

JOURNAL

Fall 2008 Volume 52 Number 4

Features

Message from the Executive Director By Jeanette Lewis	1
Mental Health of Young People in Care: Comparing Canadian Foster Youth with British and American General Population Youth By Robyn A. Marquis and Dr. Robert Flynn	2
The Role of Child and Youth Care Practitioners in Evidence-Based Practice in Group Care: Executive Summary By Dr. Carol Stewart	7
Outcomes of a Supplemental Learning Program for Children in Care at Family and Children's Services of Renfrew County By Dr. Michael O'Brien and John Rutland	11
Why do the Youth on my Caseload Harm Themselves? Communications as a Possible Factor in Youth Deliberate Self-Harm By Allison M. Cook	15
KARE Plan - Health and Dental Benefits for Children in Care Advertorial	18
Discovering Your Supervisory Style By Kimberly Brisebois	19
OACAS Rolls Out Child Welfare Professional Curriculum Announcement	21
Children Exposed to Domestic Violence: Building Safety in Child Welfare By Dr. Catherine Simmons, Dr. Peter Lehman and Anne-Marie Duguay	22



JOURNAL

The **Journal** is a major source of information for Ontario's children's services professionals.

The **Journal** is published quarterly and distributed to more than 3,000 recipients by the Ontario Association of Children's Aid Societies (OACAS).

Requests for subscription information, notice of change of address and undeliverable copies should be sent to:

Ontario Association of Children's Aid Societies

75 Front St East, 2nd Floor
Toronto, Ontario M5E 1V9
www.oacas.org

OPINIONS EXPRESSED ARE THOSE OF THE AUTHORS AND NOT THOSE OF OACAS.

National Library of Canada ISSN 0030-283x



Message from the Executive Director

All children deserve loving families, safe homes and the best opportunities to reach their full potential. Ontario's community services and programs support vulnerable families to ensure that children are never the victims of an economic slowdown.

On November 20, National Child Day, OACAS recognized the rights of all children to be protected and asked Ontarians to remain committed to securing a prosperous future for our children. OACAS also encouraged the Ontario government to continue its commitment to reducing poverty and sustaining support programs and services for children and families. At this time of widespread economic uncertainty, decreased government revenues and spending, and increased unemployment, the progress of Ontario's children threatens to be overlooked. It is more important now than ever to stand up for them. Any erosion of the safety net, in these tough times, will have a direct impact on the ability of families to cope with the stresses of job loss, housing issues, and poverty, and on the safety and protection of children.

During Adoption Awareness Month in November and Foster Family Week in October, OACAS brought special attention to the need for more caring foster and adoptive parents for children in care and Crown wards. In early fall, OACAS and member agencies launched the Child Abuse Prevention Campaign aimed at educating the public about everyone's duty to report suspected or actual child abuse to their local Children's Aid Society. In late summer, OACAS presented recommendations in a report, *Strong Families Creating a Strong Ontario*, to the provincial government as part of the public consultation regarding the impact of poverty on families in our province.

This edition of the *Journal* presents articles about programs and services for youth and children in care such as: the outcomes of supplemental learning programs; the mental health of youth in care in Canada, Britain and the United States; the supervisory and leadership style of managers in child welfare; the effect of domestic violence on children; and the KARE Plan, a health and dental benefit program for our children and youth.

Jeanette Lewis
Executive Director

Mental Health of Young People in Care: Comparing Canadian Foster Youth with British and American General Population Youth

By Robyn A. Marquis and Dr. Robert Flynn

What the Research Says about the Mental Health of Foster Children

It has been estimated that approximately 80 percent to 90percent of children and youth living in foster care have complex mental health and developmental needs that are related to a diagnosable psychological difficulty (Osborn, 2006; Stein, Evans, Mazumdar, and Rae-Grant, 1996). Commonly reported difficulties include poor interpersonal and emotion-regulating skills, physical and verbal aggression, low self-esteem, and high levels of anxiety (Kufeldt, Simard, and Vachon, 2000; Minnis, Everett, Pelosi, Dunn and Knapp, 2006; Richardson and Lelliott, 2003; Teggart and Menary, 2005). Such difficulties are exacerbated by a greater likelihood of low academic achievement, school suspensions, and problems with the law (Kufeldt et al, 2000; Minnis et al, 2006; Richardson and Lelliott, 2003; Teggart and Menary, 2005).

There appears to be a deficiency in the number of young people in foster care who are formally identified as having mental health difficulties (Pasztor, Hollinger, Inkelas, and Halfron, 2006). Many young people in the care of CASs are not formally identified as having difficulties; of those that are, few receive psychological services (Goodman, Ford, Corbin, Meltzer, 2004; Minnis et al, 2006; Pasztor et al, 2006; Teggart and Menary, 2005). Reasons proposed to explain the gap in services include poor coordination between the child welfare and children's mental health systems to facilitate assessments, and narrow referral criteria for mental health services. However, there is also a scarce number of appropriate tools to aid in the early detection of looked-after children's mental

health difficulties (Callaghan, Young, Pace, and Vostanis, 2004; Kufeldt et al, 2000).

The early detection of social, behavioural, and psychological problems among children and youth living in out-of-home care should become a priority to promote young persons' well-being (Goodman et al, 2004; Minnis et al, 2006). Advantages of screening include helping to expedite referrals for appropriate assessment and intervention services, which, in turn, could help to improve the children's focus and functioning both academically and socially (Meltzer, 2007; Minnis et al, 2006). One way to promote the early detection of children's mental health and behavioural difficulties is to use a practical measure such as the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997). The SDQ has been utilized with child welfare populations in several countries (Callaghan et al, 2004; Iversen, Jakobsen, Havik, Hysing, and Stormark, 2007; Minnis et al, 2006; Teggart and Menary, 2005). The evidence of its use among such populations lends to Goodman et als (2004) assertion that the SDQ can be used to improve the "detection and treatment of behavioral, emotional, and concentration problems among looked after children" (p. 30).

The Strengths and Difficulties Questionnaire (SDQ)

The SDQ is a brief questionnaire that assesses emotional symptoms, conduct problems, hyperactivity-inattention, peer problems, and prosocial behaviour, of children and youth aged three to 16, over the last six months or school year (Goodman, 2001; Goodman et al, 2004). The SDQ

has parent and teacher forms and a self-report version for youth aged 11 to 16. Available in more than 60 languages, it can be used with immigrant children and parents. There are three different forms available: parent report, teacher report, and a self-report for youth aged 11 to 16. Evaluations of the SDQ as a behavioural screening tool have demonstrated its ability to discriminate between community and clinical samples. Goodman et al (2004) showed that multi-informant SDQ rating of looked after children, from the youth, parent, and child welfare worker, resulted in a prediction of a 'probably' psychiatric disorder that has a sensitivity of 85 percent and a specificity of 80 percent when compared against the independent diagnosis of a clinician.

Purpose of the Study

The purpose of the current study is to investigate the difficulties youth living in out-of-home care in Ontario, using the SDQ, producing among the first Canadian SDQ data. In the absence of Canadian SDQ general-population norms, the level of mental health among Ontario youth in care was compared to British and American SDQ general-population youth. Based upon previous research with young people in care, it was hypothesized there would be considerably higher prevalence rates of behavioural difficulties in our Ontario sample, compared with the British and American normative samples.

The Ontario Looking After Children (OnLAC) Project and the SDQ

The present study was conducted within the context of the ongoing Ontario Looking After Children (OnLAC) project, an ongoing study of the implementation and outcomes of Looking After Children: Good Parenting, Good Outcomes (Flynn, Dudding, and Barber, 2006). The Looking After Children approach was originally developed in the UK, and has subsequently been adapted for use in 10 countries. Since 2006, OnLAC was mandated for all 53 Children's Aid Societies in Ontario by the

provincial government and are therefore are required to complete the second Canadian adaptation of the Assessment and Action Record (AAR-C2; Flynn, Ghazal, and Legault, 2006). The AAR-C2 assesses the needs of young people in care and is used to monitor the progress and inform the annually revised plan of care of young people in care. The AAR-C2 is completed in a conversational interview by the child welfare worker with the foster parent and the young person (if he or she is 10 years or older). The AAR-C2 includes many measures that cover the seven Looking After Children developmental domains: health, education, identity, family and social relationships, emotional and behavioural development, and self-care skills. The SDQ was embedded within the AAR-C2 in 2005-2006, as part of the emotional and behavioural development sections. The foster parent or other caregiver rates the foster child on the 25 SDQ items. Each question is rated on a 3-point scale, in which 0 = *Not True*, 1 = *Somewhat True*, and 2 = *Certainly True*. Each of the five scales—Emotional Symptoms, Conduct Problems, Hyperactivity/Inattention, Peer Problems, and Prosocial Behavior—has a potential minimum score of 0 and a maximum score of 10. A Total Difficulties score is calculated by summing the scores on the four problems scales (i.e., all of the scales except Prosocial Behavior), resulting in a potential minimum score of 0 and a maximum score of 40.

When interpreting the SDQ, a young person's scores on the five scales and the Total Difficulties score are compared to an appropriate normative (community) sample to determine within which of the three categories he or she falls: *normal/low behavioural difficulties* range, which is below the 80th percentile in a normative sample; *borderline/medium difficulties* range, between the 80th and 89th percentiles; or *abnormal/high difficulties* range, between the 90th and 99th percentiles. The SDQ website (www.sdqinfo.com) suggests that the thresholds for the two latter categories can be adjusted upward to avoid false positives or downward to avoid false negatives.

Our Participants

SDQ data were available for 492 looked-after young people aged 11 to 15 ($M = 13.18$, $SD = 1.44$), of whom 57 percent were male and 43 percent were female.. Eighty-six percent lived in foster homes, including kinship homes, and 14 percent were living in a group home placement.

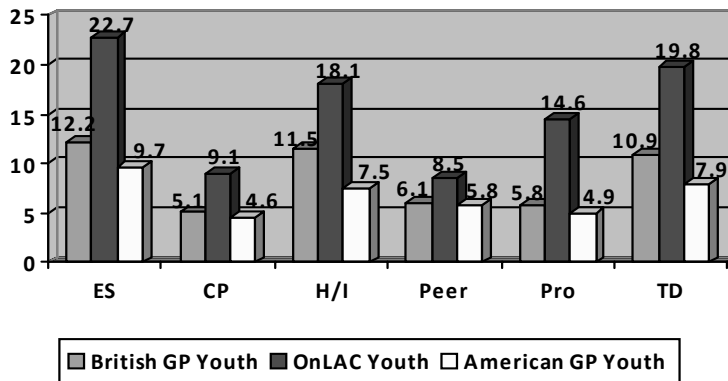
Study Findings

The following results depict the comparison of the OnLAC youth with those general population British youth (aged 11-15, whose SDQ scores were rated by their foster parents or other carers) and American youth (aged 11-14, whose SDQ scores were rated by their foster parents or other carers) for whom normative data was available (see www.sdqinfo.com). The comparisons were based

upon the scores obtained by British general population youth whose results placed them within the Borderline and High Difficulties categories on the SDQ subscales and Total Difficulties score. Due to the nature of the sample, the cut-off scores utilized were as close to the borderline and high difficulties bands as possible.

