INSIDE
CLINICAL COUNSELLING:
A VITAL PART OF CHILD
WELFARE SERVICES

**FAMILY GROUP DECISION
MAKING IN RURAL ONTARIO**

Ontario Association of
Children's Aid Societies
The voice of child welfare in Ontario

The Journal is a major source of information for Ontario's children's services professionals, published quarterly by the Ontario Association of Children's Aid Societies.

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The OACAS Journal welcomes articles from researchers and/or writers at universities, institutes and child welfare agencies on programs, projects and initiatives designed to improve the lives and outcomes of children, youth and their families. For more information on article submission visit http://www.oacas.org /pubs/oacas/journal/index.htm

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MESSAGE FROM THE EXECUTIVE DIRECTOR

Welcome to the Spring edition of the *OACAS Journal*. In the last edition, members of the newly formed Editorial Board submitted articles highlighting their background and interests. The Board enjoyed the opportunity to share their passions with our readers and are looking forward to continuing to enhance the *Journal* through the peer-review process.

Articles in the Spring *Journal* explore many different topics ranging from adolescent depressive symptomatology and family group decision making to respite for caregivers of children with Fetal Alcohol Spectrum Disorder. The authors come from many different backgrounds, from the child welfare field and from other sectors that interact with child welfare. One of the strengths of the *Journal* is the different perspectives each article brings.

Clinical Counselling: A vital part of child welfare service produced by the Clinical Counselling in Child Welfare Committee concludes in this edition of the *Journal*. This paper discusses the role that critical counselling plays in worker-client relationships and encourages agencies to move forward with the revitalization of a critical counselling role. The paper has been very well received by both the child welfare field and *Journal* readers. We look forward to sharing other research papers endorsed by the Provincial Project Committee of the Association in the Summer *Journal*.

In June, OACAS, in partnership with the Marie Collins Foundation, hosted a two-day international symposium titled *Harm in the Digital Playground - Global Forum: Online Child Exploitation and Recovery.* For the first time, this ground-breaking symposium provided the opportunity to discuss the recovery of children who have been victims of online exploitation and to share methods and theories for aiding in recovery. In recognition of the symposium and the incredible expertise of the speakers, the Summer *Journal* will feature articles from the presenters. The *Journal* is proud to be able to share this new and relevant information with our readers.

Earlier in May, OACAS released *Children's Well-Being: The Ontarian Perspective - Child Welfare Report 2011*. As a foundation for the report, a survey was conducted among Ontarians aged 36 and over on their thoughts and ideas for the well-being of children. Based on the survey results, the second annual Child Welfare Report highlights strategies for improving outcomes for children in Ontario, focusing on four priorities: protecting children of all ages from abuse and neglect; helping find permanent families for children; providing better lives for Aboriginal children; and providing better education opportunities for youth in care. To read a copy of the Child Welfare Report 2011 visit www.oacas.org.

As always, we would be interested in hearing your feedback. Are there topics or issues you would like to read about? Are there different types of articles, such as academic papers or book reviews, you'd like to see more of or authors you'd like to hear from? Send us an email at journal@oacas.org with your thoughts.

Mary Ballantyne
Executive Director

THE EXPERIENCES OF FAMILIES WITH FAMILY GROUP DECISION MAKING IN RURAL ONTARIO

By Carrie-Lynn Sherwin MA

INTRODUCTION

The use of alternative dispute resolution (ADR) methods in child welfare matters is relatively new. There appears to be consensus that family group decision making (FGDM) as it is used in Canadian child welfare is rooted in traditional Maori practices that were incorporated into New Zealand child welfare practices (AHA 2000; Ross 2000; Marsh and Crow 1998; Pennell and Burford 2002; Barsky 1997). The introduction of FGDM was based on concerns of the overrepresentation of Maori children within child welfare and juvenile justice systems. Once families became involved in the child welfare system, they were lost within it and had very little involvement in the decisions that were made for their children. In 1989, New Zealand implemented the *Children, Young Persons and Their Families Act* in response to Maori concerns about child welfare standards and practices. The Act required that FGDM be conducted prior to the court making a decision on the placement of any child in the foster care system (Desmeules 2007).

ADR methods have been implemented as a strategy to reduce court delays and encourage alternatives to court in child protection cases (OACAS, 2008). The ADR approaches that have been introduced in the child welfare system differ significantly from the traditional methods of resolving issues in child protection matters. When a family is involved in the court system, they are bombarded with affidavits written by professionals criticizing their parenting and the choices they have made. The court process is a lengthy one that typically involves several adjournments before a judge makes a decision. Parents have little control over the anticipated outcome and typically have little knowledge of the judicial system. Both children and parents are in limbo while a judge makes a decision for them (Schmid and Sykes, 2007). ADR methods, such as child protection mediation and family group decision making have been introduced in order to take a different approach when dealing with child protection issues. ADR methods are intended to be strengths-based, inclusive and collaborative. When working with families to resolve child protection disputes these methods encourage the

involvement of the family and community in order to develop realistic plans for families (OACAS, 2008).

The FGDM process is used by Children's Aid Societies (CASs) in Ontario. One of these many agencies is the Children's Aid Society of Algoma, located in the District of Algoma in Northern Ontario. The agency is responsible for the delivery of child welfare services from Hornepayne to Elliot Lake including Wawa and Sault Ste. Marie.

Since the use of the FGDM process is relatively new in child protection matters in Ontario, I chose to conduct a study on the experiences of families who have participated in the FGDM process. The purpose of this study was to gain a better understanding of the process of FGDM, specifically to hear the stories of caregivers in Northern Ontario. Those who have participated in the process first hand were presented with an opportunity to describe their experiences and perceptions of the process.

RESEARCHER MOTIVATIONS

I worked for the Children's Aid Society of Algoma for approximately three years, first as a case aide and then as a child protection worker in the family services department. In this role, I gained a significant amount of experience and knowledge related to child welfare matters. I also became familiar and frustrated with the length of time it took for child welfare matters to be resolved in the judicial system, often leaving families confused and hopeless. I could not blame families for feeling this way. I had a background in Law and Justice and a fairly good understanding of the family court system and I still struggled when trying to keep track of the complex family court legislation and procedures. I could not imagine being in a position where I had no knowledge of the court process, relying solely on counsel and judges to make decisions on my behalf without really knowing my family's personal history. Having witnessed the frustration experienced by families involved in the court process motivated me to conduct research on the use of alternatives to court in

child welfare matters and whether they could be used as a successful tool in planning for children. I specifically chose to focus on the process of family group decision making.

Anti-oppressive theory informed my research and it also provided the lens through which I conducted my study. Being an anti-oppressive researcher means

> ...that there is political purpose and action to your research work. By choosing to be an anti-oppressive researcher, one is making an explicit, personal commitment to social justice. It means making a commitment to the people you are working with personally and professionally in order to mutually foster conditions for social justice and research (Brown & Potts 2005, p.255).

In order to be an anti-oppressive researcher, I had to commit myself to the social change that I was studying and become an active participant in that change. My objective was to dig deep into the personal experiences of each participant in order to hear and understand their experiences, whether they were positive or negative. By hearing about their experiences with the programs that are put in place for them, each participant was able to provide their opinions on whether or not the process was a helpful alternative dispute resolution tool.

While conducting this research, I had to locate myself within my study and constantly reflect on this. I am a young, white, female, previously employed as a child protection worker with the Children's Aid Society of Algoma. To ensure I conducted anti-oppressive research, I had to ensure that I did not forget where I was located in comparison to the participants. Also, being an anti-oppressive researcher required me to ensure that the power was placed in the hands of participants who rarely fall into the category of the elite or powerful. By power, I am referring to the ability for these individuals to express themselves and critique the FGDM process and reflect on their personal experiences. I listened not for what I intended to hear but for "assumptions made by both myself as a listener and by the speakers attending to the dance of power" (Potts & Brown, 2005, p.55).

CONTEXTUAL BACKGROUND

The Principles of FGDM

In 2006, Bill 210 was introduced in Ontario which amended the *Child and Family Services Act R.S.O. 1990*, to include the use of alternative dispute resolution methods in child protection matters. From a historical context, FGDM grew from a developed awareness that professionals were making all of the decisions for the disadvantaged, marginalized people. Its roots are tied to anti-racist and anti-oppressive practice (American Humane Association, 2010). This amendment was a result of the recommendations made by numerous reforms and program evaluation studies that had been conducted on Children's Aid Societies in Ontario. The program evaluation conducted in 2002-2003 highlighted the need for change in the way the system was operating. There was a strong suggestion made to reduce the reliance on court ordered methods of intervention and begin focusing on permanency planning for children and the use of alternative dispute resolution methods in child welfare (MCYS, 2006).

In 2006, the Child Welfare Transformation Agenda was introduced and implemented as a result of Bill 210 and the Child Welfare Program Evaluation. It was part of a strategic plan of the Ministry of Children and Youth Services (MCYS) to create a flexible, sustainable, and outcome oriented model of service delivery (OACAS, 2006). It relates to several key areas, including permanency planning for children and strategies to reduce delays in the judicial system and encourage alternatives to court (MCYS, 2006). The legislation provides two alternatives to lengthy court proceedings:

1. Settle cases using a prescribed ADR process prior to initiating court proceedings, or at any point during litigation;

2. Grant care and custody to individuals who propose a permanent placement for a child and who are determined to be capable of providing sufficient care for the child (OACAS, 2010).

There was a shift from protection-based child welfare to prevention-based interventions. Since the implementation of the Child Welfare Transformation and Bill 210, child protection workers are required to be proactive and spend more time working with families to develop plans to keep their children safe.

The Ministry of Children and Youth Services developed a policy directive that became effective November 30, 2006. The policy speaks directly to the three different types of alternative dispute resolution methods, the reporting requirements, the use of privacy/confidentiality agreements and the qualifications and experience of persons facilitating alternative dispute resolution. It does introduce the purpose and philosophy behind ADR. I drew from this philosophy when choosing the focus of this study:

> Alternative dispute resolution (ADR) is a strategy to streamline court processes and encourage alternatives to court. It focuses on a more strengths-based, inclusive and collaborative approach to resolving child protection disputes, and encourages the involvement and support of the family, extended family, and the community, in planning and decision-making for children.

The policy does not provide directives on how to carry out FGDM processes. When I began this research I inquired as to what specific principles the CAS of Algoma relied on when conducting the FGDM process with families. I was informed that the guiding policies of the American Humane Association were followed. These guiding policies set out what the process should look like and what the goals of the process are. To summarize, these guiding policies are:

- The need for the agency to provide families with time and resources to assist them to make decisions on their own and to accept and support the safety plan;
- Acknowledging the importance of private family time and taking active steps to encourage family groups to plan in this way signifies an agency's acceptance of its own limitations, as well as its commitment to ensuring that the best possible decisions and plans are made;
- When agency concerns are adequately addressed, preference is given to a family group's plan over any other possible plan;
- Referring agencies support family groups by providing the services and resources necessary to implement the agreed-on plans.

These guiding policies are what drive the FGDM process. My study focussed on whether or not the FGDM process has been successful in these areas from the perspectives of families. By examining the legislative framework, the guiding policies, the literature review and the data collected from participants, I was able to determine whether the FGDM process has served its intended purpose for the particular participants of this study.

LITERATURE REVIEW

The approach taken to the literature review was to examine previous reviews that had been completed on the process of family group decision making, specifically looking at the areas of empowerment, outcomes for children, and the ability for families to implement and maintain long-term plans for children. I examined the literature in relation to the focus of my study which was whether or not the FGDM process had been successful in the areas set out by the American Humane Association from the perspectives of families. Very few studies were found that addressed the same research question as I and an even lesser number were from small communities, such as northern Ontario. I drew from broader literature on the experiences of caregivers with FGDM. Based on the literature that I consulted, the FGDM process is said to lead to greater feelings of empowerment for families and that participants are usually able to formulate and implement stable and secure plans for children (OACAS, 2010; Barsky, 1997; Helland, 2005; Holland & Scourfield, 2003; Nixon, et al., 2005). However, we know little about the experiences of caregivers with the FGDM process and whether they feel as though these findings are in fact true or are merely the opinions of the professionals with whom they work.

Much of the literature on FGDM is related to the FGDM process (Crampton, 2007) and does not consider FGDM effectiveness especially from the viewpoint of the service-user from a qualitative approach. "All too often what is considered evidence-based practice ignores the voices of those for whom programs are intended" (Waites et al., 2004, p.1). Child welfare as a system and as an institution is characterized by the overt use of power and control (McCallum & Eades, 2001) and power imbalances between social workers and families (de Boer & Coady, 2006; Dumbrill, 2006). Although child protection workers are trained to be sensitive when investigating child welfare matters, the investigatory nature of contact between workers and families can seem confrontational and leave parents feeling vulnerable and powerless. Turnell (1997) sug-

gests that child welfare's capacity to initiate investigations and remove children actually makes it impossible to form any power-neutral relationship between an agency and the parent. In addition to this, according to Walton et al. (2003, p.2), the "empowerment framework helps minimize the helplessness that family members often feel within the child welfare system". The child welfare system can often seem adversarial and it is no surprise that families feel disempowered when involved with it. FGDM is intended to put decision-making back into the hands of the family and thus allow for decision-making by those who have a caring and personal relationship with the child and not exclusively by those involved with the family on a professional basis (Chandler & Giovannucci, 2004).

Lastly, when conducting the literature review, I found that there is a gap in the literature surrounding the geographical location where the study was conducted, and the participants being caregivers of the children, not social workers or other professionals.

METHODOLOGY

I conducted this research using a qualitative approach in order to gain a deeper understanding of each individual's story. Qualitative researchers try to illicit an empathetic understanding within the reader through the use of narratives (Stake, 1995). I also chose an anti-oppressive framework to conduct this research in order to encourage families who are involved in an adversarial system, characterized by power imbalances, to use their voices. Brown and Potts (2005) explain that from an anti-oppressive framework, the researcher must be looking for meaning and understanding, and the power to make change.

I used case study in order to conduct this research and used a standardized, open-type of interview as the main source of data collection. In this format, interviewers adhere to a script, where there is little flexibility, however the responses of the participants are open (Patton 2002). This was advantageous because it ensured that all of the participants were asked the same questions but were able to respond openly.

I interviewed five participants. I chose a small size group of individuals to interview for this study because I was seeking to gain a deep, rich understanding of the experiences of families rather than a broad understand-

ing. This sample size also reflects Polkinghorne's (1988) recommendation that intensive studies on individuals' experiences of a particular phenomenon involve between three and 25 individuals. The use of a small sample size also reflected the underlying principles of anti-oppressive research because it allowed me to focus on the depth of the experiences. The participants had to meet the following criteria:

- They had to be caregivers of the child/ren at one time
- They had participated in family group decision making in the District of Algoma since its implementation in 2002
- They were not presently involved in the FGDM process, but had participated in the past
- They were able to communicate their experiences to me through interview

In order to recruit participants, the FGDM facilitator in the District of Algoma sent out flyers to caregivers who had participated in FGDM on my behalf. She knew all of the families from their participation in the FGDM process. In order to maintain the confidentiality and anonymity of prospective participants, she initiated the contact. The flyer contained my contact information in order for participants and potential interviewees to contact either me or the coordinator to express their interest.

I conducted private interviews with the participants in a location of their choice and I was able to maintain confidentiality as each interview was held in a private place such as their home or office. Since the FGDM process is a very personal experience, I thought that this would allow for the participants to feel at ease and open with the discussion. During the interviews, I asked the same questions to each participant and listened to their open-ended answers in order to gain a sense of their personal experience.

The secondary source of data that I used was the journal that I kept. In this journal, I noted personal observations or important details that were not detectable by the notes taken during the interview, such as facial features and body language. After each interview, I recorded any personal observations that I had made. After the interviews were conducted, I examined a third source of data, the principles of FGDM as set out by the American Humane Association and used in FGDM through the Children's Aid Society of Algoma. The pur-

pose of this was to compare the experiences of families to the underlying principles that set out the framework for FGDM.

FINDINGS

For the purpose of interpreting and analyzing the data in this study, I used a qualitative, thematic analysis approach. The focus of thematic analysis is to uncover themes that emerge during face-to-face interviews with individuals (Luborksy, 1994). Themes that emerge from informants stories are organized to form a comprehensive picture of their collective experience (Aronson, 1994).

The questions that were asked of participants related to four different categories: the experience with FGDM, thoughts on empowerment, ability to implement a safety plan for the child/ren, and the ability to maintain the plan for the time needed. During the analysis of the data, there were three main themes that emerged and within these three themes several sub themes were noted:

Theme 1: The Empowerment of Participants

- Power imbalances within the child welfare system
- Support to participate in the meeting
- The importance of support during meetings
- Enhanced communication
- Being heard at the meeting

Theme 2: Improved Outcomes for Children

- Child as the focus of the meeting

Theme 3: Ability to Implement and Maintain Plans for Children

- Availability of supports in rural Ontario
- Ability to implement and maintain plans

DISCUSSION

Theme 1: The Empowerment of Participants

A main tenet of FGDM is to assist families to empower themselves so they can develop plans that they find suitable, without such intrusive intervention from CAS.

Families are able to be creative when developing plans and this may prevent children from entering into the care of CAS. Plans that are developed by professionals are based upon the knowledge and network of the professional whereas families base their plans on their own unique network and resources, to which professionals have little access.

When participants spoke to me about empowerment they defined what it meant to them. It was interesting to note that all of the participants defined empowerment as something that one must take ownership of, in order to find a solution rather than allowing others to make the decision and impose it on them. The findings show that participants felt as though the FGDM process was empowering for them in a variety of ways, based on their definition of empowerment. For some, the process was empowering because it provided them with an opportunity to speak out and be heard while for others it was empowering because they were able to come up with plans on their own, without CAS. The use of FGDM allows for the family and their immediate community to play the central role in identifying how they can address concerns and the best way to implement solutions. In this study, it was critical to explore why participants felt that the FGDM process was empowering for them.

One of the sub-themes which emerged relating to empowerment was the use of supports during the FGDM process. Participants spoke of the use of supports as a main factor in their willingness to participate in FGDM. Several suggested that they would not have agreed to participate if their family had not encouraged them to do so. This finding supports studies that suggest that caregivers often do not trust the child welfare system due to past experience, such as the fear of losing their children or being unfamiliar or untrusting of the child welfare process. Research indicates that families are more likely to find a solution when supported by their family and to follow through with the plan because they become accountable to their entire family network rather than solely to their worker (Mirsky, 2003). It would appear that families are more apt to participate in FGDM when it is suggested by someone other than their social worker (Helland, 2005).

The findings demonstrate that in order for participants to feel empowered during FGDM, they relied on supports such as friends and family members being present to either support them or to speak on their behalf.

The participants who expressed that they felt supported at the meeting appeared to have more success with the outcomes. This finding supports other studies that speak to the power of supports and extended family during the FGDM process and that often success in the process is based on the attendance of family members (Gunderson, 1998; Merkel-Holguin, 2008). One participant spoke of how she doubted the process and was amazed with the outcome:

> We went into this meeting with some hesitation, many of us not even really knowing anything about one another. But with the group of people together, we had to build relationships and learn to communicate with each other. What normally happens over a period of months, happened right away. It was interesting because we all gained an understanding of each person at the meeting just from talking. The shift seemed to happen after the professionals all left and we all had to sit in the room and talk.

The findings suggest that there is a significant amount of weight placed on the family and other supports being present for the meeting which is consistent with the guideline policies.

The data also shows that participants felt that the FGDM process enhanced communication amongst family members. Families who participate in FGDM may have ongoing conflict between them which can often make it difficult to communicate with one another. The FGDM process allows for a forum to discuss the issues at hand and provide a better sense of understanding. Several of the participants spoke of the process allowing them to communicate more effectively and this in turn assisted them in overcoming barriers. One participant indicated:

> My daughter and I would end up fighting a lot because we would bring up issues from the past that had angered both of us and we would end up in a fight. I found that being able to communicate really addressed our [participant and daughter] anger and made me realize that we had a lot of things to work out still. Being able to communicate helped me move forward instead of backwards. My family helped me to recognize that focusing only on the past wasn't going to solve anything.

They also indicated that the process helped to reduce conflict within their families as the enhanced communication allowed for each individual to develop an understanding of one another's viewpoint. Some of the participants indicated that once they were able to discuss the underlying issues, they were able to problem solve together and their relationships with one another improved immediately.

In addition to enhanced communication among members, my findings support that each individual found that the FGDM process allowed for them to speak up about the issues that were of importance to them. This in turn created a sense of empowerment. One participant explained how her familial supports assisted her in being able to discuss all of the issues that were important to her:

> I was able to discuss everything! Absolutely! I didn't want to bring up issues of money because I felt bad but my family brought it up so that a plan for support was put together. It is expensive to raise a child so I was grateful that my family addressed it and now I am getting some financial support from the extended family.

All too often, the voices of those involved in the child protection system are ignored and the FGDM process has allowed for these people to be heard. One of the participants in my study had her friend speak on her behalf because she did not feel comfortable speaking during the process but she indicated that regardless of who spoke, she felt that her concerns were heard.

Theme 2: Outcomes for Children

The second principle that was examined during this study relates to the outcomes for children. While conducting this study, I found that at the time of the interview, none of the children who were the focus of the FGDM process were in the care of the CAS after the FGDM process had taken place. This in itself would suggest that the outcomes for children are positive. Participants consistently spoke of the FGDM process as though it transformed the ways in which they typically dealt with issues in the past. It appeared that families had been focusing on their anger and other issues rather than on the child. For example, one participant indicated:

I think that family group decision making was a very good thing. It was something that we needed because we were all arguing and having a hard time focusing on what was most important – the baby.

