JOURNAL

Message from the Executive Director

The Ontario Association of Children's Aid Societies (OACAS) believes that every child deserves a family that will love and nurture them always. There are currently more than 2,600 children legally available for adoption in Ontario foster care. A strong public adoption system is essential for children who both deserve and need a permanent family.

Children's Aid Societies (CASs) believe that successful adoptions are based on the child's needs and are committed to a strong public adoption system, free of charge for those who adopt from the child welfare system. The public system is structured, regulated and monitored, and affords the government and the public confidence in the trust placed in CASs as workers prepare and match families. Adoption through the public system is far less expensive and results are far better for children than long-term foster care.

The Government of Ontario provides special post-secondary grants for all former Crown wards, including many who were adopted; however, more is needed. Provisions must be made to make it easier for Ontarians to open their doors to children and youth in care. Ontario needs a system that makes it easier for potential adoptive parents to learn about children who might be suitable matches.

Over the past two years, OACAS has developed recommendations for change, many of which are included in the Report of the Expert Panel on Infertility and Adoption. They include:

· A fully funded provincial system, centred on the child and supported by an enabling legislation, a clear policy framework, recruitment campaigns, subsidies, post-adoption services and disclosure services. OACAS recommends building on new and emerging provincial components such as standardized and portable assessments, training and matching services.

· Public education to increase awareness and to communicate that every child and youth can have a permanent and legal family, given the right supports.

· Removal of legal and/or policy barriers that stand in the way of adoption for many, including clarification around the legal and policy definitions of "Crown wards with access" to truly facilitate open adoption.

· Adequate subsidies to enable families to adopt and for children to have families. The Report on Infertility and Adoption recommends immediate implementation of subsidies in the range of 50–80 percent of current boarding rates for special-needs children and youth.

This edition of the Journal focuses on openness planning in adoptions, mental health issues with children and youth in care, and engaging communities in the work of child welfare.

Jeanette Lewis
Executive Director

Developing a Model to Guide Openness Planning in Child Protection Based Adoptions

By Ross Plunkett

DEVELOPING A MODEL TO GUIDE OPENNESS PLANNING IN CHILD PROTECTION BASED ADOPTIONS

Much of the advocacy and research on the benefits of openness arrangements in adoption comes from **openness agreements** in voluntary adoption placements. Within Ontario's public adoption sector, the majority of children placed on adoption are as a result of serious protection issues. As such, there have been a number of questions about the benefits of openness to the child and about the long-term stability of the child's adoptive placement when applying openness agreements to non-voluntary relinquishments. New laws have been passed in Ontario that allow for a range of openness arrangements in public adoption, which previously were not legally permitted. Although legislation is now underpinned by research on attachment, the field has yet to catch up. This is partially due to a lack of training. Also complicating the matter, assessment models of openness were not provided to Ontario's child protection agencies when the openness legislation was passed. As a result, there are significant differences in how agencies apply openness in their adoption work.

The intent of this article is to review some of the research on openness in order to develop a better understanding of the potential benefits and challenges to openness arrangements in child protection based adoption work, and to provide a model that can guide openness planning in meeting adopted children's long-term needs. For the purpose of this review, it should be understood that openness arrangements in Ontario include both **court ordered openness orders** and **openness agreements**, the later of which are arranged and agreed upon outside of court. Openness is understood to involve a broad range of options, from an exchange of letters and photos to face-to-face contact. Each adoption will need to be individually assessed in order to determine what type of openness arrangement best meets the child's long-term best interests. For example, when birth parents have abused their child, contact may still be beneficial, but will need to be a safe experience for the child. As such, direct contact may not always be appropriate.[1]

BENEFITS OF ADOPTION

Research shows that when children cannot return to their birth family, adoption is the most stable form of alternative care. When children have the continued support of an adoptive family into adulthood, they gain a lifetime perspective. Research shows good outcomes across a range of measures, with late placed children in adoption having better outcomes than late-placed children in foster care. [2]

While foster care is an excellent support to children, and some children in care are able to maintain these supports and life-long commitments, it is inherently limited in providing a stable, predictable, long-term placement compared to adoption. The limitations in meeting the long-term needs of children in long-term foster care are well recognized as a serious deficit. Within the Child and Family Services Act, Section 66, the Ministry is required on an annual basis to review the status of every child in care who has been a Crown ward for two or more years. For many years, provincial data has consistently shown that on average, children in care can expect to experience a placement change, as well as a change in workers, approximately every two years. There are minor differences between agencies and from year to year, but not significantly so. Comparatively, statistics on adoption disruptions show only 5% disruptions for children adopted under one year of age, and only 20% to 30% for children adopted over one year. It is also important to note that there are often reconciliations of disrupted adoptions, with the adopted youth and their adopted family resuming their relationship. The advantages of adoption outweigh its potential risk.

Fostering in Ontario is also limited by current legislation, which only allows youth to remain in care until 18 years of age, regardless of their needs. Typically, youth leave the foster home at this time, as this is when funding for foster care typically ends. The move out of the foster home and the subsequent disruption in the school year may partially explain why educational outcomes for youth in care are significantly lower than the provincial average. Advocacy by the Ontario Association of Children's Aid Societies and youth from care groups like YouthCAN have repeatedly brought this issue to the Ontario government's attention, but no change has occurred. Four other provinces have raised the age that child protection clients can remain in foster care

and receive support, but even if legislative improvements do eventually occur in Ontario, adoption will continue to offer greater benefits to the child as there is no expiry date on an adoptive family's commitment supports, and long-term attachments. Adopted children have a much greater chance of receiving ongoing family support into their adult years, with reasonable expectations of participation in family gatherings, support with their own child rearing, as well as emotional and perhaps financial support when needed.

BENEFITS OF OPENNESS IN ADOPTION

Steinhauer's research on attachment formation and the creation of attachment disorders is well recognized and respected in Ontario's child protection field. Ever since Ontario established consistent, province-wide training of child protection workers, his research has underpinned mandatory training and is currently referred to in Child Welfare Professional Training Series, Course 6—Permanency and Continuity of Care . Steinhauer's research found that severing a child's past relationship with a primary caregiver has a cumulative impact upon their ability to make new relationships. The more changes of primary caregivers, the less invested a child is in forming close attachments. If a child experiences too many losses, they may ultimately not invest any effort in forming close emotional relationships, and may even lose the capacity to do so.

When applying these research results to adoption practice, it should be recognized that a well thought out openness arrangement can promote an adopted child's capacity to form and maintain attachments with their adoptive family. Research from the Centre for Adoption Support and Education in the USA has identified the unique needs of adoptees during adolescence, even those who were adopted as newborns. Challenges unique to this population revolve around identity formation. Like race and culture, being adopted is an integral part of the adopted teenager's identity and in developing their sense of identity they need to determine how they are alike and different from both the biological and adoptive families. The research also found that an openness arrangement improved positive outcomes for adoption stability by providing adopted teens with accurate information about their birth parents, which allows them, amongst other things, to understand and assess the reasons why their birth parents were was unable to parent them. The research also found that because adoptive parents were better informed about birth parents, they were better able to assist their adopted child to

incorporate their history into a healthy sense of self.[3]

In addition to supporting the initial attachment formation with an adoptive family, there are additional benefits of openness to the adoptive parents. Contrary to some of the concerns expressed by the field, the research also shows that adoptive parents benefit from openness, with many reporting increased feelings of entitlement, less fear of the birth family, and feeling a greater sense of empathy for the child and the birth family.[5]

OPENNESS ISSUES UNIQUE TO ONTARIO

In reviewing the research from the USA and Britain on the potential benefits of openness in adoption, it is important to note that all the research pertained to openness **agreements**. Openness **orders** are unique to Ontario alone. Given how recent this legislation is, there is currently no research available that demonstrates whether or not there are any benefits to openness **orders** over openness **agreements**. While protection to the stability and permanency of the adoptive home was built into openness orders within the Child and Family Services Act, it has not been addressed under the Family Law Act. This omission may create unintended stressors for adoptive parents who could face legal challenges similar to toxic custody battles, ultimately at the expense of the adoptive child's well-being. In addition, adoptive parents who agree to openness **orders** could face future court challenges and financial hardship resulting from the associated legal costs. In anticipating how the courts would respond to such cases, there is insufficient case law to refer to as the changes to the legislation are so recent. Until there is sufficient case law available to inform our practice, it may be advisable to direct all potential adoptive parents to seek independent legal advice before agreeing to enter into an openness **order**.

Beyond legal issues, there are clinical considerations that should be evaluated when determining the merits between an openness **order** and openness **agreement.** Well thought out adoption planning will seek to reduce unnecessary stress on the adoptive family, as their stress can have a negative impact on the child's well-being. The research finds that "the provision of substitute parents in itself represents the most radical, comprehensive and potent therapeutic change in a child's psychosocial prospects" (and) "the first level of intervention needs to ensure that" (the adoptive parents) "are sufficiently stress free in order to be psychologically available and responsive to the child's needs" (Howe,

2006, 129-130).