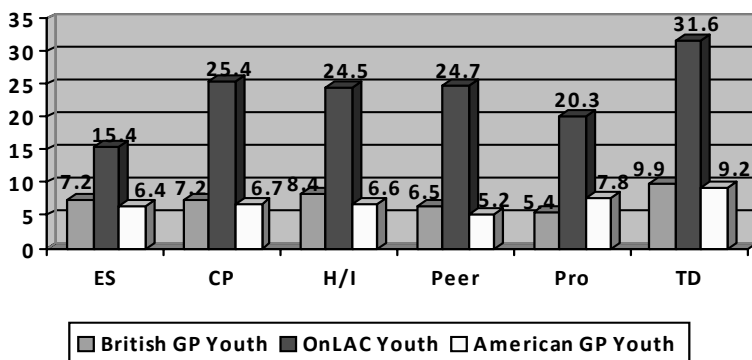
Figure 1 shows the results of the comparison between the three populations on subscale scores that are indicative of borderline difficulties. Figure 2 shows the results of the comparison between the three populations on subscale scores indicative of high difficulties.

Figure 1: SDQ Subscale and Total Difficulties Scores Indicative of Borderline Difficulties



ES = Emotional Symptom Scale (Scores = 4-5); CP = Conduct Problem Scale (Score = 4); H/I = Hyperactivity/Inattention Scale (Scores = 6-7); Peer = Peer Problems Scale (Score = 4); Pro = Prosocial Behavior Scale (Score = 6); TD = Total Difficulties Score (Scores = 13-16)

Figure 2: SDQ Subscale and Total Difficulties Scores Indicative of High Difficulties



ES = Emotional Symptom Scale (Scores = 4-5); CP = Conduct Problem Scale (Score = 4); H/I = Hyperactivity/Inattention Scale (Scores = 6-7); Peer = Peer Problems Scale (Score = 4); Pro = Prosocial Behavior Scale (Score = 6*); TD = Total Difficulties Score (Scores = 13-16)

*Because the Prosocial Behaviour subscale measures positive behaviour, lower scores indicate lower levels of prosocial behaviour.

According to the results, there were between one and a half to four-times as many Ontario in-care youths who scored in the at-risk range (i.e., in the high difficulties or borderline difficulties categories) on each SDQ subscale than the British and American general population youth. Moreover, these results demonstrate that over 50 percent of the OnLAC youth in the current sample would be considered high-risk for a likely psychiatric disorder and should be referred for services for further assessment, whereas 21 percent of the British and 17 percent of the American general population youth obtained scores that indicated further assessment would be necessary.

Implications of Findings

The findings of the present study are consistent with previous research (Minnis et al, 2006) in that the young people in-care exhibited higher levels of problematic behaviour and lower levels of prosocial behaviour than young people of the same age in the British and American general population. These results call attention to how imperative it is that appropriate referrals and services are coordinated in a timely fashion to ensure that looked-after children and youth who are suspected of having identified as having mental health difficulties are referred for further assessment and intervention in a timely fashion. Moreover, the ability of the SDQ to distinguish between looked-after and normative samples suggests it may be as useful in the field of child welfare in Canada as it has in the UK for mental-health screening, referral, and outcome-monitoring purposes.

One limitation of the present research is the relatively small size of the Ontario in-care sample. However, this problem is only temporary now that Looking After Children is mandated for use in all 53 Children's Aid Societies in Ontario. Thus, the number of young people in care in the province assessed each year with the AAR-C2 is growing rapidly. By mid-2009, we expect to have annual data on 6000 to 7000 young people in care, which will allow more definitive Ontario SDQ data.

The authors note that the early detection of behavioural difficulties and more timely referrals constitute only a useful first step. Current efforts in Ontario and elsewhere to achieve close collaboration between the child welfare and children's mental health systems are even more crucial.

Author's Note

This paper is based upon a presentation made at the conference, *Care Matters: Transforming Lives, Improving Outcomes*, in July, 2008 at Oxford University. Although the opinions expressed are those of the authors alone, we gratefully acknowledge the collaboration of the Ontario Association of Children's Aid Societies and many local Children's Aid Societies in Ontario in the conduct of the research and the funding provided by the Ontario Ministry of Children and Youth Services.

About the Authors

Robyn Marquis is a Ph.D. Candidate in Clinical Psychology at the University of Ottawa, Ontario.

Dr. Robert Flynn is the Director for the Centre for Research on Educational and Community Services.

Marquis and Flynn are both members of the Ontario Looking After Children (OnLAC) Research Team at the Centre for Research, University of Ottawa.

References

- Callaghan, J., Young, B., Pace, F., and Vostanis, P. (2004). Evaluation of a new mental health service for looked after children. *Clinical Child Psychology and Psychiatry*, 9, 1359-1045.
- Flynn, R. J., Ghazal, H., and Legault, L. (2006). *Looking After Children: Good Parenting, Good Outcomes. Assessment and Action Records*. (Second Canadian adaptation, AAR-C2). Ottawa, ON, and London, UK: Centre for Research on Community Services, University of Ottawa and Her Majesty's Stationery Office (HMSO).

- Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A research note. *Journal of Child Psychology and Psychiatry*, 38, 581-586.
- Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30, 1337-1345.
- Goodman, R., Ford, T., Corbin, T., and Meltzer, H. (2004). Using the Strengths and Difficulties Questionnaire (SDQ) multi-informant algorithm to screen looked-after children for psychiatric disorders. *European Child and Adolescent Psychiatry*, 13[Suppl 2], 26-31.
- Iversen, A. C., Jakobsen, R., Havik, T., Hysing, M., and Stormark, K. M. (2007). Mental health problems among child welfare clients living at home. *Child Care in Practice*, 13, 387-399.
- Kufeldt, K., Simard, M., and Vachon, J. (2000). *Looking after children in Canada: Final report*. Human Resources Development Canada.
- Meltzer, H. (2007). Childhood mental disorders in Great Britain: An epidemiological perspective. *Child Care in Practice*, 13, 313-326.
- Minnis, H., Everett, K., Pelosi, A. J., Dunn, J., and Knapp, M. (2006). Children in foster care: Mental health service use and costs. *European Child and Adolescent Psychiatry*, 15, 63-70.
- Osborn, A. L. (2006). A national profile and review of services and interventions for children and young people with high support needs in Australian out of home care (Doctoral dissertation, University of Adelaide, 2006). (On-line publication). Retrieved on October 1, 2007, from: <http://thesis.library.adelaide.edu.au/uploads/approved/adt-SUA20061121.135813/public/02whole.pdf>
- Pasztor, E. M., Hollinger, D. S., Inkelas, M., and Halfon, N. (2006). Health and mental health services for children in foster care: The central role of foster parents. *Child Welfare League of America*, 33-57.
- Richardson, J. and Lelliott, P. (2003). Mental health of looked after children. *Advances in Psychiatric Treatment*, 9, 249-251.
- Stein, E., Evans, B., Mazumdar, R., and Rae-Grant, N. (1996). The mental health of children in foster care: A comparison with community and clinical samples. *Canadian Journal of Psychiatry*, 41, 385-391.
- Teggart, T. and Menary, J. (2005). An investigation of the mental health needs of children looked after by Craigvon and Banbridge health and social services trust. *Child Care in Practice*, 11, 39-49.

The Role of Child and Youth Care Practitioners in Evidence-Based Practice in Group Care: Executive Summary

By Dr. Carol Stewart

The purpose of this project was to understand the factors affecting the use of Evidence-Based Practice (EBP) and Evidence-Based Treatment (EBT) in residential group care programs in the province of Ontario. The strategies and interventions used by Child and Youth Care (CYC) practitioners in the milieu were linked to EBT and theoretical models of intervention through a review of current literature and a survey of all group care programs serving children and youth with emotional and behavioural difficulties was undertaken. The analysis included consideration of differences in service delivery between child welfare, children's mental health programs and the children's private residence sector.

Overall the results of the survey indicate that:

- Interventions that are used by CYC practitioners are theoretically linked to EBPs that have demonstrated positive outcomes for children, youth and families.
- Manuals and specific procedures for implementing and evaluating these interventions in group care are not clearly developed in most programs although there is strong potential to develop these supports.
- An understanding of EBP and EBT has permeated into residential group care programs with most programs following standardized case planning procedures.
- There is differential knowledge and implementation of EBP within the various sectors that provide residential services for children and youth. Implementation of EBP was affected by organizational and individual factors, such as funding, access to information, and educational preparation of front-line workers. There were differences in these factors between children's mental health and child

welfare programs as well as among the private children's residence programs.

- More research to demonstrate the specific connections between group care models, CYC practitioner interventions and client outcomes would lead to the development of EBT models in group care that could be replicated.
- More research on the factors supporting implementation and replication of essential ingredients in group care is required for group care to demonstrate the relationship between practitioner interventions and client success (outcomes).

Design of the Project

A survey research design was used to explore the ways in which front-line CYC practitioners understand and use EBT and EBP as well as to describe the scope of practice of CYC practitioners in group care programs. Program managers and front-line CYC practitioners in group care programs received a survey in the mail. Differences among child welfare (CAS), children's mental health (CMH), and private operator (PCR) programs were assessed. The survey replicated previous work (Barwick et al, 2005) that described to what extent EBP had been adopted in the children's mental health sector and extended the analysis to child welfare and private operators.

The survey sample was structured at the program level. All staffed group care programs in the province were invited to participate, and the survey was distributed to CYC practitioners and program managers in residential treatment centres and group homes that were: (a) licensed as a children's residence, (b) worked with clients with mental health needs or diagnoses, (excluding homes whose primary focus was children who were medically

fragile, had moderate developmental disabilities, autism or were placed under the Criminal Youth Justice Act) and (c) were staffed by CYC practitioners. Foster care programs were excluded. A total of 262 programs received the surveys and 178 programs returned at least one survey. Each program received a survey for the program manager and 2 to 4 surveys for the front-line CYC practitioners. A total of 1218 surveys were distributed and 495 were returned.

Responses from the program manager of each group care program were used to divide the group care programs into 2 groups: Those that were committed to EBP and already implementing the key factors involved in such an approach (the high uptake group) and those programs that were struggling to implement EBP (the low uptake group). Statistical differences between High and Low Uptake programs were explored to understand how case management practices and CYC interventions differed among these two groups. Statistical analysis also explored the differences in scope of practice among CYC practitioners as a result of education, experience, and employment sector.

Results and Recommendations

1. CYC Practitioner's Scope of Practice has a knowledge base which needs to be developed into a documented EBT through additional research related to client outcomes.

Recommendation: Further research should be undertaken with group care programs with a High Uptake of EBP who have CYC trained practitioners to document client outcomes as they are related to CYC interventions.

2. The project was successful in piloting an instrument which measures the frequency of child and youth care intervention strategies that have demonstrated connections to the EBT and child and youth care literature. It also demonstrated our ability to measure the use of specific case management practices (EBP)

demonstrated to be effective in enhancing children's outcomes.

