducting a study of youth in care with DSH and comparing them to youth who do not self harm.

Using the 2005 SOR data set, the study uses a comprehensive file review method. Thirty Crown Wards with a DSH history (single and multiple DSH events in one year) were randomly sampled and matched by age, gender, maltreatment history, and ethnicity to 30 Crown Wards with no DSH history. Crown Wards were selected primarily because a significant proportion of DSH youth are teens and most of these have Crown Ward or ECM status. While the overall study of 60 files is set to be completed for Spring 2008, this paper presents the preliminary results of 18 file reviews conducted to date on youth with DSH in two of the four categories examined: *"Child-specific"* and "*Maternal-specific"* areas.

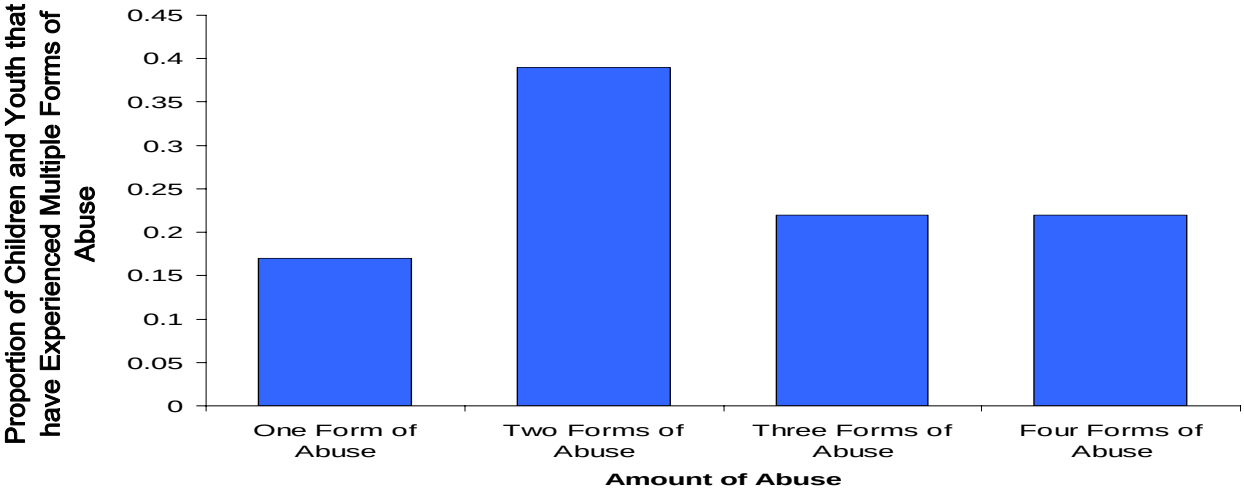
A standardized file review form was developed and data from the youths' psychosocial histories was systematically collected. Two trained reviewers conducted the file reviews. Inter-rater reliability of greater than 80% was set for the reviews to be included. A kappa value of .86 revealed a high percentage of agreement between coders. All disagreements were resolved by going back to the original file and discussed between coders until agreement was reached. The file review has four components. *"Child-specific"* predispositions (e.g. age, gender, experience of abuse and maltreatment); *"Maternal-specific"* factors describe the characteristics of the Crown Ward's mother (e.g., mental health status, education); *"Family-specific"* variables look at the family's environment (e.g., family type, mobility of family); and. *"Social-specific"* variables describe the social climate of the family (e.g., immigration status, cultural background).

Preliminary Results

Analysis of the *"Child-specific"* factors for the 18 files of youth with DSH found that the majority of

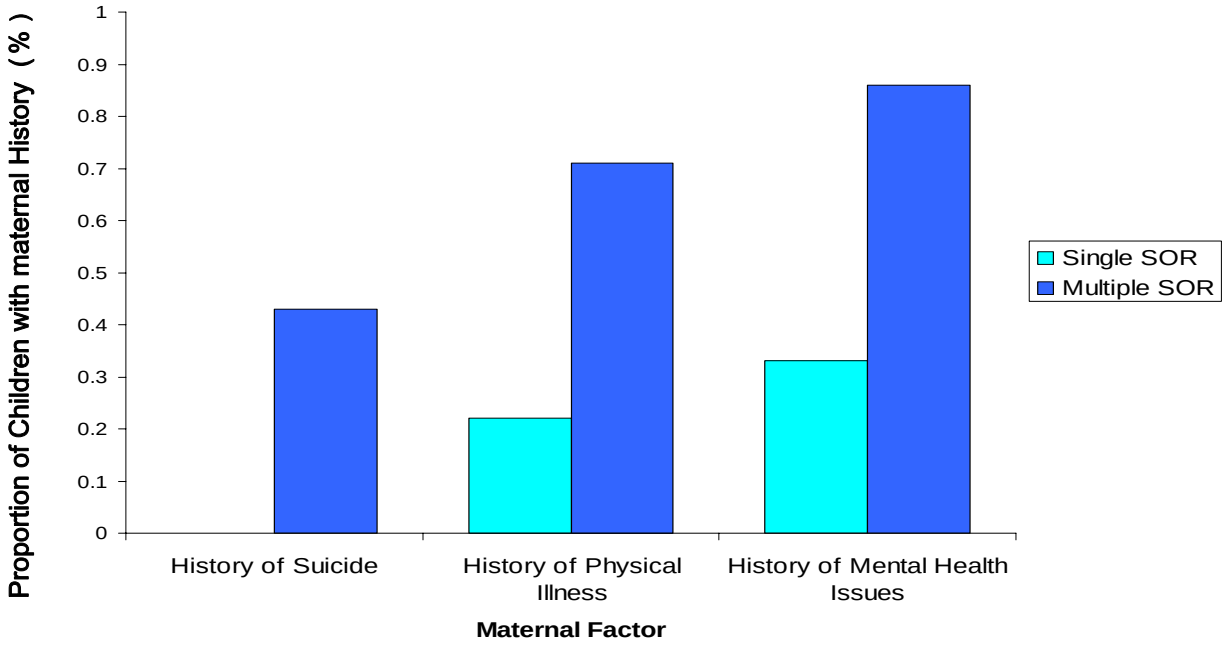
these youth experience a multitude of difficulties in different areas of functioning. More specifically, 94% have a psychiatric diagnosis and nearly two-thirds (61%) experience developmental issues such as learning difficulties and developmental delay. Many have experienced traumatic parental loss (72%) such as death of a parent, and the preponderance of these youth display difficulties in school (67%) and with peers (72%). Furthermore, their experience of maltreatment found alarming consistency as all 18 DSH youth experienced physical abuse, 72% experienced sexual abuse, 39% experienced emotional abuse and 33% experienced neglect. By collapsing the types of abuse, an overwhelming majority (83%) of these DSH youth have experienced two or more different forms of abuse. In other words, only one in six (17%) experienced just one form of maltreatment (refer to Figure 1).

Figure 1: Proportion of children and youth who have experienced multiple forms of abuse



Analysis of *"Maternal factors"* data found a high percentage of the 18 DSH youth's mothers' had a history of substance abuse (59%), mental health issues (56%), history of partner violence (35%), physical health issues (44%) and displayed risky behaviours (30%). Of note, 19% of all these mothers had a history of attempted suicide and 13% displayed self-harming behaviours themselves. Perhaps what is most compelling is the within-group differences between youth with one DSH episode compared to those with multiple DSH incidents. When examining maternal history of suicide (X^2=4.75, p=.03), physical illness (X^2=3.87, p=.05) and mental health issues (X^2=4.39, p=.03), the prevalence of mothers of youth with multiple DSH episodes who displayed these behaviours were significantly ($p < .05$) different from mothers of youth with a single DSH event. More specifically of the youth with multiple DSH instances, 43% of their mothers have a history of attempted suicide, 71% have mothers with a history of physical illness, and 86% have mothers

Figure 2: Mother's history of suicide, physical illness and mental health issues by DSH



with a history of mental health issues. Conversely, amongst youth with one DSH incident, none had mothers with a history of attempted suicide, 22% had mothers with a history of physical illness and 33% had mothers with a history of mental health issues. See Figure 2.