By law, openness **orders** cannot occur until after a child is legally free for adoption. They must be initiated by a Children's Aid Society prior to the final adoption order and must have the consent of all parties, including the adoptive family. This design is clinically sound practice, as one of the critical indicators in determining the benefit of an openness arrangement to the child is the birth parent/relatives' willingness and capacity to accept and support the child's adoption.[1] During the trial process it is not always possible to determine how a birth relative will respond to the loss of the legal right to their child. Only after a court order is made to free a child for adoption can there be an opportunity to clinically assess the birth parent(s)/relative(s)' capacity to accept the reality of their loss, as well as their willingness to support the adoption placement. This best practice is reflected in legislation, which requires that openness agreements be designed after the child is legally free for adoption.

Because the research supporting the benefits of openness is based on openness **agreements**, not openness **orders**, a very cautious approach to recommending an openness **order** would appear to be prudent. It is important that an **order** aims to reduce any potentially destabilizing situation that impedes good outcomes, including that which may undermine the adoptive parent-child relationship. Openness **agreements** have a demonstrated track record of being beneficial to an adopted child's long-term outcomes and have the benefit of greater flexibility as they have the ability to be responsive to a child's needs and changing circumstances in a timely fashion. Openness **orders**, on the other hand, require a court process to modify them, which does not allow for timely responses to changing circumstances. Openness arrangements last until the child's 18th birthday, so it is critical to recognize that "children's needs will change, so plans must be flexible."[1] "Because decisions about contact are often made in an emotionally charged atmosphere, they should be periodically reviewed post-placement. In this way one can ensure they reflect the needs and interests of the child, adopters, and birth parents."[1]

Perhaps one instance when an openness **order** might be of greater benefit than an openness agreement is when trying to ensure that contact between siblings is maintained. When siblings have well established, healthy, strong attachments, but are not being adopted into the same family, they are not in a position to negotiate or advocate for themselves. In this circumstance, an openness **order** might better ensure that their attachments are preserved. However, even in this situation, consideration must be given to potential risks that might undermine an adopted child's success. For example, if there are differences in the birth family's contact with the child's siblings, or in legal status and/or court orders, pursuing an openness **agreement** may be the prudent practice, depending upon the child's needs.

CONSIDERATIONS IN DESIGNING AN OPENNESS ARRANGEMENT

When developing an openness arrangement, there are three critical areas that must be assessed to ensure that it will succeed and be beneficial to each individual child. "Dogmatic prescriptions regarding permanent placements and subsequent contact with birth families are not supported by research evidence; decisions must be both informed by research and be case sensitive."[5]

The three critical areas in openness planning are:

1) The openness plan is based on the child's assessed needs.

For the child, "post-adoption contact with birth relatives can assist children with managing attachment and identity issues, but this will be dependent on the quality of such contact... For children who have complicated relationships with birth relatives, this complexity can make both managing contact and managing the severance of contact difficult, and children will need help with this complexity."[1]

2) The birth relatives have the capacity to be supportive of the adoptive placement.

"Qualities of birth relatives associated with more successful contact include the willingness and capacity to support the child in his or her new family, and to work cooperatively with the child's new parents. Birth relatives with problems of their own are likely to need support in sustaining useful contact with their child."[1]

"Post placement contact with birth relatives can assist children with managing attachment and identity issues, but this will be dependent on the quality of such contact."[1]

3) The adoptive parents understanding and believe in the benefits to the child of openness.

"Qualities of adoptive parents…associated with more successful contact include: an open, empathetic and inclusive attitude towards the child's birth relatives (acknowledgement of difference); a non-possessive conception of parenting; empathy for the child as an adopted…individual."[1] Therefore agency adoption practices will need to reflect this in their screening, training, assessment and selection of adoptive families.

STEPS IN DESIGNING AN OPENNESS ARRANGEMENT

Based upon the research findings, the following is a suggested model designed to systematically assess the critical factors necessary for openness arrangements that enhance the likelihood that they will last and be beneficial to the child. As the *child's best interests* is the foundation for child protection and good adoption practice, the **first step** is to assess the purpose of openness in meeting the needs of the child. The **second step** is an assessment of the type and frequency of openness needed to meet the needs of the child. The **third step** is an assessment of the birth parent(s)/relative (s)' capacity to meet the child's need for openness. The **fourth step** is in the adoption selection process is an assessment of the ability of the adopted family to understand the benefit to the adopted child from openness arrangements, as one of the many considerations that are included in the adoption selection.

It is critical to recognize that a child's best interests are not being served if openness is the only or primary consideration in a child's adoption planning. A full review of the needs of each child must be considered when selecting an adoption placement, and openness is just one of the many considerations to be addressed in sound adoption planning. In child protection adoptions, the majority of children placed on adoption have significant special needs and attempting to meet some of these serious needs will often take greater priority over other considerations, including openness.

A professional adoption planning process will be based upon identifying each child's current and potential future needs, weighing the importance of each of these needs, and the selection of the adoptive family best able to meet these needs. Openness is just one of the many considerations that should go into sound adoption planning.

STEP 1: DETERMINE THE PURPOSE OF OPENNESS IN MEETING THE CHILD'S NEEDS

a) If to maintain an existing significant attachment, **go to Step 2A**

b) If to provide opportunities for healthy self-identity formation when there is a weak attachment with the birth parents, **go to Step 2B**

c) If to maintain contact with a sibling, **go to Step 2C**

STEP 2: DETERMINE THE TYPE AND FREQUENCY OF CONTACT, BASED UPON AN ASSESSMENT OF THE CHILD'S NEEDS

Review case history, including observations of the child's interactions with the family member, and any assessments of the child.

STEP 2A - THE CHILD'S NEEDS RE ATTACHMENT

Assess the quality of the child's attachment by considering the following:

- How long the child lived with this adult

- How well the adult met the child's physical and emotional needs

- Any trauma the child associates with this adult

- How important the child has indicated this person is to them

Based upon this assessment, determine what form of openness arrangement and frequency would best meet the child's needs. "The more complicated the child's pre-placement history, the more complex contact meetings are likely to be."[5]

Once you have developed recommendations based solely upon the assessment of the child's needs, go to Step 3A.

Note: Prior to Crown ward trials, agencies often provide frequent access visits as a method of assessing and assisting family change and maintaining attachments. For adoption purposes, the frequency of face-to-face visits in openness

arrangements can be expected to be reduced, as the purpose of the visit is different. There needs to be a balance between preserving significant attachments and ensuring enough time between visits to allow the child to develop their attachment to the adoptive family. Additionally, adoptive families cannot be expected to have the time or resources to provide high levels of access visits.

STEP 2B - THE CHILD'S NEEDS RE SELF-IDENTITY FORMATION

As self-identity formation occurs throughout childhood, and research shows it has particular importance during the adolescence of an adopted youth, develop a plan for contact that is sensitive to the changing needs as the child matures. Frequency of contact does not need to be high, but face-to-face is most beneficial, where appropriate. If the child has not established a close attachment to the biological relative, occasional contact will have little adverse affect upon their adoptive placement. Even for children with insecure attachments to past "…caregivers…contact is probably better than having to reconcile questions about identity and worth in the face of perceived abandonment. For very young children, face-to-face contact is relatively straight forward because the relationship with birth parents is not an attachment relationship and less likely to be a threat to" caregivers. [5]

Once you have developed openness recommendations that are based solely upon the assessment of the child's needs, go to step 3B.

STEP 2C - THE CHILD'S NEEDS RE SIBLING CONTACT

"Children mostly do better if placed with their siblings, except when there is hostility and/or abuse between them." Despite this, siblings may not be placed together due to things like significantly different needs, different legal status or placement challenges. When siblings will be placed in different homes, determine the quality of attachment to the siblings of the child you are planning for by considering how long they have lived together, how they got along, any shared trauma, and to what degree this child has demonstrated they are missing their sibling(s). The quality of the sibling attachment should guide decision-making about the frequency and nature of contact. If the children have a weak attachment, but knowledge of each other, some form of openness is still of benefit as it provides the child

with accurate information about how their sibling(s) is doing. If there is a strong attachment, the benefit to preserving it through an openness arrangement is supported by attachment research.

Once you have developed openness recommendations based upon the child's needs, go to Step 3C.