Recommendation: A more detailed analysis of the responses could uncover those specific aspects of the CYC interventions that are influenced by organizations or developed with additional years of experience. If indeed certain interventions have a greater likelihood of influencing children's outcomes and they are mediated by organizational factors or by education and experience, such an understanding could guide organizational hiring practices.

Recommendation: The instrument has the potential to be used to bring consistency to the adaptation of EBT strategies in the group care sector (similar to the design of Wraparound, Multi-systemic Therapy, and Teaching Family Model). Further work is needed to refine the instrument and to develop a mechanism for assessing the outcomes of children and youth consistently across programs that are using these group care models.

3. EBP is used by CYC Practitioners in Group Care and EBT strategies were reported. Program managers and front-line CYC practitioners are familiar with the terminology of evidence-based practice and evidence-based treatment in all sectors.

Recommendation: The examples provided by respondents should be developed into questions to add to the instrument to capture the nature of behavioural and relationship oriented interventions.

Recommendation: It would be useful to determine which group care programs have specific planned curriculums for life skills or social skills, how these are integrated with daily living interventions (for transfer of training) and to assess specifically the outcomes of these curriculums using pre-and post existing measures such as OnLAC or built-in plan of care assessments to determine the impact and the essential ingredients. These would then meet the criteria of EBT in group care programs and could be part of a "multi-point" approach similar to MST.

Recommendation: Observing more specifically what techniques are being implemented in both individual and group sessions using strategies from Narrative Therapy, Solution Focused Therapy, SNAP, and COPE etc. would more clearly define how these approaches are being modified (if at all) and the effect on client outcomes.

Recommendation: Whittaker (2004) strongly recommended the co-location of family and residential programs to bring these aspects together and given the informal work that CYC practitioners are already doing with families, such co-location offers great benefits to group care programs and enhances the communication between family therapists and CYC practitioners working with children and youth. Programs engaged in this practice should be evaluated for client outcomes.

4. Case Management Practice is slightly different in programs that are ready to apply research-based knowledge

Recommendation: Refine the instrument to identify both common and different elements of case management and then use the survey with the selected High Uptake of EBP programs and collect children's outcomes to identify which items are good practice that reflect a more intensive case management process and therefore contribute to enhanced outcomes. High Uptake EBP programs already have the capacity to undertake this type of assessment and data collection and the relative contributions of the particular case management factors can therefore be determined.

5. Cross Sector analysis indicates there are more similarities than differences, particularly in the organizational characteristics related to the Uptake of Evidence-Based Practice

Recommendation: Given the Ministry of Children and Youth Services (MCYS) direction toward EBP/EBT and the results of this survey among group care programs, CAS sector programs need significant support to implement EBP but are aware of the

issues and concerns that need to be addressed. The Ontario Association of Children's Aid Societies (OACAS), Ontario Association of Residences Treating Youth (OARTY) and MCYS should work together to identify those agencies that need extra support and to provide training and additional support for research.

6. In spite of the similarities in types of clients served, general services provided, referral sources etc. there are significant differences in the type of treatment interventions used by agencies operating staffed group care programs based on their funding source and primary service population.

Recommendation: The survey should be repeated with parented group care, treatment foster care, and young offender facilities, with a more supportive methodology (e.g. phone survey) to determine differences in support, interventions, case management, and types of clientele as well as examining how families are involved in the lives of children that are placed in out-of-home care in order to maximize the potential for successful outcomes following return home.

Recommendation: More specific investigation of how staffed group care programs incorporate family focused EBT's and how they make use of informal family contact is warranted. Given that these services are less likely to be "prescribed" on the plan of care, there is a significant difference between the sectors in their reported provision of family counselling and that family involvement is highly recommended in the literature as one of the factors influencing successful outcomes further investigation is essential

7. There are some differences in human resources between the private and quasi-public sector of group care service providers. Employee' education and experience varies and is modified by the nature of the sector that the group care practitioner is employed in.

Recommendation: Factors such as education and experience of group care staff should be assessed and considered in program's ability to implement EBP and EBT. Additional support to programs in the PCR and CAS sectors may be required.

Conclusion

The purpose of this project was to understand the factors (systemic, organizational, and human) affecting the use of EBP and EBT in group care settings in the province of Ontario and to document the strategies and interventions that CYC practitioners use in the milieu which are supported by EBT and theoretical models of intervention. Both aspects of this purpose have been partially accomplished. The instrument developed has good face validity and the scope of practice that it assesses appears to be differentially affected by CYC education, years of experience, and employment sector. The instrument needs to be revised, but has the potential to provide a tool for assessing both case management practice and the interventions used in group care programs and identifying which ones are most clearly connected with client outcomes.

We have a beginning understanding of the factors affecting the use of EBP and EBT in group care programs. It is clear that the MCYS policy and encouragement of the use of EBT for service provision in the children's mental health sector has influenced both the CMH agencies receiving transfer payments to deliver group care services and the agencies receiving per diem funding, generally known as the private operators but more appropriately termed Private Children's Residences (PCR). It is also clear that being a PCR versus a CMH centre does not affect the programs ability to access, assess, adapt, or apply evidence-based practices in group care. Programs that are already engaged in EBP are poised to be able to help us describe and further identify clusters of milieu-based interventions which can be demonstrated to affect the outcomes of children and youth in group care and to be replicated in other programs to enhance the quality of care and service overall.

Organizational factors such as the ability to seek consultation, to identify and implement appropriate modifications to research-based knowledge, and the capacity of organizations to engage in change vary across the employment sectors. The education and experience levels of both program managers and CYC practitioners also varied across the employment sectors making system wide implementation of an EBP/EBT policy difficult without addressing these inequities and providing support to programs. It is essential that group care programs develop an understanding of the implications of a research-based approach to group care and the requirements of implementing the organizational change necessary to systematize procedures; collect assessment data as youth enter and exit programs; and maintain a system of care that remains individualized. Whittaker (2006) speaks eloquently to these challenges within a single agency. Ontario has adopted a vision for all children's mental health services which is evidence-based and accountable (Government of Ontario, 2005). This demands additional supports for research and outcome measurement for the group care programs struggling to implement this vision.

For additional detail on this project please see the full report:

Stuart, C., Sanders, L., Fulton, R., Kroll, T., Rapuano, G., McMillan, C., (2008). Child and Youth Care Practitioners Contributions to Evidence-based Practice in Group Care. Toronto, ON: Ryerson University. Available from Dr. Carol Stuart, School of Child and Youth Care. <http://www.ryerson.ca/cycp/faculty/CStuart/EBP-CYCRportv4.pdf>

About the Author

Dr. Carol Stuart is an Associate Professor at the School of Child and Youth Care at Ryerson University.

Outcomes of a Supplemental Learning Program for Children in Care at Family and Children's Services of Renfrew County

By Dr. Michael O'Brien and John Rutland

Increasingly the child welfare system in Ontario is working actively to remediate the educational deficits of children in its care. As a variety of approaches are being used, it is important to evaluate the effectiveness of the programs being implemented. Family and Children's Services of Renfrew County has been offering a supplemental learning program for children in care since 2000. We chose the KUMON math and reading supplemental program which is the largest of its kind in the world. The article will examine the outcomes achieved since we embarked on a partnership with KUMON Canada.

The KUMON method was chosen based both on the quality of the program and a belief that children in care would be able to achieve success with it. Our goal for each child enrolled in the program is to achieve grade level success. At the time of enrollment students complete a diagnostic test with their instructor. Using the results of these tests, an individualized program is established for each child. Students begin at a point at which they can complete the material comfortably. From there, students advance through the materials using a mastery learning approach. This means that students advance only when they have demonstrated mastery of the material. Daily practice is a key to success with this method. Typically the expectation is that a child will be enrolled in the program for at least one year. The method is structured to foster continuous improvement via the accurate and timely completion of worksheets. The children attend one of our learning centres twice a week to complete worksheets under the supervision of an instructor and assistants. The commitment of foster parents and social workers is essential as daily assignments that require about 20 minutes a day must be completed in the foster home. Typically we focus on children between the ages of four and

13, however, any high school student who wishes to attend is welcome. At any given time 50 to 60 children in care are enrolled in the program. Family and Children's Services holds the franchise for Renfrew County. As KUMON is a supplemental education program that can be used for both remediation and enrichment, it can be of benefit to any child. In addition to offsetting the cost of the operation of our program, the involvement of fee paying students also serves to normalize the tutorial experience. We have 90 fee paying participants in the program. Upon entering one of our learning centres one sees no difference between the children in care and the fee paying students. It is remarkable to note how smoothly the learning centres operate when one considers the behavioural difficulties being experienced by so many of our children in care.

The fundamental question to be answered through the evaluative research has been to determine whether a significant improvement in academic skills could be attributed to the math and reading supplemental program. In addition to the goal of evaluating improvement in both academic achievement and skills, the evaluation design has also included the goals of evaluating the suitability of the program for children in care, satisfaction with the program from the perspective of children, foster parents and social workers, as well as any unintended changes in the emotional and behavioural functioning of participants. Quantitative outcomes have been evaluated by examining changes in Wide Range Achievement Test (WRAT) scores and math and reading grades at school. Qualitative outcomes have been addressed through surveys of children in care, foster parents and teachers, and through focus groups with the workers for the children. The outputs that have been considered are retention and progress in completing

the levels within the KUMON program in comparison to fee paying participants both in Renfrew County and KUMON sites in Canada.

Ensuring a high level of retention in this supplemental learning program is critical to its success. The agency was aware it would face challenges around retention due to the emotional and behavioural difficulties faced by many children in care, distances in traveling to the program sites in the large geographic area of Renfrew county, and the likelihood that many children would be less than enthused about having more educational demands placed upon them. The average time spent enrolled in KUMON for children in care is usually about 20 months which is very comparable to the data collected by KUMON. The design of the program which includes self-directed learning, immediate success for any children who complete the assigned work, and regular awards and periodic special events all increase motivation and ultimately retention. Volunteer drivers are used in instances when foster parents are unable to bring their foster child to a KUMON site twice a week. Presentations have been made to foster parents and children's services workers about strategies they might use to support children in care who are participating. At each site an instructor is available to provide one-to-one support to foster parents who are having issues with their foster child's engagement with the program. The other output that has been measured since the program was launched has been the number of levels completed by children in care. KUMON is comprised of a number of levels of increasing difficulty beginning at the pre-school stage of math and reading and progressing to the level of math and reading required for secondary school graduation. We have found that children in care are completing a satisfactory number of levels, but at a moderately lesser number of levels than our fee paying participants.

School report card results and the WRAT have been used to measure the progress of children enrolled in KUMON over periods of time. The following school

report card results depict reading marks for children enrolled in KUMON reading, and math marks for children enrolled in KUMON math. The times series data was extracted from the children's files corresponding to the time period in which they were enrolled in our program, and each of the times represent consecutive report card results for the children.