Discussion

Longitudinal analysis of the Part I DSH study data indicate that between 5% to 10% of youth in care have a DSH event: most of these youth are teens and approximately three-quarters will have only one DSH event, which constitute about one-third of the yearly total of all DSH events. Between one-in-four to one-in-five of DSH youth will engage in multiple DSH events where their events total nearly two-thirds of all DSH events. In short, a small number of youth are responsible for a large number of DSH events. When youth engage in multiple DSH events, girls appear to at more risk than boys to have more than two DSH events.

The findings from the study's Part II file reviews of DSH Youth need to be treated with caution as they are preliminary, the sample size is still relatively small (n=18), and data collection remains underway for both the DSH and comparative group. That said, these initial results from the analysis of two of the four psychosocial profile areas of youth with a history of DSH suggest that self harm appears to occur more frequently amongst youth in care who are also experiencing difficulties in other areas of functioning. These early findings also indicate that a multitude of risk child and maternal factors may be associated with DSH. In particular, there ap-

pears to be considerable risk of multiple DSH events for youth with multiple forms of maltreatment and who have a maternal history weighted toward mental health and physical health issues.

Next Steps

Currently, work is ongoing regarding completing the rest of the Part II file review data on the remaining 12 DSH youth as well as with the 30 matched youth who have no history of DSH. While the full comparison of DSH to non-DSH youth is yet to occur, we anticipate certain child-specific factors may emerge as protective factors that can possibility promote resiliency in non-self-harming children. These include higher cognitive and social functioning, better mental health and good academic performance. By exploring group differences it is possible to begin disentangle how risk and protective factors operate in relation to DSH in youth in care.

Part III of the study is underway but not complete. It asks the question: Which treatment and intervention strategies are most effective in reducing self harm? To address this query, CAS-Toronto is also conducting a serious of semi-structured worker interviews where the worker has case responsibility for a youth with DSH experience. The study explores workers' perceptions of the effectiveness or ineffectiveness of various intervention and treatment strategies used with their youth who self harmed. To date, a total of six worker interviews have been conducted, three have been with workers whose youth were able to reduce or stop their self-harming behaviours and three workers where the youth did not show an improvement in their self-harming behaviours. The age of these clients ranged from 10 to 18-years-of-age with equal number of boys and girls. The results of this element of the study will also inform the larger study findings.

What We Know So Far and What We Need to Know

DSH occurs with some community youth and DSH occurs with some youth in care. Analysis to date of the longitudinal data suggest youth in care are no more likely to self harm then youth in the community. Given the multitude of risk factors youth in care often have this finding seems somewhat counterintuitive and an empirical based rationale is neither readily apparent nor self-evident. It is hoped that further research will shed light on this but one speculation is that while the rate may be similar the level of severity of DSH incidents in child welfare youth may be much greater than in the general population.

The longitudinal analysis consistently finds that DSH can commence for some children as early age six or seven, although typically most DSH incidents involve teens. Greater awareness of DSH in young children is needed along with the need of tools to assist in screening for DSH in order to actualize early intervention. We also know that of

the youth in care with a DSH event, approximately 75%- 80% will have one DSH episode whereas 20%-25% will have multiple events. What also appears to be emerging with DSH youth in care is that many have experienced multiple forms of maltreatment and display difficulties in many areas of functioning.

Preliminary results underscore the importance of a comprehensive approach to research in the area of DSH. Although we have a better descriptive understanding of self harm, what remains relatively unclear are different social correlates that may be associated with DSH. More importantly and especially for youth with multiple DSH events and in particular for those who have DSH events year after year, we have a rather limited understanding of how DSH behaviour changes over time and of the developmental trends that may be associated with this behaviour. These are important questions for the field to know and for research to begin to help answer.

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Moving Beyond the Symposium: Creating a Model for Child Welfare Supervision in Ontario

By Katharine Dill and Marion Bogo

Introduction

With the evolving Transformation Agenda of the Ministry of Children and Youth Services and an emphasis on a collaborative and strengths-based approach with clients, the need for a clinical supervisory framework became apparent. A working group led by Andy Koster, Executive Director, Children's Aid Society of Brant created the impetus for research on clinical supervisory practice. More information specifically related to the core elements of clinical supervisory practice in child welfare was required. Katharine Dill, doctoral student at the University of Toronto initiated a study of clinical supervision in child welfare with Marion Bogo, Professor at the University of Toronto. Funded by a Fellowship from the Royal Bank of Canada this study used a qualitative design to examine underlying beliefs, values and core practice elements of clinical supervision from the unique vantage point of the child welfare supervisors.

Study findings were presented at the Clinical Supervision Symposium: Realizing Best Practices in 2007, sponsored by the Ministry of Children and Youth Services and the Ontario Association of Children's Aid Societies on May 15 and 16, 2007. This article uses these findings to provide a framework and guidelines for implementing a supervisory model in organizations at the agency-based level. Individual organizations can use this template to develop a model tailored to specific local need and resources.

Brief Summary of Research Study

Eight focus groups were held in CASs across the province between November 2005 and February 2007. Focus groups provide individuals an opportunity to reflect on their perspectives and ideas with other participants with similar interests (Cresswell, 1998). A total of 51 supervisors participated in the study and provided a significant wealth of information about the core elements of clinical supervision in child welfare practice.

At the Supervisory Level

The foundational literature on social work supervision articulates three interrelated domains of social work supervisory practice: administrative, clinical and educational (Kadushin & Harkness, 2002; Munson, 1993; Shulman, 1993). Supervisors use these domains to achieve the mandate of child protection within the contemporary emphasis on collaboration, strengths, and client empowerment. The following are suggested ways to engage in a model of clinical supervisory practice within the context of child welfare.

Components of Social Work Supervisory Practice

- Administrative supervisory practices involve case assignments, reviewing and approving case recordings, and implementing quality assurance issues relating to case management (Kadushin & Harkness, 2002)

- Clinical supervision entails exploring client situations, focusing on social workers' engagement strategies and interactions with client families, attending to individual and interpersonal dynamics between family members that contribute to child maltreatment, and encouraging critical thinking and analytical skills (Bogo & McKnight, 2005; Collins-Camargo, 2006; Deal, 2003; Kadushin & Harkness, 2002; Munson, 1993; Shulman, 1993).

- Educational supervision shifts the front-line child welfare practitioner from "knowing to doing" (Collins-Camargo, 2006; Kadushin & Harkness, 2002). It applies theoretical knowledge to practice. Educational supervision involves teaching and educating social workers and assisting in developing the skills required to do their work effectively (Gitterman, 2000; Shulman, 1993).

Integrating the literature and voices of supervisors who participated in the study, the following are suggested ideas for infusing clinical supervision into a strengths-based approach to practice.

Instill the Values and Beliefs of Protecting Children and Supporting Families

Supervisors inspire workers through their commitment to the belief in the importance of child welfare work to promote healthy development for children in vulnerable circumstances. In a sense, the supervisor becomes the role model for demonstrating commitment to the safety and protection of children through their willingness to "go the extra mile."

Clinical Foundation

In our study, participants recalled their early experiences as supervisors. Certain individuals emphasized how as front-line practitioners they were trained in a specific clinical model or framework. This foundational knowledge created a "framework for supervision…a clear structure". They in turn drew upon this clinical knowledge when they transitioned into the role of the supervisor.

Some individuals reported that the risk assessment had become their dominant framework for providing child welfare supervision, thereby precluding a clinical emphasis or model of practice. Training agendas should include providing an in-depth clinical framework to front-line staff members, who in turn will become the supervisors of the future.

Moving Beyond the Administrative

Supervisors are knowledgeable about agency proce-

dures, administration, and accountability and can also focus on crucial clinical issues such as client engagement, empowerment, diversity and strengths-based approach. The Transformation Agenda sets the tone for supervisors to move beyond the administrative elements of practice and also to engage in a dialogue with staff members about the clinical components of practice.