The findings from this study show that participants were able to keep the children as the focus of the meeting, which assisted them in staying on track and avoiding unnecessary conflict amongst members. Helland (2005) speaks of participants finding the FGDM process beneficial as it provides them with a different way of looking at the issues, which in turn results in better outcomes for children.

These findings suggest that if families are able to keep the focus on the child, they are able to overcome many obstacles and avoid any unnecessary arguments. This is consistent with the guiding policies as set out by the American Humane Society.

Theme 3: Implementation and Maintenance of Plans for Children

There have been some studies completed on whether or not families are able to implement and maintain plans for their children while participating in FGDM. One such comprehensive quantitative study was conducted in Newfoundland and Labrador with 32 families and concluded that FGDM assisted the family in developing a plan however some dissatisfaction was expressed by participants who felt that both family members and social agencies had not followed through on their assigned tasks (Pennell & Burford, 2000). Another research project found that families had a difficult time maintaining their plan after the conference due to lack of follow through from those involved in the plan (Berzin et. al., 2009). Similarly, in my study, some of the participants expressed frustrations with either their family members or the social agencies with whom they were involved. Two of the participants explained how they were able to develop plans, but that these plans fell through at the onset due to lack of follow through on behalf of family members. One participant stated:

The plan itself was good but it broke down immediately because the aunt didn't enforce anything – she was a main part of the plan but she didn't follow through. She didn't implement or enforce the plan in any way, shape or form. If everyone would have followed through and we all support-

ed the plan, we would have gotten somewhere.

The availability of supports has a large impact on a family's ability to maintain plans for children for several reasons. First, parents of children often require services and supports in order to address the risk factors that are preventing their children from being returned to them. Secondly, kinship providers often require services and supports such as daycare and financial support. Belanger (2008) found that rural communities face significant challenges with respect to the availability of resources while lacking supportive social services such as addictions programs and mental health services. During the data analysis, I found that many of the participants referred to the availability of supports in northern Ontario, or lack thereof. One participant spoke of how her family was able to implement and maintain a plan for the child but she was frustrated with how long it was going to take to have her child returned to her care:

We put a plan in place and I agree with everything that I have to do but it is such a short period of time considering that I can't even go to treatment for another few months because of the wait list. We have a backup plan in place until I am able to complete everything.

The same participant spoke of the lack of support she received once her daughter was apprehended:

It was kind of stupid. Once my daughter was taken from me, the CAS didn't help me anymore because the risk to my child was gone. How am I supposed to get her back without any support? I was also kind of upset that my aunt didn't receive any financial support. Really, she is saving my daughter from going into care and nobody helps her.

The other participants expressed satisfaction with the plan implementation and maintenance. In these cases, the participants expressed that the family and social agencies were following through on their part which allowed for the maintenance of the plan.

Financial security is also important when measuring the success of FGDM plans. From the participants' perspectives, the availability of supports impacts people's willingness and ability to care for children in kinship placements. Kinship providers have expressed concern when caring for children due to the lack of

financial support (Geen, 2002). It is interesting to note that although some of the kinship providers mentioned financial support as a hardship, they did not appear to see this as a disincentive to care for the child/ren. This may be due to the fact that the kinship providers that I interviewed all felt that they were financially secure. Had I interviewed individuals from a lower economic class, the findings may have differed.

IMPLICATIONS FOR POLICY AND PRACTICE

As this was a small, preliminary study, it is obvious that the findings cannot be generalized for all of rural Ontario, although I think that they may highlight some matters that FGDM planners and programmers might address and also suggest areas for future research. Based on my particular findings, I present some possible avenues that may be considered by service providers in the field of child welfare when working with families who may have participated in FGDM in the past or who may participate in the future.

The major issue that I noted that will undoubtedly affect policy and practice is related to the lack of policies governing the FGDM in the District of Algoma and the lack of consistency throughout Ontario. With no consistency in the policies directing how FGDM processes should occur, the chance of what *should* happen according to policies and what is happening in practice, can very well be two different things. There is consistency with respect to the knowledge and experience required by all FGDM coordinators, however, this appears to be where it ends. On the other hand, in keeping with the philosophy of FGDM, there is a need to keep the program flexible.

Another implication that was evident in the interviews with the participants is the frustration with the lack of services available in rural Ontario. There are extensive wait lists for counselling services, treatment centres, doctors and geared to income housing to name a few. Individuals are often unable to participate in the programs that are needed in order to have their children returned to their care such as drug and alcohol treatment.

In most of the interviews, participants expressed dissatisfaction with the wait times for services such as drug and alcohol treatment and counselling. These types of

services are often part of the plan that the family develops and the lack of availability can cause the plan to fall through. Unfortunately, these services are funded by the government and without further funding for these types of programs, it may be impossible to improve these programs and other resources in the community.

Furthermore, all of the participants who expressed satisfaction with the implementation and maintenance of the plan indicated that those involved in the plan were fulfilling their responsibilities. Whether this was a financial responsibility, providing respite to the kinship provider, or being the liaison between the parent and kinship provider, all participants expressed that without these, the plan would have fallen through. FGDM is a tool that is used to encompass an entire group of people and community in order to assist with the care of a child or children. Therefore, would it not make sense to assume that if the key players do not follow through with their responsibilities, then the plan will ultimately fail?

In addition to a need for follow through from their family members, participants also expressed concerns over the lack of follow through from service providers. It is important for child protection workers to continue working with the family for a period of time after the plan has been implemented in order to ensure that the plan is viable. Although the FGDM process often assists in alleviating many of the child welfare concerns, there is a need for ongoing support and assistance. Once a family successfully implements a safety plan for the children, one cannot assume that after the FGDM process, the family now has all of the tools needed in order to address every ongoing concern. However, having worked as a child protection worker in rural Ontario, I am aware that with caseload demands, it is often challenging to continue to provide high quality support to families on an ongoing basis when other children who are at risk become the priority. Again, the government funds these types of child protection services therefore it is a matter of whether funding is available in order to ensure that more child protection workers are able to spend the time required with the families with whom they work.

One of the other major implications for practice that came out of the research is related to the empowerment of the family. As discussed throughout this article, empowerment was a main focus of my research and a main tenet of FGDM as reflected in the policy directive

as well as the guiding policies. The findings demonstrate that empowerment took place insofar as families were able to develop plans for their children when given the opportunity to do so. Based on the interviews, in each case, plans were able to be implemented, preventing any children from going into the care of CAS. As per the guiding policies, there is a need to believe in families and provide them with the tools they need to make their own plans, outside of court.

LIMITATIONS

As with any study, there are limitations. In my particular study, I found some limitations that I discuss further here. First, although I believe that there are benefits to using a small number of participants, there are some obvious limitations to this as well. With respect to the use of case study some limitations exist. Some scholars support the notion that case study does not allow for generalization and predictability (Yin 2003). These views are based on the fact that case studies often focus on smaller sample sizes and therefore cannot be generalized to a larger population. In my particular study, I am unable to generalize the findings to a larger population. The results of my study will not be used as a way to predict FGDM outcomes but rather, to examine experiences of those who are often not heard in the hopes of using their opinions and suggestions as a way to improve the FGDM process. Although it may have been beneficial to have a larger number of participants it would have been impossible to conduct interviews throughout the entire region while maintaining the same level of interview and analysis depth that I was able to by limiting the study size to five participants.

Secondly, it was difficult to ensure that all caregivers who had participated in the process since 2002 were invited to participate in this particular study. The reason for this is that the FGDM coordinator does not maintain contact with these individuals after the FGDM conference is over. Therefore, addresses for these individuals were unavailable. The number of individuals in rural Ontario who have actually participated in the process is not excessively large either so there were not many letters sent to people inviting them to participate in the study.

Another potential limitation was the use of interviews as a method of data collection. Interviewing individuals on a one to one basis requires a degree of rapport building that if not constructed, can result in faulty information being conveyed to the researcher. I was honest with each participant and explained that I had once worked as a child protection worker and I made it very clear that the information that was being discussed during the interview would have no impact on the services they receive from any community agency (unless there was a disclosure of child abuse). I believe that all participants felt comfortable during the interviews as evidenced by their willingness to meet with me and discuss each question that was asked of them.

CONCLUSION

Guided by the policies set out by the American Humane Association and the goals of family group decision making as described by the Ministry of Children and Youth Services, this research has attempted to explore the experiences of families who have participated in FGDM in rural Ontario. In pursuit of gaining an understanding of each individual experience, I interviewed individuals, consulted the relevant literature, and analyzed the guiding policies and other related legislation in order to determine whether the findings were consistent with what the process is set out to accomplish. Based on the analysis, it would appear that families are satisfied with the process in most areas. However, there are definitely areas of further research that are required. These may include conducting a larger study of the experiences of families in FGDM, examining the success rates of maintaining plans, or conducting research with individuals who have participated in FGDM in other jurisdictions, to name a few. There are indicators that families feel unsupported to maintain plans on a long-term basis.

Based on the data collected from the interviews, the FGDM process appears to be meeting the requirement of being an empowering and non-oppressive method of ADR. The MCYS has set out the goal of ADR methods such as FGDM to be inclusive and collaborative and encourage the involvement and support of the family, extended family and community (MCYS, 2006). Based on these findings, I feel confident in saying that the FGDM process is fulfilling what it is set out to accomplish in these areas.

Also, it appears that if families are able to keep the focus of the process on the child, they are able to overcome many obstacles and avoid any unnecessary

arguments. Based on the information collected from participants, there is consensus that this was in fact the case in each of their scenarios. The participants also expressed that an important component to the success of FGDM, is that the focus of the process be placed on the child. Based on these results, a main component to ensuring that the best outcomes for children are achieved is that the child/ren needs to be the focus during the process.

Thirdly, the results of this study are consistent with the current literature related to the implementation and maintenance of plans formulated by the family. The guiding policies from the American Humane Association also cover the importance of commitment from the child welfare agency when implementing and maintaining plans. The data indicates that participants feel some improvement is needed in this area. As per these guidelines, it is CAS' responsibility to assist the family in implementing their plans by providing the services and resources necessary. However, the resources are spread out in rural Ontario. Therefore, it is difficult to ensure that families are receiving the support and services they need. CAS cannot be fully accountable for ensuring the implementation of the plan as CAS has no control over what services are available in the community or how long wait times are to access these services. There is a need for ongoing support from numerous family members, professionals and agencies once the plan has been agreed upon in order to ensure its success. Pennell and Burford (2000) state that in order to maintain a healthy and safe family the responsibility cannot be placed on any one societal sector or agency. It must be a collective effort of families, community organizations and government services.

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INFORMATION PROCESSING IN YOUTHS WITH CHILDHOOD MALTREATMENT HISTORY AND ADOLESCENT DEPRESSIVE SYMPTOMATOLOGY

By Elbert Manalo BHSc, Dr. Christine Wekerle PhD, Randall Waechter PhD, Maria Chen BSc & Ronald Chung BSc

INTRODUCTION

As a chief context of vulnerabilities, maltreatment can be a daily experience of family tension, distrust, and unpredictability. Minimal adult monitoring creates increases in environmental toxins - exposure to dangerous persons, situations, and substances (Wekerle & Wall, 2002). Maltreatment is a demonstrated robust risk factor for mental health and substance abuse problems across the lifespan (Gilbert et al., 2009). It has been shown to cluster with other adverse childhood events and predict onset of DSM-IV disorders (Green et al., 2010), and is related to persistence of problems, such as substance abuse, mood, and anxiety disorders (McLaughlin et al., 2010). These at-risk health conditions appear to be the interpersonal response to unremitting high, and often unpredictable, daily stress and feelings of threat (DeBellis, 2001). Symptoms may be present daily, but not at diagnostic levels; these "subclinical" levels may still be disruptive to the maltreated youths' functioning. The learning in this environment will have a high likelihood of being repeated, when the environment is repeated. This is referred to as experience-dependent development (Glaser, 2003). Interactions between the child and parent (caregiver) are important in brain development and solidification of neuronal pathways (Taylor, 2003). While this is often tied with the importance of the early years, research has identified adolescence as another important period. The key issue in experience-dependent development is that the experiences that are repeated (e.g., victimization by parents, by peers, by adolescent dating partners etc.) are going to exert a greater impact. In this way, maltreatment may put into place "habits" in the communication pathways in the brain ("what fires together wires together"), until the environment is repeated to indicate new options and tendencies. For the maltreated adolescent, this includes their coping mechanisms.

Data from the Maltreatment and Adolescent Pathways (MAP) Longitudinal Study was used. The MAP study randomly selected adolescents from an urban catchment area of Ontario Children's Aid Societies and followed youths over time, testing at 6-month intervals.

The details of the MAP study are described elsewhere (Wekerle et al., 2009ab; Wekerle et al., 2011). This paper examines the existence of a negative bias in information processing in Children's Aid Society involved youth with a history of child maltreatment. We also examine how depressive symptomatology is linked with the emotionality of words that are readily available to the youth. One view is that if a person is in a negative mood, and not necessarily at mood disorder levels, the person will be more likely to attend to negative information bits (i.e., self-talk, negative mood in others, etc.).

Child maltreatment was measured using the Childhood Trauma Questionnaire (CTQ), a self-report survey that queries maltreatment experiences "while growing up". Adolescent depressive symptomatology was based on a four-item questionnaire taken from the Centre for Epidemiological Studies Depression-Scale (CES-D), a commonly used screening tool. We used a memory and word generation task as a way to code the tendency to come up with negative affect versus positive affect or neutral affect words. This task, the Controlled Oral Word Association Test (COWAT), is typically used to tap the person's verbal fluency (i.e., ease with which words are generated). Our goal was to consider the association among child maltreatment experiences and adolescent depressive symptomatology with a negative bias in information processing.

EFFECTS OF MALTREATMENT ON CHILD DEVELOPMENT

Childhood is a very sensitive period for development, as there is vast neurobiological and psychological growth over time, and particularly in the early and adolescent years (Toth & Cicchetti, 2004). Affect or emotion regulation is the way in which an individual generates, maintains, and modifies the intensity of both positive and negative emotions in relation to external events (Levesque et al., 2004). It is a process that is acquired through social interactions, especially repeated in close relationships (caregiver, best friend, dating partner). The child internalizes the emotional informa-

tion from the interpersonal exchanges, influencing their interpretation of and reaction to emotional situations in the future (Maughan, & Cicchetti, 2002). For example, an infant who is upset and crying requires an attentive parent to calm and soothe him. Over months, the infant internalizes or learns from the soothing behaviour of the parent, contributing to the child's own ability to self-soothe in future distressing situations (Schore, 2003). However, any person overwhelmed with negative affect might find it challenging to engage in self-soothing behaviours. If unhealthy strategies are easy-to-find and easy-to-use, then non-optimal stress management may dampen the opportunity to learn and practice healthy self-soothing strategies. With overwhelming negative affect and a lack of positive self-soothing strategies, the emotion regulation system may switch to "sleep" and depressed affect may ensue.

ADLESCENT DEPRESSION AND CHILD MALTREATMENT

Depression can profoundly affect an adolescent's lifestyle including his or her emotions, sense of self, productivity, and life satisfaction. According to the Diagnostic and Statistical Manual (DSM-IV-TR), adolescents display the same symptoms of major depression as adults, with the addition of irritability as a common mood symptom. The lifetime prevalence of major depression for 15 – 18 year olds is 14%, with a female to male ratio of 2:1 (Hankin, 2006). Studies have demonstrated a relationship between child maltreatment and adolescent depressive symptoms, including increased risk for major depressive disorder (MDD) (Widom, DuMont, & Czaja, 2007). Another study found a dose-response relationship between the severity of the maltreatment and major depressive disorder. The probability of chronic or recurrent MDD in this study was 83% among children who suffered marked abuse, 70% among children who suffered moderate abuse, 55% for mild abuse, and 37% for little or no abuse (Bifulco, Moran, Baines, Bunn, & Stanford, 2002).Stressors can contribute to depression, and depression causes self-generation of stressors, which further amplify depressive symptoms (Hankin, 2006). Child maltreatment experiences and adolescent depression exert potent and debilitating effects on the normal functioning of the individual, including a negative bias in information processing.

A NEGATIVE BIAS IN INFORMATION PROCESSING, CHILD MALTREATMENT AND ADOLESCENT DEPRESSION

An individual in a good mood is said to view the world with "rose-coloured" glasses, noticing positive features in the environment and interpreting information from a positive perspective. The opposite is likely for individuals in a bad mood. The likelihood that someone will "connect" to stimuli that matches his/her mood is called mood-congruent processing. When faced with negative life events (for example, child maltreatment), individuals may develop a negative schema that influences their thoughts and judgments, and manifests in tasks involving perception, attention, and memory (Gotlib et al., 2004). This cognitive vulnerability increases the likelihood of developing depression (Calvete, Villardon, & Estevez, 2007; Haeffel et al., 2008).

Depressed individuals tend to show selective attention and quicker responses to negative stimuli. In a study where individuals performed an explicit memory task that involved the identification of positive and negatively-affect words (e.g., joy; despair), depressed subjects showed bias towards negative words and controls showed a bias towards happy words. This was supported by brain imaging results, in which more cortical areas were activated in depressed subjects when processing sad words (Elliott, Rubinsztein, Sahakian, & Dolan, 2002). A similar study was conducted in which the rate of error and length of response in identifying positive or negative valence words was measured. Depressed patients made more omission errors (i.e., misses) in identifying happy words as compared to sad words. Also, depressed persons took more time to respond to the happy words. The opposite was true for the control subjects (Erickson et al., 2005). It appears that more effort is required for a depressed person to notice the positive features in the environment or to consider positive self-thoughts.[1]

Maltreated youth seem more at-risk for a bias in information processing. Evidence indicates that these youth tend to show greater attention to threatening stimuli in a laboratory-based task (Pollak, 2003). Specifically, maltreated children are more likely to respond to angry emotional expressions and require less input to identify angry facial displays (Pollak, 2003). In one study, children were presented with faces of an individual who experienced an emotional event and were required

to identify which of the five faces (happy, sad, angry, disgusted, fearful) best indicated the protagonist's feelings. Compared to non-maltreated children, maltreated children showed bias towards the angry face (Pollak, Cicchetti, Hornung, & Reed, 2000).

AN EXAMINATION OF NEGATIVE BIAS IN INFORMATION PROCESSING IN THE MALTREATMENT AND ADOLESCENT PATHWAYS (MAP) RESEARCH STUDY

The MAP study analyzes health outcomes of randomly selected youth from active caseloads of Children's Aid Societies (CAS) in a large urban Canadian centre. Youth are aged 14-17 at the initial point of testing, with most in the 15 to 16 year old range. The data presented here is based on 194 youth (61 percent females), in the 14 to 18 year old age range (mean age: 16.21; SD: 1.03). These preliminary analyses consider how word processing might be different in youth with depressive symptoms compared to youth with non-depressive symptoms. In this report, child maltreatment data was taken for initial testing, word fluency from the 6-month MAP follow-up, and depressive symptom data from the 1-year MAP follow-up for youth who had complete data.

In this study, youth provide a lifetime report of their maltreatment experiences on a self-report survey called the Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink, 1998). Examples of the items for each of the five maltreatment subscales are as follows:

Emotional Abuse: "People in my family called me things like 'stupid', 'lazy', or 'ugly'."

Physical Abuse: "People in my family hit me so hard that it left me with bruises or marks."

Sexual Abuse: "Someone tried to touch me in a sexual way or tried to make me touch them."

Emotional Neglect: "My family was not a source of strength and support."

Physical Neglect: "I had to wear dirty clothes."

In the Controlled Oral Word Association Test (COWAT) participants are given sixty seconds to generate as many words as possible that begin with the letters 'F',

'A', and 'S'. The rules of the task prohibit the generation of proper nouns (such as France or Fred), repeating the same word over, and the use of the same word with a different ending (such as "see" and "seeing"). Usually, the COWAT test is used to assess the total number of words, and that is compared to gender- and age-specific established norms. However, uniquely, the MAP study coded the emotional valence of the words given the proposition that maltreatment impairs a youths' information processing. Specifically, the maltreated youth has had more learning in negative affect and negative words, and less learning and practice with positive affect and positive words. In practical language, maltreated youths' may find it very uncomfortable to accept a compliment or hear "I love you" if they never heard it from a parent, but instead heard negative messages about the self (e.g., "I hate you; "You were a mistake"). In the MAP coding of the COWAT, the words generated are categorized according to their emotional valence: positive, negative, neutral, or ambiguous (wherein a word, such as "snake" can refer to the animal [a neutral affect] or to describe an untrustworthy person [a negative affect]).

Depressive symptomatology was based on a four-item screening questionnaire taken from the Centre for Epidemiological Studies Depression Scale (CES-D) and implemented into the Ontario Student Drug Use and Health Survey (OSDUHS).[2] The four items were used with the time reference of "the past 7 days". The items were:

1) How often have you felt sad?
2) How often have you felt lonely?
3) How often have you felt depressed?
4) How often have you felt like crying?