STEP 3: DETERMING BIRTH PARENT(S)/RELATIVE (S)' CAPACITY TO MEET CHILD'S IDENTIFIED OPENNESS NEEDS

After determining the child's openness needs, it is then necessary to assess the level of the birth parent (s)/relative(s)' capacity to meet these needs and adjust planning accordingly. If planning is not based upon realistic expectations, it will result in failure. Research indicates the most common reason openness arrangements fail is because the biological parent(s)/relative(s) do not maintain them.[1] Unrealistic expectations – those that are beyond the birth parent(s)/relative(s)' willingness and demonstrated ability - will not result in positive outcomes in openness practice.

The extensive work that goes into child protection findings, treatment efforts, assessments, access visits, and court evidence typically provides a wealth of information to guide assessment of capacity. Research also shows that the birth parent(s)/relative (s)' support systems contribute to successful openness arrangements, so the existence and strength of those support systems should also be considered in openness planning.

When considering the type and frequency of openness, it is critical to take into account potential problems with birth families that may warrant a more arms-length approach. A potential problem area to consider is one in which a birth parent "wants to exert control" or displays "difficult, unresolved feelings and an inability to accept the placement" which "can lead to behaviors that undermine the new placement."[1] Additionally, "difficulties in the relationship between the child and birth relatives are likely to persist after placement."[1] " If no contact is possible, the child's needs must be met in other ways."[1]

STEP 3A - ASSESSING BIRTH PARENT(S)/RELATIVE (S)' CAPACITY TO MEET CHILD'S NEEDS

- Identify how child-focused the birth parent/relative

Submit an article for the Spring 2010 edition of the OACAS Journal

Writers Needed!

Articles on programs, projects and initiatives to improve the lives of youth in care and Crown wards are welcomed for the Spring edition by **April 30, 2010**. The Journal – print and electronic – is distributed to 4,200 readers including child welfare practitioners, researchers, foster parents, volunteers, government representatives, community partners and the media.
Personal accounts, opinions and news articles will be considered for publication. OACAS also welcomes executive summaries, excerpts and abstracts from researchers and academics. Visit www.oacas.org for information about submission guidelines.
Inquiries can also be e-mailed to journal@oacas.org

Spring Edition Submissions Deadline: April 30, 2010
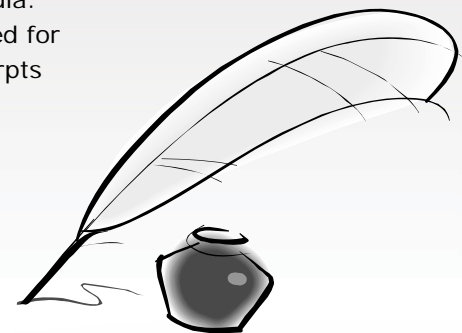
has been in their interactions with the child before and after the child entered care.

- Identify if there are any specific issues of limited capacity due to significant mental illness, addiction or compromised reasoning or intelligence. If so, identify if there are support systems in place that could support some form of openness despite these capacity issues. Determine if these support systems are willing to support openness efforts, and for how long. Informal support systems, like extended family, may have a greater ability to support long-term versus professional community-based support systems.

- Identify if there are any safety issues, such as history of violence, threats, ongoing criminal activity, sexual abuse or violence associated with drug or alcohol consumption.

- Assess how well the birth parent(s)/relative(s) have resolved and accepted the child's adoptive status, and whether they are committed to supporting the child's success in the adoptive home. This typically cannot be assessed fully until after the child is legally freed for adoption, particularly in contested trials. After the trial, birth parents may understandably need time to come to accept the reality of their loss and to decide if they want and feel able to support the child's adoption.

- Identify how reliable the birth parent(s)/relative(s) were in showing up for scheduled visits and meetings.

- Identify how stable the birth parent(s)/relative(s)' lives are in such areas as housing and their ability to maintain a telephone for contact. Determine whether they ever disappeared for periods of time with their whereabouts unknown.

- Identify how attuned the individual is while interacting with the child, including the degree of sensitivity to any special needs the child may have.

- Identify how geographically accessible the individual is for the different forms of openness contact, as well as their wishes regarding openness contact.

Once the capacity, support systems and circumstances of the birth parent(s)/relative(s) are understood, determine what modifications may be necessary to achieve a workable openness plan. **Then go to Step 4A.**

STEP 3B - ASSESSING THE BIRTH PARENT(S)/ RELATIVE(S)' ABILITY TO MEET THE CHILD'S NEEDS

- Identify the birth parent(s)/relative(s)' level of commitment to ongoing contact to support the child's understanding of their family history.

- Identify any limitations of the birth parent(s)/ relative(s) in meeting these commitments, and determine what support systems are in place to help them do so.

- Identify any safety issues.

- Identify level of cooperation experienced to-date with this relative in relation to the child's substitute care.

- Identify how available the relative is for the different forms of openness contact.

Once the birth parent(s)/relative(s)' capacity, availability and support systems are understood, the initial openness plan to support the child's self-identity needs may need to be modified. If no long-term openness arrangement appears possible or appears likely to succeed, it is critical that a well developed life book and social history accompany the child to their adoptive home, ideally with photos of birth parents and relatives, letters and/or audio-video recordings from them, which will later assist the child's understanding of their family background. **Then go to Step 4B.**

STEP 3C - ASSESSING THE SIBLING(S)' ABILITY TO MEET CHILD'S NEEDS, AND THE SIBLING(S)' PLACEMENT AND SUPPORT SYSTEM'S CAPACITY TO MEET CHILD'S NEEDS

- When possible, assess the motivation of the sibling(s) for some form of openness.

- Identify if the sibling will be adopted to another family, return to the birth family's care or remain in foster care.

- Assess how committed the sibling's home/ placement is to supporting openness in a way that is beneficial to both children. Determine whether there are any concerns about the ability of the sibling's home/placement to communicate directly and cooperatively with the adopted parents in order to coordinate the openness arrangements. Determine whether the sibling's home/placement agrees with the openness plan, including the level of commitment that is required of them.

- Identify if the sibling will have a different type and/or frequency of contact with the birth parent(s)/relative(s) and what impact that might have on the child being placed on adoption.

- Determine if the sibling's home/placement is interested in an openness arrangement, and what that might consist of.

- Determine any practical considerations of each sibling's circumstances/placement that might limit the type and frequency of openness possible.

- Determine whether there are any safety issues or concerns that may negatively impact the child being adopted as a result of having face-to-face contact with their sibling or sibling's caregivers, including a history of violence, criminal activity, addiction issues, and mental health concerns.

- Determine what support systems are available for the sibling and the siblings' placement that support openness arrangements.

Once the capacity of siblings and sibling's placements to support openness has been assessed, review the adopted child's assessed openness needs and make modifications to the plan as necessary. **Then go to Step 4C.**

STEP 4: FINDING AN ADOPTIVE HOME ABLE TO SUPPORT THE OPENNESS PLAN

In the openness planning process, the child's openness needs are determined and then modified in consideration of the capacity of the birth parent(s)/relative(s) or sibling and sibling's placement. The next step is to find the adoptive home that is best able to accommodate these plans. When doing openness planning and searching for potential adoptive families, it is critical to remember that openness is just one of many factors that are taken into consideration in the selection process. A family could potentially meet all of the openness planning requirements, but be incapable of meeting other, more critical needs that a child may have. There must not be undue emphasis on any single aspect of adoption planning as a standard practice, as the selection criteria should be supported by the assessed needs unique to each child, in order for each child's best interests to be served.

This next step can help inform the adoption search and selection process. It also recognizes that there may be a need to make modifications to the final version of the openness plan by now factoring in the adoptive parent's commitment, capacity and ability to enter into some form of openness arrangement. It is recommended that the adoption worker provide the adoptive family with a full explanation of the clinical thinking that has informed the openness planning in order to assist in greater understanding, and increase the likelihood of follow through by the adoptive parents. This information will also guide the adoptive parent's future decision-making when making adjustments to the openness plan as the child matures and his/her needs change.

STEP 4A - ASSESSING THE ADOPTIVE FAMILY'S ABILITY TO MEET THE OPENNESS PLANNING DEVELOPED TO THIS POINT RE BIRTH PARENT(S)/RELATIVE(S)

The final step to developing an openness plan that will help maintain a significant attachment to a birth parent or relative is assessing the commitment and capacity of the adoptive parents in supporting the openness plan, and then modifying it as necessary.

- Determine how well the potential adoptive parents understand the child's unique needs, including the potential benefits to the child of some form of openness.

- Determine whether the potential adoptive parents demonstrate a realistic and empathetic understanding of the birth family's challenges in a way that would promote a positive identity for the adopted child.

- Determine the ability of the potential adoptive family to deal directly with the birth family in a respectful and supportive manner.

- Determine what support systems are available to the adoptive family regarding openness issues.

- Determine how closely the adoptive family's ideas about the structure of an openness plan matches the openness plan developed by the agency and which the agency believes is in the child's best interests.