Table 1

School Report Card Results- Reading^a		
	N	Mean
Reading Time 1	24	5.50
Reading Time 2	24	5.96
Reading Time 3	24	6.54
Reading Time 4	24	7.13

a. Coding Scheme for School Report Cards:
A+=12, A=11, A-=10, B+=9, B=8, B-=7,
C+=6, C=5, C-=4, D+=3, D=2, D-=1, F=0

Table 2

School Report Card Results- Math^a		
	N	Mean
Math Time 1	26	7.08
Math Time 2	26	7.00
Math Time 3	26	7.08

a. Coding Scheme for School Report Cards:
A+=12, A=11, A-=10, B+=9, B=8, B-=7,
C+=6, C=5, C-=4, D+=3, D=2, D-=1, F=0

A paired samples t-test taken at time 1 and time 4 for the reading grades found the progress to be statistically significant at the 99 percent level (N=24). A paired samples t-test performed on a larger sample of 48 children at time 1 and time 3 was not quite statistically significant, but did show improvement in reading grades. The math grades were not found to be statistically significant (N=26).

Administration of WRAT occurs each May and June. Depending on the date of entry of a child into the supplementary learning program the initial measure may or may not be a true baseline measure. Given that some of the children are not tested until they have been in the program for a period of time it is our view that it is likely their baseline scores would have been lower had they been tested immediately upon entry into KUMON. A standard score of 100 is the average within the general population of children. Our goal has been to elevate the WRAT scores of children in care up to and beyond the standard score. Tables 3 and 4 illustrate the time series results that have been obtained with the WRAT instrument.

Table 3

Time Series WRAT Scores for Reading		
	Mean	N
reading time 1	90.85	20
reading time 3	97.70	20

Table 4

Time Series WRAT Scores for Math		
	Mean	N
math time 1	85.96	24
math time 2	90.54	24

A paired samples t-test performed at time 1 and time 3 found that change in reading scores to be statistically significant at the 95 percent level (N=20). A paired samples t-test performed at time 1 and time 2 found the change in math scores to be close to, but not statistically significant (N=24). There may be some discrepancy between the improvement in math WRAT scores versus the lack of improvement in math grades at school, but as the two samples do not each contain all the same children no discrepancy may exist at all.

Qualitative information about outcomes has been gathered from a number of sources. In June 2001, after the program had been running for a year, we surveyed teachers about their perceptions of children in care enrolled in the KUMON. The teachers stated that the children had usually improved in math if they were enrolled in our math modules and reading if they were enrolled in our reading modules. Persistence, work completion, and task focus were observed to have improved. Noticeable improvements in confidence were not reported by the teachers. In 2007, as part of a larger survey of foster parents, a set of questions about our supplementary educational program were asked. Of those who had experience with enrolling a foster child in KUMON a large percentage reported that the program had been beneficial and had improved their foster child's school grades. More than half of that group saw an improvement in the self esteem of their foster children, while few noticed any improvement in behaviour that they felt could be attributed to success in KUMON. The foster parents' perceptions about behaviour were confirmed by examining the Child and Adolescent Functional Assessment Scale (CAFAS) results for children in our care which showed no statistically significant improvements over time in total CAFAS scores related to the time period in which the children participated in our program. Children's services workers have consistently praised the effectiveness of KUMON. In addition, discussions with the workers have also been helpful in understanding some of the barriers to attracting and retaining foster children in the program, such as transportation and the extra demands placed on foster parents who often supervise children in completing their KUMON assignments. Perhaps, some of the most important information comes from the children themselves. One youngster related with pride how she was the second last person standing in her class in an oral math contest. Without her involvement in our program this moment would likely never have occurred. Another child was proud of moving from being the weakest in her class in math to becoming the teacher's math assistant. One of the children

would break down in tears any time there was a new concept introduced in KUMON. This problem persisted for a year but she now faces new concepts without hesitation. These are examples of children and youth who grew not only scholastically but also with respect to their self-confidence.

In conclusion, it has been our experience that the commitment of foster parents and parents in the case of the fee paying participants, is absolutely critical to success with KUMON. Since commitment is so important, we would like to end by sharing a situation that happened in one our centres which exemplifies commitment, albeit beyond what you would ever expect. A grandmother, who is a kinship care provider to her grandson, brought her grandson to the centre on the day her husband of 40 years passed away. She is not a very well-educated woman but has rarely missed coming to the centre. We have had the sense that she sees our program as a way out of the obstacles she and her children have faced in their lives. Although it was clearly an incredibly difficult day for her she did not want her grandson to miss a day at our program. We hope that we can all be as passionate and committed to the education of foster children as that grandmother is to her grandson's future. We have had our share of successes and failures in offering a supplementary educational program. Our biggest challenges are to continue to increase the numbers of foster children participating in the

program and to ensure their retention once they have enrolled. From many sources we see evidence we are on the right course and will continue with the investment we have made in realizing better educational outcomes for children in our care. We, will continue to use the WRAT instrument and changes in school grades to measure success. Although we have gathered some evidence about KUMON's efficacy as a supplementary learning program for children in care it is our intention to develop an increasingly large sample of time series data to buttress the findings presented in this paper.

About Authors

Dr. Michael O'Brien is the Director of Research and Quality Assurance at the Family and Children's Services of Renfrew County. He is an Assistant Professor at the School of Social Work, Dalhousie University in Halifax, Nova Scotia.

John Rutland, M.ED., is a retired special education consultant and is the Education Coordinator at Family and Children's Services of Renfrew County in Ontario.

Why Do the Youth on my Caseload Harm Themselves? Communication as a Possible Factor in Youth Deliberate Self-harm

By Allison M. Cook

It is common knowledge that children who have experienced maltreatment are at additional risk for mental health difficulties throughout their lives. Although currently not considered its own mental health disorder, youth who engage in deliberate self-harm (DSH) behaviour are more likely to have experienced maltreatment in their lives (Zoroglu et al, 2003). It is important for social workers, psychologists and counsellors alike to gain knowledge about this potentially life-threatening behaviour in order to provide effective services to youth who self-harm.

DSH is defined in the literature as “deliberate, direct destruction of body tissue without conscious suicidal intent, but resulting in injury severe enough for tissue damage to occur” (Gratz, 2006, p.1) and can appear in a number of forms including cutting, burning, head banging and suffocation, to name only a few. Other names for DSH exist including self-mutilation and ‘parasuicidal acts’. This type of behaviour has been observed throughout history; however, due to its grisly nature, empirical research concerning why individuals may engage in such behaviour has only begun in the past few decades. DSH has historically been thought to be a symptom of only the most severe psychiatric problems and was not considered to be an issue in the general population. Although DSH is linked to some diagnoses including major depression, borderline personality disorder, eating disorders and post-traumatic stress, recent research has shown an increase in this problem among community samples of people who do not fit the criteria for a mental health disorder. This increase in DSH is particularly apparent among populations of youth studied. World-wide, research has shown that in the general population, the prevalence of self-harm among adolescents is typically much higher than that of adults (Evans, Hawton, Rodham and Deeks, 2005 for

adolescent prevalence; Welch, 2001 for adult prevalence).

DSH is very dangerous and it is possible for people to die from it. Accidental death may result when someone underestimates the lethality of their methods or overestimates the likelihood of rescue. This kind of mistake may be particularly common among youth who may lack judgment or have a perception of invincibility common to young people. Those who self-harm as youth are also more likely to commit intentional suicide later in life. There is a need for early intervention to prevent this from happening.

Given that DSH is viewed as distinct from suicidal behaviour, it is very difficult for most people to understand why someone would hurt themselves without the wish to die. The lack of knowledge of the factors contributing to engaging in DSH prevents the development of a gold standard for assessment, prevention and treatment of this behaviour. What we do know is that many youth who hurt themselves have experienced adverse life circumstances such as maltreatment and so Children’s Aid Services workers may find that many of the youth on their caseloads engage in it.

Some researchers have taken the approach that this behaviour would not be done or maintained unless it served some sort of purpose for the person. One of the functions of self-harm supported by adolescents is a social-positive-reinforcement function which refers to youth being able to gain attention from those around them, solicit assistance or increase support in their social networks by self-harming. An alternative is that DSH is a maladaptive coping mechanism used to manage negative emotions. This function, known as affect-regulation, has received the strongest support and it has been

found that youth experience intense negative emotions that go away once DSH is done. DSH can also serve a self-punishment function which fits historical reports that say many people engaged in such acts to relieve themselves of their perceived wrong-doings. Functions that receive modest support in the literature are sensation-seeking, to release suicidal thoughts without risking death (anti-suicide), to manipulate others (interpersonal-influence) and to assert one's autonomy or affirm the sense of self as different from others (interpersonal boundaries).

It is possible that certain people are naturally placed more at risk for engaging in DSH due to their biological make-up (Joyce et al, 2006). Certain forms of some genes have been found to be more common among people who self-harm and so there may be a biological mechanism that makes it more likely that self-harm will be chosen as a coping mechanism for certain people. There is support for this biological theory of DSH in that many people who do it tend to have higher pain tolerance. Also, when someone is hurt, their body releases endorphins, chemicals that make us feel good. This phenomenon has been referred to as 'cutters high' and leads to DSH having an addictive quality, likely to be repeated, increasing in frequency and intensity.

As mentioned previously, the experience of childhood maltreatment is more common among youth who engage in DSH than those who do not. But why is this the case? What is it about childhood maltreatment that makes someone more likely to hurt themselves? Research has only recently been done to answer this question and the results are very specific to the population studied and by type of abuse experienced. One study found that a high level of self-criticism acts as a mediator in the link between maltreatment and self-harm. Children who are emotionally abused become overly critical of themselves and as they grow use self-harm as a way to punish themselves when they perceive that they are not good enough. It has also been suggested

that symptoms of post-traumatic stress disorder (PTSD) mediate the relationship between sexual abuse and self-harm. One of the symptoms of PTSD is dissociation or a feeling of being detached from or outside of one's body. An episode of dissociation often precedes an act of self-harm and people report that feeling pain helps them to feel anchored and reminds them that they are real and alive when they feel disconnected from 'being' in the physical sense. Some other reasons survivors of trauma may use DSH include to express trauma-related feelings of rage, frustration, guilt and shame or as a method of re-enacting the trauma that occurred. By engaging in activities that recreate the physical or emotional events that took place at the time of the trauma, the survivor may be attempting to remember an event that was blocked due to its traumatic nature, or to communicate to herself or to others what occurred. Re-enactment may also be an attempt to master a situation that was previously not manageable for the survivor, or an effort to regain a sense of control and power in a situation where they previously felt completely powerless. Being able to harm oneself and then choose when and how to stop the pain allows the survivor to have this sense of control.

Experiencing maltreatment as a child has a number of consequences as an individual grows and any of these could contribute to a youth using DSH. One consequence of maltreatment that has been documented among toddlers is a reduced ability to express oneself. Children who have been maltreated do not have the same communication abilities as their non-maltreated peers and this is particularly true of the toddler describing their own internal states, such as how they are feeling. Although this effect of maltreatment has only been studied in young children, it is possible that the effects remain as they grow. In adolescence, the ability to express ourselves becomes very important, as peer relationships become a priority and romantic relationships begin to form.

When the communication demands of the environment become too great, a youth may use self-harm as a way of expressing themselves. A study done with university women supports the idea that a lack of ability to communicate about feelings may contribute to DSH. Specifically, it was found that having experienced maltreatment reliably distinguished the women who self-harmed from those who did not, but the level of what the author calls 'emotional inexpressivity' determined the frequency of DSH.