The items were answered on a 4-point scale, ranging from "never or rarely" to "always". To be categorized as having depressive symptoms, a youth needed to respond "often" or "always" on all four items. Figure 1 shows the MAP youths' positive endorsement of the CES-D items as compared to the Ontario population of youths. Based on the results of the four-item depression screening questionnaire, about 5.4% of Ontario youth in the OSDUHS sample met the cutoff criteria for possible clinical depressive symptoms, while a significantly larger number of the MAP youths (8.8%) met the cutoff criteria for possible clinical depressive symptoms. Given the "hidden" nature of these items, direct questioning on feelings in the day, and over the past

week may alert the caseworker to the need to continue to monitor youth mood. A major depression diagnosis requires that a set of symptoms be experienced more or less everyday for a minimal period of two weeks. A physician is needed to make a diagnosis.

The four depression items are totaled to create the Centre for Epidemiological Studies Depression Scale (CES-D) sum score. As seen in Table 1, the CES-D sum score (higher depression) is associated with all types of childhood maltreatment (higher maltreatment scores across the Childhood Trauma Questionnaire [CTQ] subscale scores and CTQ total score). When considering the association between types of child maltreatment and the type of word affect, the only significant association was observed with the childhood emotional abuse CTQ subscale score and the number of negative affect words generated in the Controlled Oral Word Association Task (COWAT) (r =.16, p<.05). To

follow-up this finding, the youths' scores on the emotional abuse CTQ subscale was categorized as severe (cut-off provided by the CTQ authors; N=54) or non-severe (N=140). Adolescents who reported non-severe emotional abuse while growing up produced significantly fewer negative words to this "free response" task (i.e., 3.03 negative words on average, as compared to 3.81 negative words on average) (see Table 2). In the COWAT, youths respond spontaneously within the restrictions of start letter (i.e., F, A, S) and in the limits of time (60 seconds per letter). Given the context of some "pressure" in performance or responding (e.g., rules, time-limits), the severe emotionally maltreated youths are better at accessing negative affect words (e.g., F,A,S - frightened, anxious, sad).

Figure 1: Percentage of Youth Endorsing Depressive Symptomatology
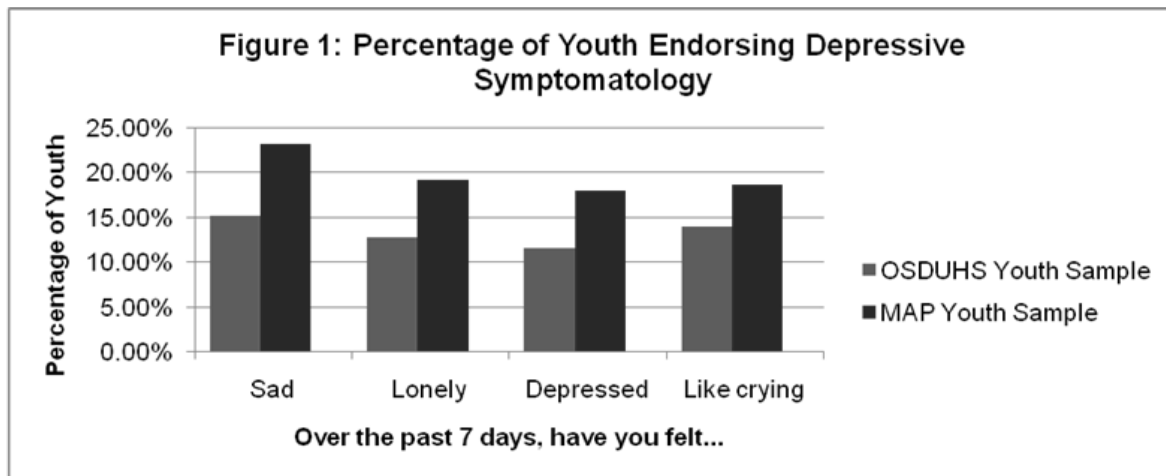
Table 1: Pearson Correlation Values Between the Centre for Epidemiological Studies Depression Scale (CES-D) Sum Score and the Childhood Trauma Questionnaire (CTQ) Total Score and Subscale Scores (N=194)

| | CTQ Total Score and Subscale Scores | | | | | |
	Total	Emotional Abuse	Physical Abuse	Sexual Abuse	Emotional Neglect	Physical Neglect
CES-D Sum Score	0.25*	0.24*	0.19*	0.16*	0.21*	0.18*

*- p<0.5

Table 2: Comparing Number of Words Generated in the Controlled Oral Word Association Task (COWAT) between the Non-severe Emotional Abuse Group and Severe Emotional Abuse Group (N=194)

	Emotional Abuse		
	Non-severe (N=140)	Severe (N=54)	t-value
COWAT: Negative Words Mean(SD)	3.03(2.48)	3.81(2.53)	0.19*

*- p<0.5

These results suggest the need for considering adolescent depressive symptomatology among maltreated youth in child welfare systems, particularly emotionally abused youth, and the link it may have to a negative bias in information processing. Also, it highlights that emotional abuse growing up may continue to "live" in the adolescent's mind, influencing their thinking and capacity to access positive words and, perhaps, make positive communications in their close relationships. These results are consistent with the notion that youth with a history of maltreatment are more likely to experience symptoms of depression than their non-maltreated peers. Given that adolescence is a time of transition to adult roles, greater fluctuations in mood can be expected. At the same time, depressive symptoms that persist require further clinical follow-up.

INITIATIVES TO ADDRESS EMOTIONAL MALTREATMENT

In this section, we consider some of the approaches that have been considered to date that assist in supporting positive emotional development. Barlow and Schrader-MacMillan (2010) summarize initiatives and interventions that may be helpful in addressing emotional maltreatment. The basis of interventions are focused on parenting and facilitating interactions between maltreated youths and their significant others towards greater balance between positive and negative information being processed, rather than a preponderance of negative affective information.

A) *Parent-focused interventions*: aimed at changing an aspect of the parents' well-being or an aspect in their parenting that contributes to emotionally abusive interactions with the child:

i) Cognitive behavioural program involves training parents by counselling (for example, changing unrealistic expectations), and improving their problematic behaviours regarding stress management, self-control, and problem-solving skills;

ii) Behavioural social work involves teaching the parents key parenting tasks (for example, playing with child, "watch, wait, and wonder" about the child's response, and responding appropriately) based on the use of social learning principles;

iii) Home visiting involves having a professional visit parents at their homes to provide maternal support and promote parenting skills, with the greatest evidence for child maltreatment prevention with the Nurse-Family Partnership. One of the main goals in this program is to improve the child's health and development by helping parents provide sensitive and competent care for the child as reflected in fewer injuries that may be associated with child abuse and neglect (Olds, 2006).

B) *Parent and child-focused interventions*: aimed at changing an aspect of parent-child interactions that contributes to emotionally abusive interactions with the child:

i) Psychotherapeutic approach involves helping the parent to reconstruct representations of self in relation to others (particularly child) through the experience of a positive and therapeutic relationship with therapist;

ii) Video-Interaction Guidance involves using clips of the parent and infant interacting with each

other to highlight and train the parent to respond sensitively to their infants.

CONCLUSION

These results are consistent with the notion that verbal and emotional abuse can lead to the development of "mental maps" or self-schemas that may operate outside of conscious awareness (Sachs-Ericsson, Verona, Joiner, & Preacher, 2006). In this way, youths may think of negative self-thoughts automatically and therefore, not realize that their "inner" dialogue is harsh and critical. Recent evidence has shown that emotional abuse has a greater predictive power than physical and sexual abuse across different outcomes, including psychopathology. It has also shown to exacerbate the negative effects of physical and sexual abuse, which further illustrates its potent effects (Berzenski & Yates, 2010). This suggests that the impact of emotional abuse is under-considered, and it may be especially salient for adolescents who are pondering about their self-identities. Since maltreatment awareness and disclosure are on-going processes, checking in with youths regarding their feelings and the self-talk that occurs during both positive and negative life experiences provides an opportunity to enforce positive input in order to achieve a realistic, but generally self-compassionate approach towards oneself.

ENDNOTES

1. For one person's humour-inclined For one person's humour-inclined approach to depression, see the Maltreatment and Adolescent Pathways (MAP) study knowledge translation (KT) homepage [www2.oacas.org]. Preliminary analysis of the negative word processing question was presented at McMaster University's Pediatric Department Research Day.

2. For a copy of the Ontario Student Drug Use and Health Survey, see http://www.camh.net/Research/osdus.html

ABOUT THE AUTHORS

Elbert Manalo graduated from the Bachelor of Health Sciences Honours program at McMaster University. He completed his undergraduate thesis working with the Maltreatment and Adolescent Pathways (MAP) Project under the supervision of Dr. Christine Wekerle, focusing on adolescent depression and information processing in youth. Since then, he has continued his work in data coding with the MAP Project. In September of 2011, Mr. Manalo will pursue a Masters in Global Health at McMaster University.

Dr. Christine Wekerle is an Associate Professor in Pediatrics and an Associate Member of the Offord Centre for Child Studies, McMaster University. Dr. Wekerle's research areas are broadly in the areas of parenting and the prevention of family violence. She has edited a book on the overlap among child maltreatment, dating and courtship violence, partner violence and substance abuse (Wekerle & Wall, 2002, *The Violence and Addiction Equation,* Taylor Francis), written a book for a broad audience on maltreatment (*Child Maltreatment*, Wekerle, Wolfe, Miller & Spindel, 2006, Hogrefe, translated into Spanish), as well as a book and treatment manual on a dating violence prevention program ("The Youth Relationships Project") which remains one of the few programs evaluated in a randomized control trial with at-risk youth. Dr. Wekerle is an Associate Editor of Child Abuse & Neglect: The International Journal (Editor, Practical Strategies), as well as Editor, Special Issues for the International Journal of Mental Health and Addiction.

Dr. Randall Waechter, PhD, is a scientist in brain and behavior, and former project manager of the MAP Project. He holds a courtesy appointment to the Child, Youth, and Family Program at the Centre for Addiction and Mental Health in Toronto and lectures in psychology. His research interests include examining the impact of child maltreatment-related anxiety on attention, reasoning, and decision-making.

Maria Chen is a Social Work Master's candidate at the University of Manitoba. She received her BSc in Psychology from the University of Toronto. Following her undergraduate career, she began a research assistantship with the MAP Project, and volunteered at the Toronto Distress Centre as a hotline worker. Her clinical/research interests include crisis intervention and child welfare policy development.

Ronald Chung graduated from York University with a BA in Psychology. To pursue work with adolescents, he has been a research assistant for over two years to the MAP project, working in data coding, subject recruitment, and report support. Mr. Chung is interested in pursuing a career in psychology or a related field.

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FETAL ALCOHOL SPECTRUM DISORDER (FASD) RESPITE PILOT PROGRAM: A COLLABORATION

By Kristen Lwin BSW, Debbie Schatia & Dr. Tara Black PHD

BACKGROUND

Fetal Alcohol Spectrum Disorder (FASD) is an issue for children and families served by the child welfare sector (Murphy, Christian & Caplin, 2006; Brown, Bednar & Sigvaldason, 2007). Not only is the diagnosis stressful on the child, research indicates caring for a child/youth diagnosed with FASD is stressful for the caregiver (Murphy, Christian & Caplin, 2006).

Caregivers note various areas in their lives affected by caring for a child/youth diagnosed with FASD (Brown & Bednar, 2004; Brown et al., 2007). For example, there is a need for assistance with the child/youth's behaviour, time for themselves (caregiver), the ability to make short- and long-term plans for the child/youth, collaboration with the educational system, and involvement in social activities. Paley, O'Connor, Frankel, and Marquardt (2006) explored the need for additional resources and support not only for children/youth diagnosed with FASD, but also their caregivers.

In an effort to reduce caregiver stress and with an ultimate goal of reduced placement and family breakdowns, a respite program for caregivers of children with FASD was created in 2006. The collaboration of efforts is between Alliance Relief and Respite Services, the Children's Aid Society of Toronto (CAST), Catholic Children's Aid Society (CCAS), and Native Child and Family Services of Toronto (NCFST). The result is the *Fetal Alcohol Spectrum Disorder (FASD) Respite Pilot Program*.

THE FASD RESPITE PILOT PROGRAM

The FASD Respite Program is a pilot project designed to provide relief and respite to caregivers whose children/youth are diagnosed or highly suspected of having FASD. Eligible caregivers must be involved with one of the collaborating agencies: CAST, CCAS, or NCFST. Four types of caregivers are suitable for the program:

- Families in the community
- Kinship families
- Foster families
- Adoptive families

Additionally, children/youth must meet *at least one* of the following criteria:

1. Children/youth who have been previously diagnosed with FASD

2. Children/youth where there is documented evidence of prenatal exposure to alcohol

3. Children/youth who are highly suspected of having FASD and are on referral for diagnosis including all of those children who are currently being assessed under this pilot project

4. Children/youth where FASD is suspected and meet one of the following three criteria: there is knowledge of family history that would indicate pre natal alcohol exposure; or child/youth exhibits known FASD characteristics but no diagnosis; or child/youth is unable to learn from traditional methods of intervention.

The *FASD Respite Pilot Program* offers various types of support to those who qualify. The different forms are as follows:

Type of Support	Activity
Volunteers, Community Friends, or Family Members	Volunteers, community members of family members who are available to provide relief to families caring for children/youth with FASD. Relief may take place either in or out of the home, depending on the caregivers needs.
In-Home Support	Workers trained in FASD concepts and management provide support and assistance to caregivers in their own home.

In-Home Support, cont'd	The worker may assist in different activities such as routines, homework, creating and implementing activities or providing the caregiver time away from their in home responsibilities.
Out-of-Home Respite	Caregivers specifically trained to care for and manage children/youth with FASD take them into the community to provide the caregiver time in their home with fewer responsibilities and for the child/youth to engage in activities in the community.
Overnight Respite	Workers trained in caring for and managing children and youth with FASD provide overnight supervision of children and youth within a certified out-of-home placement (e.g. group home).

PROGRAM EVALUATION

The evaluation is important to provide an assessment as to whether the project is effective in providing caregivers with the relief and support they need in order to care for their child/youth. Another outcome under examination is whether the program is having an impact on reducing the number of placement breakdowns. Lastly, evaluation will indicate whether the program requires modification in terms of accessibility for caregivers.

Methodology

The *FASD Respite Pilot Program* is currently being evaluated by the Child Welfare Institute at CAST. Data are being collected primarily from caregivers in the community in a variety of ways. A mixed method approach has been taken. Pre-tests (prior to respite) and post-tests (after respite) are completed by voluntary participants who have used the *FASD Respite Pilot Program*. A series of three post tests are being collected: immediately after the respite, 12 months later, and a further 24 months after service began. The goal is to evaluate whether the respite and support services are having a long term effect on caregivers and children/youth. Lastly, when families are leaving the program they are invited to participate in an exit survey.

Sample

Since September 2006, a total of 59 families have been referred for respite/relief services. Twenty-one of these families completed both the pre-test and the post-test, resulting in 21 matched pre and post-tests. Between March 2009 and April 2010, ten caregivers consented to participate in the follow-up surveys. Two of these participants completed both the follow-up surveys at 12 months and 24 months (n=2).

Data Analysis

All quantitative data have been entered into Statistical Package for Social Sciences (SPSS) version 15.1. Descriptive analysis, as well as independent and matched paired t-tests were conducted. A significance level was set prior to analyzing data at less than 0.05. Qualitative data has been entered into Word and analyzed for themes and sub themes according to direct information provided by participants.

Results

The information provided by participants illustrates the *FASD Respite Pilot Program* is making a difference for those caregivers. Caregivers have indicated that since participating in the *FASD Respite Pilot Program* they have enough time to complete daily tasks ($p < .05$), whereas prior to becoming involved in the program they did not. Further, the caregivers felt they had enough breaks from parenting their child/youth diagnosed with FASD ($p < .05$). Thus, the *FASD Respite Pilot Program* has been effectively providing its participants with support and services allowing them time to complete daily tasks. In addition, they have supplementary time away from the stress of caring for a child/youth diagnosed with FASD. Results indicate caregivers use the program's services with the primary goal of reducing their stress. The areas where the program has not produced significant results are: caregivers feeling they have enough agency support, caregivers feeling they have enough community support, the amount of FASD training caregivers have attended, caregivers feeling they have enough family support, and their overall stress levels.

Limitations

Certain limitations and difficulties have been encountered during the research process. These include a limited numbers of consenting participants for the

follow-up surveys, the limited amount of time (i.e., 10-15 minutes) that caregivers can provide to complete the questionnaire, and the lack of consistency between surveys to make results comparable. The current sample size is too small to generalize the results, however, provides important information about experiences with the *FASD Respite Pilot Program*.

FUTURE STEPS

Because it is difficult for caregivers to complete the surveys associated with the program evaluation, an alternative method of gathering data needs to be explored. In the future some alternate techniques of data collection and analysis will include file reviews and individual telephone interviews with caregivers. The *FASD Respite Pilot Program* will continue to provide support and services to caregivers in need. The program is scheduled to be completed in March 2011, where a complete evaluation will be available.

PARTNERSHIP

It is important to provide thanks to all collaborating agencies, Catholic Children's Aid Society, Native Child and Family Services of Toronto, Alliance Relief and Respite Services, and Children's Aid Society of Toronto. The shared goals and responsibilities are essential to a successful program for all service users. The *FASD Respite Pilot Program* would not have been created or maintained without the ongoing support of the Ministry of Child and Youth Services.

ABOUT THE AUTHORS

Kristen Lwin is currently a Research Project Coordinator at the Child Welfare Institute, Children's Aid Society of Toronto (CAST). Kristen holds a BSW, Hon. BA in psychology, diploma in Assaulted Women and Children Counsellor/Advocate Program and is currently working on completing a MSW. Kristen has 12 years of social work experience. She worked for five years on the frontline at the Victim/Witness Assistance Program in criminal court. In 2003, Kristen began working on the front-line at CAS-T and held various positions such as Intake worker, Family Service worker, Children's Service worker and Senior Social worker.

Debbie Schatia is the Director of the Child Welfare Institute, Children's Aid Society of Toronto. She has worked in a variety of roles at CAST for the last 19 years. Over the last five years Debbie has taken leadership in a variety of FASD related initiatives both at CAST and in the community including: development and evaluation of respite services; development of a FASD certificate program; chair of the Toronto FASD Coordinating Network; partnerships with HSC, Motherisk Program; and development and oversight of an FASD Training, Consultation and Mentorship Leadership Team.

Tara Black received her PhD and MSW at the University of Toronto, and Bachelor of Science degree from Queen's University. Dr. Black is the Co-Manager for the 2008 Canadian Incidence Study of Reported Child Abuse and Neglect (CIS-2008), and Supervisor of Research and Program Evaluation at the Child Welfare Institute, Children's Aid Society of Toronto. She has worked for ten years in various capacities including: positions at youth treatment centres, front-line child protection, Sessional Lecturer for the Factor-Inwentash Faculty of Social Work, University of Toronto, and report writer for the United Nations Secretary General's Violence Against Children Regional Consultation.

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"WORKING WITH FAMILIES WHERE THEY'RE AT": FRONT-LINE CHILD WELFARE IN NEIGHBOURHOOD SETTINGS

By Dr. Nancy Freymond & Dr. Trudy Smit Quosai

INTRODUCTION

For more than a decade, *The Partnerships for Children and Families Project* has worked to develop a deeper understanding of the daily realities for the families and children involved with child welfare systems in Ontario and for the workers who provide services to them. This article explores dimensions of child welfare work at the front lines in neighbourhood settings.

The challenges facing Ontario's child welfare system are numerous, well documented and experienced daily in the jobs of front-line child welfare workers. A list of the most acute would include parental fear and resistance to child welfare involvement, the minimal supports and services available to families and children, difficulty in developing consensual helping relationships, reliance on legal authority to engage families, high levels of employee stress and exhaustion, and excessive time spent in accountability documentation (Cameron, Coady, & Adams, 2007; Differential Response Sub-Committee of Ontario Children's Aid Society Directors of Service, 2004; Freymond & Cameron, 2006; Kufeldt & McKenzie, 2003; Swift & Callahan, 2009).

In response to these service challenges, several agencies in southern Ontario have experimented with neighbourhood models of service delivery. Workers are located in spaces where they may encounter child welfare families routinely, including schools, daycare centres or townhomes in social housing developments. The workers see families and children on a regular and often informal basis. They are encouraged to build collaborative relationships with a range of service providers throughout the education, health, and social service sectors and with any other community members who may have an important role in the child and family's life (for example, neighbours or relatives). Neighbourhood workers are expected to develop and maintain thorough knowledge of local community resources and to connect families with these sources of support. The workers may be active in community development initiatives as well.

The neighbourhood model differs in many respects from the central or agency-based model of service delivery, in which workers are grouped together, often in a large building in an urban centre, and provide services across a broad geographical area that may include surrounding rural areas. Typically central models locate child welfare workers in agency premises that are physically distant from the families they serve. Workers may drive to the homes of families and children or arrange meetings at the office. They may make referrals to professional services to address particular concerns for families. In southern Ontario the vast majority of child welfare work is practiced in a central setting.

Exploratory research done in 2005 by *The Partnerships for Children and Families Project* showed that neighbourhood models tended to emphasize cooperative helping relationships and a broader range of service options for families, as well as enable partnerships with other service organizations. Overall, neighbourhood models appeared to have a positive impact on how families perceived the child welfare agency (Frensch, Cameron & Hazineh, 2005). In the same year, Ontario's Transformation Agenda was unveiled. The Transformation Agenda emphasizes consensual worker-client relationships, limited court involvements, working partnerships with professionals and non-professionals and customized responses to the unique needs of the family (Child Welfare Secretariat, 2005, 2006).