- Determine whether the proposed adoptive family have professional or personal experience/knowledge that would assist them in understanding the birth family in a balanced and empathetic manner, like knowledge about addiction, for example.

- Determine whether a cultural/racial match between birth parents and the proposed adoptive family might enhance understanding and communication between them, and help to preserve the child's culture and/or help the child to value his/her sense

of racial identity.

-Determine if there are practical considerations, like distance from birth parents, which may limit openness options.

STEP 4B - ASSESSING THE ADOPTIVE FAMILY'S ABILITY TO MEET THE OPENNESS PLANNING DEVELOPED TO THIS POINT RE IDENTITY FORMATION

The final step to developing an openness plan for healthy identity formation is to assess the commitment and capacity of the adoptive parents in supporting the plan for openness. In cases where the child has a limited attachment to the birth parent(s)/relative(s), the success of the openness planning will be dependent on the adopted parent's belief and understanding of the future benefits of openness to their adopted child. The goal is to have openness arrangements firmly established by the time the adopted child reaches adolescence, which is the time when openness can most assist a child with forming a sense of identity.

STEP 4C - ASSESSING THE ADOPTIVE FAMILY'S ABILITY TO MEET THE OPENNESS PLANNING DEVELOPED TO THIS POINT RE CONTACT WITH SIBLING(S)

The final step to developing an openness plan for sibling contact is to apply the assessment areas identified in Step 4A to openness with siblings by assessing the belief, commitment and capacity of the adoptive parents in supporting some form of openness.

THE FINAL OPENNESS PLAN

Once the above steps have been completed, an agency should be able to recommend the type and frequency of an openness plan, and identify the potential challenges to be addressed. It is both unfair and unrealistic to expect adoptive families to have the expertise to develop a well thought out openness arrangement. They will be reliant on adoption workers and independent legal advice to guide them in their efforts. Agencies should develop

models of agreements and orders which provide direction for methods of problem resolution, as well as developing alternative forms of openness if circumstances change, such as when one of the parties moves a significant distance away. Agreements should also guide decision-making around other needed changes, such as alternative methods of communication, and the need for flexible arrangements that accommodate the changes in a child's life, such as participation in summer camps, extra-curricular activities, part-time employment and travel.

Clear expectations and reasonable responses that address challenges such as late or frequent cancellations, missed calls or other repeated failures to meet the agreed upon openness arrangements should be specified. If the child is being negatively impacted by openness arrangements, it may be necessary to reduce openness contact to a more arms-length arrangement. Having the expectations and responses to regular noncompliance of openness agreements clearly understood can reassure adoptive parents and reassure birth parents that contact will continue if they meet the expectations they have agreed to.

SUMMARY

Research on the benefits of openness in attachment formation and on forming a positive sense of identity "cannot provide a blue print for practice; decisions must be sensitively dealt with on a case by case basis."[1] Openness is most likely to be beneficial when:

1) It is based upon the child's needs and is designed to be flexible as the child's needs change and when issues of child safety (physical, sexual, emotional) are managed.[1]

2) The parents/birth relatives have consistent motivation, are geographically accessible and have good support systems.

3) The birth parent(s)/relative(s) show acceptance and the ability/capacity to support the adoptive placement.
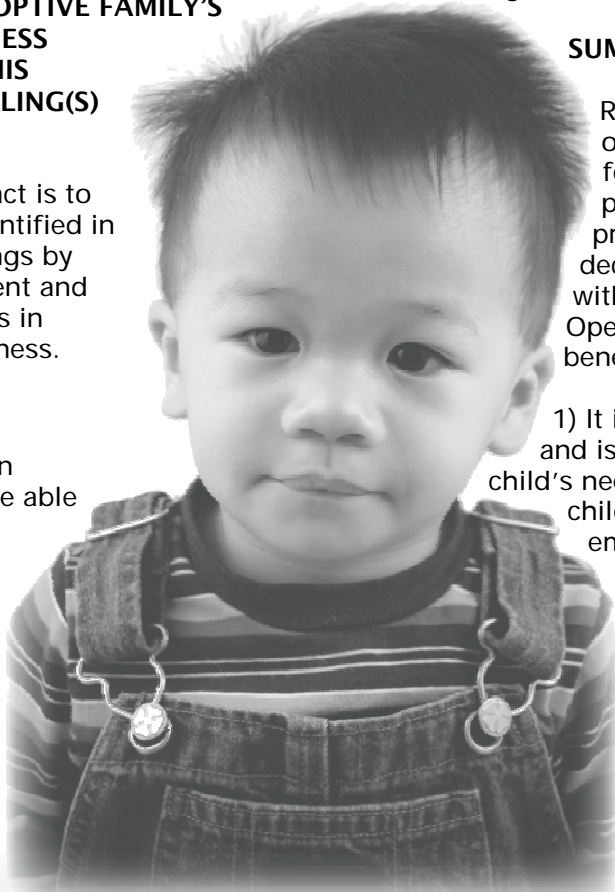
4) The adopting family "has an open and empathetic attitude towards child and birth family."[1]

Openness is a new area to consider in public adoption in Ontario. Because of its potential benefits, it requires due attention. However, it is critical to remember that openness is only one of many factors to consider in adoption planning and selection. An assessment and weighing of a child's multiple and unique needs, which may include openness, should go into every adoption plan. Undue emphasis on openness over all other needs is not supported in research as being in any child's best interests.

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3) Beneath the Mask, Understanding Adopted Teens, Case Studies and Treatment Considerations for Therapists and Parents, Debbie Riley M.S. with John Meeks M.D.

4) Developmental Attachment Psychotherapy with Fostered and Adopted Children, David Howe, publisher Child and Adolescent Mental Health 11 (3), 2006.

5) Choices in Permanent Family Placements, Beth Neil, lecturer in Social Work, University of East Anglia, held on Feb.7, 2002.

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Adoption Workers, Approved Practitioners, Licensees,
Resource Staff, Directors of Service are invited to Adoption Training

"The Invisible Realities of Successful Adoption"

April 27, 2010   9:30 a.m - 3:30 p.m.

North American adoption expert Maris H. Blechner, MEd, MCSW, will present "The Invisible Realities of Successful Adoption" at the Metro Toronto Convention Centre on April 27, 2010.

This training focuses on understanding families who wish to adopt, successful transitions, and keeping families strong post-placement. This training will be of interest to all CAS workers and approved adoption practitioners who conduct homestudies and are involved in planning permanency families for children in care. The training also qualifies for credit as part of the mandatory annual training requirements for adoption licensees and approved practitioners in Ontario.

Where:	Metro Toronto Convention Centre
	Room 101, North Building
	255 Front Street West,
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Fee:	$65/day
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Visit www.oacas.org/successfuladoptions for more information.

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Examining the Role of Self Compassion in the Mental Health of A Child

By Meghan McPhie, BA; Christine Wekerle, PhD; Randall Waechter, PhD; Maria Chen, BSc

SCOPE OF THE PROBLEM

Child maltreatment is a substantial issue in Canada, with an estimated 22 per 1000 children at risk (Trocmé, Fallon, MacLaurin, Daciuk, Felstiner, Black, et al., 2005; Wekerle, Chen, Leung, Waechter, Wall, MacMillan, et al., in press). According to the Ontario Association of Children's Aid Societies (OACAS), between 2007 and 2008, Ontario's Children's Aid Societies (CAS) investigated 77,089 referrals from families, teachers, doctors and neighbours concerned about the protection, safety and well-being of children and youth (OACAS, 2009).

The impact of maltreatment often extends far beyond the actual occurrence of the maltreatment episode or the period of time spent in the maltreatment living environment (Goldberg, Muir, & Kerr, 1995). It is an experience that has been associated with a wide range of challenges across the lifespan (Wekerle, Chen, Leung, Waechter, Wall, MacMillan, et al., in press). Some of these challenges include impairment in areas of basic physical functioning (e.g., eating, sleeping), cognition (e.g., attention, memory, learning, academic achievement), emotion (e.g., mood disorders), motivation and relationships (Wekerle, MacMillan, Leung, & Jamieson, 2008). The effects of maltreatment vary depending on the circumstances of the abuse or neglect, personal characteristics of the child, and the child's environment (Child Welfare Information Gateway, 2008). Maltreatment is a major problem that not only impacts the child and family, but through related costs to public entities such as human services, health care and educational systems, impacts society as a whole.

MALTREATMENT AND DEVELOPMENT

Maltreatment imposes serious risks on the developing child, not only during the immediate period in which the maltreatment is occurring, but across the lifespan (Goldberg, Muir, & Kerr, 1995). Developmental research has demonstrated that insufficiently responsive parenting heightens a child's risk for problems with future relationships, managing

emotions, self-efficacy (e.g., belief about one's ability to accomplish a task) and violence (Dube et al., 2001; Kim & Cicchetti, 2003; NICHD Early Child Care Research Network, 2004).