A communication function of DSH has long been documented among people with developmental disabilities as a way to elicit help or attention from their caregivers. Although the stereotypic self-harm among this population is different from that seen among typically-developing youth, there may be similar factors contributing. Many adolescent self-harmers give "to show how desperate I am feeling" or "I wanted to be noticed" as reasons that they self-harm and youth who engage in DSH have been found to have less people they feel they can talk to.

Using data from the Maltreatment and Adolescent Pathways (MAP) project at the Centre for Addiction and Mental Health under the supervision of Dr. Christine Wekerle, a study is currently being done to see if there is an association between a youth's basic communication abilities and their use of DSH. If this link is supported, it may point to new approaches for prevention and treatment of self-harm and may indicate an importance of workers providing a safe place for youth to express themselves and in teaching them how to do so. It is hoped that a better understanding of deliberate self-harm among youth who have experienced maltreatment will help in the development of effective services for these young people.

About the Author

Allison M. Cook is a Master of Education Student at the University of Western Ontario in the Counseling Program, working on a thesis from the Maltreatment and Adolescent Pathways (MAP) Project dataset, with Dr. Christine Wekerle, Associate Professor,

Education, Psychology and Psychiatry, The University of Western Ontario.

Recommended Readings

Beeghly, M. and Cicchetti, D. (1994). Child maltreatment, attachment, and the self system: Emergence of an internal state lexicon in toddlers at high social risk. *Development and Psychopathology*, 6, 5-30.

Evans, E., Hawton, K., Rodham, K. and Deeks, J. (2005). The prevalence of suicidal phenomena in adolescents: A systematic review of population-based studies. *Suicide and Life-Threatening Behaviour*, 35(3), 239-250.

Favazza, A. (1998). The coming of age of self-mutilation. *The Journal of Nervous and Mental Disease*, 186(5), 259-268.

Glassman, L.H., Weierich, M.R., Hooley, J.M., Deliberto, T.L. and Nock, M.K. (2007). Child maltreatment, non-suicidal self-injury, and the mediating role of self-criticism. *Behaviour Research and Therapy*, 45, 2483-2490.

Gratz, K. (2006). Risk factors for deliberate self-harm among female college students: The role and interaction of childhood maltreatment, emotional inexpressivity, and affect intensity/reactivity. *American Journal of Orthopsychiatry*. 76(2), 238-250.

Joyce, P.R., McKenzie, J.M., Mulder, R.T., Luty, S.E., Sullivan, P.F., Miller, A.L., and Kennedy, M.A. (2006). Genetic, developmental and personality correlates of self-mutilation in depressed patients. *Australian and New Zealand Journal of Psychiatry*, 40, 225-229.

Klonsky, E.D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review*, 27, 226-239.

Zoroglu, S.S., Tuzun, U., Sar, V., Tutkun, H., Savas, H.A., Oztruk, M., et al (2003). *Suicide attempt and self-mutilation among Turkish high school students in relation with abuse, neglect and dissociation.*

KARE Plan – Health and Dental Benefits for Children in Care



For three decades, Morneau Sobeco has had a long-standing relationship with the Ontario Association of Children's Aid Societies (OACAS) to provide benefits consulting services.

In the mid-90's, it was identified that no consistent approach existed for providing health and dental benefits for children in care at each of the 53 Children's Aid Societies (CASs) in Ontario. These agencies were concerned that having different processes for delivering health and dental benefits meant there was a lack of efficiency, administration and reporting as well as cost-effectiveness.

Upon hearing these concerns, Morneau Sobeco undertook a process that began with interviewing a number of the agencies to determine the processes in place, and listening to their "wishes" for improvement.

In response to these concerns, Morneau Sobeco designed the proprietary KARE Plan to provide effective delivery of extended health and dental benefits to children in care, with an enhanced focus on the child, as well as service improvements for the foster parent. The mandate of this plan, for the agencies involved, is to:

- decrease health and dental costs
- allow for portability of children's drug and dental records
- create a child health and dental database
- allow for streamlined administration, to reduce reliance on internal resources
- provide enhanced reporting

For the foster parent, the advantages are fewer out-of-pocket costs and less paperwork. For the child, there is better medical and dental care through more consistent records and review at the point of purchase. Agencies not involved in the KARE Plan have invoices from multiple providers (such as pharmacies and dentists), and often are required to write special purchase orders.

The KARE Plan is celebrating 10 years of success this year (1998-2008). Today, 24 Children's Aid Societies participate in the KARE Plan with more than 10,000 children in care being covered.

The following agencies currently participate in the KARE Plan:

- Brant
- Brockville
- Bruce
- Chatham-Kent
- Durham
- Haldimand and Norfolk
- Hamilton
- Hamilton Catholic
- Halton
- Kawartha-Haliburton
- Kingston
- Lennox-Addington
- Lanark and Smiths Falls
- London-Middlesex
- Niagara
- Oxford
- Peel
- Sarnia Lambton
- Elgin
- Simcoe
- Stormont, Dundas and Glengarry
- Toronto
- Waterloo
- York

The KARE Plan continues to offer unique cost containment opportunities that otherwise would not be available if each participating agency had continued to process claims internally.

This initiative has introduced several **automatic cost control features**, including:

- **drug utilization review**
- **dispensing fee cap**
- **national pricing policy for drug ingredient costs**
- **intervention edits***

*Identifying claims submitted to the KARE plan for children that have been discharged, duplicate claims or claims submitted by an ineligible provider.

For the 2007 policy year, approximately \$10.1 million of health and dental claims were adjudicated and processed. As a result of the cost control features and intervention edits, the KARE Plan members saved over \$1.4 million over the past year. This represents 14 percent of all claims paid during the 2007 policy year.



MORNEAU
SOBECO

Discovering Your Supervisory Style

By Kimberly Brisebois

Supervisory style is a term that is often used to define characteristics of an individual supervisory personality. It is often generalized, rarely defined and often taken for granted (Munson, 2002). It is a concept that should spark some reflection for supervisors. Understanding the use of self in supervision is just as important as self-awareness for our workers. By evaluating and understanding our own values, techniques, and interactions with workers, we can increase our effectiveness as supervisors. Supervisory styles can affect one's relationship with their supervisor and can be a critical factor in one's job satisfaction. Munson (2002) has characterized two main styles, active or reactive. Which one are you? Take a minute to answer the following questions:

1. Do you ask pointed questions?
2. Do you give direct advice?
3. Do you offer interpretations?
4. Are you problem focused?
5. Do you explore alternative interventions?
6. Do you focus on client/family dynamics?
7. Are you speculative about outcomes?
8. Are you subdued during supervision?
9. Do you ask limited questions?
10. Do you focus on the process of treatment?
11. Do you explore issues about interaction?
12. Do you allow workers to struggle with their own solutions
13. Do you focus on worker dynamics?

If you answered "yes" to questions 1-7, you have more of an active style. The active supervisor is very direct and pointed with questions and information. The process of active supervision is primarily lead by the supervisor. The worker is given information freely through an expedited process. If you answered "yes" to questions 8-13, you have more of a reactive style. The reactivist promotes that the worker's learning comes from within. The worker is an active participant and is expected to make her own suggestions for change.

There is no style that is better than the other, it is merely a way of acting. Depending upon the worker's preference, certain worker's may respond better to one style over another. Despite your style, it is important that consistent, scheduled supervision occurs. Simply maintaining an "open door policy" is not conducive to learning. Impromptu supervision is often crisis driven and short in duration. This type of supervision does not promote quality decisions nor does it challenge the worker's learning. In addition, the element of trust between the supervisor and worker needs to be ingrained in the working relationship. Trust in a superior is born out of the provision of consistent support and competence in the supervisor/supervisee relationship (Kadushin and Harkness, 2002).

Once you have determined your main supervisory style, you can identify with a certain sub-style. Munson (2002) has identified three sub-styles of supervisors - philosophers, theoreticians and technicians. You may find that you do not always fit perfectly into these styles, and you may find variations; however, over time you should be able to identify a pattern.

The philosopher tends to be more abstract in her thinking. "A philosophy of practice is a belief system that guides a person's activity" (Munson, 2002, p.212). This style can be helpful in supervision, but only when it is not a consistent pattern of supervisory interaction. Philosophies should be brief and pointed. It is helpful for the worker to be given the time to relate such philosophy to her casework. Philosophers need to be cognizant of their tendency to be overly abstract and lengthy in their discussions if those discussions have no immediate value to the worker.

The supervisor that tends to use theory and broader practice implications as the primary focus in supervision is known as the theoretician. (Munson, 2002). Understanding theory is believed to translate into gaining a better understanding for future work. Theory can provide a useful schema that helps to understand family dynamics (Germain and Gitterman, 1996). It is important that the theoretician does not remain in discussions of abstract theory, but rather uses these theories to relate them directly to specific cases. Connecting and translating theory to practice is of utmost importance for workers. Learning a theory and applying the theory are two different tasks (Munson, 2002). By ensuring that both of these tasks are discussed in supervision, the supervisor is providing the worker with a practical approach to her work with families, while ensuring that she is grounded in her thinking.

The supervisor that uses a technical strategy is mostly problem focused. The technician is patient and empathic. The technician may be more likely to allow the worker to vent regarding her negative feelings about difficult clients. This can be helpful to the worker so that she understands and accepts that her reactions are normal "The supervisor reduces

stress by normalizing unprofessional feelings, noting that workers may often feel negative or critical about some clients" (Kadushin et al, 2002, p. 251). The technician can also be viewed as demanding (Munson, 2002). Supervision is based on planning intervention strategies and focuses mostly on future strategies rather than discussions of family history. Technicians can tend to tell the worker what to do instead of allowing the worker to maneuver through on her own. While this style can work well with the novice worker, the worker with more experience may come to resent not being given the opportunity for more autonomy.

It is important for supervisors to maintain an open dialogue with workers about their supervisory style, and to be open to feedback. This dialogue should include aspects of supervisory style that are beneficial or hindering to each individual worker. A good place to start could be during the worker's annual performance evaluation, however these discussions should occur on an ongoing basis. Being knowledgeable about the types of styles that are different from your own can assist you in modifying those aspects of your approach that may not be conducive for certain workers. Be open to feedback and willing to accept constructive criticism. It is through this process of self-evaluation and analysis that you can ensure that your role as a supervisor is a contributing factor to that worker's success and longevity in child welfare.

About the Author:

Kimberly Brisebois is the Family Service Supervisor at Windsor-Essex Children's Aid Society.

References

- Germain, C., and Gitterman, A. (1996). *The Life Model of Social Work Practice*, (2nd ed.). New York: Columbia University Press
- Kadushin, A., and Harkness, D. (2002). *Supervision in Social Work* (4 th ed.). New York: Columbia University Press.
- Munson, C. (2002). *Handbook of Clinical Social Work Supervision* (3 rd ed.). New York: The Haworth Press.

Announcement

OACAS Rolls Out Child Welfare Professional Curriculum

(formerly known as New Worker Training Series)

Yes, we've changed the name of this valuable training series! Look for it under its new name: Child Welfare Professional Training Series, included in the category Foundations of Child Welfare Practice.