Against the backdrop of the exploratory research and the priorities of Transformation Agenda, we wanted to learn more about what child welfare workers (CW)[1] and parents are saying about child welfare services in a neighbourhood setting. A new research project was launched, called *Transforming Front-line Child Welfare Practice*, to compare centrally located service-delivery settings with neighbourhood settings that were more accessible to families. This research was born from our commitment to explore promising possibilities in the delivery of child welfare services. Its focus on workers and families reflects our belief that we need to hear the voices of those at the front-lines, which have been too often dismissed or silenced. They have much to say; their perspectives are important in shaping a child wel-

fare system that responds effectively to the needs of families and children and produces positive outcomes.

RESEARCH APPROACH

Models of child welfare intervention are by nature complex and multi-layered. To generate rich comparative data, this study used qualitative and quantitative methods in addition to a quasi-experimental outcomes design. Data were gathered from multiple sources. We spoke with workers and parents from six neighbourhood and five central settings at six child welfare agencies in Ontario: the Children's Aid Society of Brant, Family and Children's Services of Guelph Wellington, the Children's Aid Society of Hamilton, the Catholic Children's Aid Society of Hamilton, Chatham-Kent Children's Services, and the Halton Children's Aid Society.

The majority of the child welfare workers who answered the written employee survey were women (91.8% of agency-based and 87.5% of neighbourhood respondents) and had been in their current position for between two and three years (35.0 months for agency and 27.4 months for neighbourhood workers). There were some differences between the sites with respect to workers' educational attainment. Workers in neighbourhood sites were more likely to have master's degrees (29.2% vs. 7.5% at agency sites), and social work degrees (78.3% vs. 45.8% at agency sites) while workers at agency sites were more likely to have bachelor degrees (90.3% vs. 66.7% at neighbourhood sites). There were no significant differences in measures of worker satisfaction between agency and neighbourhood sites that could be attributable to these differences. We cannot determine the degree to which differences in families' experiences with workers at the two types related to differences in workers' education.

Parents who received ongoing protection services were eligible to participate in this study. The profile of parents receiving services at neighbourhood sites was relatively consistent with those at central sites. Parents were predominately female. The average age of parents was 35 years old. Ninety-two percent of parents reported that they were born in Canada and almost 10% of parents self identified as a First Nations person. More than half were not living with a spouse or partner and most lived in poverty with more than half having a total household income of less than $20,000 before taxes.

The qualitative data were grouped and organized using NVivo 8. Emerging ideas were collated into themes and further refined using constant comparison methods (Strauss & Corbin, 1998). Descriptive analyses were conducted with measures of the families' experience with the child welfare agencies and with employees' satisfaction with their work. This article presents highlights of the larger research project that took place over three years (2007-2010). In the following discussion, we focus on the characteristics of child welfare work at the front lines of neighbourhood settings.

Table 1 shows the sources of data for the full research project. The larger project examined differences between central-site and neighbourhood-site child protection approaches in the following areas:

- Family functioning (e.g., perceived stress, quality of life, and perceived parenting competence)

- Child protection system indicators (e.g., court involvement, out-of-home placements of children)

- Aspects of worker-client relationships including workers' satisfaction with these relationships and parents' satisfaction with the services they receive

- Front-line workers' satisfaction with their employment

A close examination of these differences deepened our understanding of the possibilities and unique opportunities that child welfare in neighbourhood settings offers. If you are interested in reading about these comparisons please consult the in press article at Children and Youth Services Review cited in our bibliography (Cameron et al., in press). If you are interested in the findings of the full research project you can find them on our website at http://www.wlu.ca/pcfproject.[2]

TABLE 1: Description of Data Sources

Data Source	Data Type	Procedure
Service Recipients		
Parents case-opening (n=26l)	1.5 hour survey using a set of standardized outcome measures to assess family functioning and service satisfaction	In-home interviews
Parents 8-10 month follow-up (n=188)	1.5 hour survey using a set of standardized outcome measures to assess family functioning and service satisfaction	In-home interviews
Parents 8-10 month follow-up (n=73)	30 minute qualitative interview about parents' perceptions of child welfare services.	Primarily in-home interviews
Service Providers		
Front-line workers (n=150)	18 focus groups each comprised of a team of workers + interviewer observation notes	Audio-taped and transcribed
Supervisors and senior managers (n=17)	Semi-structured individual interviews + interviewer observation notes	Audio-taped and transcribed
Front-line workers (n=115)	Employment satisfaction survey	Mail-in survey completed manually
System Indicators		
Agency records (n=201)	Court Involvement	
Agency records (n=10)	Child Placement	

STUDY HIGHLIGHTS

Philosophy and Values

Neighbourhoood child welfare workers talked about the uniqueness of the service delivery in neighbourhood settings. Many had worked in central settings and often presented their experiences in relation to this history. They emphasized a unique philosophy that guided their practice. A reoccurring theme in their discussions was the importance of their proximity to families and their connectedness to the community:

> … it's almost something that you can't put your finger on because it's really a philosophy that comes from your heart, that you believe the best type of work that you can do is if you're actually working with the families where they're at. And I'm really fortunate that … that philosophy wasn't a big shift for [my team] …to be out here and doing that work with families. And I think you just really have to believe that this… is the kind of work that you want to do. And if you believe that, whether you're in the school or you're in this area, you're more connected, you're connected to a community. You're part of a bigger team than just the CAS. And your community partners and your families make that connection with you and I think … it really does change the shape of the kind of the work that you can do, both in your school community and this community and then directly with their families…

Beyond physical proximity, *"working with the families where they're at"* appeared to have two other important dimensions. First, neighbourhood child welfare workers encouraged drop-ins and casual connections. During one research interview with a supervisor in a low income neighbourhood, one woman from a neighbouring housing unit dropped in. The supervisor and the woman addressed each other by first name and spoke for some time about the woman's frustration with her income tax forms. I (first author and a former child welfare worker) noted the ease of their communication, the informality of the encounter and also that the conversation appeared to have little connection in

child protection issues. Later, the supervisor empha-sized the importance of casual impromptu conversa-tions, which she believed to be essential to reducing stigma and building trust. She felt that an established relationship enabled workers to address difficult issues when necessary:

> …when you walk by the door and say hello and say to the neighbour, god that's a great haircut. That looks fantastic! And what that does for your relationship in the long term, it's… building your foundation and making the work that much better…

Second, informal relationships were considered impor-tant particularly when safety concerns arose. Work-ers said that they could rely on the strength of their relationships to resolve difficult situations and that they had more information about families:

> I think you get a view through a centre like this, in terms of a practice where the safety of children and best interests of children are paramount, but part of that is supporting their family to be able to meet the needs of that child; so when you're in a centre and visible all the time you get to see their siblings, you get to see the parents more, see what kinds of supports they're getting, needing, as they're reaching out. So I think you get a better assessment of the family.

Although physical proximity was viewed as an advan-tage for building relationships, workers also reported challenges. They were often dispersed in school or community locations, and sometimes they described feeling disconnected from other child welfare workers. Some school-based workers, for example, described feeling like a member of the educational team rather than a child welfare team. They also reported that the downside of being approachable and accessible was that their work schedule included frequent interrup-tions that made completing paperwork difficult.

Additionally, in "working with the families where they're at" CW workers were mindful of inherent power differ-ences, recognizing that most families fear child welfare involvement. CW workers tried to reduce these barri-ers by presenting themselves as approachable. Some avoided formal business clothing and chose to drive modest cars. Sometimes they hosted social events for families or participated actively in other community events. They reported that families appreciated them more as "real people"

> … this is somebody who came from a very adver-sarial relationship with our agency, but over years of seeing us, getting to know we're real people and getting to know us, started to realize how we work and why and what it's about, to the point where they're seeking us out now and to let us know the significant events in their life.

Building Community Partnerships

Professional partnerships are important in connecting families and children to useful services and supports. Workers at neighbourhood sites described the impor-tance of professional partnerships.

> We believe strongly in working with partners and community in a collaborative and community-based approach to child welfare… I think we're pretty good at drawing upon their experience and their expertise to help us figure out what we're doing.

Professional partnerships (with counselling or public health resources, for example) helped CW workers feel less isolated in their work and develop a broader understanding of the issues affecting the family.

Workers from the neighbourhood sites were much more likely to describe informal partnerships. They in-dicated that access to informal resources, for example, a neighbour who might be able to provide child care on short notice, provided families and children with additional useful support. Notice how this worker emphasizes the importance of his proximity to "clients" and how that proximity helps him to connect them with neighbourhood resources:

> I'm just thrilled that I have clients whose home I can walk to … I think one of the biggest things that we can do for our families is to show them, to teach them what is available in their communi-ty to help them … it'll reduce our concerns about the children and it's just a short walk over here and I can take them around and introduce them to all the programs.

Parents' Satisfaction with Services

CW workers' experiences tell only part of the story of the happenings at the front line of child and family welfare. We spoke with parents in both neighbourhood and central sites about their perceptions of child welfare services. Across settings, parents reported at least some positive changes for their families as a result of CW involvements.

We talked to parents about different aspects of service satisfaction. Four aspects that we will highlight here are connections to services, overall satisfaction with services, willingness to recommend CW support to another person, and willingness to access CW support for their own family in the future. A larger proportion of parents at neighbourhood sites said that their CW worker was able to connect them with all of the services and supports that their family needed (42% at neighbourhood sites compared to 21% at central-based settings). See Figure 1.
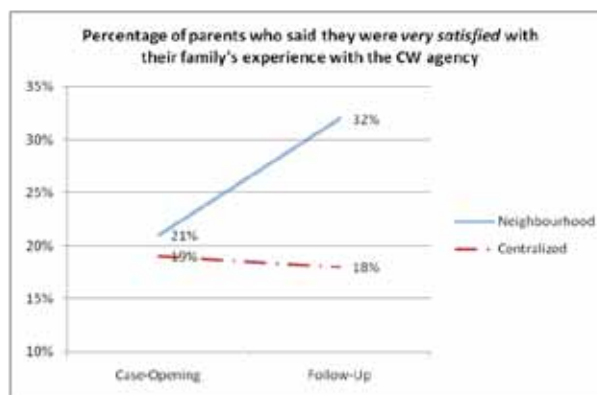
FIGURE 1:

Percentage of parents who said that the CW agency staff were able to connect them with *all the services and supports needed*
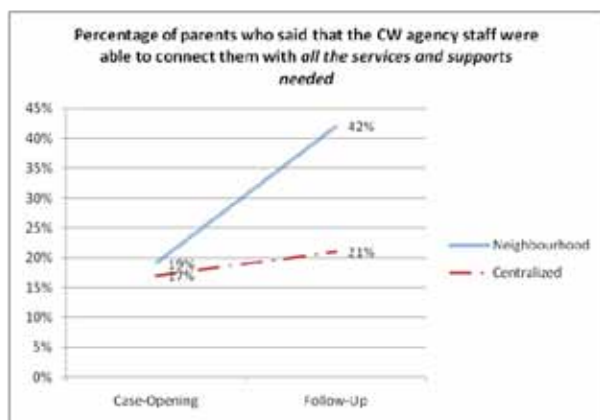
Overall, at the beginning of the study, neighbourhood and central-site parents appeared to be comparably satisfied. But at a follow-up interview 8 to 10 months later, neighbourhood-site parents were more positive about aspects of their CW involvements while parents at central sites became slightly more dissatisfied with services as time went on (see Figure 2).

Another potential indicator of parents' satisfaction is their willingness to ask for help in the future should problems arise and to advise others to contact child welfare services for help. Parents' willingness to engage child welfare services could lead to earlier intervention and reflects a greater understanding of the family's cir

FIGURE 2:

Percentage of parents who said they were *very satisfied* with their family's experience with the CW agency

cumstances and need for services. At the outset, there was little difference between neighbourhood and central parents in their ideas about contacting child welfare services for help in the future or advising a friend to do likewise. But at follow-up these ideas changed: the proportion of parents who said they would definitely or probably call the child welfare agency for help increased for parents at neighbourhood sites (from 56% to 61%) at the same time that the proportion decreased for parents at centrally located sites (from 50% to 41%). See Figure 3.

FIGURE 3:

Percentage of parents who would *definitely* or *probably* contact the CW agency for help for their own family
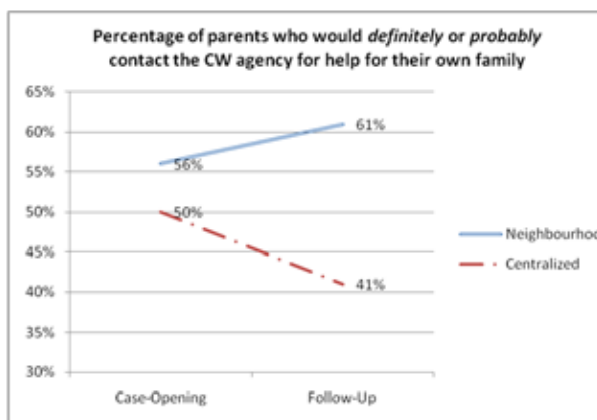
The differences were even greater when parents were asked if they would refer a friend to the child welfare agency for help. The proportion of parents at neighbourhood sites who would refer a friend increased from 49% to 65% while the proportion of central-site parents who would refer a friend declined from 49% to 39% (see Figure 4).

Although sample numbers were small, these data do suggest that parents' experience at central and neighbourhood sites differ, and that parents served at neighbourhood locations attitudes about services became more positive.

FIGURE 4:
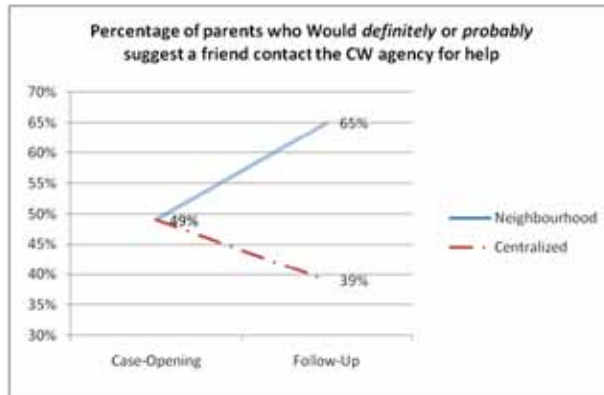
SHARED STORIES OF TOO MUCH WORK

The stories that child welfare workers tell themselves and others about their jobs are linked directly to how they understand their working lives and their relationships with families and children. While neighbourhood CW workers talked about the positive aspects of their work with families, they also acknowledged the relentless workload and high stress levels associated with the job. Whether workers were located in neighbourhood or central locations, they unanimously agreed that their jobs were interesting and challenging but also that the pressures were intense. Workers spoke frequently about excessive expectations, particularly with respect to paperwork:

> Never ending, never ending. It's just so much...I mean, it's part of the Ministry standards that all of this stuff has to be done within a certain timeline but something has to give. Do we spend our time at our computer all day, or do we have time with our clients?

CW workers from both settings were asked to estimate the proportion of their work spent on documentation. Their responses ranged from 50% to 70% of their total work time. They placed a high value on demonstrating their accountability by meeting timelines and complet-

ing recordings, viewing this compliance as a way to protect themselves, their agency and the Ministry if a tragedy occurred.

CW workers frequently expressed the tensions between the time consumed by the administrative aspects of their job and their desire to be optimally responsive to the needs of families. Approximately three-quarters of front-line workers reported not feeling like they had enough time to complete their work. More than one-third of front-line workers said that they thought about leaving their jobs at least some of the time. Additionally, they expressed concern that CW workers leaving their jobs created pressure on more seasoned workers while replacement employees learn about their role and responsibilities.

Findings from a mail-in employment survey of 115 front-line CW workers showed that workers at all sites found their jobs interesting and challenging and more than 75% reported that they felt personal accomplishment from their work. However, there were two measures of particular concern, depersonalization and emotional exhaustion. Depersonalization is defined as an unfeeling and impersonal response toward clients. Emotional exhaustion is defined as the extent that someone feels emotionally overextended and exhausted by work. In 2008, 69% of CW at centralized sites and 54% at neighbourhood sites reported medium or high levels of depersonalization. Also of concern, approximately 75% of CW workers across sites scored in the medium and high range of an emotional exhaustion scale. These findings are similar to the results from previous surveys conducted in 2004 (Frensch, Cameron & Hazineh, 2005) and in 2001 (Partnerships for Children and Families Project, 2003) and suggest the persistent nature of these concerns.

DISCUSSION

Regardless of the setting, keeping children safe was a high priority for all workers. One of the clear findings of this research is that workers at neighbourhood sites are delivering child welfare services in a way that emphasizes accessibility, co-operative helping relationships, and collaboration with other professionals and that this approach appears to improve families' satisfaction with services. The proximity of CW workers to families and children, and the possibility of frequent chance meetings appear to change the nature of their

contact. Workers at neighbourhood sites described the importance of careful interactions with families and children in which they make efforts to minimize power differences. Informal meetings provide the workers with opportunities to reach beyond the mandated child welfare procedures. In the long term, it is their belief that positive relationships will contribute to a changed image of the child welfare worker and ultimately to enhanced safety and well-being of families and children.

Whether CW workers were located in central or neighbourhood settings, we marvelled at their dedication to their work and their strong sense that what they do is important. When they talked about the challenges, it was clear that their time and energy was monopolized by scripted procedures and accountability paperwork. The emotional exhaustion of CW workers as well as the depersonalization of families and children is troubling. Responding optimally to the needs of our most vulnerable parents and children is challenging work under the best employment conditions. The impact of CW worker emotional exhaustion on service delivery requires careful examination and thoughtful solutions (Stalker et al., 2007). The circumstances under which engagement in local communities might reduce feelings of depersonalization is worth exploring. At the same time one must be mindful of the added emotional toll and the work load challenges associated with an open-door approach.

As we reflect on our interviews, we can see that these workers' sense of what they could be doing if given the opportunity to invest their creative energy into helping children and families increases their frustration and stress. A better balance between transparency by documentation and direct investment in supporting children and families must be found. Additionally, there is a clear need for a deeper understanding of the values and philosophies that currently guide worker interactions with families and children as well as those that workers might embrace, if given the chance. Amid the burgeoning child welfare bureaucracy, it is in these interactions that the needs of families and children can be known and optimal responses can be achieved. .

Setting helps to shape the approach to work with families, to relations with colleagues and to workers' understanding of their role and responsibilities in the broader community. Future research might explore the possibilities for neighbourhood settings in responding to the diverse cultural needs of families and children. It is our hope that the focus on partnerships can further a shared responsibility within communities for the care and safety of all children. As child welfare work continues its transformation, the setting for service delivery and its capacity to shape a more meaningful approach to child welfare service needs our attention.

ENDNOTES

1. CW worker refers to workers who provide direct services to families with children. We consider these workers and their supervisors, both of whom have encounters with families and children, to be at the front lines of child welfare work.

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CLINICAL COUNSELLING: A VITAL PART OF CHILD WELFARE SERVICES - PART THREE

By Clinical Counselling in Child Welfare Committee

THE COUNSELLING TOOLS WE USE

COUNSELLING MODALITIES

"Growing up in care was very difficult and challenging. My worker spent a lot of time with me helping me work through many issues such as the loss of my family, the death of my dad, my adoption disruption, my numerous foster care moves... Although she often suggested that it would be beneficial for me to attend some formal counselling, I was never open to such. I think what we didn't realize then was that, by default, she became my counsellor. She provided me many opportunities for changes. It was through the support and attention of my worker that I became the man I am today."
Chad, former Youth in Care

As shown by the above quote, counselling is not simply something that occurs in a therapy room; it also occurs in the daily interactions child welfare workers have with the children and families they serve. Indeed, child welfare workers cannot avoid the ways they interact with clients impacting the ability of children in care to make (or not make) progress, and the parents they serve to improve (or not improve) their abilities to protect and meet their children's needs. Workers, therefore, who are usually already trained in the basics of counselling from their social work education, are required to purposively draw on this education and these skills to achieve child welfare objectives. In this section we outline and discuss six counselling modalities that child welfare workers may find useful in their counselling role: Crisis Intervention, Cognitive Behavioural Therapy, Motivational Interviewing, Miiyobin Approach, Solution-Focused Therapy and Narrative Therapy. These modalities and their corresponding skills, much like the skills and competencies in previous sections, are to be applied critically in accordance with social work values, with the informed consent of the client, within the competency of the individual worker, and within the procedural and legal frameworks of their role. We recommend that such counselling be provided as a component of the overall service plan.

The inclusion of different modalities in this paper is meant to expand child welfare workers existing counselling skills, and build confidence in their ability to undertake a counselling role in their work. Child welfare workers often utilize a particular counselling modality in the course of their involvement with families and youth. For example, a children's services worker may support children in care with narrative therapy techniques to address feelings of grief and loss; a family services worker may utilize solution-focused therapy techniques to assist a mother with identifying her strengths and connect with community resources; and an intake worker will certainly utilize crisis intervention strategies to help people cope with disclosures of child abuse.