Power and Authority

Supervisors understand the tensions inherent in the dual aspects of child welfare work: 1) the worker has power and authority as a result of the agency's mandate to protect children and 2) the worker is also expected to work collaboratively with clients to assist them in their parenting while holding them accountable for non-abusive parenting practices. Supervisors in turn can use their power and authority with workers based on knowledge and skill about how to manage this tension. Supervisors communicate in a mutual style that invites dialogue and is open to hearing different opinions.

Staying Current

Supervisors are knowledgeable about current professional literature and empirical findings and model evidence-informed practice. This can be achieved through participating in journal or book clubs, peer supervision groups and a linkage to schools of social work to learn about current trends in research and evidence-informed practice.

Supervisory Relationship

The supervisory relationship is highly influential and is characterized by a number of features and processes.

- **Availability of the supervisor**: Supervisors provide regularly scheduled supervision conferences that are structured. They protect the time and find a private place to meet. Since there is never enough time supervisors use their time strategically to focus on worker development.

- **Provide a positive and supportive relationship** where the supervisor demonstrates "faith in the worker's capacity to learn and grow." With this strong foundation, trust can develop, difficult issues discussed, and challenge can be accepted as growth producing rather than judgmental or punitive.

Integrate Educational Approaches

- **Supervisors develop an individual learning** and development plan for each worker that takes into account the worker's experience, learning needs and style.

- **Supervisors develop workers' skill** through examining workers' interaction with clients and helping workers transfer new knowledge and skill to their work with subsequent clients

- **Supervisors use questions and discussion to**:

◊ Enhance workers' critical thinking and self-reflection skills, to identify clinical questions in cases (i.e. to formulate assessments that address the dynamics and processes in a specific family that lead to involvement with child protection) and in workers' relationships with clients (i.e. enhancing workers' self-awareness and understanding of their own reactions to specific behaviors and attitudes on the part of clients)

◊ Contribute to workers' understanding of dynamics between worker and supervisor, and in team interactions.

- **Supervisors use teaching techniques** such as case review and observation of workers in their practice through video review, going out with workers to visit families, and observing interviews from behind a one-way mirror. These methods are also useful to assess workers' skill and progress.

At the Organizational Level

Integrating the review of the literature and voices of supervisors who participated in the study, the following are suggestions for organizational support and professional development of supervisors.

New Supervisors

New supervisors require a foundational level of support, guidance and mentoring when they begin in their new role. Just as new workers require orientation, professional training and support, so do supervisors. Organizations require a training plan for new supervisors which should include OACAS training as well as structured observation and discussion of their supervision, peer support and mentoring from more experienced supervisors.

Supervisory Professional Development Series

The following topic areas could become the framework for a supervisory professional development series that can be developed within agencies or provincial zones. Topics in this outline are particularly beneficial for supervisors who are just beginning their role. These suggested themes and subject areas should be supplemented by topics that reflect organizational and geographic characteristics and needs:

- Role of the Child Welfare Supervisor
- Child Welfare Supervisory/Leadership Competencies
- Promoting Critical Thinking in Child Welfare Supervision
- Parallel Process: What is it and how do We Promote Self-Awareness for ourselves and staff members?
- Balancing the Need for Clinical, Educational

and Administrative supervision
- Role of the Child Welfare Supervisor as the Adult Educator
- Managing and Leading a Team Environment
- Impact of Stressors on Front-line and Supervisory Staff
- Ethical Issues in Child Welfare Supervision
- Liability Issues for Child Welfare Supervisors
- Culturally Competent Child Welfare Supervisory Practice
- Integrating Evidence-Based Practice into Social Work Supervision

Supervision for Supervisors

Supervisors themselves require a venue for exploring issues of parallel process and critical thinking and analysis. Despite this, many supervisors in the focus groups highlighted the lack of structured supervision for themselves to enhance their clinical capacity. Senior managers need to ensure that a structured supervision schedule is in place for their entire supervisory group despite the supervisor's years of experience and level of capacity. All supervisors, new and experienced require a venue for exploring the complex issues of child welfare practice.

Peer Support

One of the fundamental findings resulting from the study was the ongoing need for peer support for child welfare supervisors. Peer support can occur through informal or formal support networks including journal or book clubs, mentoring programs for newer supervisors, and on-line peer support networks for supervisors operating in remote locations.

Organizational Support

All levels of management contribute to the organizational climate for clinical supervision. Understanding the conceptualization of clinical supervision in child welfare, its contribution to positive client outcomes, job satisfaction, and employee retention enables Executive Directors, Directors of Service and Branch Managers to champion and support the time and activities associated with this view of supervision. The role of the senior management team and in particular the Executive Director of the organization is essential to the overall success and sustainability of a clinical supervisory framework.

Executive Directors in particular require an understanding of organizational parallel process: their decisions and actions influence those around them, and these behaviours ultimately have an impact on client outcomes. Executive Directors who understand their own challenges as leaders and are open to dialogue and support the enhancement of supervisory skills can promote and sustain an overarching organizational model of supervisory practice.

Senior managers can:

- Validate supervisors' role as clinicians

- Provide emotional support to supervisors
- Help supervisors balance clinical and administrative issues
- Assist supervisors in attending to their own personal and professional reactions to difficult and challenging case situations

Research and Practice

One of the core functions of the supervisor is to enhance the professional knowledge of supervisees. Therefore, any supervisory model of practice should include the dissemination and integration of relevant research findings into practice. The promotion of critical thinking and analysis of research is critical in the ongoing development and formation of child welfare supervisors. Supervisors can access high quality child welfare and related research through the following links:

OACAS Members website:
www2.oacas.org

Child Welfare League of Canada website:
www.cecw-cepb.ca

Centre of Excellence Website:
www.cwlc.ca/index_e.htm

Provincial Centre for Excellence for Child and Youth Mental Health at CHEO (Children's Hospital of Eastern Ontario) website:
www.onthepoint.ca

Specific findings from this study can be accessed at the Faculty of Social Work, Institute for Evidence-Based Practice, Competency for Professional Practice Initiative:
www.socialwork.utoronto.ca/competency

As the field grows and develops and further research evolves there will continue to be development of a supervisory model of practice. The ideas presented here are guidelines for supervisors and organizations that emanate from the literature and the voices of child welfare supervisors in Ontario. Ultimately, they will need to be tested to determine their effectiveness in improving client outcomes and performance of the child welfare sector.

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How useful do Ontario Child Welfare Workers and Foster Parents find the Assessment and Action Record in the Looking After Children Approach?

By Sarah Pantin and Bob Flynn

The Looking After Children approach (LAC), originally developed 15 years ago in the United Kingdom but adapted to a Canadian setting, is now being used widely in Ontario. A core document of this approach is the Assessment and Action Record (AAR) which is used annually to assess children in care. The document currently in use is the Second Canadian Adaptation of the AAR, commonly known as the AAR-C2 (Flynn, Ghazal, & Legault, 2006). The purpose of this article is to briefly describe the LAC approach and report the findings of two recent studies which investigated how useful child welfare workers and foster parents in Ontario found the Assessment and Action Record in their work with children.

What is LAC?

In the nineties, there was a growing concern that many children and youth in long term foster care in England were not getting the type of care and resources that they needed (Jackson, 1988/89; Parker, Ward, Jackson, Aldgate, & Wedge, 1991). The LAC approach was developed to address some of these concerns and to try to ensure that workers and foster parents systematically identify and target the child's changing needs. The LAC documentation addresses seven central developmental domains in the child/youth's life (Parker et al., 1991): health, education, identity, family and social relationships, social presentation, emotional and behavioral development, and self-care skills. In

order to do this, the team providing care needs to be aware of the child's strengths, current service needs and available resources, information which is obtained in major part through the completion of the Assessment and Action Record (AAR). The LAC approach was imported into Ontario in the late nineties and its use has continued to grow since that time.

How Does the AAR Work?

The AAR-C2 is the core document by which the Looking After Children approach is operationalized in Ontario. The purpose of the document is to monitor the progress of the child/youth, and it is designed to be completed by the child welfare worker, foster parent and the young person (if he or she is 10 years of age or older) during a conversational interview, conducted once a year. The document consists of items covering the seven developmental domains mentioned earlier and is used to assess the child's functioning in each domain. Based on the findings, the participants then collaboratively develop a plan of care that will build on the child's strengths and address the needs identified. It is intended that the process will open up dialogue and strengthen the relationships between the child, his caregiver and the worker (Klein, Kufeldt & Rideout, 2006).