Typically, each child needs to form a secure relationship with a primary caregiver, which fosters normal social and emotional development. Attachment is an enduring emotional bond that develops during the first year of life while the infant is completely dependent on his or her caregiver for survival (Miller-Perrin & Perrin, 2007). Children become attached to caregivers who exhibit confidence, sensitivity and responsiveness in social interactions. For the infant, these caregivers become a secure base from which to explore the world and to return to for support and security. These positive attachments create mental working models which help guide the child's feelings, thoughts and expectations in later relationships.

Maltreatment during childhood constitutes a serious failure of the caregiving environment. This failure can seriously hinder the child's ability to accomplish the tasks that are necessary for successful development (Goldberg, Muir, & Kerr, 1995). For example, the child may experience difficulty in developing emotional intimacy, may develop abnormal eating behaviours (e.g., hoarding food) or develop uncharacteristic soothing behaviours (e.g., biting themselves; Perry, 2001). Dysfunctional attachments exert a considerable effect on the development of psychological disorders and symptoms that are commonly associated with child maltreatment (Goldberg, Muir, & Kerr, 1995), and contribute to difficulties later in life such as the ability to form close personal relationships (Miller-Perrin & Perrin, 2007). For example, failure to develop a secure attachment with a caregiver may impact a child's ability to regulate stress. A secure attachment with a caregiver serves as both a source of stress regulation and a model of stress regulation to be internalized (Wekerle, MacMillan, Leung, & Jamieson, 2008). This internal model is used in future situations as a central means

to regulate stress (Goldberg et al., 2001). Stress regulation is compromised in circumstances involving an abusive relationship. The caregiver who is supposed to be a source of predictable comfort and support is instead a source of fear, confusion and hesitancy (Lyons-Ruth & Jacobvitz, 1999).

Attachment dysfunction in maltreated children is a serious concern to healthy development; however, the effects of maltreatment also negatively impact social learning. Social Learning Theory (SLT; Bandura, 1973) emphasizes the significance of observational learning in the attainment of interpersonal skills in children. Observational learning is a type of learning that occurs as a result of observing, retaining and replicating novel behaviours performed by others. Learning in the child is strengthened through rewards and punishments given by the caregiver. This learning process can lead to the development of healthy behaviours and thoughts; however, the opposite effect is also possible. When children are exposed to maltreatment (e.g., physical abuse), they are being exposed to a set of norms and rationalizations that justify the maltreatment (Miller-Perrin & Perrin, 2007). For example, if a father hits his child for "mouthing off", this behaviour is reinforced within a social context and teaches the child that hitting is effective because it "shut him up".

Additionally, as a result of maltreatment, the child is deprived of the chance to learn healthy, appropriate and nurturing forms of adult-child relations that are typical of non-maltreated children. Furthermore, children are also informed about how stress is regulated within a close relationship through the experience of interacting with their caregivers. Maltreatment creates relationship representations wherein maladaptive ways of coping with stress are modelled by the caregiver, and the experience is reinforced by the outcome (Wekerle, MacMillan, Leung, & Jamieson, 2008).

Attachment and Social Learning Theory provides a framework within which to conceptualize, treat and understand the development and possible transmission of the risks of maltreatment for abnormal developmental and psychological problems in children. Strong bonds between a caregiver and a child are critical for developing a sense of trust and security, a sense of self, and an ability to explore and learn about the world (Ainsworth, 1973; Bowlby, 1980).

Despite the unfavourable conditions and circumstances in which maltreated children are reared, some children demonstrate resiliency. Resiliency is the ability to do better than expected in bad conditions (Gilligan, 2009). Resiliency is a dynamic process that involves shifting the balance of protective and vulnerability factors in different risk circumstances, and at different developmental stages. Many factors can influence resiliency, which can in turn help to prevent the negative outcomes of child maltreatment such as psychiatric disorders.

PSYCHIATRIC DISORDERS AND CHILD MALTREATMENT

Youth who have experienced child maltreatment are at an increased risk of experiencing psychological problems such as depression, anxiety, post-traumatic stress disorder, dissociation, oppositional behaviour, suicidal and self-injurious behaviour, substance misuse, anger and aggression, and sexual symptoms and age-inappropriate sexual behaviour (Gilbert, Kemp, Thoburn, Sidebotham, Radford, Glaser et al., 2009). Data collected from caseworker observation and reported diagnoses in the Ontario Incidence Study (OIS) show higher incidences of depression and/or anxiety and Attention Deficit Disorder (ADD) or Attention Deficit Disorder with Hyperactivity (ADHD) in children with a history of maltreatment compared to those with no history of maltreatment (Wekerle, Waechter, Leung, & Chen, in press).

Depression is a serious debilitating disorder that is strongly related with maltreatment. Studies have demonstrated that depression outweighs other problems in individuals with a history of maltreatment, and such individuals have a three-fold increased likelihood of developing depression during adolescence or adulthood (Wekerle, MacMillan, Leung, & Jamieson, 2008; Brown, Cohen, Johnson, & Smailes, 1999). The *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition* (DSM-IV; APA, 2004) states that the symptoms of depression in children and adolescents are the same as those experienced by adults; however, symptoms may be more

prominent at different ages. For example, irritable mood and somatic (i.e., body pains) complaints are particularly common during childhood and adolescence.

Anxiety disorders are another common mental health problem observed in individuals with a history of child maltreatment. Maltreated children typically exhibit general symptoms of anxiety, nightmares, inappropriate fears of certain places, and a tendency to cling to parents (Giardino & Giardino, 2002; Kendall-Tackett et al., 1993). Additionally, children with a history of maltreatment were described by their parents as being significantly more afraid of being left alone with others, exhibiting more suspicion, and getting upset when touched, in contrast to non-maltreated children (Kolko, Moser, & Weldy, 1988).

Given the traumatic nature of maltreatment, some children who have been abused or neglected go on to develop post-traumatic stress disorder (PTSD). Symptoms include flashbacks and nightmares, avoidance of stimuli associated with the trauma, difficulty falling or staying asleep, anger and increased arousal (Wekerle, Waechter, Leung, & Jamieson, 2008). It is important to note that subclinical levels of PTSD symptoms can be as important as clinical-level symptoms, in that both can lead to significant functional impairment in youth (Carrion, Weems, Ray, & Reiss, 2002). PTSD is commonly found in association with mood and anxiety disorders, and symptoms of PTSD are an important link between maltreatment and negative outcomes such as substance abuse or dating violence (Risser, Hetzel-Riggin, Thomsen, & McCanne, 2006; Wekerle et al., 2001; Wekerle et al., 2009). Thus, developing interventions that target PTSD symptomatology may be an important avenue of study.

An important concept to look at in relation to well-being in maltreated youth is self-care. The concept of self-care involves meeting and managing physical (e.g., nutrition), emotional (e.g., anger), behavioural (e.g., aggression) and cognitive (e.g., learning) needs or impulses. The process of self-care involves self-discovery, self-soothing, self control, self-health and health seeking, and self-compassion.

SELF COMPASSION AND CHILD MALTREATMENT

Self compassion is a component of self-care and represents a warm and accepting attitude towards those characteristics of oneself and one's life that are disliked (Neff, Kirkpatrick, & Rude, 2007). It is comprised of three main components, which combine and mutually interact to create a self-compassionate state of mind (Neff et al., 2007). The first component is self-kindness versus self-judgment. It involves being kind and understanding to oneself in circumstances of suffering or perceived inadequacy (Neff et al., 2007). When a disliked trait is noticed, rather than attacking and criticizing oneself for being inadequate, the self is offered warmth, support and unconditional acceptance (Neff, 2009). For example, a flaw is treated gently, and the emotional tone of language used towards oneself is soft and caring (Neff, 2009).

The second component is having a sense of common humanity versus isolation, for example, accepting that pain and failure are part of the shared human experience (Neff, Kirkpatrick, & Rude, 2007). It is the ability to recognize that all humans are imperfect, all people fail, and all people make mistakes (Neff, 2009). For example, people often feel isolated and cut off from others when they are considering personal flaws, or believe that they are the only ones struggling when they experience a difficult point in their lives. However, a person encompassing common humanity would feel connected to others when experiencing pain and would likely view it as a shared human experience. This realization can provide a certain level of comfort.

The last component of self compassion is mindfulness versus over-identification. This involves having a balanced awareness of one's emotions in which one has the ability to bare painful thoughts and feelings (Neff, Kirkpatrick, & Rude, 2007). It involves having a balanced outlook in the present moment so that one neither ignores nor ruminates on personal traits or aspects of one's life that are disliked (Neff, 2009). For example, taking a step out of oneself and encompassing an overall perspective on one's own experiences means that less bias is imposed, and the situation can be considered from a more objective perspective.