"Our staff uses a variety of counselling modalities every day and many times they are providing counselling without naming the modality." Survey Participant
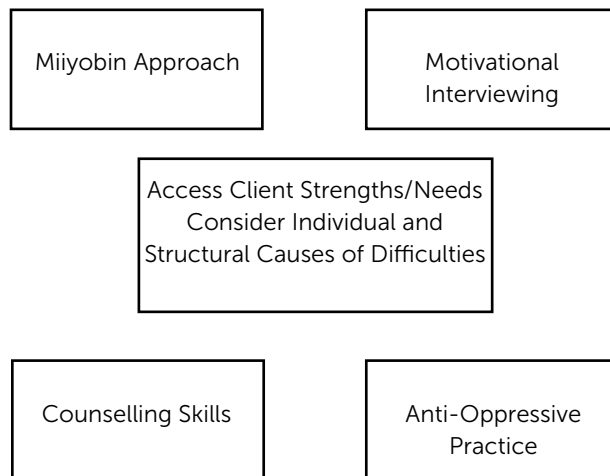
There are many different counselling modalities commonly utilized by social workers and child welfare workers in particular; the following is not meant to be an exhaustive list limiting the child welfare worker. Similarly, the exclusion of other modalities is not meant to diminish their value or effectiveness. These modalities were selected because they are strength-based, empowerment focused, client-centred, evidence-based, brief, commonly used, change-oriented, and/or culturally sensitive. Moreover, they were chosen because they were identified by survey respondents as being effective and commonly used. The outlines presented in this section should be regarded as an introduction to the modality and how it might be applied in one's work. Various symbols included throughout this section are explained as follows:

- Points particularly worthy of additional critical reflection
- Examples of the words the worker might use in application
- Examples of what a client may be thinking and feeling
- Comments from participants in the survey conducted and described earlier

- Points that are simply interesting and might be worth noting

For many workers, their understanding of these modalities is far more advanced than what is discussed here. Further education than what is shared here is highly recommended; we provide some direction to useful resources that may assist in this regard and we encourage people to pursue additional training in the modality when possible. Additionally, it is recognized that child welfare workers need to be flexible and responsive to diverse clients' situations and cultures and should, therefore, be creative in their application of the modalities and techniques to support their client's individual needs. Finally, in many situations an eclectic approach (vs. adherence to one particular modality) may be useful. For each modality, we include: a brief overview of the modality; its main principals/guidelines/characteristics; a selection of techniques/tools used; a discussion of some useful applications in child welfare; and a critique of the modality. At this stage it is a matter of collating the theories, skills, social work values and counselling modalities—like pieces of a puzzle (Figure 1).

FIGURE 1: Putting it all together

Miiyobin Approach	Motivational Interviewing

Access Client Strengths/Needs
Consider Individual and
Structural Causes of Difficulties

Counselling Skills	Anti-Oppressive Practice

CRISIS INTERVENTION

Crisis: "A perception or experiencing of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms. Unless the person obtains relief, the crisis has the po-tential to cause severe affective, behavioural, and cognitive malfunctioning." (Gilliland & James, 2004, p. 3).

Most crises typically last 4-8 weeks and in time people will achieve a degree of equilibrium that is either the same, worse or better than before the crisis occurred (Hepworth et al., 2002). (See Figure 2). In simple terms, Crisis Intervention (CI) aims to support and empower clients to resolve the crisis and return to their previous level of functioning or even better if possible (Hepworth et al., 2002).

According to Hepworth et al. (2002) describe the typical "stages" of a person's reaction to a crisis (p. 383-384), which are summarized here:

Step 1: Rise in tension accompanied by shock and even denial. The individual tries their usual problem-solving skills to reduce the tension and cope with the crisis. When these are unsuccessful, tension increases.

Step 2: Tension increases in severity causing confusion, helplessness, anger and/or acute depression. The amount of time spent in this stage depends on the nature of the event, the individual's strengths and coping skills, and the amount and quality of social support. People generally need immediate support to stabilize and begin adaptation.

Step 3: People will utilize various coping strategies in an attempt to stabilize themselves. The outcome of this largely depends on the extent to which the strategies are adaptive or maladaptive strategies. If the latter are utilized, tension may continue to escalate, and in some cases can reach the point of a breakdown or even a suicide attempt. If adaptive strategies are used, however, they can help the individual regain their sense of equilibrium, and can even help the person to achieve a higher level of functioning than they had before the crisis occurred.

It is important to note that perceptions of events are not only subjective to the individual, but are also culturally-based: "Cultural factors are vital in understanding and assessing clients' reactions to crisis situations. Situations deemed as crises vary widely from one culture to another, as do the reactions to them" (Hepworth et al., 2002, p. 385).

FIGURE 2: Crisis Window for Change
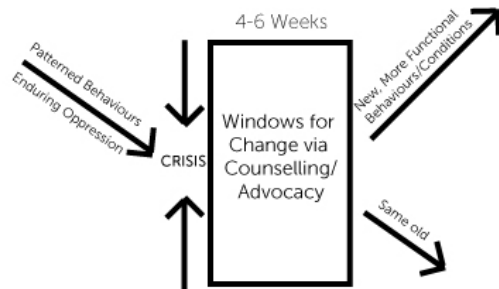
Practice Principles/Guidelines/Characteristics

Lewis and Roberts (2002) explain that Parad & Parad (1990), Ell (1995), and Roberts (1995, 1996, 2000) offer primary assumptions of CI, which are reproduced here (p. 209):

• Everyone, at some time in his or her life, will experience acute stress that is not necessarily pathological. It is the overall context in the person's life that deems whether or not the stressor is a crisis event.
• Homeostasis is a natural state that all people seek, and when an individual is in a state of emotional disequilibrium he or she strives to regain emotional balance.
• A period of disequilibrium in which the individual (or family) is vulnerable to further deterioration or assistance is present when a stressful event becomes a crisis.
• This disequilibrium makes the individual more amenable to intervention.
• New coping mechanisms are needed to deal with the crisis event.
• The dearth of prior experience with the crisis event creates increased anxiety and struggle and the individual often discovers hidden resources.
• The duration of the crisis is somewhat limited depending on the precipitating event, response patterns, and available resources.
• Certain affective, cognitive, and behavioural tasks must be mastered throughout the crisis phase to move to resolution of the stressor.

Additionally, crisis intervention is (Hepworth et al., 2002):

• Time-limited (usually 6-8 weeks in duration)

• Focused on the problems of living (vs. psychological difficulties)
• Oriented to the here and now – the present crisis
• Task-oriented
• Eclectic so that that can accommodate various practice theories and interventions

Intervention Techniques/Strategies

Research supports crisis intervention as a process with associated stages. Eaton & Roberts (2009, pg. 210-212) outline Roberts' well-established seven stage crisis intervention model, which is summarized here:

Stage 1: Plan and conduct a crisis assessment.
• Quickly assess risk and dangerousness with regards to violence, suicide, homicide, need for medical attention, current substance use.

Stage 2: Rapid establishment of rapport and the therapeutic relationship.
• This often occurs in Stage 1.
• Conveying respect and acceptance are essential.
• Ensure a neutral and non-judgmental attitude.
• Maintain a calm and controlled demeanour.
• Begin the intervention "where the client is at".

Stage 3: Identify the issues pertinent to the client and any precipitants to the crisis.
• Ask open-ended questions; encourage the client to explain the problem, and tell her/his story.
• The client needs to feel that you are truly interested in what they have to say.
• Solution-focused questions are useful in identifying strengths, such as asking clients about coping skills that have been helpful to them in the past.

Stage 4: Deal with feelings and emotions by effectively using active listening skills.
• Reflection, paraphrasing and emotional labelling skills are useful.
• Show the client you are listening by being encouraging ("okay", "uh huh" "I see") paraphrasing and reflecting back what they are saying to you. This is especially important with telephone intervention as lengthy periods of silence may be perceived as lack of attention or interest in what is being shared.

Stage 5: Generate and explore alternatives by identify-ing the strengths of the client as well as previous suc-cessful coping mechanisms.
- This involves working together collaboratively with the client to develop an action plan.
- Together you can brainstorm potential resources and alternatives.
- Be creative and flexible.
- View your client as resourceful and resilient.
- Strengths and solution-focused approaches are helpful in helping the client to identify past suc-cesses or to remember a time when things were going well.

Stage 6: Implement the action plan.
- Assist in the least restrictive manner possible to en-able client empowerment.
- Provide adaptive coping mechanisms.
- Help the client identify helpful resources, support people and community services.

Stage 7: Establish a follow-up plan and agreement.
- Workers should follow-up with clients check in about how they are doing and whether the crisis has been resolved.

Usefull Applicatons in Child Welfare

Crisis situations are not unusual in child protection: an incident of domestic violence, the apprehension of a child, a family member's drug overdose, the discovery of sexual abuse, the loss of a job are a mere sample of the crises experienced by those involved with child welfare services (Gentry, 1994). For some, involve-ment of child protection services in and of itself can be highly destabilizing.

> The most common counselling modality is likely Crisis Intervention in situations where there is a crisis in a family situation (i.e. parent/child conflict or where a parent or child may request placement due to a con-flict or family breakdown)." Survey Participant

Because child welfare workers often intervene during crises our clients will benefit from workers' knowl-edge of crisis intervention theory and the application of corresponding skills. Furthermore, in keeping with our child protection mandate, it is critical that workers have these skills to support their role as change agents. During the resolution of a crisis, individuals and families tend to be more accepting of assistance, which pres-

ents a unique opportunity to support people to make changes in the direction of enhanced safety and well-being. Indeed, the consequences are dire if workers are not competent with these skills in this time of need:

> If help is not available when a family is open to new ways of coping, family members may sink deeper into maladaptive patterns such as more violence, heavier substance use, deeper with-drawal, or more destructive scapegoating. Under such circumstances, there is increased risk of child abuse and neglect. (Gentry, 1994, p. 11)

> "The problem addressed was a teenage child in re-lationship conflict with [the] parent and step-parent. The initial approach [was to] apply Crisis Intervention theory to settle the crisis and build on past efforts by the parents at coping with the issues. Application of solution focused strategies supported the family to better connect with extended family, improve the parents' understanding of child development and the natural effort for a teen to find independence and increased the parents' [ability] to find joy in parenting their teenager." Survey Participant

Critique

There are a few concerns/limitations of Crisis Interven-tion noted in the literature:

- There is literature on various types of crises, however, there is little on culture, gender, or age differences among crisis client populations (Knox & Roberts, 2001): "It is important that crisis workers be culturally competent and tailor crisis interven-tion practices to different ethnic and racial groups" (Knox & Roberts, 2001, p. 198).

- A strength of CI is that it is time-limited; however, workers often don't get to see the end results of the initial intervention and as a result it may seem like a "band-aid approach" (Knox & Roberts, 2001, p. 199).

COGNITIVE BEHAVIOUR THERAPY

Cognitive Behaviour Therapy (CBT) is a well-established, short-term, evidence-based approach to therapeutic intervention that is often used in clinical social work practice. It actually composes a number of related therapy models (Vonk & Early, 2009) and essentially examines the relationship between our thoughts and behaviours:
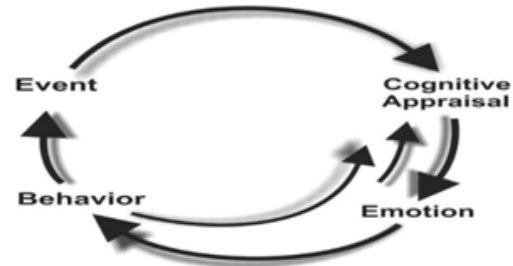
> [CBT] views behaviours as learned and shaped by our interpretations of the world (our cognitions). When flawed or inaccurate, these interpretations can lead to irrational or maladaptive behaviours. Therapists using this approach work with clients to understand the thought patterns that bring about certain behaviours, as well as what is sustaining these patterns or behaviours. The next step is to help clients re-interpret events in her or his environment and reshape the conditions that are sustaining the negative behaviours. The focus of CBT is on problem-solving and promoting more accurate ways of understanding the world. (Hick, 2010, p. 70)

CBT can be used with a variety of populations with a range of difficulties: "depression, post-traumatic stress disorder, substance misuse, eating disorders, grief and bereavement, children and adolescents, victims of abuse and trauma, aging adults, and families (Reinecke & Freeman, 2003; Ronen & Freeman, 2007)" (Vonk & Early, 2009, p. 247).

Practice Principles/Guidelines/Characteristics

The "Basic Cognitive Behaviour Model" by Wright, Basco & Thase (2006, cited in Wright, 2006), reproduced in Figure 3, captures the approach of CBT. This model highlights the way in which an individual's cognitive appraisal of an event can influence their emotional response, which influences their behavioural response. In particular, it highlights the two-way relationship between cognition and behaviour—each influences the other. "Because cognition and behaviour are so closely linked, the clinician can opt to intervene at either the cognitive or the behavioural level, using practical methods of interrupting the cycle and encouraging more adaptive responses"(Wright, 2006, p. 174).

FIGURE 3: Basic Cognitvie Behaviour Model

According to the National Association of Cognitive-Behaviour Therapists (NACBT) (http://www.nacbt.org/whatiscbt.htm, retrieved on April 9th, 2010), while there are variations, most CBT therapies have the characteristics listed below in common: (Note: characteristics are summarized from this website; additional research is also added where relevant.)

1. CBT is based on the cognitive model of emotional response.
   • Our thoughts influence our feelings and behaviours.
   • We can change the way we think in order to feel and act better (even when the situation doesn't change).

2. CBT is briefer than other therapies and is time-limited.
   • It is not an open-ended, never ending process.
   • Its directive nature and use of homework assignments reduce the length of intervention.

3. A sound therapeutic relationship is necessary, but not the focus.
   • A trusting relationship while important is not enough.
   • Clients change because they learn how to think differently and how to act on that learning.
   • Of note, Wright (2006), Miller (2006), and Regehr (2001) indicate, however, that CBT relies on elements of the therapeutic relationship, such as genuineness, understanding and empathy.

4. CBT is a collaborative effort.
   • Client goals are elicited and clients are helped to achieve those goals.
   • Wright (2006) notes that the therapeutic relationship is one of "collaborative empiricism" whereby

clinician and client work together as a team to identify maladaptive cognitions and behaviours, test their validity and make changes where needed.

5. CBT is based on aspects of stoic philosophy.
- Not all CBT therapies emphasize stoicism; however, the emphasis is on feeling calm when confronted with undesirable situations.
- Learning to calmly accept a problem allows us to feel better which puts us in a better position to use our strengths and resources to resolve the problem.

6. CBT uses the Socratic Method.
- Questions are used to gain a good understanding of clients' difficulties.

7. CBT is structured and directive.
- There is a specific agenda, and specific techniques/concepts are taught.
- Clients are not told what to do; they are encouraged to think and behave in ways to obtain what they want—their goals.

8. CBT is based on an educational model.
- CBT is based on the assumption that most emotional and behavioural reactions are learned.
- Goal is to unlearn unwanted reactions and learn new helpful reactions.

9. CBT theory and techniques rely on the "inductive method".
- This method encourages us to look at our thoughts as hypotheses that can be questioned and tested.
- If we can find new information to show that our hypotheses are incorrect then we can change our thoughts accordingly.

10. Homework is a central feature of CBT.
- Clients are assigned homework to practice the techniques learned.

Vonk & Early (2009) describe basic fundamental concepts used in CBT that refer to our three elements of cognition (p. 242-243), which are summarized below:

i. Actual content of our thoughts:
- Automatic thoughts: these come into our minds immediately; we are often very aware of these thoughts. Example: "I can't handle my kids."

- Rules or assumptions: we develop these to interpret out experiences; we are often less aware of these thoughts. Example: "I need to be a perfect mother."

ii. Schemas or core beliefs:
- These are "global, durable beliefs about the self and the world that are formed through early life experiences. They are maintained through a process of attending to information that supports the belief while disregarding information that is contrary to it (Beck, 1995)" (Vonk & Early, p. 243). These are deeper levels of cognition. Example: "I am a bad person. I don't deserve happiness."

iii. Cognitive Distortions:
- Maladaptive or ingrained styles of processing information.
- There are many cognitive distortions, such as "catastrophizing" or "all-or-none-thinking. Example: "If my 15-year-old daughter goes to that party she will be killed." (Catastrophizin)

Miller (2006) notes that we must be cautious when intervening with CBT to change people's assumptions or their "distortions" as we all have different perspectives on the world around us. In social work practice, people's thought patterns should be changed only when they are seen to be having a negative impact or causing harm to the individual or others in their lives, or when the individual requests such help.

Intervention Techniques/Strategies

Vonk & Early (2009, p. 244) observe that the various CBT models commonly share the following elements:

- Identifying the cognitions (assumptions, beliefs, expectations, self-talk, attributions).
- Using techniques to examine cognitions to determine their impact on emotions and behaviours.
- Exploring the development of the cognitions to enhance self-understanding (this is sometimes used).
- Using techniques to facilitate the adoption of more adaptive cognitions, which then produce positive affective and behavioural changes.

Vonk & Early (2009) also share how CBT can be applied in steps (p. 244-246):

Step 1: Conduct Cognitive Behavioural Assessment
• This includes a definition of the client's problems (including duration, frequency, intensity, and situational circumstances), strengths, and intervention plan. It may also include a "cognitive analysis of the problem" (a prioritized problem list and a working hypothesis of what thoughts and underlying beliefs maintain unhelpful emotional states or behaviours) (p. 244).
• Miller (2006) discusses this assessment as an outline of what triggers and maintains unhelpful behaviours or affect across six dimensions (p. 67):
    1. Situational – what environmental factors were present?
    2. Behavioural – what did the person do?
    3. Cognitive – what thoughts were present at the time?
    4. Affective – what emotional reactions occurred?
    5. Interpersonal – who else was present?
    6. Physiological – what physical/bodily reactions occurred?

Step 2: Teaching the "ABC Model" to the Client
• A – Activating event or Antecedents
• B – Beliefs or attitudes represented as thoughts or images
• C – Consequence (emotional or behavioural)

Step 3: Helping the Client to Identify Cognitions
• The client is helped to identify their thoughts and beliefs
• There are many techniques that can be used; Vonk & Early (2009) suggest a "daily thought record" described below.

Step 4: Helping the Client to Examine and Replace Maladaptive Cognitions
• The client is helped to examine evidence that supports or refutes the cognitions.
• The client is encouraged to replace unhelpful cognitions with realistic or helpful ones. Vonk & Early (2009) indicate that asking a variety of questions can helpful in this regard (p.246): What is the evidence for and against this belief? What are alternative interpretations of the event or situation? What are the pros and cons of keeping this belief?

There are a great number of techniques that can be utilized in each step of CBT. A selection of techniques is briefly summarized. Further inquiry is recommended:

• *The Socratic Method*: used to help a client uncover their unhelpful automatic thoughts. It involves asking a series of questions that guide the client to become actively involved in finding their own answers to their questions; it includes systematic questioning, inductive reasoning, and the construction of universal definitions (Miller, 2006; Wright, 2006).
• *Daily Thought Record*: used to help clients identify their cognitions. In three columns clients record the activating events, their emotional reactions, and their automatic thoughts related to the event. (Vonk & Early, 2009)
• *Relaxation Training*: used to help clients learn to relax their muscles and slow their breathing. (Vonk & Early, 2009)
• *Activity scheduling*: used to help clients to plan useful or pleasurable activities to meet an identified need. (Vonk & Early, 2009)
• *Graded Task Assignments*: used to help clients break problems down into manageable steps and develop a plan to cope with and address challenging situations. (Wright, 2006)
• *Desensitization*: "Provides clients with graduated exposure to anxiety-provoking situations while engaged in behaviours that compete with anxiety, such as relaxation. The exposure may be real or imaginary" (Vonk & Early, 2009)

Useful Applications in Child Welfare

CBT can support workers in becoming more aware of how our clients' beliefs about themselves, others, and the world manifest as assumptions and automatic thoughts that then influence their presenting feelings and behaviours (Miller, 2006). CBT theory and skills can help workers to better understand these processes so that they can intervene in ways that can engender positive changes.

For example, we may highlight to a client the benefits of attending a parenting class, but then become very frustrated when s/he does not attend despite previously agreeing. This then could be interpreted as client resistance; however CBT would encourage us to look deeper. It could be that this client has several unhelpful automatic thoughts, such as "No one will like me.

They'll see what a failure I am. I can't do this." Taking the time to explore and understand the client's automatic thoughts and how they may impact on her painful feelings (anxiety, shame, fear) and resulting behaviour (unable to attend) empowers the worker to adapt their approach and intervene in ways to meet the needs of the individual client.

For children and adolescents in particular, CBT offers a wide range of empirically supported treatment options for specific child and adolescent mental health symptoms and "disorders". Further information in this regard can be accessed easily at http://www.effectivechild-therapy.com.

"The case involved sibling incest. The adolescent was treated in the Society's Child Abuse Intervention Program, adolescent offenders group. This group is a psycho-educational/cognitive behavioural based group. The child victim was treated through the Child Abuse Intervention Program [with] trauma based art & play therapy. When both the offender and sibling completed treatment they were reunified through a clarification process, also facilitated by the Child Abuse Intervention program." (Survey Participant)

Critique

CBT has significant empirical support and applicability to a wide range of clients and difficulties, however, there are concerns/limitations/contraindications noted in the literature:

- Importantly, Miller (2006) reminds us of the need to attend to the structural causes of our clients presenting problems when utilizing CBT in social work practice:

    A cognitive behavioural assessment considers only the factors present when an individual has an unhelpful emotional or behavioural outcome to an event on a basis regular enough to impairing social functioning. What this assessment lacks from a social work perspective is a broader exploration of the social and relationship factors that could also be maintaining an emotional or behavioural response. The assumption with this model is that some form of cognitive distortion exists ... However, we need to be mindful of the experiences of poverty and oppression in various

forms and social and emotional deprivation can generate problems with anxiety and low mood... This form of assessment would mostly best fit with social work practice after wider social factors have been given attention. (p. 68-69)

- CBT's simplicity and transparency can become liabilities if the model is applied inappropriately. Regehr (2001, p. 177) shares pitfalls for inexperienced clinicians:
    o Focusing on the use of techniques and ignoring the importance of the worker-client relationship.
    o Focusing too much on cognition and behaviour can overshadow the affective experiences of the client.
    o Short-term behavioural and affective change can only be maintained if the client has insight into their belief systems and their origins. Clinicians must take the time to explore past experiences that have lead to the development of these beliefs.