The Two Studies

The purpose of the two studies summarized here was to investigate how useful child welfare workers and foster parents in Ontario found the AAR-C2. The current research was part of a larger evaluation of the implementation of LAC in the province of Ontario (Flynn, Angus, Aubry, & Drolet, 1999). Specifically, we were interested in investigating the relationship between training, experience in using LAC, and the perceived utility of the AAR-C2 for child welfare workers and foster parents.

Child welfare worker study

In our first study, we surveyed 228 Ontario child welfare workers and supervisors who had been using the AAR-C2 (in this article, we refer hereafter to the AAR-C2 simply as the AAR). The survey consisted of a number of items asking about the perceived quality of training, how much they had used the AAR, and whether they used the AAR in supervision (see Pantin, Flynn, & Runnells, 2006, for study details). We hypothesized that the amount and quality of LAC training, the amount of experience in using the AAR, and the frequency of discussion of AAR-derived information in supervision would all be positively and significantly related to a more favourable evaluation of the AAR by the workers and supervisors.

Who took part in the child welfare worker study?

Of the 126 who responded, 93 (74%) were currently child welfare workers, 30 (24%) were super-

visors, and three (2%) had assumed other positions (e.g., coordinator of training) within their local agencies. Overall, the participants were relatively experienced, 52% having worked in child welfare for more than 10 years and only 1% for less than two years. Most had been employed for a substantial amount of time at the local CAS where they were working at the time of the survey in 2004: 48% had been at their local CAS for more than 10 years, and only 2% for less than two years. The size of their active caseloads ranged from zero (in the case of 20% of the participants who occupied exclusively supervisory or other non-direct-service roles), through One to 10 young people in care (9% of the participants), 11-15 (10%), 16-20 (22%), 21-25 (26%), and more than 25 (13%).

How much training had they had?

The majority of respondents had received two or more days of training. Ten percent of the 126 core respondents said they had received less than one day of LAC training, 29% had had one day, 34% two days, and 27% three or more days of training.

With how many young people in care had they completed the AAR?

Seven percent of the study sample had completed the AAR or used it in supervision with only one young person in care, while 11% had used it with 2 young people, 14% with 3, 16% with 4 or 5, 16% with 6-9, 20% with 10-15, 2% with 16-20, and 15% with more than 20 young people in care.

How frequently did the participants discuss the information in the AAR in supervision?

Eight percent of the child welfare workers said that they used it **"**often or always," 46% did so "from time to time", and 46% "rarely or never." By contrast, the 30 supervisors were considerably more likely to have discussed AAR information in supervision: 23% said they did so "often or always," 70% "from time to time," and only 7% "rarely or never".

Quality of training

Table 1 shows that the majority of respondents found the training prepared them either "well" or "very well" to use the AAR.

Utility of the AAR

Table 2 shows that the majority of respondents found the AAR useful or very useful. Respondents appeared to find the AAR most useful in helping them better understand the needs of the young person in care and in helping them collaborate more effectively (directly or through supervision) with the foster parents or other caregiver in implementing the young person's plan of care.

Key findings

We tested our hypothesis that the predictor variables—the amount and quality of LAC training, the amount of experience in using the AAR, and the

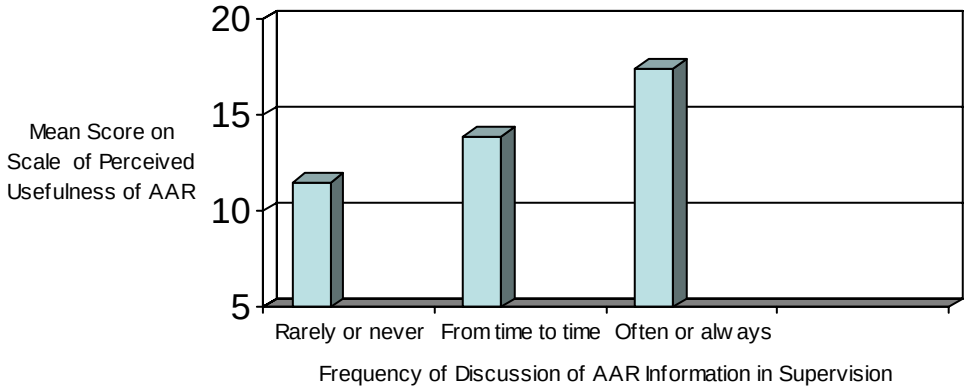
frequency of discussion of AAR-derived information in supervision –would all be positively and significantly related to a more favourable evaluation of the AAR.

When we calculated the degree of correlation (relationship) among the variables, we found that all four predictor variables were positively and significantly related to the outcome variable, namely, the utility of the AAR. The frequency of discussion of AAR information in supervision had the strongest association with the utility of the AAR ($r = .57$).

When all four predictors were used together, each of them added to the overall predictability of the utility of the AAR in the eyes of the workers and supervisors. The most important predictors were the quality of LAC training and the frequency of discussion of AAR information in supervision, but the amount of LAC training received and the number of young people with whom the AAR had been used also provided additional predictive power.

We went on to examine the role that frequency of discussion in supervision played in the perceived usefulness of the AAR. As can be seen in Figure 1, respondents who reported that they frequently discussed AAR information in supervision evaluated the utility of the AAR significantly more favourably than those who did so only rarely or virtually never.

Figure 1. Mean Scores on Scale of Perceived Usefulness of AAR, by *Frequency of Discussion of AAR Information in Supervision*



What do these findings suggest?

The results of this first study indicate that there are two especially important factors associated with how useful child welfare personnel find the AAR. First, it is important that child welfare workers and supervisors receive **high quality training**. The training event should, therefore, last for the full two days called for in OACAS' OnLAC training model, so that all the curriculum material is adequately covered. Second, it is important that the **information from the AAR be discussed in supervision on a regular basis,** as workers and supervisors who report that they discuss such information in supervision often or always perceive the AAR as considerably more useful than those who discuss it only from time to time or rarely or never.

Foster parents' study

The findings of the first study led us to investigate whether we find the same things among foster parents. Specifically, we hypothesised that foster parents would perceive the AAR as more clinically useful if they had had more rather than less LAC training, had perceived their training as being of higher rather than lower quality, and had had more rather than less experience in using the AAR. Since foster parents do not receive ongoing supervision, we did not examine this predictor.

Who took part in the study?

For the second study, the pool of potential participants included the foster parents and kinship-care providers for all children and youth aged 10 and over currently living in a foster home in Ontario and who had completed an AAR in Years 1 and 2 of the study. There were a total of 228 foster children in this sample and 196 foster parents (some of the latter provided care to more than one foster child). Ninety-three of the foster parents had responded to the survey, had used the AAR, and had also received LAC training. These 93 foster parents formed the research sample for Study Two. The same instruments were administered as in the child welfare worker study, with the question relating to supervision omitted.

What did we find?

Of the 93 foster parents, 31% (n = 29) had received one day or less of training, while 69% (n = 64) had received two days or more. Twenty-eight percent had completed the AAR with only one young person in care, while 26% had used it with 2 young people, 13% with 3, 14% with 4, and 19% with five or more. Concerning the quality of LAC training received, Table 1 shows that, as had been the case with the child welfare workers and supervisors, most of the foster parents found that the training prepared them either "well" or "very well" to use the AAR. As can be seen from Table 2, foster parents found the AAR most useful in helping

them contribute to more useful plans of care and having more targeted discussions with the young person in care.

Hypothesis Test

When we looked at the correlations among the variables, the quality of LAC training (as rated by the foster parents) had a relatively strong relationship with the outcome, namely, the perceived utility of the AAR. The amount of LAC training was also significantly related to the perceived utility of the AAR (r = .58), whereas the amount of foster-parent experience in using the AAR, on the other hand, was not. When we combined the quality and amount of LAC training in a predictive model, only the quality of training emerged as a significant predictor of the perceived usefulness of the AAR.