Self compassion is important for protecting against

excessive or unrealistic negative self-feelings or self-thoughts (Neely, Schallert, Mohammed, Roberts, & Chen, 2009). For example, consider stress tolerance. A maltreated child exhibiting self compassion may feel panicky in the presence of abuse cues (e.g., driving past a house where abuse occurred). He or she might think about the abuse, reassure him/herself that it is natural to be upset, and feel sorry for him/herself for what has happened. On the other hand, a child who does not encompass self compassion may not engage in this process of assessment and self-talk but act out his/her feelings in other ways, such as through self-harm behaviours. There are several routes through which one can obtain self-compassion. For example, Neff's (2003) Self Compassion Scale (SCS) uses the following six subscales to assess the level of self compassion:

Self-kindness: For example, "I try to be loving towards myself when I'm feeling emotional pain."

Self-judgment: For example, "I can be a bit cold-hearted towards myself when I'm experiencing suffering."
Common humanity: For example, "I try to see my failing as part of the human condition."

Isolation: For example, "When I fail at something that's important to me, I tend to feel alone in my failure."

Mindfulness: For example, "When something painful happens I try to take a balanced view of the situation."

Over-identified: For example, "When something upsets me I get carried away with my feelings."

Sample items were provided for each subscale; however, all items can be found in the full Self Compassion Scale available on Neff's website: https://webspace.utexas.edu/neffk/pubs/listofpublications.htm.

One way to develop self compassion involves paying more attention to events as they happen in the present, rather than ruminating. This is also known as "mindfulness". Self compassion can also be fostered by taking an objective view of personal events in order to self-identify less with the content and more with the awareness of content. Lastly, it is important

to increase acceptance or tolerance of the thought or feeling, rather than processing it for personal meaning.

AN EXAMINATION OF SELF COMPASSION IN THE MALTREATMENT AND ADOLESCENT PATHWAYS (MAP) RESEARCH STUDY

A group of CAS-involved youth that took part in the MAP research study completed the self-report Self Compassion Scale (SCS; Neff, 2003). The MAP is an ongoing longitudinal study that examines the health outcomes of maltreated youth who are randomly selected from all the active CAS case files in a large Canadian urban centre. MAP youth complete an initial testing and have follow-up assessments every six months for three years. Here, data on self compassion is presented from a sample of 90 youth (60 percent males) who participated in the two-year testing point of the MAP where the SCS is administered. Additionally, youth also reported on PTSD symptoms and psychological problems. The mean age of the adolescents in the current sample was 18.1 years, and on average, the adolescents in the sample were with CAS for 10.1 years. MAP study youth were composed of a diversity of ethnicities as depicted in Figure 1. CAS status of the youth in the study is shown in Figure 2.

Figure 1. Proportion of youth by ethnicity in MAP sample.
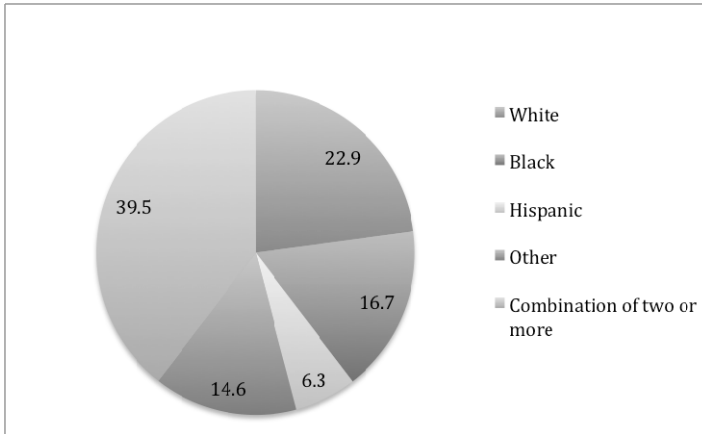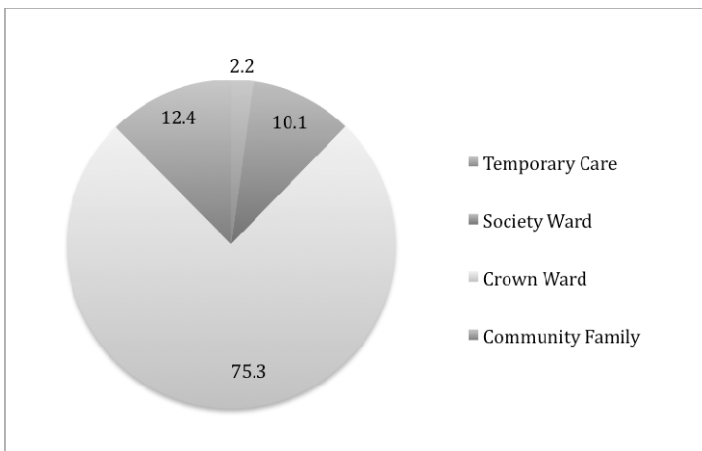

Figure 2: Proportion of youth by CPS status in the MAP sample.

The result of this analysis indicates a significant relationship between child maltreatment and self-compassion. Specifically, youth who have been physically and emotionally abused, and physically and emotionally neglected, have lower levels of self compassion (e.g., greater tendency to isolate oneself, to impose negative self-judgment, and to over-feel). As reports of emotional abuse increased, self compassion decreased. Some maltreated youth go on to experience PTSD symptoms. Some of the symptoms of PTSD include depression (e.g., feeling lonely), anxiety (e.g., feeling nervous or jumpy inside) and anger (e.g., wanting to hurt other people). Those youth in the study who reported experiencing such symptoms had lower levels of self-compassion.

Specifically, the youth reported greater self-judgment, self-identification and isolation, and less self-kindness. Psychological problems, as assessed by responses on the Brief Symptom Inventory (BSI; Derogatis, 1975) were positively related to lower levels of self-compassion. Youth who reported lower levels of mindfulness were more likely to report a greater number of psychological symptoms.

IMPLICATIONS

The results of this analysis suggest that self-reported self compassion may be an important target for intervention that can address negative moods and other mental health issues among maltreated CAS-involved youth. It is thought that self compassion enhances well-being by helping individuals feel cared for, connected and emotionally calm, all of which may be lacking in children and youth with a history of maltreatment (Gilbert, 2005). Several studies have looked at the impact of using self compassion as a buffer against psychological problems and have found similar results to the present analysis. For example, a study by Neff, Kirkpatrick and Rude (2007) found that self compassion buffered against anxiety and was associated with increased psychological well-being. Thus, self compassion appears to be a promising trait that can be used to help promote well-being in maltreated children and youth.

Neff (n.d.) provides several tips and thoughts on how to increase self-compassion:

Self-kindness: To increase self-kindness, it is important to develop a kind and constructive way of thinking about and rectifying mistakes and thinking about ways in which one can do better in the future. For example, a child who is experiencing a period of suffering due to maltreatment may ask him or herself, "What would a caring friend say to me in this situation?"

Self-judgment: Remembering that human beings are not supposed to be perfect and that mistakes are a

means of learning may decrease negative self-judgment. For example, a child who may have been physically abused for making a mistake may ask him or herself, "How will I learn if it's not okay to make mistakes?" Furthermore, before commenting on a child's behaviour, parents should ask themselves whether a caring mom would say this to her child if she wanted the child to grow and develop.

Common humanity: In order to promote common humanity, one should think about the human condition and how all humans are vulnerable, make mistakes, and have experienced pain and difficulty. It is important for an individual to recognize all the other people who have made similar mistakes, gone through similar situations, and been in similar positions. A child who has experienced maltreatment may ask him or herself, "How does my experience of neglect or abuse give me more insight into compassion for the human experience?"

Isolation: Preventing a sense of isolation involves taking responsibility for mistakes and failings, as well as recognizing and understanding that nothing happens in a vacuum – actions and behaviours are connected to the actions and behaviours of others. For example, a child who may feel alone in his or her experience of maltreatment may remind him or herself that "I am not the only one going through such difficult times, a large proportion of people experience difficulties like this at some point in their lives."

Mindfulness: Trying to see the situation clearly with calm clarity and a balanced perspective can increase mindfulness. For example, a child may let him or herself feel the pain associated with the maltreatment without suppressing, resisting or avoiding it, and let him or herself be moved and touched by his or her own pain.

Over-identification: Trying to avoid getting lost in the storyline of the situation and feeling the feelings as they are without getting carried away by them can help to reduce over-identification. Incorporating these strategies into one's thought processes can

help to improve levels of self-compassion. For example, a child or youth who has experienced maltreatment may say, "These painful emotions and experiences do not define me, such feelings will inevitably change and pass away over time."