- Because there are so many types of therapies under the umbrella of CBT, we cannot provide an all-encompassing list of contraindications. For example, Trauma-focused CBT for children and adolescents is contraindicated when clients have behavioural problems predating the trauma, are acutely suicidal and/or have active substance misuse problems (Child Welfare Information Gateway, 2007). Accordingly, we recommend that the particular contraindications for each particular CBT model be reviewed prior to use.

MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) is a client-centred, directive counselling modality developed by William Miller and Stephen Rollnick. In particular, it seeks to "[enhance] intrinsic motivation to change by exploring and resolving ambivalence" (Miller & Rollnick, 2002, p. 25). With this approach, clients are encouraged to reflect on and evaluate their "problem" behaviour within the context of their own goals and values (Forrester et al., 2008).

Motivation is fundamental to change. But, what is motivation? According to Miller & Rollnick (2002), there

are three critical components which are reflected in the well-known phrase, "ready, willing and able":

- Willing: the extent to which we want change; it is the amount of difference between the current situation and the envisioned future.
- Able: the extent to which we feel confident in our ability to change.
- Ready: we can be willing and able, but not quite ready, which is a reflection of our relative priorities.

The motivation to change is, however, not simply an internal process; it is also considered to be an interpersonal process—the outcome of interactions between people (Miller & Rollnick, 2002). This is important in that people will often require the assistance of a counsellor or helping professional to explore and enhance their motivation for change.

This modality is particularly suited for individuals who are ambivalent about engaging in counselling altogether or who do not feel that they need to make changes that others see are needed, such as with, for example, drug or alcohol addictions.

"Successes working with families were made possible when we used motivational interviewing techniques and solution focused approach. Very effective when we succeed in developing a trusting relationship with the client." Survey Participant

Practice Principles/Guidelines/Characteristics

Miller & Rollnick (2002) discuss (in a table reproduced below) that MI interviewing is more than the use of a set of techniques; there is a "fundamental spirit" that underpins this approach, which should inform how clinicians think about and understand the MI process (p. 35):

Fundamental approach of motivational interviewing	Mirror-image opposite approach to counselling
Collaboration. Counselling involves a partnership that honours the client's expertise and perspectives. The counsellor provides an atmosphere that is conducive rather than coercive to change.	Confrontation. Counselling involves overriding the client's impaired perspectives by imposing awareness and acceptance of "reality" that the client cannot see or will not admit

Fundamental approach of motivational interviewing	Mirror-image opposite approach to counselling
Evocation. The resources and motivation for change are presumed to reside within the client. Intrinsic motivation for change is enhanced by drawing on the client's own perceptions, goals, and values.	Education. The client is presumed to lack key knowledge, insight, and/or skills that are necessary for change to occur. The counsellor seeks to address these deficits by providing the requisite enlightenment.
Autonomy. The counsellor affirms the client's right and capacity for self-direction and facilitates informed choice.	Authority. The counsellor tells the client what he or she must do.

(Miller & Rollnick, 2002, pg. 35)

There are four general principles that underpin MI (Miller & Rollnick, 2002, p.36-41):

1. Express empathy:
- Empathy is used from the beginning and throughout the process.
- Empathic communication is used to understand the client's feelings and perspectives without judging, criticizing, or blaming.
- An attitude of acceptance facilitates change. This is not the same as agreement or approval.
- Ambivalence is seen as "normal" and to be expected—otherwise the individual would have already changed prior to seeing you.

2. Develop Discrepancy:
- The goal is to create and enhance a discrepancy between the client's present behaviour (ex. drug abuse) and their own goals and values (ex. parental success, children's happiness).
- MI uses internal vs. external motivators (for example, their own reasons vs. pressure from family, court orders etc.).
- If done well, the client, and not the counsellor, is the one who will voice their reasons for change.

3. Rolling with Resistance
- "Resistant" behaviours are indicators that the counsellor needs to shift their approach.
- Avoid arguing with the client for change, or directly opposing the client's resistance to change; doing so can cause the individual to defend their behav-

iour, which is counter-productive.

- Rolling with resistance means actively involving the client in the problem-solving process.
- You can offer new information and perspectives on their situation; however, they are not imposed. Essentially, solutions to problems should come from the client.

4. Supporting Self-Efficacy

- A person needs to believe in the possibility of change in order to be motivated to make change; if a person recognizes that she or he has a serious problem, but no confidence in their ability to change, they won't likely bother to try.
- Show belief in your client's ability to change. Your expectations about the client's success can influence the outcome (a self-fulfilling prophecy).
- The client, and not the counsellor, is responsible for selecting the kind of change they wish to make, and making that change; with MI you can enhance the client's confidence in their ability to manage the obstacles and succeed in change.

Intervention Techniques/Strategies

According to Miller & Rollnick (2002) MI occurs in two phases: Phase 1 involves building intrinsic motivation for change; Phase 2 involves strengthening the commitment to change and developing a plan to achieve change. There are far too many MI techniques employed in these phases to list and fully describe. We share, however, a selection of the more salient techniques.

We recommend further exploration/training in MI as this is necessary for its competent application. Some additional useful resources include the official website for the network of MI trainers at http://motivation-alinterview.org and a workbook on MI skills application (Building Motivational Interviewing Skills: A Practitioner's Workbook by David B. Rosengren).

PHASE ONE: Building Motivation for Change

There are "five early methods" that can be used right from the first session onward. The first four methods form the foundation to motivational interviewing and are based on client-centred principles; they help clients to explore their ambivalence and express their reasons for wanting to make changes (Miller & Rollnick, 2002). These four methods are captured by the acronym

OARS: open-ended questions; affirmations; reflective listening; and summaries. The fifth method, eliciting change talk, has a more directive approach in helping the person resolve their ambivalence. Miller & Rollnick (2002, 65-78) explain these five methods as follows:

1. Ask open-ended questions
- These are questions that invite conversation and enable the client to explore their concerns. Example: "Tell me about your drinking. What do you enjoy about it? What concerns you about it?"
- The client should be doing most of the talking.
- Avoid asking three questions in a row; instead, follow an open-ended question with reflective listening.

2. Affirm:
- Affirmations are statements that genuinely acknowledge client strengths and efforts. Example: "You have been managing many stressors quite well."

3. Listen reflectively:
- This seems like a simple skill, yet is one of the most important and most challenging skills in MI.
- Reflective listening is more than just keeping quiet; it is a statement that makes a guess as to what you believe your client means. It is a way of checking (vs. assuming) that you know what they mean. Example: "You are not quite sure you are ready to make a change, but you are quite aware that your drug use has caused problems in how you are caring for your children, and that your family and friends are worried about your health."
- Statements (vs. questions) are useful because they less likely to cause resistance.
- Tone: your voice tone should turn down at the end of a statement (as opposed to up at the end of a question).
- This is not a passive process; it can be very directive as the counsellor decides what to reflect and what to ignore. Focus on "change talk" and give less attention to non-change talk.
- This is not simply repeating what the client has said. A skilled counsellor is able to move the conversation forward, but too far too fast.
- Reflecting unstated emotions can be quite powerful. If you are right, the emotional intensity of the session tends to deepen. Example: "Your children aren't living with you anymore; that seems painful for you."

- Most responses should be reflective listening in the beginning phase of MI to keep the forward momentum. A ratio of three reflections for every question asked is recommended.

4. Summarize:

- Summary statements link and reinforce what you've already discussed.
- Summaries help show your interest in a client and their situation, build rapport, and highlight important parts of the discussion.
- Summary statements can also be used to shift the focus when the interview has become unproductive or heads in a problematic direction.
- Provide summaries frequently.
- An effective summary begins with a statement that you are about to summarize, and is followed by a list of selected elements, an invitation to make corrections, and usually an open-ended question. Any ambivalence by the client should also be included in the summary. Example: "Let's stop here so I can summarize what we've just talked about. My understanding is that you're upset that I'm here today; but at the same time you've also mentioned that you're overwhelmed by your children and don't know how to handle it all. You shared that to cope with all of this you've been going out to bars with your friends all night. Have I missed anything? What are your thoughts about all of this?"

The four above methods "OARS" are important for MI, but a more directive approach is needed to help the client move past their ambivalence. The fifth method, "eliciting change talk" helps in this regard.

5. Eliciting change talk:

- Change talk is self-motivating speech that includes reasons for and advantages of change.
- Change talk falls into four categories:
    i. Recognizing the disadvantages of the status quo. Example: "I hadn't really thought about the impact this all has on my children."
    ii. Recognizing advantages of change. Example: "It would be better for my health in the long run."
    iii. Expressing optimism about change. Example: "I quit once before. I guess I could do it again."
    iv. Expressing intention to change. Example: "I'm not going to put my family through this anymore."
- These statements all bring the person closer to change.

There are a quite a few useful techniques used in Phase 1 of MI. There are several techniques under each of the following categories: evoking change talk, responding to change talk, responding to resistance and enhancing confidence (Miller & Rollnick, 2002). As above, we recommend further exploration for competent practice.

PHASE TWO: Strengthening Commitment to a Change Plan

Typically, the shift to Phase 2 takes place when the individual is ready and willing to change and just about ready. When the individual has reached a point of "readiness" to change, there is a window of time/opportunity in which change should be initiated. Miller and Rollnick (2002) discuss Phase 2 (p. 129-139):

1. Initiating Phase 2:
- i. Recapitulation
    - Summarize your client's current situation.
    - Highlight as many reasons for change as possible.
    - Acknowledge their reluctance/ambivalence.

- ii.Key Questions
    - Elicit from clients what they want/plan to do.
    - Use open-ended questions. Example: "What changes, if any, are you thinking about making?"
    - The basic theme to these questions is: What is the next step?

- iii. Giving Information and Advice
    - Share your expertise with clients in two circumstances: when the person requests it or with their permission.
    - Before giving advice, ask yourself two questions: (1) Have I elicited the client's own ideas and knowledge on the subject? (2) Is what I am going to share important for safety or likely to enhance the client's motivation for change? If the answer to both questions is yes, proceed (with their permission). "Would it be alright if I shared my concern about your plan? I have an idea that may or may not be useful. Would you like to hear it?"

2. Negotiating a change plan:
- i. Setting Goals
    - Set clear goals that are realistic and are the clients' (not yours).

- If you don't agree with the client's goals, you can offer your advice; however, the client is free to accept or disregard it.

- ii. Considering Change Options
  - Explore possible methods for achieving the goals.
  - Brainstorm and evaluate possible strategies collaboratively.
  - Draw on the person's own internal resources and social supports.

- iii. Arriving at a Plan
  - As much as possible elicit the plan -- have the client voice it themselves.
  - A written change plan that summarizes what the client plans to do can be useful.

- iv. Eliciting Commitment
  - Look for the client's approval and commitment to the plan.
  - Commitment can be enhanced by sharing the plan with others, such as family members.

3. Transition:
- The commitment to a change plan completes the formal MI cycle.
- A client may proceed with change on her/his own, or may need to be supported by "action-focused counselling" if s/he chooses.

Useful Applications in Child Welfare

MI is not only consistent with social work values, but it also produces good outcomes: the literature on the effectiveness of MI is large and rapidly growing; in particular there is strong evidence for its effectiveness with alcohol problems and promising results for drug problems (Forrester et al., 2008).

While MI has a lot of evidence for its effectiveness, Forrester et al. (2008) explain the potential challenges in applying MI within a child welfare setting:

It is important that the focus remains on the child while engaging the parent. It may require highly sophisticated practice to remain empathic whilst also addressing unacceptable behaviour. Furthermore, the increasing emphasis on tight timescales and rapid turnover in carrying out assessments in social work may make using any person-centred

style of work difficult. (p. 1304)

Despite the challenges, and despite more research being required in this area (applying MI in child welfare), Forrester et al. (2008) explains that, "MI offers great promise as a way forward for social work, for the issues of resistance, behaviour change and confrontation that it deals with go to the heart of social work with children and their families" (p.1317). We assert that MI may be usefully applied in child welfare because it can provide the framework and the tools to support the worker in their change agent role.

"[I use] Motivational Interviewing as a means to guide parents with substance abuse problems to recognize and address their addiction as a means to preserve their family unit and ensure the security and well being for their child(ren)." Survey Participant

Critique

There are some concerns/limitations/contraindications noted in the literature about MI:

- Although it may seem obvious, it bears noting that MI is not applicable for those who are already ready, willing and able to change; MI skills may, however, be a useful way to interact with clients to support their continued success (Bisono, Manuel & Forcehimes, 2006)

- There are situations where MI can create ethical dilemmas. Miller & Rollnick (2002) highlight three ethical complexities that clinicians need to consider (p. 168):
  1. When the client's aspirations are dissonant with the clinician's opinion as to what is in the client's best interest.
  2. When the clinician has a personal investment in the direction taken by the client.
  3. When the interviewer has coercive power to influence the direction taken by the client.

Miller & Rollnick (2002) offer a few guidelines to help in this regard (p. 169-175):

Guideline 1: When you sense dissonance in the relationship or an area of ethical discomfort, clarify the client's aspirations and your own.

Guideline 2: When your opinion as to what is in the

person's best interests is dissonant with what the person wants, reconsider and negotiate your agenda, making clear your own concerns and aspirations for the client.

Guideline 3: The greater your personal investment in a particular client outcome, the more inappropriate it is to use the method of MI. It is clearly inappropriate when your personal investment may be dissonant with what is in the client's best interests.

Guideline 4: The more your role includes a coercive power to influence the person's behaviour and outcomes, the more caution is warranted in the use of MI. When coercive power is combined with a personal investment in the person's behaviour and outcomes, the use of MI is inappropriate.

In regard to Guideline 4, Miller & Rollnick (2009) discuss an example of how MI was applied by probation officers who clearly have legal power over their clients. Their advice to the probation officers was to be straightforward about their own aspirations for their clients and also to be clear about the purpose of this type of counselling. They provide a sample dialogue, which we have modified slightly for use in child welfare:

"I have two different roles here, and it is sometimes tricky for me to put them together. One of them is [to follow legislated guidelines to protect child safety and well-being] and I have to honour that role. The other is to be your counsellor, to help you make changes in your life that we agree would be beneficial [for you, your child, and your family]. There are also likely to be some areas we'll discover where I am hoping to see a change that you're not sure you want to make. What I hope is that by talking together here every week, we can resolve some of those differences and are able to find areas of change we can agree on. I'm sure I'll be asking you to consider some changes that right now don't sound very good to you, and that's normal. We'll keep exploring those issues during our time together, and see if we can come to some agreement. How does that sound to you?" (p. 174)

THE MIIYOBIN APPROACH

The Miiyobin Approach was developed by staff of Native Child and Family Services of Toronto (NCFST). This approach was originally developed to bring both child welfare and support services at the agency together to provide an enhanced service to the individuals/families in common; however, given that this is a cultural-based approach that encompasses spirituality, and also a holistic approach in that it examines all facets of people's lives, it has since been utilized effectively in virtually all of the agency's work.

The Miiyobin approach has a clear beginning, middle, and end. It begins with the initial event: the "Talking Circle". In this Talking Circle, a consensual plan (meaning that all members of the circle agree to the plan) is developed using techniques rooted in Aboriginal culture. Thereafter the Miiyobin Process begins, which is essentially the implementation of the plan. The Miiyobin Process is a flexible one that incorporates many Aboriginal approaches to service provision; this process is comparable to the Wraparound Model that has shown considerable promise for high risk families with multiple complex needs. The Miiyobin Approach concludes with the final event, another Talking Circle, which completes the whole process and has a celebratory component where possible.

Practice Principles/Guidelines/Characteristics

The primary principle with respect to this approach, simply put, would be following the Seven Grandfather Teachings which are: Wisdom, Respect, Love, Honesty, Bravery, Humility and Truth.

Everyone participating in the Circle is expected to follow these teachings.

As noted above, the Miiyobin Approach begins and ends with the Talking Circle. Pat Paul (November 2007) describes in the Wulustuk Times the spirit/principles of the Talking Circle (p. 2-3):
• The Talking Circle is a traditional instrument for dealing with the things that interfere with the normal everyday concerns of a person or their community whether the concern is trivial or serious in nature.
• The Circle may be applied safely and confidentially to resolve conflicts, misconceptions, disagreements or deeper problems.

- It can be taken as both an opening or a closing of a door, depending on the individual's circumstances or the objective in mind.
- A Talking Circle is a place of comfort, wisdom, security and redress.
- It is where people come in search for new directions, abandoning the old, making amends, righting the wrongs and establishing new pathways for tomorrow.
- It is a sacred place that is usually directed by a Circle leader, a mentor or a person of distinct nature and attachment to the spirit realm who intervenes and directs the flow of collective energies in the Circle.
- •The Talking Circle consists of a number of people, ranging from two to twenty for the best results, gathered together in a circular formation to share ideas, hopes, dreams, cares and energies in total unity and a sacred connection to one another.
- It is also a place where individuals come to seek help, support, healing and understanding for any particular discomfort or instability they may have, or has been with them for some time.
- The Circle is a protective shield of honesty, trust and comfort.
- The material brought to the Circle is usually private, personal and/or confidential. As a general rule, therefore, all material heard in the Circle stays in the Circle, unless a waiver or consent has been rendered beforehand.

It bears noting that the Talking Circle is highly consistent with the Alternative Dispute Resolution directive related to Family Group Conferencing (FGC), which was developed by the George Hull Centre in Toronto; the FGC is described as follows:

> [It is] a process that brings together the family (including the child where appropriate), the child's extended family and community, child protection workers, and service providers to develop a plan that addresses the protection concerns identified. A trained and impartial coordinator, with no decision making power, assists the participants throughout the process. An integral component of family group conferencing is providing the extended family group with an opportunity to meet privately, independently of professionals, to develop this plan. The plan must be approved by the child welfare agency. (OACAS, para 4)

Intervention Techniques/Strategies and Application in Child Welfare

There is clear application of the Miiyobin Approach in Child Welfare. The approach can be understood in four phases, which are each described below:

PHASE ONE: Nstaadmowin "Reaching an Understanding"

The initial Talking Circle indicates Phase One of the Miiyobin Approach, which is called Nstaadmowin: "Reaching an Understanding". The initial Talking Circle can be triggered by Child Protection Services, and it is utilized when the client consents to a culture-based approach. Features and focus of the initial Talking Circle include:

- It will attempt to resolve matters related to safety of children, which is the primary consideration.
- Facilitated by the "Circle Facilitator" it should take place in a space not identified as much with child protection as with the culture-based approach of support services.
- Attendees may include extended family, First Nations representatives, child protection staff, support services staff and any other stakeholder deemed significant in both naming and resolving the problem.
- The focus is to help the family describe and identify experiences and feelings about their situation, and get to a place where all involved agree on what is needed to rebuild a foundation for quality child and family life.
- It further allows Child Protection to speak in a more cultural way about why they are involved and concerned.

Tasks of this phase include:
- Identify the issues and make connections with historical impacts on Aboriginal people. For example, blood memory relative to interconnectedness, the impact of residential schools, and strengths assessment with the goal of instilling pride (vs. shame) in one's ancestry.
- Support the family in moving beyond their initial understanding of their situation to develop a more hopeful alternative perspective. For example, explore ways in which problem situations might be opportunities for growth and change.
- (Re)introduce traditional teachings related to rites of passage and spiritual abuse, an example

of which would be removing children from their families and forbidding them to use their own language. For example, from the families' viewpoint, initially, you may provide alternative cultural translations of what they are sharing.

- Tap into families' spiritual resources and help enable them to see themselves, others, and the world around them in more creative ways. For example, how can cultural knowledge apply in today's reality?
- Help families identify a leverage point – one problem situation that, if managed successfully, will contribute to the management of others. For example, how resolving the issue (s) that brought them into child protection in the first place, may help to alleviate other difficulties in their lives.
- Initiate the process of identifying internal and external supports.
- Support the family in envisioning alternative and realistic practices.
- Above all, the initial Talking Circle will formulate a consensus-based plan, one acceptable to all parties involved that will be implemented within the phases that follow.

PHASE TWO: Gezbenan "Putting Things in Place"

Phase Two of the Miiyobin Approach is called Gezbenan: "Putting Things in Place". Here the focus is on implementing the plan developed in Phase One. It is case managed by staff deemed most appropriate in the initial Talking Circle.

Tasks of this phase include:
- Incorporate a Family Healing Model that is culturally appropriate and inclusive of all family members, as well as significant others that are requested by the family.
- Further clarify each difficulty/issue/concern by identifying the specific patterns of experiences, behaviours and feelings.
- Identify what actions must be taken to address the difficulties/issues/concerns.
- Work with families to identify the consequences of their possible choices.
- Assist families to evaluate their actions for clarity, realism, relevancy; and congruency with family values, strengths, liabilities, and child protection standards/mandate.
- Modify plans in the light of any new information/realities.