What does this mean for foster parents?

Again, the findings suggest that training is an important factor in how useful foster parents perceive the AAR to be. The majority of foster parents found that the training prepared them either "well" or "very well" to use the AAR. As with the child welfare workers, the quality of training is clearly very important in how useful foster parents perceive the AAR to be.

Comparing child welfare workers/supervisors and foster Parents

Table 2 shows the levels of perceived usefulness of the AAR for our samples of child welfare workers/ supervisors and foster parents. Although both groups found the instrument useful in their work, the foster parents gave it slightly higher ratings, perhaps because their role in completing it is less onerous. It is noteworthy that both the foster parents and the child welfare workers/supervisors identified the AAR as being particularly useful, respectively, in contributing to or constructing the plan of care. Also, the child welfare workers/ supervisors identified the AAR as helping them collaborate more effectively with the foster parents or other caregivers in implementing the young person's plan of care, a sentiment that was echoed by the foster parents.

The role of the amount of experience in using the AAR seems to be different for child welfare workers and foster parents.

In the child welfare worker study, the amount of experience (i.e., the number of children with whom the AAR had been completed) was found to be a significant predictor of perceived utility, suggesting that the more the child welfare worker or supervisor uses the instrument, the more useful s/he finds it. This was not the case for foster parents, where there was no significant association between the amount of experience in using the AAR and per-

ceptions of its utility. This may be because, on average, the foster parents reported less experience with the instrument than did the workers/ supervisors. Specifically, 19% of the foster parents indicated that they had used the AAR with five or more children, whereas 53% of the workers/ supervisors reported using it with 6 or more children. Thus, although the "experienced" foster parents were experienced relative to their peers, they had less experience with the tool than the workers/ supervisors did. Given that the AAR is a comprehensive and detailed document, **foster parents may need to accumulate relatively more experience in its use before they are able to see its usefulness for their work**. Also, LAC training should aim at promoting high but attainable goals in work with foster children and adolescents. Situating the AAR within the broader context of LAC's emphasis on child development and resilience will encourage high but realistic expectations about **how quickly progress is likely to be achieved with children whose needs and strengths vary over a broad range.**

The role of supervision

One of the central issues to emerge from these studies is that discussion in supervision of the information provided by the AAR was strongly associated with workers' and supervisors' perception of the usefulness of the tool. For foster parents, on the other hand, the AAR seemed most helpful in helping them formulate suggestions about the plan of care. This suggests that foster parents are likely to find the approach more useful when the AAR is meaningfully used in the foster parents' contact with the agency. Although the plan of care will remain the central document used in providing daily care to the foster child/youth, **it is important to stress to foster parents that the information in the plan of care is frequently identified through completion of the AAR. Thus, their role in the AAR conversational interview is very important, such that the eventual plan of care is based on the views of all members of the foster team.**

About the Authors:

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Table 1.
Percentage of participants responding that the LAC training covered items either "Well" or "Very Well."

Item	*% of child welfare workers responding "Well" or "Very Well"* *(N=126)*	*% of foster parents responding "Well" or "Very Well"* *(N=93)*
Coverage of key values and principles of LAC	98	98
Preparing foster parents (or child welfare workers) to play their part in the preparation of (or prepare) the AAR	88	96
For preparing foster parents to play their part in implementing the plan of care.	79	91

Table 2., next page

Table 2.
Percentage of Child Welfare and Foster Parents who Responded that the AAR helped them to Perform their Duties "Well" or "Very Well."

Item	*% of child welfare workers responding "Well" or "Very Well"* *(N=126)*	*% of foster parents responding "Well" or "Very Well"* *(N=93)*
Helping them better understand the needs of the young person in care	77	79
Helping them collaborate more effectively (directly through supervision) with the foster parent or other caregiver in implanting the young person's plan of care	73	79
Helping them prepare (or contribute to) more useful plans of care	70	84
Helping them assist the young person in planning his or her future	70	77
Helping them to do their direct-service or supervisory work more effectively/ Helping them to clarify foster parent responsibility	66	73
Helping them have more targeted discussions with young person in care	64	80

Changing Household Demographics: Ontario Incidence Studies of Reported Child Abuse and Neglect 1998 and 2003

By Bruce Leslie

The following is a ***Brief Research Note*** *identifying changing demographics in the families served by Ontario child welfare agencies. The author was assisted with the data analysis by the Canadian Incidence Study research team, especially Barbara Fallon and Tara Black.*

The Ontario Incidence Study of Reported Child Abuse and Neglect (OIS) was conducted in 1993, 1998 and 2003, providing the opportunity to examine some of the factors underlying the changes in reported and substantiated maltreatment in the Ontario child welfare system during the past two decades. The OIS-1998 and the OIS-2003 were part of a Canada-wide national incidence study (the Canadian Incidence Study of Reported Child Abuse & Neglect) that is the cornerstone of the Public Health Agency of Canada's child maltreatment surveillance system and is conducted

with a team of university-based researchers.

The study does not capture new allegations of maltreatment on ongoing cases or maltreatment that is only reported to the police. The findings reflect the initial assessment after an investigation of child maltreatment and are not independently verified.

In the OIS-2003 a multi-stage sampling frame was used, first to select a representative sample of 16 child welfare service areas across Ontario and then to sample cases within these offices. This resulted in a sample of 7,172 child maltreatment investigations that are weighted to derive provincial estimates of the annual rates and characteristics of investigated child maltreatment in Ontario. An estimated 128,108 child maltreatment investigations were conducted in Ontario in 2003, a 98 % increase from 1998. Most of this increase can be attributed to substantiated maltreatment. There was a 145% increase in substantiated child maltreatment investigations, from 24,190 substantiated investigations in 1998 to 58, 424 in 2003. The overall rate of substantiation increased from 37% in 1998 to 46% in 2003. The largest number of investigations and biggest increase identified was for those with a primary identification of "Exposure to domestic violence" (DV). In 1998, 4,353 investigations were identified as DV, accounting for 19% of substantiated investigations. In 2003, these numbers had increased to 18,518 investigations, representing 32% of substantiated investigations.

Historically, the family structure most associated with child welfare investigations has been 'single-parent led households.' A comparison of the OIS-1998 and OIS-2003 reveals that investigations involving two parent households (including biological and blended families) have increased from 46% to 51%, whereas the percentage of investigations involving single parent households has decreased from 49% to 46%.

Another changing characteristic is that families investigated for child maltreatment concerns are unemployed and do not own their own homes. In the 1998 study, 42% of investigations involved households with "full-time employment" as a primary source of income and 30% owned their own homes. In 2003, "full-time employment" had increased to 64% and home ownership 37%.

The figures identified above characterize a shift in demographics of families being investigated for child maltreatment possibly, in part, related to the major increase in domestic violence investigations.

About Author:

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Risks, Needs, Strengths, and Outcomes in Child Protection: What We Know About Who We Serve

By Michael O'Brien

Over the last eight years Family and Children's Services of Renfrew County has increasingly used clinical instruments to assess children and to evaluate the impact of services delivered to them. The agency has accumulated information through the Ontario Risk Assessment, the Brigance Developmental Screen, the Child and Adolescent Functional Assessment Scale, the Strengths and Difficulties Questionnaire, and Kidscreen. We now have a picture of the impact of our services on children in care (O'Brien, 2006). However, at this point most of the information about children receiving a child protection service relates to assessment. In time, much more data will be available about the progress being made in promoting better developmental outcomes for children living in the community. And so, we are able to share what we know about risks, needs, strengths, and protective factors in the lives of children for whom there are child protection concerns, as well as some preliminary data about outcomes.

In 2004, Family and Children's Services completed a study of its Ontario risk assessment data (N=295).

It is instructive to focus on the variables most related to understanding how abuse and neglect might be affecting children. The risk factors concerning abuse/neglect, and risk of abuse/neglect, the child's response to the parent, and child behaviour were slightly below the intermediate level of risk. The mental and emotional development of children was rated at the moderately low level of risk, and parental acceptance of the child was rated slightly below the moderately low level of risk. The same study when conducted again in 2006 found very similar results (N=267). It was concluded that the key risk variables related to long-term consequences that might occur due to maltreatment indicated the possibility of mild to moderate harm.