In order to orient current trainers about the critical changes made to the materials, OACAS will be hosting six web conferences on the following dates:

December 12: 10:00 a.m.- 1:00 p.m. Course 1-4

December 16: 10:00 a.m. - 1:00 p.m. Course 1-4

January 7: 9:00 a.m.12:00 p.m. Course 1-4
1:00 p.m. - 4:00 p.m. Course 5-8

January 8: 10:00 a.m. - 1:00 p.m. Course 5-8

January 9: 10:00 a.m. - 1:00 p.m. Course 5-8

Who should register:

- Trainers who have previously delivered New Worker Courses 1 - 9
- Agency Training Designates who are interested in how the trainer curricula has changed
- Supervisors and Managers who need to know about the training materials their team members are receiving

What to expect:

- An overview and update on the changes to the Child Welfare Professional Training courses
- Trainer tips
- How to use the new Trainer Guide
- Information on new terminology and supplementary training tools
- An update on our course evaluations

We recommend that you bring copies of the current course curriculum for your reference to the training sessions.

How to register:

Each trainer will need to attend one session which includes the courses s/he trains. If a trainer is interested in attending a session that s/he does not currently train we would be happy to accommodate them. Contact your Agency Training Designate to register you online through OACAS.

The **deadline to register** for the December 12 and 16 sessions is **December 8**; and the **deadline to register** for the January 7, 8, 9 sessions is **December 23**. These deadlines will allow us enough time to send you confirmation letters, which include the instructions on how to participate in the web conferences, prior to the sessions taking place.



Children Exposed to Domestic Violence: Building Safety in Child Welfare*

By Dr. Catherine Simmons, Dr. Peter Lehman and Anne-Marie Duguay

Child protection workers are no strangers to the dangers when children are exposed to Domestic Violence (DV) and it is well known that such exposure is one of the most stressful work-related areas of professional life. Despite the ever expanding body of knowledge detailing the relationship between childhood exposure and DV, the field continues to grow, developing new and better “best” practices vital to the safety of children and their families (Merkel-Holguin, 2004). Focusing on professional knowledge, the current article first provides a summary review of the recent literature detailing how DV impacts children. Next, components of one “best” practice as found in the *Signs of Safety* approach is addressed. Five practice skills are highlighted for workers having clients where DV is a concern. These skills may be considered an important part of child protection work that aims to help families build safety from violence and harm. Further, they reflect the strengths, engagement and purposeful planning and management side of a differential response model of child welfare currently practiced in Ontario and elsewhere (Sawyer and Lohrbach, 2005).

Professional Knowledge

Each year in Canada and in the United States upwards of 15 million children see, hear, intervene in and/or cope with the aftermath of DV (McDonald et al, 2006). Although the immediate/short term concerns of physical and emotional safety dictate an intervention of some kind, for some children the effect of this exposure can last longer. As stated above, the literature detailing the impact of exposure to domestic violence on children is well documented (e.g. Buckley, Holt, and Whelan, 2007; Cunningham and Baker, 2004; Edleson, Ellerton, and Seagren, 2007; Fantuzzo and Fusco, 2007; Geffner, Jaffe, and Suderman, 2000; Holden, Geffner, and Jouriles, 1998; Jaffe, Wolfe, and Wilson, 1980; Peled, Jaffe, and Edleson, 1995). Six themes continue to summarize what is already known (Carlson, 2000).

First, a number of theoretical perspectives explain children's diverse behavioral, emotional, and cognitive responses to DV exposure (Carlson).

Second, some children's reactions to DV exposure include emotional distress, anger, fear, anxiety and a desire to intervene (Carlson). Third, children's short-term reactions can include externalizing, internalizing, and social problems (Carlson). Fourth, children exposed to domestic violence can experience long-term adjustment problems (Carlson). Fifth, a number of mediating factors affect children's responses (Carlson). Sixth, a link between exposure to domestic violence and trauma responses exists for some children (Carlson).

Responses to DV Exposure

In the province of Ontario, a referral where the only allegation is exposure to domestic violence does not in itself meet the definition of a child in need of protection under *The Child and Family Services Act*. The challenge for child protection workers then, may be to better identify which children are at most risk. Thus, it is helpful to cluster child exposure responses into two categories: *typical responses* and *trauma responses*. The first of these clusters, *typical response* refers to problems many children report. Although these typical responses are often problematic, they are considered to be normal responses to abnormal situations, thus not technically diagnosable. As illustrated in Table 1, these responses can be further divided into three subcategories; (a) immediate concerns, behavioral and emotional, (b) physical functioning, and (c) long-term concerns, behavioral and emotional.

*By permission of Oxford University Press portions of this manuscript are re-printed by the authors from the chapter "Children Exposed to Domestic Violence: Assessment and Treatment Protocols" by P. Lehmann and C. Simmons included in the *Social Workers' Desk Reference*, 2nd edition, edited by Roberts, A., and Greene, G.

Table 1: Typical Childhood Responses To Domestic Violence

Immediate Concerns Behavioral and Emotional	Physical Functioning	Long-Term Concerns Behavioral and Emotional
<ul style="list-style-type: none"> • Internalizing, externalizing and social competency problems (e.g. sadness, withdrawal, social skill problems) • Cognitive/Social functioning • School difficulties (e.g. difficulty learning, concentrating) • Delinquency related behavior • Emotional difficulties (e.g. depression, self-blame/guilt) 	<ul style="list-style-type: none"> • Somatic and physical complaints • Developmental delays 	<ul style="list-style-type: none"> • Adult depression and reduced self-esteem • Poor interpersonal skills • Intergenerational repetition of violence • Adult criminal behavior

It is important to note that these responses may be impacted by mediating and protective factors. As seen in Table 2, mediating factors are those aspects of the child’s environment and life that work to buffer risk. Protective factors are the strengths, competencies, and/or resources that can be

observed or accessed in family members. Essentially, every child and family’s experience is unique thereby allowing each child protection worker avenues in which to focus on factors that can either help or hinder how a child/family might cope.

Table 2: Child Exposure: Mediating and Protective Factors

	<i>Child Factors</i>	<i>Family Factors</i>	<i>Secondary/Associated Factors</i>
<i>Mediating Factors</i>	<ul style="list-style-type: none"> • Age • Type of exposure • Singular vs. multiple exposure • Child exposure to maltreatment • Child exposure to community violence • Child exposure to media violence (e.g., television, videos) • Time since last violent event • Child temperament (e.g., shy, fearful) 	Intensity of maternal exposure to: <ul style="list-style-type: none"> • violence/maternal impairment • Child temperament (e.g., shy, fearful) • Co-occurrence of substance abuse • Single parent household • Poverty • The cultural context 	<ul style="list-style-type: none"> • Legal difficulties • Multiple moves including both home and school • Already existing school and or community related problems • Inappropriate law enforcement
<i>Protective Factors</i>	<ul style="list-style-type: none"> • Intelligence • Interpersonal skills • Emotion and problem-focused skills • Temperament • Child’s appraisal of events • Child’s knowledge of safety 	<ul style="list-style-type: none"> • Positive parental and family support • No history of multiple victimization • Emotional availability of mother • Role of extended family • Community Factors • Availability of community safe homes and shelters • Response of community providers • School intervention projects 	

The second cluster of responses can be grouped into trauma developmental disorders (Cook et al., 2005; NTSN, 2003; van der Kolk, 2003). This specific cluster goes beyond assessing typical PTSD symptoms (re-experiencing, avoidance, arousal) (Rossman, 1994; 1998; Silvern & Kaersvang, 1989) taking into account some children may display more complex behaviors illustrated in Figure 1, *trauma developmental disorders* are organized around three major issues how children might respond to traumatic events: (1) emotional and/or behavioral upset typically follows exposure to traumatic events, (2) many children experience a sense that the violence will continue, and therefore (3) organize their behaviors to avoid the impact of the traumatic event.

Figure 1: Trauma developmental disorders

A-Exposure	Multiple or chronic exposure to one or more forms of interpersonal trauma (e.g. exposure to violence and/or various forms of maltreatment)
B-Triggered pattern of repeated responses to the presence of cues. Responses can persist and may include:	<ul style="list-style-type: none"> Affective (emotional) Somatic (e.g., physiological, motoric) Behavioral (e.g., reenactment, cutting) Cognitive (e.g., fear it will happen again, confusion, dissociation) Relational (e.g., clinging, acting out, oppositional) Attributional (e.g., self-blame, guilt)
C-Altered beliefs and hopes	<ul style="list-style-type: none"> Negative self-beliefs Distrust of caretaker Loss of expectancy of protection by caretakers Loss of trust in professionals Lack of access to social justice/retribution
D-Possible resulting Impairment	<ul style="list-style-type: none"> Educational Familial Peer Work
(Adapted from NCTSN, 2003; van der Kolk, 2005)	

Two important conclusions can be made from the literature summarized above. The first is that as knowledge at assessing risk in children exposed to DV has expanded, child protection workers have greater access to specific information that is likely to increase or decrease child safety. Second, workers are now in a position to develop their own "best" practice at intervention that can be safety-focused (e.g. aimed at reducing risk and/or its impact), protection-focused (e.g. counterbalancing risk by resource building), and process-focused (e.g. building child and family competencies) (Masten and Coatsworth, 1998).

Intervention: Building Child and Family Safety

In response to the needs of children exposed to DV, a number of interventions have been developed. Among them are population specific group therapy approaches (Loosley, Drouillard, Ritchie, and Abercromby, 2006), crisis intervention (Lehmann and Spence, 2007) individual, and/or play therapy (Osofsky, 2004), and family therapy (Brendler, 2006) to name a few. The timeliness and clinical importance of these practice models have signaled a shift in the professional field including child welfare; one that has moved the child protection worker/client relationship from being defensive (Connolly and Doolan, 2007), rescue-based (Patti, 2000), and paternalistic (Turnell and Edwards, 1999) to one that promotes competencies and strengths (Chapman and Field, 2007), involves the family in decision-making (Connolly, 2007), with a focus of seeing all family members as capable of solving their circumstances (Chapman and Field). Consequently, the final section of this paper summarizes the *Signs of Safety*, one additional model child welfare workers may find useful with children and their families.

The *Signs of Safety* approach (Turnell and Edwards, 1997; 1999; Turnell, 2003; Turnell, 2007; Turnell and Essex, 2007; Turnell, Elliott, and Hogg, 2007) has been developed as a compassionate and safe yet rigorous child protection risk assessment guide to be used within child welfare. Underlying the *Signs of Safety* approach is a purposive attempt to find

and create more constructive ways to engage families in the development of creative strategies to address risk or worrisome situations. Koziolok (2007) has also explained the *Signs of Safety* approach as being firm and fair with families but also helping them to think through and find their own safety solutions. Consequently, in keeping with a safe-from-harm perspective, attempts are made to create a balance between (a) potential dangers and risks, (b) recognizing the safety/competency the family demonstrates and (c) setting goals with the family to build enough safety and ultimately close the case.