PHASE THREE: Biindged "Come In"

The third phase, Biindged: "Come In", is designed to create an enhanced plan that will incorporate both the original plan and the ideas that have emerged in the course of its implementation. Original stakeholders are involved and a Talking Circle format is utilized. In this phase, there is a strong emphasis on the cultural determinants of family health and on ways of achieving them from a more traditional perspective. The focus of this phase is to devise strategies and a plan of action that matches family needs, resources, and values; the focus is also on long term reintegration into one's larger environment.

Tasks of this phase include:
- Incorporate training, such as for parenting and life skills, while restructuring support systems in order to transition families into community supports.
- Bringing in external supports, particularly those that are culturally based.
- Guiding the family in identifying paths to health and family wellbeing.
- Identify potential obstacles, strengths and resources for the development of a sustainable long term plan.
- Evaluate the plan: What is working? What is not?

PHASE FOUR: Dgobzod "Fly Among Others"

The final phase, Dgobzod: "Fly Among Others", is a Talking Circle format event that concludes the Miiyobin Approach. This final phase can only occur when Child Protection concerns are no longer evident. All who attended the initial Talking Circle and all stakeholders are involved. The focus is on acknowledging and celebrating the progress made by the family; the focus is also on transferring the family out of the child protection system and transitioning more fully into the community.

Tasks of this phase include:
- Acknowledge the strengths of the family and identify the progress made.
- Make a plan for reintegration in the wider community/communities.
- Make long-term plans to manage problems as they arise.

SOLUTION-FOCUSED THERAPY

Solution-Focused Therapy (SFT) is a brief, strength-based, client-focused approach developed by Steve de Shazer, Insoo Kim Berg and colleagues beginning in the late 1970's. It was developed when de Shazer, Berg and colleagues at a family therapy centre decided to pay attention to which clients were making progress and what the clinician was doing (de Shazer et al., 1986 cited in DeJong, 2009). They discovered that when clients had a clear vision of what they wanted to be different, and could identify times when problems were absent, they made progress (DeJong, 2009).

As the name implies, SFT is a way of having a "[carrying] on a useful conversation with clients" whereby the purpose is to co-construct solutions to achieve desired goals (DeJong, 2009, p. 253). Social constructivism is the theoretical foundation for SFT in that reality is seen as subjective, and is understood within social context and culture (Miller, 2006). More simply: there are many realities and they are all equally correct. Following from this, SFT focuses on a brighter future in which clients are free from the problem and are able to create their own personalized version of success (Pichot & Dolan, 2003).

SFT starts from the premise that change is possible and that goals will be achieved. Clients are viewed as having the necessary strengths and resources to overcome their problems and achieve their goals; as such, the task of the clinician is to elicit and enhance existing strengths so that clients can apply their solutions effectively (Corcoran, 2001).

"Our agency took a training strategy to develop strength in Solution-focused interventions. We ran a two [day] intensive training [for] all social work staff and managers. The expectation is that our clinical staff is using a model [and is] not just flying by the seat of their pants." Survey Participant

SFT is applicable for a wide range of clients (children, adolescents, adults, groups and mediation) with a wide range of difficulties (alcohol abuse, posttraumatic stress disorder, personality disorders) (see Bannink, 2007, p. 90 for full list of sources). It has wide applicability in that the client simply needs to have a goal or is able to develop one with clinician assistance (Bannink, 2007).

Additionally, while the number of sessions is not determined in advance, it seems as though three conversations is sufficient (Bannink, 2007).

Practice Principles/Guidelines/Characteristics

Pichot & Dolan (2003) share the following eight principles for SFT (p. 13):

1. If it's not broken, don't fix it.
2. If something is working, do more of it.
3. If it is not working, do something different.
4. Small steps can lead to large changes.
5. The solution is not necessarily directly related to the problem.
6. The language requirements for solution develop ment are different from those needed to describe a problem.
7. No problem happens all the time. There are always exceptions that can be utilized.
8. The future is both created and negotiable.

Berg & Kelly 2000) provide the groundwork to assist in the implementation of a solution-focused approach to child welfare services through the following twelve guiding principles (p. 273):

1. Families know more about their situations than anyone.
2. Respect the dreams and aspirations clients have for themselves and their children.
3. Families are able to formulate their own goals and build their solutions.
4. Families tend to maintain solutions they create.
5. Families are doing the best they can in difficult situations.
6. Family strengths can be enhanced and change can happen.
7. Families are our partners and need our support.
8. Families can enhance and improve the well-being of their children, with assistance and support.
9. Safe solutions will be found in partnerships among parents, workers, supervisors, and other community partners.
10. Families have a right to be supported for their efforts to improve their children's well-being.
11. Most children can be protected by their parents.
12. Child protection must also focus on family protection.

Intervention Techniques/Strategies

Pichot & Dolan (2003, p. 29-44) discuss a step-by-step "individual session map" for SFT that they have found useful with clients with substance misuse difficulties:

- Find out what needs to happen (client's goal) in order for intervention to be useful for the client.
- Verify that [your] understanding of the goal is accurate by asking "difference questions" or "scaling questions". If goal is unclear, repeat step one.
- Ask the "miracle question" and get as many details of the miracle as possible.
- Listen for exceptions and follow up on them by getting as many details as possible. If no exceptions are identified move on to step five.
- Ask a "scaling question" to determine clients' current levels of progress toward their goals.
- Referring to the previous scaling question, find out what the client has done to reach and maintain the current level of progress.
- Find out where on the previously mentioned scale (step five) the clients think others (probation officer, caseworker, children, spouse or pets, employer etc.) in their lives would rate them.
- Find out what the client thinks the significant people identified in step seven would say that the client is doing which caused them to rate the client at the level described in step seven.
- Ask the clients what difference they think significant others would say the behaviours identified in step eight are making.
- Ask the client where on the scale (in step five) they hope to be by the next session. Continue to ask questions about how the clients will know they are   at this specific place on the scale, what will be different then, etc.
- Use scaling questions for the clients to rate their confidence in their ability to sustain the changes (or to scale the referral source's confidence that the clients can sustain the changes). Although we list scaling confidence questions at this stage, we also use this question as needed at any stage throughout the process.
- Based on responses to questions one through eleven, invite the client to assign self homework.

Other techniques and strategies commonly used in SFT are as follows:

- The Miracle Question: this question asks the client

to look into the future to a time when the problem is resolved and to imagine how life will be different without that problem. It invites the client to imagine and describe their hopes and dreams for their future. The following is a suggested phrasing:

> Now, I am going to ask you a rather strange question (pause here). After we finish talking, obviously I am going to go back to my office and you will do your routine – whatever you need to do the rest of the day, such as feeding the children, looking over their homework, watching TV, or whatever. And of course it will be time to go to bed. And when all of your family members are sleeping and the house is very quiet (pause), in the middle of the night, a miracle happens (pause), and the miracle is that the problems that you might have with your children, or that other people think you have (use clients exact words here to describe problems), all the problems you face are solved (pause) – so people like me will no longer meddle in your life. Poof! Gone! But because all of this happens when you and your family are sleeping, nobody knows that the problems are all solved (pause). So, when you are slowly coming out of your sleep, what differences will you notice that will make you wonder if there was a miracle overnight and the problem is all solved? (Berg and Kelly, 2000, p.113)

- Scaling Questions: "Scaling is a useful way to help clients express complex, intuitive observations about past experiences and future possibilities in concrete terms. Clients are asked to scale an observation or possibility from 0 through 10" (DeJong, 2009, p. 254). Scaling questions can be used to gauge confidence, safety issues, hope and investment, as well as other issues that can be difficult to describe in words. For example, a child may share that their fear rises from a 2 to an 8 when parents argue. Example: "On a scale from one to ten, where 10 is your miracle has come true and one is not at all true, where are you right now?"

- Difference Questions: "Difference questions identify and accentuate the effects of the clients' changes or potential changes, thereby providing an 'ecology check' to ensure that proposed chang-

es are realistic, feasible, and worthwhile" (Pichot & Dolan, 2003, p. 2). They can result in increased motivation to make changes and increased hope that such change is possible (Pichot & Dolan, 2003). Example: "What difference will these changes make to your family?"

- Exception-Finding: This involves the search for exceptions to problems, which are really client successes; this can help to find and enhance client strengths and resources (DeJong, 2009). Example: "Tell me about a time when you were enraged, but did not yell and scream at your child."

- Coping Questions: a coping question can be useful when clients are finding it difficult to be hopeful or optimistic and/or are quite discouraged (DeJong, 2009). Example: "Despite all of your difficulties, how are you able to get out of bed each morning and get dressed?"

- Relationship Questions: these assist the client with viewing the desired solution from a variety of per- spectives. They can help the client to increase their understanding of and empathy for others. (Pichot & Dolan, 2003). Example: "What will be different for your children when you have stopped using drugs?"

Useful Applications in Child Welfare

SFT's emphasis on clients defining their own goals and on the belief in clients' strengths to achieve those goals fits well with social work values. For clients who are involved with child welfare services and who are strug- gling and stressed by their difficulties and the impact on their lives, the focus on strengths, solutions, and on what the client is doing right can offer a sense of hope that things can improve. Moreover, its wide applicability and brief nature means that it can be used to support a variety of clients in identifying and implementing solutions to a variety of difficult problems in a relatively short period of time.

Of course, as with other modalities, this has to be ap- plied carefully within the context of our legal and pro- cedural mandate. Miller (2006) explains this dilemma for social work:

> The opportunity for a pure solution-focused ap- proach rarely presents itself in   most social work

settings. However, the language of the approach can be incorporated into our work as a means to empower people to share their own account of their experience and to find outcomes that are fa- vourable to them. At times these outcomes might not include those required by the agency and this is a factor that social workers need constantly to question. (p. 132)

"The problem was parent teen conflict. The mother had been abused as a child. There was ongoing domestic violence in her current relationship. There were two children in the home. The oldest child and the mother would get into physical fights with one another. Mom did not appear to have the skills to parent the child. There had been chronic child welfare involvement with the family in the past. The family presented itself to the CAS and requested removal of the oldest child.   A CPW and CYW were assigned to the file to assess the situation and put supports into the family system. Solution-focused intervention was used by both workers, primarily with the mother. The intervention worked very quickly by starting with the miracle question. Within four months the mother was able to end her relationship with her abusive partner, went to counselling to address her history of abuse and stopped hitting her child. The youth and mother started engaging in activities together once a week. The youth was not removed from the home. The file has not re-opened in the last 2 year period." Survey Participant

Critique

While SFT has wide applicability, there are concerns/ limitations/contraindications noted in the literature:

- SFT does not fully account for the impact that so- cial structures and oppression have on clients' abil- ity to find solutions and make changes. Structural problems require structural solutions and we must be careful to not download the responsibility for such solutions on to the individual. Miller (2006) discusses this:

> We … need to keep sight of the socio- political factors that could stand in the way of even small successes, such as poverty limiting use of the phone for communicat- ing with friends, poor local transport imped- ing travel possibilities etc. Where possible,

the role of the social worker is to access resources to reduce the impact of poverty and social exclusion. This would need to be part of a care plan for any work undertaken, rather than identified as a solution-focused goal to direct the onus of responsibility away from the service user. (p. 137)

- It is critical to not lose sight of the importance of the worker-client relationship in terms of the role that this plays in achieving positive outcomes with SFT (Berg & Kelly, 2000). SFT is not simply the application of a few clever techniques; attention must be given to the development of a collaborative and therapeutic relationship in order for the approach to be effective (Corey, 2009)

- When threats of safety are involved, such as in situations of family violence. "Empirical study suggests that attitudes about violence toward women and, to a lesser extent, the ability to engage in rational thinking, may need to be targeted in order to affect men's violent behaviour (Eisikovits, Edleson, Guttman, & Sela-Amit, 1995)" (Corcoran, 2001, p. 339).

- SFT may be limited for abuse or trauma, such as sexual abuse or sexual assault (Corcoran, 2001). "With child victims of sexual abuse, it is unknown whether a solution-focused approach alone would assist in recovery. The research on child treatment suggests that, for sexual abuse issues, a targeted rather than a nondirective approach is appropriate (Celano, Hazzard, Ebb, & McCall, 1996; Cohen & Mannarino, 1996)" (Corcoran, 2001, p. 339-340).

- SFT is contraindicated where it is not possible to establish a dialogue with a client, such as with severe depression or acute psychosis (Bannink, 2007).

- Good progress can be made with clients who have impaired cognitive functioning; however, it may be useful to also work with those caring for the client (Wester & Bannink, 2006 as cited in Bannink, 2007).

- If SFT has been applied well, but yielded disappointing results, "diagnostic research or a lengthier form of psychotherapy may be indicated. However, if the therapist is not prepared or not able to let go of his (sic) attitude as an expert, solution-focused therapy will not work" (Bannink, 2007, p. 90).

NARRATIVE THERAPY

Narrative therapy (NT) was developed in the 1980's by social worker/family therapist Michael White and social worker/family therapist, David Epstein. The approach was developed as a part of postmodernism, which challenges the idea of objective reality and absolute truths. As with postmodernism, NT views personal experience as ambiguous with multiple understandings and interpretations.

Life is complicated so we often find ways to explain it. These explanations become stories that we tell ourselves to help organize our experiences and shape our behaviour. Importantly, those stores are shaped through multiple influences:

The stories that people develop incorporate the dominant social and cultural stories of gender, ethnicity, and power, as well as personal stories co-constructed in interaction with others (family, friends, and professional helpers). These stories constitute the knowledge that people hold about themselves and their worlds. (Kelley, 2009, p. 273)

We all have an abundance of lived experiences; however, because we cannot attend to it all, we are selective in the parts, or "dominant themes", that we can readily recall (Miller, 2006). These dominant themes develop into our own "dominant narrative":

We actively filter out exceptions to this dominant story of who we are – exceptions that may challenge the 'script' we use to author our lives (Byng-Hall, 1995). This authoring both re-enacts and recreates the dominant themes so they are repeated in patterns that become entrenched behavioural and emotional responses while the exceptions can barely even be recognized, so attuned we are to excluding them from our recognition. (Miller, 2006, p. 108)

Clients who have limiting "problem-saturated" stories may benefit from NT as they can be helped to re-write their dominant narrative:

The goal of the social worker using narrative therapy is to provide opportunities for an individual to share her or his life narrative in order to reflect upon and process the meanings ascribed to specific events and experiences. This process helps to reveal how our problems are expressions

of oppressive stories about ourselves and our re-lationships. By collaboratively "re-authoring" such narratives, the client and worker can point future experiences in a more positive direction. (Hick, 2010, p. 69)

"Our agency has been using a narrative modality as a part of our work with adolescents and their families where there was parent-teen conflict. On many occa-sions, positive results were achieved." Survey Participant

Practice Principles/Guidelines/Characteristics

Several authors (Kelley, 2009; Buckman, Reese & Kin-ney, 2001; Morgan, 2000), have shared the following of NT:

- NT challenges the hierarchy of power that privi-leges professionals' views over clients' views of the problem.
- Realities (including problems) are seen as socially constructed and constituted through language.
- Efran and Fauber (1995) explain, "Problems are not just sets of circumstances … They are appraisals – in words and symbols – of what should and should not be, what might or might not happen, what is fair or unfair, lucky or unlucky, malleable or fixed" (p. 279). As these words and symbols are woven into stories, there exists the possibility of making meaning from life experiences that are helpful or problematic. (Buckman et al., 2001, p. 280)
- Realities are seen as organized and maintained through narrative or stories.
- Problems are viewed as separate from the people who have them. As such, the use of labels and categories is avoided – clients are seen as having a problem, but not constituted by it. For example, a person has a drug addiction vs. is a drug addict.
- NT takes a collaborative approach to working with clients. Clients are regarded as the experts in their lives. Client and clinician work to understand and deconstruct the stories together. Clinicians are willing to learn from their clients.
- NT is an empowerment-based approach in that it strives to elicit and mobilize clients' strengths, re-sources, and capacities to assist them in address-ing the challenges and difficulties in their lives.
- The clinician is curious and willing to ask questions to which the answers are genuinely not known. There are no presumptions made about the client.

The client is carefully listened to so that their per-ceptions and meanings can emerge. In this regard, the clinician takes a "non-expert, not knowing" position. It is important, however, to note the limits to this principle in social work practice:

> This stance is not the same as neutrality, for some stories are clearly less useful or even harmful (for example, violence) than others, but here the therapist assesses the outcomes and consequences with the cli-ent and may challenge the story through deconstruction and by assessing its origins. (Kelley, 2006, p. 275)

- The focus is more on meanings than on specific behaviours.
- NT is generally short-term with a few sessions spread over a longer period of time.

Intervention Techniques/Strategies (Conversations, Dialogue and Re-Written Stories)

O'Hanlon (1994) shares the following steps to the NT process (cited in Corey, 2009, p. 389):

- Collaborate with the client to come up with a mu-tually acceptable name for the problem.

- Personify the problem and attribute oppressive in-tentions and tactics to it. Investigate how the prob-lem has been disruptive, dominating or discourag-ing to the client.

- Invite the client to see his or her story from a dif-ferent perspective by offering alternative meanings for events.

- Discover moments when the client wasn't domi-nated or discouraged by the problem by discover-ing exceptions to the problem.

- Find historical evidence to bolster a new view of the client as competent enough to have stood up to, defeated or escaped from the dominance or oppression of the problem. (At this phase, the per-son's life story and identity begin to get re-written).

- Ask the client to speculate about what kind of fu-ture could be expected from the strong competent person that is emerging. As the person becomes free of the problem-saturated stories of the past,

he or she can envision and plan for a less problematic future.

- Find or create an audience for perceiving and supporting the new story. It is not enough to recite the new story. The client needs to live the new story outside of therapy. Because the person's problem initially developed in a social context, it is essential to involve the social environment in supporting the new life story that has emerged in the conversations with the therapist.

Narrative therapy is not simply the application of a collection of techniques. It is "about conversation, dialogue, and mutually re-written or re-authored stories. It is not about intervening … [as this implies] power and private knowledge held by the therapist, to be imposed on the client" (Buckman et al., 2001, p. 288). That being said, the skilful use of questions and the ability to help guide the therapeutic process are necessary in NT. A selection of examples of NT techniques is shared:

- *Externalizing Conversations*: in externalizing conversations with clients, the problem is separated from the person. The problem, and not the client, is targeted for change. Example: "How has addiction come between you and your children?" Morgan (2000) aptly describes this in more detail in a chart that is reproduced below (p. 29-31):

Externalized Conversations	Internalized Conversations
See the problem as the problem.	See the person as the problem.
The problem is spoken of as outside of the person. This creates space for discussion about the person's relationship with the problem.	Locate problems inside the person.
Locate problems in a context that is external or outside of the person and their identity.	Look for what is 'wrong' or 'deficient' with individuals.
Actions seen as events that have occurred in sequence, across a time period according to a particular plot.	Actions seen as surface manifestations of a central core or self.
Invite people to discern their own meaning and explanations for events.	Seek the opinions of others to explain behaviours or problems.

Externalized Conversations	Internalized Conversations
Allow for multiple descriptions of identity.	Descriptions tend to totalize the person and their identity leaving little room for other descriptions of identity.
Make visible the social practices that promote, sustain and nurture the life of the problem.	Make invisible the social practices that promote, sustain and nurture the life of the problem.
Lead to rich descriptions of lives and relationships.	Lead to thin conclusions about life, the self, and relationships.
Examine the cultural, socio-political stories that influence the lives of people who seek help.	Examine the internal influences on people who seek help.
Celebrate difference and challenge notions of 'norms'. Embrace difference and seek to make discriminatory practices visible.	Lead to categorization of people in terms of how 'different' they are from the 'norm'. Labels or terms are devised to describe people's experiences of the problem. When people are seen as different, they often experience discrimination.
Involve consulting people about changing or re-negotiating relationships with problems.	Understand problems as 'part of people and their identity'. Conversations are therefore centred around ways of 'living with' the effects of certain diagnoses, e.g. 'autism' or 'ADD'.
People hold the expertise over their own lives and relationships.	Those outside of the influence of the problem (e.g. professionals) are seen as the experts.
The agent of change is communal. Externalizing conversations seek to discover what skills and knowledges are present.	The agent of change is considered to be the strategies designed by others that will 'fix' the problem.
Language used is often 'It is …'	Language used is often 'I am…'
Seek alternative descriptions and stories outside of the problem description.	Often involve talking a lot about the problem and its details.

(Morgan, 2000, p. 29-31)

- *Mapping the Problem's Influence*: the client is encouraged to examine the impact of the problem over time (past, present, predicted future) and over many domains (sense of self, family, work, social life, thoughts, feelings, health, and so on). (Kelley, 2009). Example: "When did Conflict enter your life? How has it affected how you think about yourself as a father?"

- *Examining Problem Saturated Stories*: these are the restrictive one-dimensional stories that clients have about themselves. These stories are examined as one of many possible truths (Kelley, 2009). Clients are encouraged to expand their view of themselves, which involves "deconstructing" problematic stories and the client's assumed truths (Morgan, 2000). Example: "What are some of your beliefs about a father's role in a family? How did these ideas develop? Which ideas are helpful or unhelpful?"