One of the changes that came about through studying the agency's risk assessment data has been to focus more attention on understanding the needs of children, rather than being preoccupied with making predictions about future harm to their development based on limited information. The Child and Adolescent Functional Assessment Scale (CAFAS) has been used by Family and Children's Services to assess children in care since 1999. Since it is first administered immediately after a child comes into care it does provide information that can be used to understand the mental health of children who have been living in the most troubled families being served by the agency. The average CAFAS score for children at the time of admission is 70. This score is considered to be an intermediate level of severity, and indicates the child may need services beyond outpatient care. The most serious problems identified by CAFAS pertain to behaviour at home, school, and the community. Issues having to do with moods/emotions, self-harm, and substance abuse do not present as a serious concern for most children admitted to care. Those with more serious mental health difficulties are often placed in residential settings outside of the agency.

Since January 2006 the Strengths and Difficulties Questionnaire has been utilized to evaluate the mental health of all children involved with the agency due to a child protection issue. It has been found that hyperactivity, followed by conduct issues are the most significant problems being experienced (N=225). Not surprisingly the 4 to 10 year old category present as having less serious hyperactivity and conduct problems than do adolescents. Somewhat surprising has been the finding that both the 4 to 10 year olds and 11 to 17 year olds fall within the normal range of pro-social behaviour over 80% of the time. Thus they fit within the norms for the general population (Goodman, 1997). It was also found that the emotional functioning of the 4 to 10 year old child protection clients falls within the normal range 80% of the time. The agency will pay attention to these strengths as it seeks to learn more about how to support and promote the protective factors operating in children's lives. Statistical analysis of our data suggests that hyperactivity is the key predictor of the overall Strength and Difficulties Questionnaire score. As a result of that finding Family and Children's Services is increasing its investment in the prevention

of negative outcomes due to hyperactivity both at home and school. An examination of outcomes after children have been receiving a child protection service for six months shows the following: a slight improvement in the total difficulties score; a modest improvement in both the conduct and hyperactivity sub-scores; and a modest deterioration in the peer problems sub-score (N=80). More outcome data will be required prior to attaching any statistical significance to that data.

The Brigance Developmental Screen is a tool used to assess the development of children from birth to 6 years old. Children in care and children receiving a child protection service are now assessed routinely. We have found the following preliminary results: of the 41 children assessed on child protection caseloads 19.5% exhibit an advanced level of development at the initial assessment, 54.2% are normal, and 26.3% are at-risk; similar results were found for 78 children at the initial assessment completed immediately upon admission to care. The evidence thus far is that children in care are making significant gains, but more outcome data is required before drawing conclusions about progress for the children on child protection caseloads.

Research methods pertaining to the measurement of a construct such as need favour the use of more than one instrument (McKillip, 1987). Any one method, because of its limitations, will only partially measure the construct. For this reason the agency has begun to ask children on child protection caseloads about their needs and well-being. KIDSCREEN which was developed through the World Health Organization has been widely tested across Europe (Ravens-Sieberer, 2006). It is an instrument used to ask children between the ages of 8 and 18 about how they perceive their quality of life. The scoring of the instrument breaks down the results into a category for 8 to 11 year olds, and a category for 12 to 18 year olds. Our results (N=67) to date show the following: Both age categories are above (more positive than) the European norm in perceptions about their physical health as well as social support and peer relationships; both age categories are substantially below the norm in the areas of feeling bullied, their access to financial resources, and perceptions about their moods and emotions; the 8 to 11 year olds have a slightly more positive self- perception than do European children, but slightly more negative view about their relationship with their parents; and the 12 to 16 year olds on child protection caseloads are slightly below the European norm regarding how they view their psychological well-being. The one possible anomaly encountered is that the 8 to 11 year olds fit within the normal range for how they view themselves on the psychological well-being, and self-perception dimensions, but are significantly below the norm with respect to how they see their moods and emotions. A partial explanation may be that the psychological well-being questions pertain more to general happiness about life while the moods and emotions questions are more about specific moods experienced on a day to day basis.

Assessment and measurement of outcomes is part of the solution, but in between assessment and outcomes there sits intervention. Although we are limited in the resources that can be directed towards families, the agency has adopted a strategy which we believe will bring about some positive results. In addition to our traditional strategy of supporting parents we are now focusing more intensely on the developmental needs of children. The challenge Family and Children's Services has taken up is to not only ensure child safety but to also make a significant improvement in the development of children prior to terminating our involvement with a family. Our staff uses Threshold, a decision-making tool developed at the Dartington Social Research Unit, to assess levels of impairment to child development, and to predict future impairment by evaluating the interaction of risk and protective factors in the lives of children on our child protection caseloads. Threshold, combined with the various clinical instruments being administered permits staff to create service plans that have a greater child development orientation than was the case in the past. It is expected that some improvements in child development will occur as a result of our efforts to implement the more child development oriented service plans. However, it is evident that increased funding is also required to meet the many needs we are identifying.

The evaluation research at Family and Children's Services strongly supports the dual child safety and child development strategy being pursued. To a large extent, the data suggests that many of the children on the agency's child protection caseloads are experiencing inconsistent parenting, a lack of stimulation at an early age, and likely a lack of consistent emotional availability from their parents. The majority of these children do not show evidence of experiencing developmental or mental health problems. Significant emotional difficulties as identified by the Strengths and Difficulties Questionnaire are not part of the typical profile of child characteristics, but are part of the adolescent profile. More investigation is warranted though given the early Kidscreen results which found that 8 to 11 year olds often feel they have difficulties with moods and emotions. Typically, hyperactivity, conduct, and education are the predominant issues for those experiencing difficulties, and therefore these issues have become the focus of a more intense concentration of our resources. Although we now have a substantial understanding of the risks and needs pertaining to children, we are in the early stages of systematically analyzing strengths and protective factors. In spite of a multitude of problems within the families served by the agency strong evidence about pro-social behaviour of children and youth has emerged with regard to showing kindness, and being considerate and helpful. Many children and youth feel they have a network of friends; survey information collected by the agency suggests that parents are much more involved in activities with their children than expected; and social workers have found that in the majority of child protection cases the protective

factor of there being someone outside the family who cares about the child is operative. In conclusion, the cumulative result of using the clinical instruments that have been described is that we now know enough about risks, needs, and protective factors to predict that it is likely with sufficient support the development of many of the children with whom the agency is working can be improved. Lastly, we have gleaned a much clearer sense of what needs to be done to achieve better outcomes.

About Author

Michael O'Brien is the Director of Research and Quality Assurance at Family and Children's Services for the County of Renfrew and the City of Pembroke.

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The Zen of Child Welfare

By Joe DaRocha

As a Zen Buddhist practitioner I have studied the work of various other therapists, social workers, clinicians, and human service professionals who have integrated Zen Buddhism into their practice. There are several aspects of Zen that have assisted practitioners in adopting a fresh approach to both therapy and community interventions.

In child welfare, Zen can assist a beginner in three different ways; it can provide a different perspective on one's emotions, reduce stress and gain a greater understanding of individual dynamics.

Child protection work regularly engages the individual emotionally on many different levels. At times one is left emotionally drained or exhausted. The weight and inherent responsibility of child welfare can be a psychologically exhausting experience.

Not only is a child protection worker required to manage her own emotions but the emotions of others as well. The child protection worker is often the recipient of constant and contrary emotions from anger and ridicule to appreciation and gratitude within a very short period of time. This emotional roller coaster drains one's energy and negatively affects the physical and psychological health of the

worker. What exacerbates the harm is that individuals identify themselves emotionally. "I'm upset", "I'm
disappointed", "I'm nervous". The worker's identity is defined by and attached to her emotional states.

Zen can assist in keeping this "emotional effect" in check. In Zen, one is not their emotions. Emotions are just emotions, nothing else, transient and impermanent. They are only a function of the mind, a process, a reaction. They are certainly not who one "is" (or the "Self").