An important idea with respect to children and domestic violence, but also one underlying the *Signs of Safety* approach is that the worker is always cognizant the risk for potential harm and danger is never minimized. Yet, because the approach is seen as a “safety organized practice”, (Chapman and Field, 2007, p. 23), one can also focus on and ask about times or moments of safety that do exist in families. Questions such as “tell me about some of the happy times with mom and dad”, “what is something you’ve done to keep the kids safe when tensions build”, “have there ever been situations where you could have gotten angry and lost it but instead did something else” let the family know the worker is looking to find a balance and is interested in hearing about positive aspects of their life, not simply the incident that brought them to the attention of the child welfare agency. With this perspective, the child protection worker uses the momentum from the strengths and safety side as energy to deal with the risk factors or danger the child faces (Turnell, 2003) (see Figure 3 for a visual explanation). Safety organized practice is specific and evidence-based and requires the careful analysis and evaluation of data gathered. Using a collaborative and respectful approach is likely to yield more detailed and candid information than a more forensic approach. The Signs of Safety model encourages workers to harness the expertise of their clients and their extended families/networks to help them better understand the meaning of this information and to engage in a plan to address the risks.

Rigorous safety planning while being solution focused does not involve merely accepting a person’s promise not to repeat a certain action, but to have all parties think through the risk factors and work together to develop strategies to mitigate the future harm.

For the purposes of working with children exposed to DV, the *Signs of Safety* approach may be seen as an applied intervention that is built on the work of Masten and Coatsworth (1998) and focused on two fundamental notions of “best” practice; aspiring to partnership and solution building. A child protection interview can be used as a forum for change and provide family members with customized, supportive intervention.

Aspiring to Partnership

A central feature of the *Signs of Safety* approach is to develop partnerships with children and/or their caregivers (Turnell, 2000). Partnership is “a notion that promotes participation, cooperation, and collaboration” (p.8) between the worker, child and/or family. The worker abandons the “expert” position and genuinely elicits the family’s opinions regarding their situation, as well as their suggestions to address the difficulties or danger. A *Signs of Safety* notion then, views partnerships as learned professional skills that stems from (a) encouraging the caregiver and child’s participation in defining the issues and treatment planning, (b) providing a safe environment for the expression of feelings, (c) eliciting caregiver input that will build at providing stability/consistency and (d) building nets of safety with the caregiver from violence in the home, school or community. Furthermore, Turnell and Edwards (1999) specified five fundamental tasks that help child protection workers develop successful partnerships including (a) being detailed about getting accurate information, (b) being mindful of properly planning with the child and family, (c) being goal focused on what the child/family wants, (d) recognizing all families have signs of safety and are able to keep their kids safe at least some of the time and (e) working to create small changes with children and/

or families. One outcome of good partnerships is that it invites caregivers to detail their own ideas/solutions/plans about what needs to happen as opposed to relying solely on professional expectations.

Solution Building

A *Signs of Safety* approach also includes a second notion of “best” practice, that of creating helpful conversations around building safety with children and families. To accomplish this, Turnell uses a solution-focused brief therapy (SFBT) approach. SFBT is a goal-directed and non-deficits approach to practice developed by Insoo Kim Berg, Steve De Shazer and colleagues at the Brief Therapy Center in Milwaukee, Wisconsin (de Shazar et al, 2007). SFBT develops respectful relationships with clients, working to recognize their strengths, exceptions to problems (in this case danger/risk), and what solutions may exist (in this case, signs of safety) that will be helpful to what concerns them. An important feature of SFBT helps clients define their goals (however small) for change by attending to “*solution talk*” rather than “*problem talk*” (de Shazer et al, 2007). As illustrated in Figure 2, SFBT is operationalized by a number of assumptions that can be incorporated into specific interventions that are referred to as Practice Skills.

Figure 2: SFBT Assumptions

If it isn't broken, don't fix it
If it works, do more
If things aren't working do something different
Small steps can lead to big changes
The solution is not necessarily related to the problem
The language of solution development is different from that needed to describe a problem
Every problem has an exception, and
The future is created and negotiable

(de Shazar et al, 2007)

Practice Skills

A *Signs of Safety* approach incorporates five practice skills child protection workers can use when building safety with families where domestic violence is an issue. To aid in this process, the worksheets (Figures 3 and 4) have been adapted from the *Signs of Safety Assessment and Planning Form* (Turnell and Edwards, 1999) and can be filled in by workers together with families. The worksheet and practice skills have an advantage of helping workers recognize the potential clinical issues (e.g. Table 1, Figure 1) a child faces when considering the worry or danger side. At the same time, the forms and practice skills below can be used effectively to help determine the impact of the violence, to elicit information regarding the worries held by each family member, and to start to take small steps towards shared safety goals.

Figure 3: Worry to Good Things Form*

WORRY (or danger)	<i>(some items can be between)</i>	GOOD THINGS
What worries you/your family?		What are good thing that happen to you/your family?
Complicating factors		
Contributing to worry (or danger)		
Scaling Worry: If 10 means your worries (or danger) are the worst and 0 is the opposite, where are you today?		
Agency Goals: (how much safety is need [specific/detailed] for this case to be closed?)		
Child/Family Goals: What would you like different? (specific, in detail)		
What' the first sign of small progress you will see?		

*Adopted from Turnell and Edwards, 1999

Figure 4: Questions that will help build an understanding about the position of each family member

1. How can we help you?
2. Would you like to tell us what happened?
3. What worries you the most about your situation?
4. What is the most important thing you would like to talk about?
5. Do you feel safe? How do you make yourself safe?
6. How do you manage your child's behaviour?
7. How are you coping now?
8. What bothers you the most about what happened?
9. Can you tell me about what scares you the most?
10. What worries you about your children?

Practice Skill 1: Understanding the position of each family member

The first practice skill, *understanding the position of each family member* helps the child protection worker recognize the potential impact DV has on the child and/or all family members as they unpack the values, beliefs, and meanings of violence (Turnell and Edwards, 1999). The key to practice skill 1 is for workers to not just listen for and notice clinical issues but also give family members a chance to talk about experiences. For example, asking how the child feels about what happened, where “dad” may fit into the picture or how the violence has affected them at school gives the child a chance to answer in a way where she/he feels heard. These questions in effect ask the “how, what, where, or when” of past violence that details what is important to the child/family. Thus, a partnership can develop by talking about (a) what happened and what a caregiver’s ideas are about being safe, (b) the impact on the child/ and what worries the caregiver, and (c) what it is the child or family would like to see changed.

Practice Skill 2: Discovering exceptions and strengths

The second practice skill, *discovering exceptions and strengths* helps the child welfare worker

improve their skill of listening for, asking about, and finding exceptions to danger or risk in children and family members. There will be times when a child or adolescent does not experience typical symptom responses or when a mother has found a way to soothe her anxious child. Asking questions such as those from Figure 5 individualizes helpful behaviors, however small but effective. Because children and families who experience DV can feel hopeless and demoralized, identifying strengths and exceptions can be another way to help build competencies that already exist (Macdonald, 2007; Turnell and Edwards, 1999).

Figure 5: Question that will help build a discovery of

1. When are the times you don't feel this way? When are the most happy? What's your best day like?
2. Tell me about one good day you've had at school?
3. What is it about being a Dad that you are most proud of?
4. Are there some things you do to help your child have fewer nightmares? What are they?
5. Tell me about a time when you were arguing with your wife, but you didn't lose your cool and hit her. What was different then? What helped you to control your anger.

Practice Skill 3: Goal setting

The third practice skill, *goal setting* helps the child welfare worker and family build an understanding about what needs to happen for everyone to be safe. This practice skill is predicated on the idea that successful work with clients depends on knowing what small goal(s) family members want to accomplish (George, Iveson and Ratner, 2000). Inquiring about what one wants out to “work on” or “what their best hopes are” is an important place to start. Asking the questions included in Figure 6 can facilitate goal setting with children or their families exposed to DV. Goal setting should be detailed and specific, ultimately becoming the central focus of work. Further, one should have a sense goals are doable, can be practiced, and small enough to be

accomplished. The worry to good things form (Figure 3) is one example how goal(s) can be charted as part of an action plan.

Figure 6: Questions that will help build goal setting

1. What might we be able to accomplish together that would make you feel like this referral to CAS was helpful for your family?
2. What will you be doing that will help your son know the violence is not going to happen again?
3. What's the first thing you will be doing when you feel safer?
4. What needs to happen that will tell you your child's behavior has improved?
5. What goal would you think is important to set for yourself when it comes to parenting, especially those things that worry you?

Practice Skill 4: Scaling safety and progress

The fourth practice skill, *scaling safety and progress* is a user-friendly SFBT tool that rates the position of the child/parent on a particular point of view, behavior, feeling, etc. Although scaling responses from 0 through 10 are subjective, family members can provide information in real time about where one stands (Figure 7).

Figure 7: Questions that will help build safety and progress

1. On a scale of 0 to 10 where 10 means you regularly skip doing activities you usually enjoy because you're worried that your Dad will seriously hurt your Mom and 0 means you are never worried that this will happen, where would you rate yourself? (this type of example allows one to gauge the impact of the violence on the child's functioning)
2. Mom, if 0 is you feeling completely safe and 10 is the danger is the greatest, where do you think you are today?
3. How well do you think you have helped your child cope with what's happened? 0-10?
4. How sure are you 0-10 that you've seen the last violence? What makes you this sure?

Macdonald (2007) has also characterized scaling as helping clients take action;

moving from an unlikely all-or-nothing position to something small yet manageable. For example, consider the question, "what other helpful things will you be doing when you get to a 6 from your current 5 of managing your anger when you feel others are pushing your buttons?" The "managing" is rated in its current form and while listing what they've done to get to their point, new actions might be identified for taking the next step.

Practice Skill 5: Asking about willingness, confidence, and capacity

The fifth and final practice skill, *asking about willingness, confidence, and capacity* is based on the assumption that human change is ongoing. Therefore workers are in the position of helping family members decide which direction they want to go (Iveson, 2007). Consequently, asking questions from Figure 8 builds an understanding of the client's willingness, confidence, and capacity to move forward from where they are.

Figure 8: Willingness, confidence and capacity questions

1. How confident are you your safety plan will work?
2. If I were to ask you to enroll in our counseling program for families affected by domestic violence, how would you rate your willingness 0-10 to give it a try?
3. What makes you so willing to say you no longer want violence to be a part of your family's life? How would you rate your confidence that you can do something to improve the situation at home? What makes you so confident? What else?
4. When you hear your Dad say that he wants to change, how confident are you that he can and will do the work to make this happen? How will you know he is trying?
5. Tell me how capable you feel you are in teaching the children to use 911.

Carrying out plans of safety, setting new rules for nonviolence in a family, saying no to drugs or alcohol, or agreeing to speak softly to one's upset child may be hard for clients to accomplish. At the same time, questions in the final skill are intended to move a child or family towards more safety and ultimately, in small concrete ways, build their belief in themselves and hopes for a non violent future.

Conclusion

Children who have been exposed to DV has come to represent a real safety issue for the child welfare profession. Thus, the problems surrounding the impact are broad, requiring one to have an informed understanding of all the issues. This paper has focused on two sections; a summary of behavioral and traumatic indicators of exposure to violence and a series of interventions that can build safety in the lives of children and their families. To this end, a *Signs of Safety* approach based on the "best" practice of partnership and solution building was considered. Five *signs of safety* practice skills were included for child protection workers to use with children and their families.