Very little literature has examined interventions that target self-compassion. However, several important findings may prove useful in helping to promote self compassion or identifying circumstances in which self compassion may be in jeopardy. Neff and McGeehee (in press) found that maternal support, harmonious family functioning and secure attachment all predicted higher levels of self compassion among youth. A teenager with a secure attachment bond, supportive mother and functional family unit is likely to have greater self compassion than one with a problematic family environment, under circumstances that care and compassion have been appropriately modelled by family members. Therefore, in addition to providing direct care and support during periods of affliction, good family relationships may indirectly influence functioning by fostering compassionate inner dialogues.

In contrast, dysfunctional family relationships are prone to translate into self-criticism, negative self-attitudes, and a lack of self-compassion, thus resulting in restricted internal and external coping resources (Neff & McGeehee, in press). For youth with histories of child maltreatment, self compassion may provide a way to learn new methods of self-to-self relating that are more balanced and supportive, in contrast to the aversive process of self-judgment and evaluation. It is important for future researchers to examine ways in which self compassion can be targeted in interventions in order to promote well-being, specifically in relation to child maltreatment.

For further information on mindfulness training, please visit the following websites: http://www.mindfulnessandacceptance.org;

https://www.jeffersonhospital.org/cim/article5030.html

CONCLUSIONS

It is critical to be aware of the factors that can exacerbate or moderate negative outcomes in maltreated youth. Data presented here highlights the strong connection between child maltreatment, self-compassion, PTSD symptoms and mental health problems in a sample of CAS-involved youth. It may be possible to enhance outcomes among maltreated children and youth by enhancing self compassion among the most vulnerable youth. There are a number of ways to accomplish this, and several points are presented here.

Foster the traits identified by Neff that lead to an increase in self compassion (e.g. self-kindness, mindfulness and common humanity) and helping to reduce those that have a negative impact on levels of self compassion (e.g., isolation, over-identification and self-judgment).

Early on in childhood, make sure that the child is under the care of someone who is able to foster the development of a secure attachment (e.g., a responsive caregiver).

Raise or place the child/youth in an environment that is supportive, nurturing and harmonious.

Make sure that the child/youth is provided with direct care and support during periods of affliction.

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OACAS LAUNCHES PRACTICE GUIDE AT CRITICAL CONNECTIONS SYMPOSIUM

The guide was launched on March 9, 2010 and is titled *Critical Connections: Where Woman Abuse and Child Safety Intersect - A Practice Guide for Child Welfare Professionals in Ontario*. The English and French guides are available online for $25 for members and $30 for non-members.

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First Class,
College Student

"I entered Air Cadets at twelve. Neglected at home. I was in Children's Aid care at fourteen. The structure of Cadets, and the affection of my foster mom, gave me the confidence I needed to succeed. One summer at Cold Lake, I was responsible for 600 fellow Cadets. I now have a scholarship to college and I'm committed to earning a Master's Degree."

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Residential Treatment Outcomes with Maltreated Children Who Experience Serious Mental Health Disorders

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ABSTRACT

This study explored long-term outcomes for children with histories of maltreatment who were referred directly from a community's child protection service to an intensive residential mental health treatment program. The results for children referred from child protection showed that their reduced symptom trajectories reflected favourably when compared to children with mental health symptoms of a similar nature and degree who were not under Crown wardship at the time of admission. Reductions within the maltreated group reflected a decrease of approximately 40 percent, relative to symptom levels at admission, two years following their admission. Residential treatment within the children's mental health system is often referred to as the "last chance" for children and youth with serious mental health disorders. It is encouraging, therefore, that intensive residentially based service for the study group can have a positive effect on mental health symptoms. However, the long-term outcomes from treatment are dependent on the nature and quality of the follow-up services at discharge. If this intensive and expensive form of service is to have a maximum effect, close co-ordination between residential and community-based treatment providers is a necessity.

INTRODUCTION

Poor long-term treatment outcomes for children/ youth with histories of physical abuse, sexual abuse and/or neglect reflect the challenge of providing effective interventions with this population (Conner, Miller, Cunningham & Melloni, 2002). While there is some research identifying significant positive gains from intensive short-term residential treatment for seriously mental health disordered (SMHD) children/ youth without maltreatment histories (St. Pierre, Leschied, Stewart & Cullion, 2008; Green et al., 2007; Lyons**,** Martinovich, Peterson, & Bouska, 2001), these results have yet to be replicated with a child welfare sample. The primary objective of this study was to examine the differential impact of child welfare status in predicting treatment gains and sustainability for up to two years following discharge from residential treatment.

LITERATURE REVIEW

There are numerous explanations for why children who experience maltreatment are more resistant to therapeutic change. The one most often cited reflects the very nature of the abuse itself, suggesting that childhood victimization is related to numerous chronic mental health outcomes including post-traumatic stress disorder, anxiety, depression, self-abuse and suicide (Allen, 2008; Fergusson, Boden & Horwood, 2008). The subsequent involvement in the child protection system itself has also been linked to poor outcomes. Repeated placement failures for maltreated children once admitted to child welfare care perpetuates an inability to form trusting relationships, thereby compromising the formation of a therapeutic relationship (Cloitre, Koenen, Cohen, & Han, 2002; Hughes, 2004; Saywitz, Mannarino, Berliner, & Cohen, 2000; Leslie et al., 2005; Hughes, 2004; Saunders, Berliner, & Hanson, 2004; Newton, Litrownik, & Landsverk, 2000).

Residential treatment

Residential treatment (RT) within the spectrum of the children's mental health system serves as a tertiary care provider, reserved for children with serious mental health disorders (SMHD). However, the outcome literature related to RT in children's mental health has only recently been developed, since RT has been identified as the most expensive form of service due to its intensity and access to a full range of treatment professionals (Bates, English, & Kouidou-Giles, 1997). Frensch and Cameron (2002) suggest that RT is a "last chance" intervention for children with SMHD. Two studies by Lyons and his

colleagues (1998; 2001) suggest that it can be a promising approach. Green et al. (2007) report encouraging results related to RT. St. Pierre et al. (2008), in a two-year follow-up related to RT, indicate that reductions in mental health symptoms can be identified two years after treatment discharge, averaging a 40 percent reduction in externalizing disorders. However, no studies to date have focused on the impact of RT as it relates to achieving reductions in mental health symptoms in children/ youth with maltreatment histories, which is the focus of this study.

METHOD

Participants

The current sample was drawn from consecutive admissions to one RT provider for children and youth aged 6-17 years (n=225, M=12.06 years, SD=2.46, 171 boys). Children/youth who had contact with the Children's Aid Society (CAS) but were not Crown wards at the time of admission were not part of this analysis, as the intent was to examine CAS that who were intensively involved with child welfare resources. Of the 225 children/ youth identified within the time period, 170 children/youth and their families consented to participate in the overall study (for description see St. Pierre et al., 2008). These study participants had in common a history of mental health and behaviour concerns beginning, on average, at age six as well as multiple previous treatments and educational supports being provided prior to their referral to RT.

The total number of children and youth with CAS involvement was 58 (out of the original 170) children/youth (M=11.59 years, SD=2.62, 87 boys). There were 35 children who were Crown wards at the time of admission. Consent to review the Children's Aid Society files was obtained for 23 (M=11.59 years, SD=1.68, 15 boys) of these 35 children.

Procedure

Ratings were provided on child coping based on two measures. The Brief Child and Family Phone Interview (BCFPI; Cunningham, Pettingill & Boyle, 2004) is a standardized parent/guardian-based telephone interview. Data based on the BCFPI was collected at three different time points: pre-admission, and six-month and two-year post-discharge. The Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000) is a clinician's rating of functioning of children/youth collected every three months throughout treatment and, by trained telephone interviewers, at the two-year follow-up. Additional data was collected from the casebooks of the Children's Aid Society for the 23 Crown ward children/youth approximately three years post-discharge using a standardized casebook data retrieval instrument, the Child Welfare Data Retrieval Instrument (CWDRI; Leschied, Chiodo, Whitehead, Hurley, & Marshall, 2003).

Referral Process to RT

All children/youth referred to RT first proceed through their local community single-point-of-access mechanism. This multiple-gating, single-point integrated community intake process utilizes standardized clinical measures within a "least intrusive intervention" model of practice in an attempt to ensure adequate community treatment efforts have been exhausted prior to the child/youth proceeding to RT. This referral process ensures that only those children/youth with extreme levels of need and risk are accepted for RT.