Emotions are something one experiences, like rain or wind. Zen teaches that in experiencing emotions one is always aware that there is a "Self" behind the emotion, that emotions pass, the Self remains. It is a tremendous leap for the Western mind to make. So much of western psychology and therapy is invested in treating and managing emotions, especially the negative ones. In Zen, there is nothing to manage, nothing to treat. There is a Self, an identity separate from the psychological reactions that are experienced and generated by the mind.

"I am not my anger", "I am not my anxiety" are powerful Zen statements. Zen divorces the emotion from the "Self", "I experience anger, the anger comes from me, but it is not me". Again, a very difficult concept for the western mind to grasp. In the East amongst Buddhists, the separation between mind, its products –emotions and thoughts – and the "Self" is an accepted reality.

Zen can remind the worker that "frustration" is a product of mind, temporary, fleeting, transient. Not permanent, not who one is.

Consider this simple exercise. Sit down, close your eyes and reflect. Where does the emotion come from? It increases, decreases, it fades, it is gone, and the "Self" is still there, as it has always been. It may be worthwhile to explore this further and pursue what Zen Buddhists have been doing for

Origins of Zen

Zen Buddhism is a branch of Buddhism stemming from the teachings of Bodhidharma (a Buddhist monk) who traveled from India to China approximately 1500 years ago. From China disciples of Zen Buddhism spread it's teachings to Japan, Korea, Vietnam and the rest of Asia where existing cultural and spiritual practices influenced Zen further. There are two schools of Zen Buddhism, the Soto and Rinzai. The differences between these schools are stylistic rather than ideological. Due to the individualistic nature and foundation of Zen Buddhism there is no emphasis on conversion. In fact, Zen shuns the practice of influencing others to adhere to its tenets.

Buddhism today has approximately 364 million adherents world wide, about 6% of the global population. Its popularity in North America has risen dramatically in the last 50 years with Zen Buddhism being the most popular.

millennia, recognizing emotions for what they are, and obtaining the ability to detach from them at will.

What of the emotions of others? Mental health concerns aside, there is the angry father, the defiant child, the anxious mother. Behind the anger, defiance and anxiety who are these people? Where is the Self behind the emotions? A Zen Buddhist would ask, "I see your emotion, but who are you?"

To share a personal experience, sometime ago, an angry father was berating me in his home. I noticed some kitchen tiles that were being installed. I asked him who was installing the tiles. He said he was. I started talking about the tiles. Was this hard work? Why did he choose that particular tile, that colour? We spoke about kitchen tiles for a while. I spoke to him, his "Self", not his anger.

A western counselor might say that the client was "distracted". As a Zen Buddhist, I would disagree. I spoke to the person behind the anger. I recognized a self behind the emotion and I engaged that Self.

In the end he still did not agree with me, in regards to the child welfare plan but his anger was gone. Where is it now? Where did it go?

The mind thinks all the time, it never stops thinking. It is preoccupied with thoughts about either the past or the future. It even thinks while one is asleep. Thinking, thinking, thinking.

Thoughts lead to emotions, and like emotions, thoughts are products of the mind, they are not the "Self", not "who you are".

Similar to emotions, individuals have been trained to identify themselves with their thoughts. The question of "Who are you?" is usually answered by reciting a list of opinions, beliefs, perspectives, reflections, judgments, values, expectations, ideologies, desires. Simply, "Who you are is who you think you are". But like emotions, thoughts change.

It is incredible how pervasive and deep rooted this self definition is. Furthermore, in North American society a tremendous amount of media and societal pressure is aimed at perpetuating self definitions based on emotion and thought.

The French philosopher and mathematician Rene Descartes, said over 350 years ago, "I think, therefore I am", and this has been how individuals have defined themselves since.

Zen takes Descartes' statement and reverses it. In Zen Buddhism it is not "I think, therefore I am", it is "I am, therefore I think". Thinking and thoughts are not the "Self", not "who you are". Like emotions thoughts are transient products of mind. They occur as fast as the speed of light; they can be pervasive, disturbing, funny and intelligent. However, they are not "you". They emerge from the mind. Like hair grows, thoughts emerge. But hair is not how one defines "Self" and neither are thoughts.

Zen Buddhist social workers have been pioneering therapies based on this for decades. There is research on how meditation (the Zen Buddhist approach to achieving a separation between thought and self) has successfully treated many with addictions, negative behaviour and anxiety.

More than any other spiritual practice Buddhism has had a strong association with relaxation. Primarily, this has been due to the Buddhist practice of meditation and detachment. Meditation as a form of relaxation is being accepted more and more in North America. It is important to mention however that meditation from a Buddhist and particularly Zen Buddhist perspective is not a method of relaxation.

Relaxation or a relaxed state is a well documented "side effect" of meditation but not the reason meditation is practiced by Buddhists. Buddhists world wide practice meditation to increase awareness, quiet the mind and obtain detachment.

Despite this, meditation can still be used as an effective method of relaxation. In the busy world of child protection meditation does not have to be as formal as it is practiced in Buddhist temples. It could be as simple as pausing.

For the child protection worker one can find a variety of different moments to pause. It is one of the benefits of child welfare work. In between home visits, while driving from one home to another, stop the car, turn off the engine and sit still (relax) for 10 minutes. Take some deep breaths and observe. Self reflect.

Park a reasonable distance from your destination and (weather permitting) walk to where you are going. Enjoy the walk. Get up from your desk go sit some where else. Do nothing for 5 minutes, in silence. It all seems inconsequential but when practiced regularly it assists in reducing stress.

Child protection staff are accustomed to viewing the work as unstoppable. Certainly tasks need to be attended to some faster than others but it cannot be (and is not) that way all the time. In Zen, one's personal energy is viewed as one would view fuel in a car, limited and requiring periodic monitoring to ensure that the car does not "run dry".

Consider paying the same attention to yourself as one does to the machine that transports you to and from work. Check in, observe, how much energy do you have today, how much energy do you have now? One's individual energy is vital. It needs to be replenished and it has limits. When is your energy at its peak? When is your energy low? When your energy is low, stop and rest. Think about this, but not too much: that would be a waste of energy.

A central tenet of Buddhism is detachment. In Buddhism attachment is a source of suffering and pain and therefore one needs to cultivate an ability to detach.

In child protection, one is being engaged con-

stantly. One is pulled psychologically, intellectually, cognitively in different directions, causing stress. When this happens one becomes emotionally exhausted.

Detachment allows the worker to buffer the demands of child protection. It permits one to "detach" and remain "detached" from the most draining and exhaustive aspects of the work. To clarify, focusing one's skill, training and ability to seek the best outcome for the child is Zen. Being emotionally mired and enmeshed while pursuing the same outcome is not.

The popular view that one must "feel" constantly (be emotionally active) is contrary to Zen, and the often heard expression "When I stop feeling, I can't do child protection anymore" is (from a Zen Buddhist point of view) a self destructive mind set.

This expression only compounds what was stated earlier, that "you are what you feel". With this mind set one runs the risk of becoming addicted to emotions and moving from feeling to feeling without pause or reflection. Apart from anything else, this is the road to burn out.

There is another point of view. One cannot "feel" all the time. One can stop feeling and focus on the task. One can set aside "feeling" in order to get the job done. In Buddhism "feeling" (emotion based on attachment) is different than empathy (understanding). If allowed to seek detachment and separate from the emotional and psychological turmoil that may surround an activity, then that activity becomes easier, less intrusive and productive.

One does not have to become a part of another's anxiety, nor one's own anxiety. The emotional upheaval that is generated during a difficult task does not have to be internalized. When the day ends, one can detach and leave it behind.

Understanding cognitively, intellectually is insufficient. Yet so much of western thinking emphasizes and promotes this type of understanding. Not that it's wrong, it has its place, it is useful (science) but it's not the only way.

There's a Zen saying "Reason is a fine tool, so is a hammer. Try building a house with just a hammer". Theories, academia, tools, approaches, interventions, all very useful, but "do you understand?"