About the Authors

Dr. Peter Lehmann teaches social work at the University of Texas at Arlington and co-directs the Community Service Center (CSC), a campus/ community mental health center. He also trains Child Protective workers in Texas and Oklahoma.

Dr. Catherine A. Simmons is an assistant professor at the University of Tennessee, College of Social Work.

Anne-Marie Duguay is an intake supervisor at Peel Children's Society

References

- Brendler, J. (2006). A model for disrupting cycles of violence in families with young children. In L. Combrinck-Graham (Ed.). *Children in family contexts*, (pp.433-455). New York: Guilford.
- Buckley, H., Holt, S., and Whelan, S. (2007). Listen to me! Children's experiences of domestic violence. *Child Abuse Review*, 16, 296-310.
- Carlson, B. E. (2000). Children exposed to intimate partner violence: Research findings and implications. *Trauma, Violence, and Abuse*, 1, 321-342.
- Chapman, M., and Field, J. (2007). Strengthening our engagement with families and understanding practice depth. *Social Work Now*, December, 21-28.
- Connolly, M. (2007). Practice frameworks: Conceptual maps to guide interventions in child welfare. *British Journal of Social Work*, 37, 825-837.
- Connolly, M., and Doolan, M. (2007). *Lives cut short: Child death by maltreatment*. Wellington, NZ: Office of the Children's Commissioner
- Cook, A., Spinnazzola, J., Fored, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., and van der Kolk, B. (2005). Complex trauma in children and adolescents. *Psychiatric Annals*, 35, 390-398.
- Cunningham, A., and Baker, L. (2004). *What about me? Seeking to understand a child's view of violence the family*. London, ON: Centre for Children and Families in the Justice System.
- Edleson, J.L., Ellerton, A.L., and Seagren, E.A. (2007). Assessing child exposure to adult domestic violence, *Child and Youth Services Review*, 29, 961-971.
- Fantuzzo, J.W., and Fusco, R.A. (2007). Children's direct exposure to domestic violence crime: A population-based investigation. *Journal of Family Violence*, 22, 543-552.
- Geffner, R.A., Jaffe, P.G., and Sudermann, M. (Eds.). (2000). *Children exposed to domestic violence: Intervention, prevention, and policy development*. New York, New York: Haworth.

- George, E., Iveson, C., and Ratner, H. (2000). *Solution focused brief therapy course notes*. London, UK: Brief Therapy Practice.
- Holden, G.W., Geffner, R., and Jouriles, E. N. (Eds.). (1998). *Children exposed to marital violence: Theory, research and applied issues*. Washington, DC: American Psychological Association.
- Iveson, C. (2007). Personal communication. November, 01, 2007.
- Jaffe, P.G., Wolfe, D. A., and Wilson, S. (1990). *Children of battered women*. Newbury Park, CA: Sage.
- van der Kolk, B. Trauma developmental disorder. (2005). *Psychiatric Annals*, 401-408.
- Koziolk, D. (2008). *Implementing the signs of safety in Carver County Minnesota*. Retrieved July 1, 2008, from <http://www.signsofsafety.net/pages/implementations.html>
- Lehmann, P., and Rabenstein. S. (2002). Children exposed to domestic violence: Impact, Assessment, and Treatment Issues. In A.R. Roberts and G. Greene (Eds.) *Resource Guide for Social workers*. (pp.673-678). New York: Oxford.
- Lehmann, P., Spence, E., and Simmons, C. (2006). Children exposed to domestic violence. *Family Violence and Sexual Assault Bulletin*, 22, 12-20.
- Lehmann, P., and Spence. E. (2007). Complex trauma and crisis intervention with children in shelters for battered women. In A.R. Roberts (Ed.). (pp. 181-212). *Battered women and their families: Intervention strategies and treatment Programs*. New York: Springer.
- Loosley, S., Drouillard, D., Ritchie, D., and Abercromby, S. (2006). *Groupwork with children exposed to woman abuse: A concurrent group program for children and their mothers*. London, ON: The Children's Aid Society of London and Middlesex.
- Macdonald, A. (2007). *Solution-focused therapy: Theory, Research, and practice*. Los Angeles, CA: Sage.
- Masten, A.S., and Coatsworth, D. (1998). The development of competence in favorable and unfavorable environments. *American Psychologist*, 53, 205-220.
- McDonald, R., Jouriles, E. N., Ramisetty-Mikler, S., Caetano, R., and Green, C. E. (2006). Estimating the number of American children living in partner-violent homes. *Journal of Family Psychology*, 20, 128-136.
- Merkel-Holguin, L.(Ed.). (2004). Advancing partnership-based practice with families. *American Humane*, 19, 1-68.
- National Child Traumatic Stress Network, (NCTSN). (2003). *Complex trauma in children and adolescents*. Available from the National Child Traumatic Stress Network. Retrieved July 1, 2006, from <http://www.nctsnet.org>
- Osofsky, J.D. (2004). *Young children and trauma: Intervention and treatment*. New York: Guilford.
- Peled, E., Jaffe, P. G., and Edleson, J.L. (Eds.). (1995) *Ending the cycle of violence: Community responses to children of battered women*. Thousand Oaks, CA: Sage.
- Rossman, B.B. (1994). Children in violent homes: Current diagnostic and treatment considerations. *Family Violence and Sexual Assault Bulletin*, 10, 29-34.
- Rossman, B.B. (1998). Descartes's error and posttraumatic stress disorder: Cognition and emotion in children who are exposed to marital violence. In G.W. Holden, R. Geffner, and E.N.

Jouriles (Eds.), *Children exposed to marital violence: Theory, research and applied issues* (pp.223-256). Washington, DC: American Psychological Association.

Sawyer, R., and Lohrbach, S. (2005). Differential response in child protection: Selecting a pathway. *Protecting Children*, 2 and 3, 44-54.

de Shazar., S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., and Berg Insoo, K. (2007). *More than miracles: The state of the art of solution-focused brief therapy*. New York, New York: Haworth.

Silvern, L., and Kaersvang, L. (1989). The traumatized children of violent marriages. *Child Welfare*, LXVIII, 421-436.

Turnell, A. and Edwards, S. (1997). Aspiring to partnership: The signs of safety approach to child protection. *Child Abuse Review*, 6, 179-190.

Turnell, A., and Edwards, S. (1999). *Signs of Safety: A solution and safety oriented approach to child protection work*. New York, New York: W.W. Norton and Co.

Turnell, A., (2000). Aspiring to partnership: The signs of safety approach to child protection. Unpublished document. Perth, AU.

Turnell, A. (2003, May). Signs of safety. Workshop presents at Salesmanship and Youth Club of Dallas: Dallas. TX.

Turnell, A., (2007). Thinking and practicing beyond the therapy room: Solution-focused brief therapy, trauma, and child protection. In T.S. Nelson and F.N. Thomas (Eds.) *Handbook of solution-focused brief therapy: Clinical Applications*. (pp. 295-314). New York, New York: Haworth.

Turnell, A., and Essex, S. (2007). *Working with "denied" child abuse: The resolutions approach*. New York, New York: Open University Press.

Turnell, A., Elliott, S., and Hogg, V. (2007). Compassionate, safe and rigorous child protection practice with biological parents of adopted children. *Child Abuse Review*, 16, 108-119.

Board of Directors 2008/09

President: Donna Denny

First Vice President: Jane Anderson

Second Vice President: Keith Sparling

Secretary/Treasurer: Al Law

Past President: Dennis Nolan

Region 1 Charron Sippola

Kenora-Patricia C&FS, Rainy River F&CS

Region 2 Vacant

Dilico Anishinabek FC, Payukotayno James & Hudson Bay FS

Region 3 Frank Gillis

Algoma CAS, Sudbury-Manitoulin CAS

Region 4 Dennis Draves

Jeanne Sauvé FS, C&FS of Timmins & District, Timiskaming C&FS

Region 5 Nancy Ringham

Thunder Bay CAS, Tikinagan North C&FS

Region 6 John Stopper

FY&CS of Muskoka, Nipissing & Parry Sound CAS

Region 7 Bill Wellman

Northumberland CAS, Kawartha-Haliburton CAS

Region 8 Al Law

Hastings CAS, Lennox-Addington F&CS, Prince Edward CAS

Region 9 Keith Sparling

Frontenac CAS, Renfrew F&CS

Region 10 David Huether

Leeds-Grenville F&CS, Lanark CAS

Region 11 Barbara MacKinnon

Ottawa CAS

Region 12 Ray Barnes

Prescott-Russell CAS, Stormont, Dundas & Glengarry CAS

Region 13 Tim Maloney

York Region CAS, Durham CAS

Region 14 Tiffany Woodfine

Simcoe CAS, Dufferin C&FS

Region 15 Paul Zarnke

Peel CAS, Jewish F&CS, Native C&FS of Toronto

Region 16 Sue Makin

CAS Toronto

Region 17 Marilyn Dumaresq

Toronto CCAS

Region 18 Jan Lord

Halton CAS, Wellington F&CS

Region 19 Gary Harron

Grey CAS, Bruce CAS

Region 20 Tom Knight

Huron- Perth CAS

Region 21 Harry Emmott

Waterloo F&CS, Brant CAS

Region 22 Ron Sharegan

Hamilton CAS, Hamilton-Wentworth CCAS

Region 23 Jane Anderson

Niagara FACS, Haldimand-Norfolk CAS

Region 24 Jane Fitzgerald

London-Middlesex CAS, Oxford CAS

Region 25 Jerry Collins

Chatham-Kent CS, Elgin F&CS

Region 26 Richard Newton-Smith

Windsor-Essex CAS, Sarnia-Lambton CAS

40% of food bank clients in Ontario are children.

One in six children in Ontario live in poverty.

Over the past year, more than 77,000 allegations of abuse and neglect were investigated by Ontario's Children's Aid Societies. More than 27,000 children were in CAS care.

Almost 40% of women assaulted by spouses said their children witnessed the violence; in many cases the violence was severe.

One-third of children seeking mental health services in 2007 were still waiting at the end of the year.

A society is measured by the well-being of its children.

At a time of widespread economic uncertainty, the progress of Ontario's children threatens to be all but overlooked. That's precisely why standing up for them has never been more important than it is right now.

In this, our Ontario, too many of our children are denied the basics of a safe home and adequate food and clothing. Too many lack the nurturing family and community supports essential for them to succeed and thrive. Too many aren't developing in the essential ways they must, in order to reach their full potential. And it's been this way for too long, in good times as well as bad.

Today, on National Child Day, we ask all Ontarians to make our children and families, particularly our most vulnerable, a priority in our thoughts and actions. Their well-being is the true measure of our society. At a time when so much is uncertain, ensuring that our children continue to grow has never mattered more.



Ontario Association of
Children's Aid Societies

The voice of child welfare in Ontario

**OACAS, in support of its members,
is the voice of child welfare in
Ontario, dedicated to providing
leadership for the achievement of
excellence in the protection of
children and in the promotion of
their well-being within their
families and communities.**