Description of Residential Treatment

The mental health residential treatment program consists of five cottage-like milieu treatment units consisting of three child and two adolescent units. Treatment efforts reflect evidence-based programming elements, which emphasize multimodal clinical assessment, adaptive skill development, family and guardian involvement and co-ordinated discharge planning, which includes a combination of psychological, psychotropic, psychosocial, family-oriented and educational interventions. All
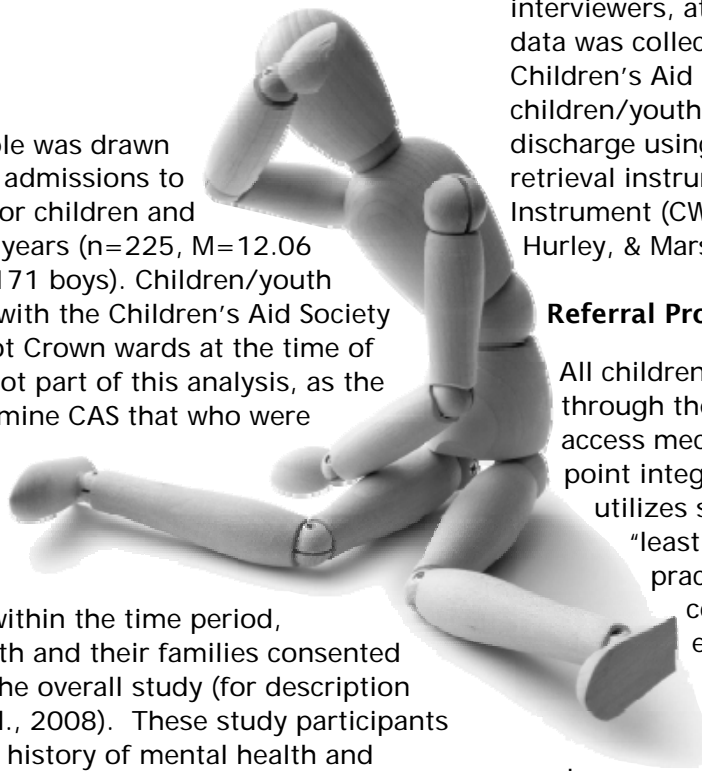
participants have an individualized plan of care, formally reviewed monthly by the family/guardian, community case manager, and RT clinicians. Discharge dates are flexible, based on the child's/youth's progress and dictated by the needs of each client. The average length of stay for the child/youth in the present study was four months, with outpatient services provided during the immediate pre-admission and post-discharge phases. Post-discharge follow-up could include outreach assistance in the home or classroom as well as ongoing therapeutic contact. Active involvement and support of the parent/guardian is essential. A majority of children and youth in RT return home every weekend, thus over a quarter of their stay while in RT is spent in the community with child and family/guardian goals in place.

RESULTS

Sample. The sample was comprised of N=23 (16 male, 7 female) children/youth who were under the care of the CAS; 95.7 percent of the current sample remained under state-sponsored Crown wardship three years after their initial referral to RT. Age of admission to RT ranged from 9 to 15 years (M=11.59, SD=1.68). The comparison group of non–child welfare involved referrals consisting of N=112 (87 males, 25 females) children/youth with no previous CAS involvement. Age of admission ranged from 6 to 17 years (M=11.59, SD=2.62).

Treatment outcomes

A 2 x 3 split-plot multivariate analysis of variance was utilized to examine differences between CAS and non-CAS referrals over time. The 'within' subject factor of 'time' was comprised of three levels: admission, six-month and two-year follow-up. A group variable (CAS vs. non-CAS) was utilized as the 'between' subject factor. For the purpose of analysis, the 'externalizing' component of the BCFPI and CAFAS total scores were isolated as measures of interest. The multivariate effect of the interaction between group and time was not significant, $[F_{(4, 188)} = .247$, n.s.]; however, the multivariate main effect of time was significant, $[F_{(4, 188)} = 8.37$,

p<.001]. At the univariate level both measures (externalizing, CAFAS total) were significantly predicted by the main effect of time, $[F_{(2, 94)} = 12.48$, $p < .001]$ and $[F_{(2, 94)} = 8.07$, $p < .001]$ respectively. Univariate analyses are presented in Table 1.

Table 1
Means (and standard deviations) across time points for CAS and non-CAS clients.

DISCUSSION

	Admission		6 Months		2 Years	
	Ext	CAFAS	Ext	CAFAS	Ext	CAFAS
CAS	88.11 (10.64)	123.33 (33.54)	77.22 (16.76)	90.00 (63.64)	78.22 (15.66)	124.44 (47.46)
Non-CAS	83.77 (8.21)	113.00 (34.36)	72.47 (10.90)	66.75 (40.53)	73.52 (13.29)	94.50 (55.56)

Differential treatment benefits were compared for seriously emotionally disturbed children/youth with a history of involvement at admission with child welfare, relative to those with no such involvement. Children and youth receiving multidisciplinary residential mental health treatment demonstrated a statistically significant downward trend in reported symptom severity over two years across numerous domains. Behaviour change was most apparent immediately after treatment completion. Findings suggested that both parents and clinicians viewed significant improvement with respect to overall severity of dysfunction and externalizing problems regardless of child welfare status from admission to discharge. These results provide evidence to suggest that a period of four months of intensive inpatient psychiatric milieu therapy combined with community/caregiver supports and full access to a treatment classroom has a significant impact on reducing symptomatology. Overall, some slippage occurred in those gains during the two-year period since treatment occurred, but gains remained below the level reported at admission for parental report.

This data offers parental rating support for the conceptualization of out-of-home mental health treatment as a means to reduce crisis-level symptomatology, reflected in a substantial reduction in behavioural problems and improved functioning. This is consistent with other research (Fernandez del Valle & Casas, 2002) suggesting that outcomes of RT with non–CAS-involved children/youth can be statistically significant and clinically meaningful (Green et al., 2007; Corbillion, Assailly, & Duyme, 1991).

A more fine-grained analysis of the CAFAS sub-scales, however, suggested that CAS children/youth were more likely to develop substance abuse problems at the two-year follow-up, compared to the non-CAS children and youth. This is consistent with other research suggesting that maltreated children and youth have a tendency to cope through the use of illicit drugs and alcohol (Arata, Langhinrichsen-Rohling, Bowers, & O'Brien, 2007; Wall & Kohl, 2007). Researchers have found that all types of maltreatment are associated with substance abuse (Lo & Cheng, 2007) and should be considered a risk factor for substance abuse, particularly during adolescence (Moran, Vuchinich, & Hall, 2004). Given that the strength of the association between maltreatment and substance use varies by the type of maltreatment, youth who have experienced both physical and sexual abuse are at especially high risk for substance abuse (Moran et al., 2004). These findings have implications for the clinical field given that the prevention and treatment of the negative impact of childhood maltreatment should focus on reducing alcohol and drug abuse in adolescence and adulthood (Hamburger, Leeb, & Swahn, 2008).

At this point, identifying the key factors associated with treatment gains within the current sample is not possible. Outcome studies of residential treatment have indicated that family support and the provision of after-care services following discharge are critical to successful reintegration into the community (Hoagwood & Cunningham, 1992). Given that these two factors are the most crucial aspects of treatment sustainability, maintenance of treatment gains may be more problematic for children/youth in care, as there often is no consistent caregiver to work with them during treatment. Previous research has indicated that improved functioning post-treatment can be improved by being discharged into a positive, stable and supportive environment (Quinn & Epstein, 1998). Furthermore, after-care planning can be difficult due to permanency placement problems. For children/youth in "out of home" placements, working closely with foster parents and group home staff is needed to enhance treatment sustainability. Intensive residential treatment can promote a greater understanding of the youth, which can expedite the planning process to permanent care (Milburn et al., 2008).

POLICY IMPLICATIONS SPECIFIC TO CHILDREN IN CHILD WELFARE

There is a significant need to monitor the continuum of care for all children discharged from residential treatment; this is particularly true for children already involved in the child welfare system. Many children and youth within child welfare have some combination of cognitive, adaptive, social and/or behavioural functional impairments (Callaghan, Young, Pace & Vostanis, 2004; Leslie, Gordon, Ganger & Gist, 2002). Mechanisms to ensure that this vulnerable population has timely and adequate access to a co-ordinated mental health service are critical in reducing placement instability among children/youth removed from their homes (Hurlburt et al., 2004; Milburn et al., 2008; Ringeisen, Casanueva, Urato, & Cross, 2008)).

FUTURE DIRECTIONS AND POLICY IMPLICATIONS

Child and youth inpatient treatment for mental health problems is an extremely expensive resource. However, the resources expended reflected in the current study suggest that significant mental health gains can be achieved in the externalizing domains. It can be safely argued that the costs of untreated childhood disorders are equally high if not higher (Scott, Knapp, Henderson, & Maughan, 2001). Further studies examining cost-effective alternative treatment options could possibly alleviate years of child suffering, family dysfunction and parenting stress, and alter pathways of delinquent and antisocial behaviour among many children and youth, particularly those with histories of maltreatment.

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