In Toronto during a home visit many years ago, a mother of two small children was explaining to me why she hadn't attended a requested appointment with a counselor. Rationalizations, expectations, theories, terminology, were all going through my mind in preparation to counter her excuses for "not following through". In frustration and desperation she said to me "Look, I'm doing the best I can, do you understand that?!"

I paused, looked at her, her children playing contently on the floor and her "messy" home. In the pause, experiencing that moment all the theories,

arguments, answers, defensiveness left my head and my "Self" took over. There was only the moment and there was also understanding. "Yes, I understand," I replied, and did.

She was doing the best she could. She may not have been succeeding, but she was trying. I understood her a little better that day.

It is useful to understand behaviours, motivations, consequences, decisions; but what about the person? The "Self?" Within the mind there is all the fears, uncertainties and foibles that everyone shares. But in the "Self" there is only one's humanity.

Such understanding breeds compassion and honesty. A friend of mine, a protection worker was approached in court by a parent. The parent said, in reference to the unresolved child welfare issues, "I'm tired of this." And with empathy, my friend replied "I'm tired too". And for a moment, each understood the other, two tired people, no barriers.

Zen Buddhism practices may not be for everyone. However, it does offer options to assist in managing the more taxing aspects of child welfare. Its practices and philosophy can provide a different perspective on our emotions, reduce our stress and gain a greater understanding of the dynamics around us.

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Culture Shift

By Katharine Dill, Deanne Walters, and Jennifer Bauer

Drawing upon the experiences of the Children's Aid Society of Ottawa (CASO), this article explores the 'lessons learned' to date when creating an organizational change initiative related to culturally competent child welfare practice. This article highlights the strategies used to promote, understand and integrate culturally competent practice (Mederos & Woldeguiorguis, 2003; Nybell & Gray, 2003) The following paper provides an exploration of CASO's challenges and successes in relation to this ever-evolving organizational change initiative.

CASO began this journey towards culturally competent practice over a decade ago with a Multicultural Service Plan in 1995. By 1998 this resulted in improved standards of care for children and an increased emphasis on accountability. These changes have increased the number of children served by CASO, heightened the formality of intervention and decreased the flexibility of the Society to respond to diversity within the community, creating barriers within the community and with service providers. Based on this phenomenon coupled with the recognition of the changing demographics of the City of Ottawa, CASO Senior Management identified the need for an oganizational development process. This resulted in CASO's Board establishing a Cultural Competency Work Group in March 2004 to support this long-term initiative. The Work Group consists of a forum of key stakeholders (board members, staff members, foster parents and community professionals) to address the perceptions, issues and concerns related to CASO's ability to provide services in a culturally competent manner.

Building on the momentum of the workgroup, an internal committee put the recommendations of the Board Work Group into action. On November 29, 2004 a Professional Development Day was held to launch CASO's Cultural Competency Initiative. The intent of the launch was to encourage individuals within the Society to recognize the importance of this initiative and its integration into the organizational culture of CASO. There were a number of key events and presentations throughout the day to begin the dialogue and learning about cultural competency, while sharing in some cultural traditions and ethnic foods. The purpose of this professional development day was to capture interest and commitments from those who would directly impact service delivery within diverse communities and create a change in the workplace ethos.

Evaluation results of the launch indicated a strong awareness of the importance of cultural competency in child welfare and an organizational readiness for change. A self-assessment instrument was developed to establish a benchmark of CASO's performance in relation to cultural competency,

based on the perception of those working within the organization. A self-assessment tool was seen as an effective way to engage and educate the organization about the concepts that embrace cultural competency and diversity.

Survey Design

The Cultural Competence Work Group reviewed several self-assessment tools to evaluate organizational cultural competency. From research, only one organizational self-assessment tool could be located that would best fit the needs of child welfare. The Child Welfare League of America was identified as having the most appropriate tool; however, it required modifications, particularly in relation to the utilization of an American survey within the context of a Canadian child welfare agency. Dr. Rashmi Luther, from the Carleton University School of Social Work, reviewed and modified the tool to meet the specific needs of the Society and ensure it was an appropriate research instrument for the specified purpose. The survey instrument included five separate questionnaires that were designed to target groups of individuals based on their varied responsibilities within the organization. The questionnaires were intended to have each group:

- Highlight the key elements of cultural competency specific to them
- Identify strengths and weaknesses in response to the needs of culturally diverse children and families
- Establish a benchmark of their perception of the Society's performance in relation to cultural competency

  Provide information for developing action steps for specific management, staff and service delivery improvements to integrate

  Provide information for developing actions steps for specific management, staff and service delivery improvement to integrate cultural competency principles from their perspective

Survey Goal/Objectives

The organizational self-assessment tool was distributed to staff members with the goal of assessing the Society's current level of cultural competency against established indicators in five key areas:

- Organizational norms and principles
- System administration and management
- Human resource practices
- Programming and services
- Client/user satisfaction

The objectives of the survey were to:

- Inform the Society on its current perception of organizational cultural competency
- Understand the key indicators of a culturally competent organization and identify critical areas for the development of change strategies to increase competencies
- Provide a basis and focus to engage

strategies for the Society

Sampling

The five target groups surveyed were distinguished based on their distinct responsibilities and varying interests within the Society. These five target groups were: All Society Personnel (including all staff, volunteers and students); Service Delivery Professionals (including Service Delivery Supervisors, Front-Line Staff, Lawyers and Psychologists); Foster Parents; Directors and Managers; and Board Members.

Data Collection

A pilot of the Self-Assessment survey was conducted in August 2005 with supervisors and front-line staff members to elicit feedback on survey design. Final modifications were made to the survey and in January 2006**,** an organizational strategy was developed to elicit a high response rate that included scheduling times for staff members to complete the survey. For board members, foster parents and volunteers, the survey was mailed out with a self-addressed stamped enveloped to facilitate a high return rate. For the CASO self-assessment survey, a total of 959 questionnaires were distributed, of those 659 were returned for a response rate of 68.7 % and 275 of these surveys contained qualitative responses.

Findings

1. Cultural diversity must be acknowledged in all aspects of the work
2. Human resources practices are required to recruit and retain culturally competent
3. Policies and procedures that support the practices philosophical underpinnings of culturally competent practice are required by employees
4. Professional development opportunities should include an understanding of how to integrate cultural competency into the work environment as well as everyday practice
5. Service planning with clients requires attention to cultural issues
6. More emphasis on client advocacy
7. Client evaluation surveys and feedback are needed to promote and sustain al change in this crucial area.

Discussion

The operationalization of culturally competent service delivery in the context of child welfare practice is a significant challenge. In the fall of 2004 CASO began an open dialogue with some established community partners as a precursor to full community consultations which took place in early 2007. This consultation process highlighted a disconnect between our organizational self-perception and that of the external cultural community. By this we mean that the community identified both a lack of flexibility within service delivery that is culturally relevant and child welfare practice that does not

promote basic tenets of culturally competent practice.

Managing the scope and magnitude of such a project is paramount. It was clear from the outset that not all issues related to diversity could be addressed simultaneously, thus a strategic decision was made to begin changing the organizational paradigm with respect to this subject. Culturally competent practice can be a value-laden subject that is complex and requires significant organizational and personal insight. Complex issues require time and a clear strategy and action plan. It was recognized that communication of timelines and action plans on a regular and consistent basis are key to achieving success in this long-term initiative. Communication to staff via email and a staff newsletter, "The Grapevine", gives individuals the message that this subject is important and that their voice is important. Continuing communication to key stakeholders has been the foundation to continuing support and partnership in ensuring the voice of cultural communities affects the internal al change.

Conclusion

CASO as an organization continues to grow and develop through this cultural competency initiative. This continues to be an evolutionary change process that has both successes and challenges. The organization can now identify and articulate the issues that represent barriers to staff members and clients from diverse backgrounds. The development of a cultural competency action plan creates a foundation for organizational change that will need to evaluated and modified throughout this learning process.
It is hoped that our lessons learned can help inform other child welfare organizations who will be embarking on similar initiatives. The journey will continue, as the commitment to becoming a culturally competent is far from complete.

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