- *Discovering "Unique Outcomes"*: these are times where clients have not been overcome by the problem (Kelly, 2009). They are "known as 'sparkling events' as they are like events that shine or stand out in contrast to the dominant story. A unique outcome may be a plan, action, feeling, statement, quality, desire, dream, thought, belief, ability or commitment" (Morgan, 2000, p. 52). They may represent new truths for the client and often identify strengths and resources (Kelley, 2009). Example: "Can you remember a time when depression hasn't gotten in the way? What happened?"

- *Examining the History and Meaning of the Unique Outcomes*: after discovering a unique outcome, narrative therapists try to learn as much information about it as possible (Morgan, 2000). Example: "When that happened, how would you describe your relationship with your partner? What did it take for you to do that? What does it say about what is important for your life? "

- *Creating and Naming a New/Alternative Story*: as clients' strengths and resources are identified, they come into the foreground along with a new alternative story while the problematic story moves into the background (Morgan, 2000). The client is assisted in reconnecting with these strengths (Morgan, 2000).

- *Thickening the Alternative Story*: this involves assisting the client to stay connected to this new story (Morgan, 2000). Example of such NT strategies include:
  - Holding rituals and celebrations that let others know about the positive change and successes.
  - Therapeutic documentation (certificates, documents, declarations) can help to solidify the changes. For example, everyone in a family could sign a "Family Peace Document", or a client could earn a "Certificate in Breaking Free of Violence".
  - Therapeutic letters can be used to extend the work done in session. For example, a "session summary letter" can be given to the client to help keep the client connected to their new story between sessions.

Useful Applications in Child Welfare

Many, if not most, of our clients contend with the daily impact of marginalization and oppression. Certainly, oppression in its various forms is the root cause of many problems for our clients that have resulted in our involvement. NT helps workers to appreciate the ways in which societal, political, cultural and interpersonal influences have impacted our clients and the construction of their ("problem-saturated") stories. NT can be used in conjunction with a more directive approach as it can provide a space for clients to share their stories, the nature of their problems and the ways in which it affects their lives from their perspective. NT can empower workers to collaborate with clients to help deconstruct their unhelpful dominant story and resist personal blame for structural problems (for example, the impact of racism, sexism, heterosexism, classism, and so on). This will open up space to help clients' recognize and mobilize their strengths, resources, and capabilities to regain control over their lives.

Kelley (2009) shares a relevant application of NT with a family that is having a difficult time coping with a teenager's rebelliousness and risk-taking behaviour:

> [Family members] discussed perceptions and stories of the situation. ... After each member had heard the stories and fears and frustrations of the others, the meanings they made of the events shifted. Control and strictness were seen as love and caring, and rebelliousness was perceived

as attempts to change and grow. Adolescence was externalized as a new force entering their lives. They discussed ways to welcome the "new member," making it a positive force instead of a negative one. As the family developed more empathy and understanding for each other and began laughing as they found ways to welcome the new member, compromises were reached, where new independence could be earned by following certain rules. Better judgments equalled new freedoms. (p. 275)

Critique

There are some concerns/limitations/contraindications regarding the use of NT noted in the literature:

• There are criticisms that NT's emphasis on a socially constructed reality fails to see that there are very real problems, such as poverty or racism, that do have a very real impact on people (for example, Minuchin, 1991, cited in Buckman et al., 2001). Buckman et al. (2001) share in response, however, that NT, like postmodernism, "does not dismiss or minimize any person's experiences and meanings of life; it promotes awareness of how important and real these constructions are" (p. 297).

• There are other criticisms that NT's objection to an objective reality and truth leaves us "adrift in a sea of uncertainty and moral relativism" (Buckman et al., 2001, p. 296). Buckman (2001) acknowledges this criticism, however, in response points out that adhering to an objective reality contributes to structural inequalities: "It is interesting that few point out the dangers of having an objective foundation on which to base one's beliefs and actions. … Seemingly objective statements … are laden with values that typically support the interests of the powerful and the status quo" (p. 296).

• Miller (2006) asserts that NT is not applicable for those clients who deny that there are any problems:

> Caution is given to embarking on this approach when the client does not believe that he or he has problems, but that referrers do … The individual … might believe that their behaviours are acceptable within society, their community or group of peers and thus domi-

nant the narrative is not problem-saturated. In such instances it is important to discuss the concerns held by others and attempt to establish whether a narrative approach would be one that could be adapted or would be mismatched with the type of concerns and the beliefs held by clients about them. (p. 112)

• NT can be at odds with the more authoritarian role of the child protection worker. Miller (2006) advises that it be used in conjunction with, rather than instead of, a more directive approach.

• Some narrative interventions such may not be applicable for particular populations. For example, in Carey's (1998) NT intervention, "Competing Voices", she advised against using it with young children or more mature people who are very literal, and also noted that it is contraindicated for people with dissociative identity disorder.

TAKING THE PLUNGE

FACILITATING IMPLEMENTATION

Implementation "is putting the game plan to work on the field" (Nall, Prince, Davis, & Murray, n.d.)

"Nothing stops an organization faster than people who believe that the way they worked yesterday is the best way to work tomorrow. To succeed, not only do your people have to change the way they act, they've got to change the way they think about the past" (Madonna, 1997, cited in Cortvriend, 2005).

In this section we discuss how agencies can begin to implement clinical counselling at their sites. We share broad ideas about change and change management along with more concrete and specific suggestions; however, each individual agency will ultimately need to take inventory of its own strengths, needs and resources in relation to such implementation. Essentially we hope to provide some guidance and structure to the process, but also intend for there to be sufficient flexibility for agencies to have the autonomy to meet the needs of their unique workplace and communities.

First, we share a change management model that we have adapted from other change management models

so that it could be more usefully applied within child welfare agencies. We hope for this model to provide a birds-eye view of the whole process. We then discuss the change process in further detail by discussing "five key success factors" that are seen as critical to effective change, and four "layers of transition" to help breakdown a process of this size. We conclude with a discussion of the components of successful program implementation. Of note, for further useful guidance in implementation of a clinical counselling approach, we also direct readers to the Best Practice Guidelines for Family Counselling Services (Revised 2009) by Family Service Ontario (http://www.familyserviceontario.com/publications.htm), which is a comprehensive guide for professional counsellors.

Change Management Model

The following is a change management model adapted from Bridges (1995), Clarke & Garside (1997), Cortvriend (2005), Cummings & Worley (1997), Kotter (1996), and Paton & McCalman (2000). In the left column we list the five-key success factors, however, they are discussed in more detail in the pages to follow. It is included here, however, so that it can be viewed in relation to the "change management process" (middle column) and the corresponding recommended actions (right column).

5 Key Success Factors	Change Management 'Process'	Change Management 'Actions'
Commitment	Motivating change	• Create readiness for change by communicating the need for change • Make desired goals transparent • Enlist enthusiasts (change champions) to encourage others • Recognize the varying levels at which people engage with

5 Key Success Factors	Change Management 'Process'	Change Management 'Actions'
Commitment, cont'd		change (discussed below in "layers of transition") • Build teams through people involvement and a shared vision
Social & cultural issues	Create a shared vision	• Involve people early and at all levels • Communicate and maintain an ongoing discussion about the vision • Maintain commitment at management level • Build upon the energy and enthusiasm of people at all levels • Have clear desired future outcomes
Communication	Develop political support	• Form strong coalitions (i.e. Universities, Ministry, OACAS, private therapists etc.) • Identify key stakeholders • Focus on collaboration and partnership • Empower a broad-base of action

5 Key Success Factors	Change Management 'Process'	Change Management 'Actions'
Tools & methodology	Manage the transition	• Communicate relentlessly • Educate staff and train in conjunction with partnerships • Utilize multiple methods of learning dissemination • Use pilots to test feasibility Commit to planning tasks • Increase clinical supervisory support to workers
Tools & methodology, continued	Manage the transition	•Use various tools and strategies i.e. risk analysis, performance management
Interactions & Early Success	Sustain momentum	• Provide ongoing resources for change – i.e. a handbook • Recognize and celebrate early successes • Develop new competencies, skills and procedures • Build support systems for change • Acknowledge and reinforce the importance of the desired change • Use role models to set examples

Key Success Factors

"Key success factors" are identified as being integral to change management practice. They are particular

attributes that strongly drive performance and help to ensure that goals and objectives are attained (Keck & Lollet, 1995). Essentially, if these factors are focused on, effective change is more likely. Clarke & Garside (1997) describe them as follows (p. 541–542):

1. Commitment
- Change is recognized as an integral part of the organizational strategy.
- There is a level of ownership of the change process throughout the organization (particularly in senior management).
- There are adequate resources provided for the project to operate effectively.
- All employees at all levels of the organization are involved in all stages of the project.
2. Social and Cultural
- The focus is on the 'people' element of change (i.e. issues involving behaviour, perceptions and attitudes towards all aspects of change).
- The level of involvement and sustainment of change are examined.

3. Communication
- Issues related to internal and external communication are covered.
- Includes timing, methods for and content of communication.

> Communication is a vital component to change management, yet is often given insufficient attention. According to Kotter (1996) failure to attend to the importance of communication, "can lead to failure of the change initiative" (Cortvriend, 2005, p.7). Managers are advised to appreciate that any change to current practices creates feelings of initial resistance, insecurity, uncertainty, loss and fear. Therefore, communicating clear objectives, consistency, and ensuring workers understand and are aware of the reasons for and intentions of change are competencies that build trust and confidence in the organization's leadership (Carnall, 2003).

4. Tools and Methodology
- The main focus is on the use of project management methodology (project teams and managers); however, also includes use of benchmarking, performance and process measurements.

- Covers the underlying knowledge required for the change to take place effectively, along with the use of external inputs and training to facilitate the process.

5. Interactions & Early Successes
- Looks at the methods in place for dealing with interactions within an organization.
- Recognizing early successes is vital in countering scepticism and encouraging buy-in.

Four Layers of Transition

Paton & McCalman (2000, as cited in Cortvriend, 2005) identify a need for change managers to develop a framework of 'perpetual transition management'; this includes maintaining commitment to the identified vision and awareness of the four layers of transition that accompany any change management endeavour. Paton & McCalman's four layers (trigger, vision, conversion, and maintenance and renewal) are described as follows:

1. Trigger Layer: identifying needs and openings for major changes; these should be formulated in the form of opportunities, rather than crises.

Examples and suggestions include:
- Start small and build up – introduce new ideas gradually.
- Help staff to recognize that they have already been using counselling skills and modalities in their work without adequate recognition.
- Give staff more autonomy and 'say' in the direction of the project.
- Provide meaningful challenges.
- Maintain a focus on the desired change and the people involved - bridge the two together.

2. Vision Layer: articulating a vision and communicating this effectively in terms of where the organization is heading.

Examples and suggestions include:
- CAS practice has focused more on development and refinement of investigative skills and less on clinical counselling skills. A clinical counselling role can help us better protect the safety and well-being of children (and their families).
- Various counselling modalities and skills can be provided and used to help facilitate change in cli-

ents' behaviour and alleviate emotion states.
- Counselling skills are used to build positive worker-client relationships, which itself is related to positive outcomes.
- Counselling can be used to address clients' needs more quickly and thus expedite service provision and change.
- Counselling skills can help us to meet client needs by addressing gaps in service provision in the community.
- Counselling can help us to better fulfill our social work values.
- Use of counselling can increase workers' confidence in their abilities to address the underlying issues that have contributed to the presenting difficulties.
- Support staff to see change as an ally – counselling can help workers provide more help to their clients, which can result in increased job satisfaction and reduced burnout.

3. Conversion Layer: mobilizing support for the vision as the most appropriate way forward.

Examples and suggestions include:
- Ongoing education and training for all staff (university collaborations, webinars, private therapist trainers, mentorship programs, annual refreshers, case formulations).
- Regular clinical supervision to review modalities (reduced caseloads to allow for more intense clinical intervention and assessment).
- Ongoing and strong commitment demonstrated by senior management.

4. Maintenance and Renewal Layer: identifying ways in which changes can be sustained and enhanced via changes in attitudes, values and behaviours. Moving back to 'old' ways of working is discouraged.

Examples and suggestions include:
- Recognize early successes – this helps to identify opportunities, build enthusiasm, and increase confidences levels.
- Acknowledge and assist with staff challenges; however, continue to move forward at an even and balanced pace.
- Develop ongoing strategies with provincial partners re: training programs.
- Have in-house planning and review meetings to evaluate practices – include recommendations

from all staff on how practices can be improved.

- Utilize recruitment and hiring practices that emphasize expected competencies.

Successful Program Implementation

Here we discuss the components of successful program implementation generally and the clinical counselling project specifically. There may be some overlap/repetition of the material discussed above, however, that is understandable as the components of change are transferable to the various levels of implementation (i.e. whether it be for change management in general or with program implementation specifically). The information here is based on and adapted from Mihalic, Irwin, Fagan, Ballard & Elliott (2004, p. 1-9). Suggestions from Nall et al. (n.d.) are also included where relevant.

1. Assess and Enhance Site Readiness

Consider communication strategies, available resources and ways to prevent potential problems as a means of assessing and enhancing your site's readiness.

- Communication: Communication is not one-way. Collaborate with all who are involved, or potentially involved, with the project: clients, workers, supervisors, directors, executive directors and community partners.
  - Let all staff know about the project early on. This will allow everyone to have a deeper understanding of the rational for the project and how it will affect the work they do.
  - It might be useful to have "feasibility discussions" with everyone who is involved with the project to discuss any issues related to implementation and request their input. This will help to troubleshoot problems early on and enhance motivation for implementation.
  - Build an environment that is supportive of the project. Creating an environment that will foster a positive experience will result in higher quality implementation and, ultimately, more positive outcomes for clients.
  - It is important to collaborate with "the Zone" so that some initiatives may be discussed prior to its conclusion.

- Resources: As mentioned at the outset, agencies will have to assess where they are at in terms of their strengths, needs and resources in relation to

implementing this project. In terms of resources, Nall et al. (n.d.) caution: "Often we under utilize our resources by simply asking, 'How much do I have to spend?' ... Not utilizing all available resources in an appropriate manner results in ineffective programs that do not produce desired outcomes" (p. 1). Agencies could benefit from asking themselves:

- What do we need to be able to implement the clinical counselling project at our agency?
- What is already in place that will facilitate implementation?
- What local resources are available?
- What other external resources can we partner with (mental health sector, university, etc.)?
- How can we mobilize those needed resources?

Remember that resources include more than just money and things; they also include people, places, knowledge and anything else that can help you achieve your goals (Nall et al., n.d.).

- Problem prevention: In general, it is important to create plans to identify potential problems in a preventative capacity. Try to explore and identify possible resolutions to those problems and initiate an action plan to resolve the problems early. It is better if this is initiated internally rather than by external forces.

2. Build Organizational Capacity

To build organizational capacity for implementation, administrative support, agency stability, a shared vision and interagency links are required.

- Administrative support: successful implementation depends on this. When the executive and management team supports the program, it has a better chance of success and longevity.
  - A program can "make or break" depending on the abilities of administrators to lead and motivate everyone, generate enthusiasm, and articulate the vision of the project.
  - Administrators need to back up their words with tangible actions that show their commitment to the project and support staff who are implementing it.
  - Administrators can be involved in explaining the project to staff, attending any staff training

workshops, meeting with staff regularly to keep informed of progress as well as listen to and respond to any problems that arise.

- Shared vision: develop a shared vision for the project's goals, objectives and desired outcomes. Have everyone involved in this process.

- Agency Stability: agency stability, such as rate of staff turnover, can affect implementation. We anticipate that this project will facilitate increased agency stability in that workers will be more likely to feel that they have had a positive impact on their clients thus improving overall job satisfaction and reducing turnover.

- Interagency Links: developing and collaborating with interagency (or intra agency if applicable) linkages can help with successful implementation. Our project will do better if the larger systems are receptive to it.
  - Create awareness of the clinical counselling project.
  - Share a clear explanation of the project as this can prevent misunderstanding, resolve problems, and prevent possible "turf issues" early on in the process.
  - Utilize marketing strategies as part of the implementation plan to "get the word out".
  - Staff members who serve on interagency committees can communicate the project to other organizations.

3. Qualified Staff and Training Assistance

It is important that workers have the appropriate credentials and requisite skills to undertake a clinical counselling role. We highly recommend clinical counselling experience and skills are considered when hiring new workers. Training is essential; workers will need to be trained in regard to their new clinical counselling role along with training in skills and modalities. (This section applies to supervisors as well as they too will require support/training so that they may be competent in supporting workers in their new clinical counselling role).

- It is important that workers are aware of the purpose of the project, the reasons for this change (for example, research studies), and the ways in which they will be affected (there are many posi-

tive impacts discussed throughout this paper, such as increased job satisfaction and enhanced child safety/well-being). Early training in this regard will help to reduce fear of the unknown and garner support and motivation for the changes.

- Workers will also require initial and ongoing training in clinical counselling skills and modalities (the extent to which these are developed/enhanced/refined will depend on their individual and collective skills and experience; an H.R. analysis can be conducted to assess this and anticipate training needs). It may be helpful to conduct educational programs on counselling topics and create a supportive educational environment. Make it fun and a learning opportunity for those involved. Keep it simple.

- There will likely be some expenses incurred such as that which will be required to provide the necessary training. Early and ongoing training in skills and modalities will, however, build clinical competency and confidence, which will enhance the likelihood of a successful implementation as well as provide an improved service to our clients.

- It is important that workers have opportunities to obtain advice/input regarding difficulties that arise in their new role. We recommend additional opportunities for mentorship and supervision around clinical issues as well as regular meetings among all workers to discuss issues (successes and challenges) collectively. It may also be useful to have expert advice on clinical issues.

- It is expected that time issues will arise during implementation. Workers will require extra time to learn about their new role, learn new skills, and make changes in their practice; it may be necessary to reduce caseloads accordingly in the beginning. Keep in mind that all of the above points about involving workers in the process early on and gaining their support for the project will make it more likely that they will devote the time and energy necessary for successful implementation.

4. Project Champion(s)

A project champion can help facilitate a successful implementation. The champion is typically the project coordinator. S/he is the motivator who will lead the

implementation, generate communication about the project, and provide a base of support for workers.

- The champion should be someone who has the power to make decisions and changes, and keep things on course; but, also has positive rapport with workers to earn their support and sustain their motivation.

- The champion should be someone who believes in the project so that they will continue the work when confronted with obstacles and competing priorities.

- Coordinating or managing the project involves human, task, fiscal and risk management activities (Nall et al., n.d.). Problems can arise if the champion is not provided enough time to coordinate the effort. A good strategy is to have more than one champion, as the role could be overwhelming for one person.

5. Implementation Fidelity

Implementation fidelity refers to how well the program has been implemented in comparison with the original design. Fidelity is generally considered to be preferable; however, we expect modifications to be made to suit the needs of individual agencies and communities. Moreover, we also expect modifications after the project is piloted and eventually implemented under "real-world" settings.

6. Measuring Progress and Outcomes

The project champion (or champions) may use and encourage the use of process indicators and outcome indicators on a regular basis to monitor the quality of the clinical counselling services provided. The following are potential examples:

- The percentage of cases where counselling is provided, and what type (specific skills or modality) is provided, in protection, children's services and support services cases where applicable.
- Any increase in % of cases diverted from court from use of clinical counselling.
- Worker feedback regarding the counselling they've provided (satisfaction with process and outcome).
- Client feedback regarding their satisfaction with counselling provided (process and outcome).

(Flynn & al (2002) have translated and validated a tool, an Outcome questionnaire that permits the social worker to have direct feedback from clients about their perception of the success of the session, which then enables the worker to make quick adjustments if needed.)

Additionally, workers can be encouraged to do the same. Workers' attention to client feedback and following up on that feedback can improve client outcomes with counselling services: "The mere act of measuring yields improved outcomes" (Miller, Hubble & Duncan, 2007, p.3).

CONCLUSION

Our committee began this project to better understand clinical counselling in the role of the child welfare worker. This paper was designed to be a critical discussion of clinical counselling along with more practical guidance regarding how the individual worker and/or agency may apply this in their practice/agency.

We started with the view that workers were already undertaking a counselling role and this view has been confirmed through the process of working on this project and producing this paper. Essentially, child welfare workers are engaged in a whole spectrum of counselling activities including the daily use of discrete counselling skills used to build quality relationships and get the work done, as well more comprehensive counselling modalities used to support clients with their change process. This is why our committee focused not on how we are starting or infusing a clinical counselling approach, but instead on why and how we are revitalizing one that has always been there – not only in practice, but also in our child protection mandate under the CFSA (1990). In other words, child welfare workers are doing this work, they're meant to be doing this work, and we have a responsibility to support workers in doing it well.

There are many ways that a clinical counselling role will help to provide a better service to our clients. Most importantly, however, our committee supports the revitalization of the clinical counselling role in child welfare practice primarily due to its fundamental link to the building of quality worker-client relationships that provide a context in which we can facilitate needed change, which, in the child welfare arena, entails

change that protects the safety and well-being of children, families, and communities.

In concluding we want to emphasize, as we have endeavoured to discuss throughout the paper that a counselling role needs to occur alongside recognition of the structural causes of presenting individual difficulties. Clinical counselling is not a panacea for the complex and multi-faceted problems our clients face; many of these problems will only be adequately addressed with macro-level responses, such as policies to address poverty and the oppression of marginalized families and communities. However, clinical counselling has a role to play in supporting and empowering clients to undertake the change that needs to be made now for the immediate protection of children and families.

Accordingly, we invite and encourage workers, supervisors, and agencies to take the challenge to move forward with the revitalization of a clinical counselling role.

AUTHORS

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